The Duty to Survive Well: Neoliberal Governance, Temporality and Breast Cancer Survivorship Discourse

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Abstract

This study critically examines how discourses of breast cancer survivorship are constructed within professional and popular fields of knowledge production. In this thesis, I used critical discourse analysis (CDA) methods informed by Foucauldian, feminist, and queer theoretical perspectives to analyze a sample of texts, published in the Springer Journal of Cancer Survivorship and by the Canadian Breast Cancer Foundation, in order to elucidate a complex understanding of how discourses of breast cancer survivorship effectively privilege and exclude particular forms of subjectivity and temporal trajectories. I argue that these discourses of breast cancer survivorship operate as neoliberal technologies of governance that invoke particular constructions of responsible and healthy citizenship, gender, and the future in order to direct the capacities and conduct of women affected by the disease, and the population at large, towards normative ideals. The specific forms of subjectivity constructed in these discursive fields include: the Chronic Survivor; the Resilient, Fit Survivor; the Decliner; the Universal Woman At-Risk; the Child At-Risk. This theoretically-informed, empirically-grounded CDA suggests that the forms of subjectivity idealized in these discursive fields charge post-treatment women with the duty to ‘survive well,’ cultivating particular forms of bodily and civic fitness that reinforce individualized notions of responsibility for health, dampen women’s resistive potential, and encourage complicity with traditional forms of femininity and gendered responsibilities. The findings of this study further highlight how the temporal and affective dimensions of survivorship discourses operate to orient and mobilize survivor subjects towards a future secured by biomedicine in ways that align with the aims of neoliberalism and the biopolitical imperative to optimize life. Ultimately, I argue that breast cancer survivorship discourses govern post-treatment
women, and the population at large, by assuming and inciting anticipatory temporal trajectories and modes of conduct that are characterized by a moral imperative to live and think towards the (reproductive) future. These findings raise pressing concerns about how breast cancer survivorship discourses, and the forms of subjectivity it inspires, are informed by neoliberal political rationalities, heteronormative and ageist assumptions, and contemporary anxieties about women’s social and political roles, and are thus implicated in the reproduction of gender, sexual, and citizenship norms.

**Keywords**

Breast Cancer Survivorship, Critical Discourse Analysis, Governmentality, Queer Theory, Feminism, Citizenship
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Chapter 1

1 Introduction

In October 2016, Sophie Grégoire-Trudeau, the wife of the popular Canadian Prime Minister, Justin Trudeau, addressed the nation to issue a “very special thank you” to the citizens who participated in the annual CIBC Run for the Cure. This popular national event emerged out of a “trailblazing partnership” between the Canadian Breast Cancer Foundation’s (CBCF) and the Canadian Imperial Bank of Commerce (CIBC) in 1997, and has since become the largest single-day fundraising event in Canada (CBCF, 2017). Standing in front of a Canadian flag, Grégoire-Trudeau, in her bilingual address, thanks the 97,040 “changemakers” for their philanthropic participation and dedication to supporting the CBCF’s efforts to create a “future without breast cancer.” She praises the CBCF, the largest charitable funder of breast cancer research in Canada, for their $360 million-dollar investment in biomedical research—which she credits with “making treatment and care more accessible for Canadians.” Despite these laudable accomplishments, Grégoire-Trudeau, emphasizes that the fight against breast cancer is still ongoing and there remains much work to be done. She concludes her address by urging Canadians to prioritize their health and wellness, calling upon viewers to continue to “run,” in the pursuit of a cure. This remarkable 68 second national address reflects the prominence of breast cancer, and this particular fundraising event, on the Canadian national stage. It also affirms the taken for granted notion that fundraising for biomedical research is an important national priority, and a responsibility that is attached to good citizenship.

In part, Grégoire-Trudeau’s address is a reflection of the sustained political interest in breast cancer since the 1990s and its place in Canadian national discourse. The formation of

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1 The Run for the Cure is managed and organized by the Canadian Breast Cancer Foundation and sponsored by CIBC. For more information see: http://cibcrunforthecure.supportcbcf.com/site/PageServer?pagename=2017_about

2 See: https://www.youtube.com/watch?v=xYKeVL1Mokg
of a parliamentary subcommittee on the issue of breast cancer in 1991 was a landmark event that propelled breast cancer, and breast cancer survivors in particular, into the national spotlight (Batt, 2017). The 1992 report, issued by this subcommittee, titled *Breast Cancer: Unanswered Questions*, was informed by the powerful testimony of women who had survived breast cancer and publicly highlighted the gaps in biomedical knowledge about the disease and admonished the lack of biomedical research concerned with its causation and prevention. While the primary aim of this report was to place the disease at the forefront of the national research and policy agenda, it also sparked an intense public interest in breast cancer survivorship (Batt, 2017).

Patient advocacy, breast cancer support groups, and philanthropic organizations synergistically expanded in the years that followed, and a number of public events dedicated to breast cancer and survivors emerged. Among these included the first Run for the Cure, which was held in Toronto in 1992 and organized by a small group of local activists to raise funds for biomedical, cure-oriented research (CBCF, 2017). Since the late 1990s, pharmaceutical and corporate sponsorship have transformed the landscape of breast cancer activism and philanthropy by providing financial resources for Canada’s 67 registered breast cancer charities. This injection of resources has enabled these charities to organize and choreograph highly profitable, glossy events that, combined, raised over $67 million dollars in 2013 (Brownell, 2017).

Alongside the dramatic funding increase for breast cancer research, awareness campaigns featuring survivors and their narratives of hope and bravery have made breast cancer into a highly visible disease. Public monuments like Niagara Falls, the CN Tower and the Ottawa Parliament buildings have all been illuminated in pink – the colour now ubiquitous with breast cancer philanthropy - and October has been declared the official Breast Cancer Awareness month (Elliot, 2007). Beyond these symbolic gestures, popular and news media have extensively reported on breast cancer survivorship, with features ranging from interviews with celebrity breast cancer survivors to the National Post’s *New War on Cancer* series that issues plain language summaries of biomedical advances in genetic testing and pharmaceutical drug trials.
Breast cancer survivorship pervades the public imagination, and discourses on breast cancer circulate across a wide range of discursive fields, from the scientific to popular and philanthropic. Both powerful and profitable, representations of breast cancer survivorship, and the larger cultural discourses of breast cancer in which they are situated, function to do much more than promote ‘awareness’ for a culturally ubiquitous disease, inform the public of the latest biomedical research, and celebrate the recovery of individual women; they also promote a particular type of responsible, healthy and gendered citizenship. As I will argue in this thesis, in this cultural moment, breast cancer survivorship has become a powerful discourse that shapes how we come to think about women, gender, citizenship, morality, sexuality, and the future. As I will illustrate, the insidious effects of this discourse are significant; they operate to reinforce and uphold dominant neoliberal configurations of power that constrain women’s agentic possibilities. This dissertation is concerned with tracing breast cancer survivorship discourse, as it has emerged in both professional and popular fields of knowledge production, and its power effects by examining how constructions of breast cancer survivorship operate to shape and reinforce our ideas about what it means to be a good citizen and a woman in contemporary Canadian culture.

1.1 Tracing the Discursive Field of Survivorship

While today the notion of ‘survivor’ may appear to be inextricable from breast cancer, as a form of identification, the ‘survivor’ has a long and varied history with roots that forge connections with a wide range of experiences of suffering and subjective positions, including rape and incest survivors, child abuse survivors, Holocaust survivors, genocide survivors, survivors of natural disasters and illness. Far from being a monolithic concept, ‘survivor’ has various discursive meanings within a diverse range of contextual fields. However, there are some common threads across the discursive sites, suggesting that the survivor, broadly speaking, describes a person who has continued to exist despite trauma, suffering and/or danger. As a form of identification, the survivor, in its most basic sense provides an explanatory framework that shapes and informs how individuals who have endured some form of trauma or suffering understand, act and think about themselves and their relationship to the world. Importantly, the most prominent construction of
survivorship emphasizes the person’s emergence from the conditions of their suffering (i.e., triumph), as opposed to the source or condition of that suffering. As Orgad describes, the survivor has come to be a “pertinent embodiment of the individual’s success not the society’s failure” (Orgad, 2009, p. 152). Underpinning dominant survivor discourse is the notion that suffering can and should be overcome by the active self. Suffering, anger, trauma, and despair are obscured and absent.

In the 1980s and 1990s, feminist activism and activity around sexual violence drew on the language of survivorship to transform the subjective position of women who had endured physical or sexual violence from “victims of abuse” into “survivors of violence” (Alcoff & Gray, 1993). These feminist interventions were highly influential in facilitating the legitimatization and cultural embrace of the survivor as a legitimate and agentic identity that held the potential for social transformation in the public realm (Alcoff & Gray, 1993). The feminist contribution to the discursive construction of the ‘survivor’ is significant in two key ways; firstly, it framed survivorship as a political category and presented the act of speaking as central to the survivor’s politicization, and secondly, it generated public backlash because a politicized conception of survivorship produced both social criticism of, and anger towards, the social and gender structures that made sexual violence possible. Orgad (2009) argues that the message of this backlash was clear: “survivorship is legitimate and desirable as long as it is devoid of anger or criticism, as long as agency is directed to harmonious and peaceful forum and activities” (p. 143). This message has become central to contemporary mainstream breast cancer survivorship discourse in which anger, social criticism, and protest are constructed as illegitimate and deviant (King, 2006), while hope, optimism, and cheer are embraced as acceptable and appropriate responses to breast cancer.

Health and illness have also been key sites for the discursive formation of survivorship. The emergence of the ‘survivor’ in these sites is closely tied to the transformation of illnesses such as AIDS and breast cancer from silent, invisible, and private troubles into highly publicized illnesses and public issues. In the 1990s, these illnesses, and breast cancer in particular, came out from the ‘closet’ with the publication of several prominent autobiographic accounts of the disease and gradually became commonplace through the
continued proliferation of patients’ voices and experiences in the public realm (Leopold, 1999; Lerner, 2001). The first articulation of cancer survivorship in biomedical texts can be traced back to a July 1985 “occasional note” published by Dr. Fitzhugh Mullan in the New England Journal of Medicine. This brief reflection, *Seasons of Survival: Reflections of a Physician with Cancer*, signaled a major medical and cultural shift in the United States whereby cancer ‘patients’ were transformed into ‘survivors.’ Drawing on his own experience with acute cancer, Mullan argued that the medical language associated with acute illness and cure did not accurately capture the experiences of persons with cancer. He wrote:

As with most cancer patients, the quality of my life during this period was severely compromised, and the possibility of death was always present. I was, in fact, surviving, struggling physically and mentally with cancer, the therapy and the large-scale disruption of my life. Survival, however, was not one condition but many. It was desperate days of nausea and depression. It was elation at the birth of a daughter in the midst of treatment. It was the anxiety of waiting for my monthly chest films to be taken and lying awake nights feeling for lymph nodes. It was the joy of eating Chinese food for the first time after radiation burns of the esophagus for four months. These reflections and many others are a jumble of memories of a purgatory that was touched by sickness in all its aspects but was neither death nor cure. *It was survival – an absolutely predictable but ill-defined conditional that all cancer patients pass through as they struggle with their illness* (Mullan, 1985, p. 271).³

This complex and rich description of survivorship acknowledges the multifaceted ways that the experience of cancer affects the lives of persons with the disease, noting not only its physical effects but also its temporal and affective qualities. It also articulates survivorship as an experience and form of identification that begins at the moment of cancer diagnosis and that continued on for the “balance of the person’s life” (Mullan,

³ Italics added for emphasis
1985, p. 271). Drawing on this conception, in 1986, Mullan aided in the founding of the National Coalition for Cancer Survivors (NCSS). This organization provided survivorship with institutional legitimacy and worked to advocate for the needs of cancer survivors. Importantly, although the NCSS was formed and located in the United States, it was also influential in Canada, and Canadians participated in its membership at both the general and board level (Batt, 2011).

However, it wasn’t until the mid-1990s that cancer survivorship came to represent a category of scientific inquiry and phase of the cancer experience that was deserving of research (King, 2006, p. 107). Since this time, survivorship has emerged as a subset of biomedical knowledge production and field of study, as well as an object of critical inquiry. The contemporary relevance of the cancer survivor has also been reflected in new professional journals, most notably Springer’s Journal of Cancer Survivorship, first published in 2007.

While the survivor has been constructed as a desirable identity for all persons with cancer, the most prominent form of cancer survivorship in North American is the breast cancer survivor. Bell (2014) argues that the breast cancer survivor has overshadowed and eclipsed other forms and aspects of cancer identification to the degree that “the two appear to become all but synonymous” (p. 58). In Canada, the survivor identity has also become a highly visible cultural phenomenon through fundraising campaigns such as the Canadian Cancer Society’s Relay for Life, and the breast cancer-specific CIBC Run for the Cure. These immensely popular social events make cancer survivorship publicly visible by attracting large numbers of mostly female participants annually (nearly 100,000 Canadian participants in 2016) (CBCF, 2017), and through widely distributed promotional materials that advertise the Run.

Recent medical developments have also contributed to the popularization of survivorship as there are presently more women living after a cancer diagnosis in Canada than ever before (Canadian Cancer Society [CCS], 2016). Current estimates suggest that there are currently more than 190,000 Canadian women currently living who have received a breast cancer diagnosis in the past ten years (CCS, 2016). While prevalence rates have
remained relatively stable since the mid-1980s, there has been a marked decrease in mortality. This decrease in mortality is reflected in increased five-year survival rates; in 2016, 87% of women diagnosed with breast cancer were expected to survive at least five years, compared to 79% in 1986 (CBCF, 2016). The stable rate of prevalence and the increasing survival of women renders breast cancer survivors as a large and growing population of women.

1.2 Chapter Overview

This brief overview of the emergence of the ‘survivor’ as a discursive object provides an entry point to critically consider contemporary discursive constructions of breast cancer survivorship and the forms of governance that enable, and are enabled by, these constructions. In this study, I critically analyze how breast cancer survivorship discourse is constructed and consider how the forms of survivor subjectivity promoted by the discourse map onto and reflect neoliberal framings of citizenship, gender, and health. Using breast cancer survivorship as my focal point, I draw on the theoretical perspectives of governmentality (Foucault, 1991), biopolitics (Foucault, 1978) and queer notions of temporality (Freeman, 2010; Sedgwick, 1993) to explore how the articulations of survivorship within professional and popular discursive fields operate to constitute women who have been diagnosed with and treated for breast cancer as particular kinds of subjects with specific responsibilities that align with particular temporal trajectories.

In Chapter Two, I present a review of critical, interdisciplinary scholarship on breast cancer and breast cancer survivorship. In the first portion of this chapter, I present central shifts in biomedical understandings, treatments, and regimes of breast cancer management over the last century and describe the ways that these shifts have shaped and produced distinctive subjective possibilities for women affected by the disease. I then draw on critical health scholarship to outline how neoliberal political rationality and risk discourse have expanded and intensified women’s responsibilities for breast cancer prevention and produced new forms of survivor subjectivity. Next, I review feminist and cultural analyses which highlight how popular discourses of breast cancer survivorship constrain the subjective and agentic possibilities of women with cancer. Finally, I discuss how the emerging body of queer scholarship on breast cancer survivorship
illuminates the non-normative subjects, experiences, and temporalities that these discourses render unintelligible.

In **Chapter Three**, I outline the theoretical perspective of governmentality (Foucault, 1991) that informs my approach to the study of breast cancer survivorship. I describe the central features of this analytic approach and how it can be fruitfully used to facilitate critical feminist inquiry. In the second portion of this chapter, I turn to particular theories of queer temporality (Freeman, 2010; Luciano, 2007) and describe how these conceptual tools enable a critical examination of the temporal and affective dimensions of governing discourses. I conclude this chapter by articulating how insights from a queer theoretical perspective can be productively used to complement and extend the analytic purview of governmentality.

I present my methodological approach in **Chapter Four**. I introduce critical discourse analysis (CDA) as a broad, flexible approach to social science research and then describe how I employed CDA in this study in a manner consistent with my theoretical framings. I outline the research questions that guided this study and provide a detailed description of my sampling techniques and the texts that comprised my sample. In my reflexivity statement, I locate myself in relation to the subject of inquiry by clarifying my personal interest and investments in the study of breast cancer survivorship and identifying the assumptions and experiences I bring to the research. In the final section, I chart my analytic process and describe how I arrived at my interpretations.

**Chapter Five** is the first of two chapters that present the findings of this study. In this chapter, I describe the central discursive constructions of breast cancer survivorship identified in my analysis of a selected sample of articles published in the Journal of Cancer Survivorship. I describe a range of discursive strategies through which survivorship is rendered a legitimate object of scientific study and biomedical expertise. I then detail how breast cancer survivorship is constructed as a unique and chronic condition that requires life-long biomedical and self-management. Next, I consider how post-treatment women are interpolated into chronic survivorship, which is characterized by particular regimes of discipline and self-care and highlight the new spaces for
governance and self-governance that are produced by these regimes. I conclude this chapter by describing the anticipatory temporal trajectories that post-treatment women are oriented towards as subjects of a chronic disease regime with new responsibilities for risk management and bodily optimization.

In Chapter Six, I present the central discursive constructions that emerged from my analysis of a sample of promotional materials produced by Canadian Breast Cancer Foundation for the CIBC Run for the Cure. First, I describe the expansive field of breast cancer survivorship that is constituted through the sample and highlight the discursive strategies that operate to incorporate all women into the field survivorship. I then outline how breast cancer is invoked in the promotional materials as an interruption that threatens the structure of heterosexual, nuclear family. To do so, I focus particularly how the figure of the child is invoked to construct participation in the Run as a duty of responsible Canadian citizenship. In the final section of the chapter, I turn my attention to the ways in which survivorship is constructed as a new, subjective category that functions to bring women back into traditional gender roles and describe the extended responsibilities for civic fitness that are assigned to all women in the discourse.

In Chapter Seven, I return to my theoretical perspective of governmentality and my analytic interest in temporality to explicate how, in light of my findings, breast cancer survivorship operates as a technology of neoliberal governance. Drawing on governmentality theory, in the first portion of the chapter I describe how the ‘duty to survive well’ manifests and operates across the popular and professional survivorship discourse to idealize particular forms of conduct for breast cancer survivors that reflect gendered ideals of bodily, moral and civic ‘fitness.’ I then turn to queer theories of temporality to describe how the discursive imposition of a particular temporal trajectory of survivorship, characterized by a moral imperative to live and think towards the future, operate to extend domains of governance. In particular, I outline how ‘hope’ is invoked in both genres through particular discursive strategies and incantations of risk and danger to direct survivors towards the promise of safety and future security offered by biomedicine, a promise that is, I argue, cruelly optimistic. I conclude this study with a concise reflection on directions for future research.
Chapter 2

2 Literature Review

I recent years, there has been a proliferation of scholarship on breast cancer from a variety of disciplinary perspectives. This proliferation reflects and mirrors the Western cultural fascination with breast cancer and the popular figure of the breast cancer survivor. In this context, a robust field of critical scholarship has emerged that seeks to understand the significance, meanings and functions of our cultural (and scholarly) fixation on breast cancer. It is within this diverse and interdisciplinary field that I situate this study. In this chapter, I review scholarly literature that takes a critical perspective on breast cancer and breast cancer survivorship. The review I present draws from several fields, genres, and perspectives to describe the scholarly contributions that have brought about shifts in the conceptualization and theorization of breast cancer and breast cancer survivorship.

I begin this chapter by outlining the important transformations in the biomedical understandings, treatments, and regimes of breast cancer management, highlighting the ways in which shifts in management regimes have shaped the subjective possibilities for women affected by the disease. I focus specifically on the ways that women with breast cancer have been called to responsibly manage their bodies through strategies of surveillance, screening, risk management and compliance with biomedical advice, technologies, and treatments. Next, I draw on critical health scholarship to show how neoliberal political rationality and risk discourse have expanded and intensified women’s responsibilities for breast cancer prevention and risk management. I then turn my attention towards critical scholarship concerned with popular discourses of breast cancer survivorship. I focus first on feminist and cultural critiques that highlight how popular discourses of breast cancer survivorship provide a limited interpretive framework through which women can understand and articulate their experiences of breast cancer. I then highlight how dominant discourses of survivorship operate to constrain the subjective and agentic possibilities of women with cancer by reinforcing hegemonic femininity, a paternalistic relationship with biomedicine and delegitimizing women’s responses of anger, fear, and, ultimately, critical political engagement. Finally, I discuss an emerging
body of queer scholarship that considers the exclusionary potential of dominant discourses of breast cancer survivorship and illuminates the non-normative subjects, experiences, and temporalities that these discourses render unintelligible.

2.1 Biomedical Constructions of Breast Cancer

Medical knowledge of breast cancer, and its practices of detection, diagnosis and treatment have undergone dramatic transformations between the end of the 19th century and the present day. A number of scholars have critically examined medical histories of breast cancer in North America, and articulated how the specific historical practices of diagnosis, treatment and management shaped the ways in which women with the disease have been constructed and understood (Comeau, 2007; Gardner, 2006; Klawiter, 2008; Lerner, 2001; Olson, 2002; Reagan, 1997; Wailoo, 2011). The premise that breast cancer and the treatment of women affected by the disease cannot be understood outside of the socio-historical context in which the practices emerged underpins this critical field of scholarship. Collectively, this work highlights how discourses of gender, sexuality, race, morality, and citizenship have been central organizing principles in the medical constructions of breast cancer and women with breast cancer.

Of particular importance and relevance to the present study is Maren Klawiter’s (2008) historical analysis of the medical management and public administration of breast cancer in 20th century America. Drawing on the work of Foucault (1978), Clarke at al., (2003), and Zola (1972), Klawiter identifies two distinct regimes of breast cancer – medicalization and biomedicalization – and forwards a compelling conceptual framework to organize and explain the broad historical shifts in the conceptualization and medical management of the disease. Using this framework, Klawiter, traces the advances and developments in medical knowledge, practice, and technology throughout the 20th century that have contributed to the constitution of new subjectivities for women that have both constrained and enabled particular forms of collective action. In this section, I will draw on Klawiter’s organizing framework to chart and describe the important shifts in the conceptualization and biomedical management of breast cancer.
2.1.1 The Medicalization of Breast Cancer

Klawiter (2008) traces the origins of the medicalization of breast cancer in the United States to the twentieth century. The term medicalization was developed by Irving Zola (1972) to describe the extension of medical expertise and authority into new areas, particularly into areas that had previously been considered social in nature. Zola describes medicalization as “largely an insidious and often undramatic” process that extends medical control by “making medicine and the labels ‘healthy’ and ‘ill’ relevant to an ever-increasing part of human existence” (Zola, 1972, p. 487). Klawiter illuminates how the practices and regime of medicalization shaped the subjectivities of women diagnosed with breast cancer in three significant ways. Firstly, through the identification of ‘danger signs’ and practices of early detection, healthy women were incorporated into the breast cancer continuum as patients. Secondly, the patriarchal norms of medicine and the practice of nondisclosure constructed women with breast cancer as passive patients who were called to unquestionably accept and comply with medical advice. Finally, after undergoing radical mastectomy, women were directed towards normalizing technologies such as prosthesis and wigs in order to reconstruct their bodies, reconstitute their femininity, and enable the return to ‘normal’ life. In the following section, I will describe each of these significant constructions.

Klawiter locates the emergence of the regime medicalization in the beginning of the 20th century and the professionalization of medicine. At this time, medicine emerged as a unified, and respected profession empowered by the authority of new scientific knowledges and understandings of the body. This new scientific approach transformed the ways that breast cancer as a disease was understood and conceptualized. Prior to the 1900s, breast cancer had been viewed as a systemic disease that spread throughout the body and was largely unamenable to treatment (Comeau, 2007; Lerner, 2001). This conceptualization was fundamentally changed by scientific discovery that breast cancer is a localized disease that starts in the breast and then spread outward in a slow and orderly fashion (Lerner, 2001). No longer an automatic death sentence, breast cancer was transformed into a treatable and survivable disease. Local surgery, particularly the radical Halstead mastectomy, emerged as a promising treatment due to new biomedical
understandings of infection and developments in anesthetic technology (Lerner, 2001; Gardner, 2006). As a result, breast cancer was reconfigured into a disease that could be treated if detected in its early stages and potentially “cured” (Lerner, 2001).

The new status of breast cancer as a ‘curable’ disease gave rise to a discourse of early detection, and new related responsibilities for women to be aware of their bodies and any signs of disease (Gardner, 2006; Lerner, 2001; Reagan, 1997). In 1913, this message was circulated by the American Society for Cancer Control (ASCC) in popular periodicals such as the Ladies Home Journal, warning women over 45 to be aware of potentially dangerous bodily changes (Reagan, 1997). By the 1930s, this messaging intensified through campaigns designed to persuade women and physicians that breast cancer, if found early, could be cured by surgery, thus, constructing bodily awareness and vigilance as a matter of life and death (Gardner, 2006; Klawiter, 2008; Reagan, 1997).

Gardner (2006) argues that, in promoting strategies of early detection, public health discourses constructed compliance with biomedical advice and (often paternalistic authority) as an important responsibility of moral womanhood and citizenship. In effect, these early detection campaigns drew upon, circulated, and produced a new form of ‘risk’ subjectivity for women. Specifically, women with breast cancer, or who exhibited warning signs of cancer, were constructed as both “dangerous and endangered” (Klawiter, 2008). Women with warning signs of the disease (i.e., breast lumps), constituted a danger to themselves and their families and were incited to respond by adopting the sick role and seeking out their physician as soon as possible for medical and surgical intervention (Gardner, 2006; Klawiter, 2008). Significantly, women who failed to follow this script by not identifying the ‘warning signs,’ who sought medical intervention too late, or not at all, or who refused the radical and disfiguring surgery were held responsible for the deadly spread of their cancer, and ultimately their own deaths (Klawiter, 2008; Wailoo 2011).

Discourses of early detection intensified and proliferated throughout the 1950s through a variety of popular, educational and health media (Gardner, 2006; Reagan, 1997), and called healthy women with ‘danger signals’ to reconstitute themselves as responsible,
well-informed citizen-subjects by actively engaging in processes of medicalization. The transformation of healthy women into symptomatic patients was facilitated by the processes of medical diagnosis and surgical treatment. Klawiter argues that it was under the “sovereign gaze of the surgeon,” that women became subjected to, and subjects of, the medicalized regime of breast cancer in which they were positioned only as passive patients (2008, p. 75). Within this patient role, there was no permissible space for women to ask questions or participate in the decision-making processes regarding her treatment or her body (Gardner, 2006). The roles and responsibilities of women within this regime of medicalization practices were thus fraught with contradiction. On the one hand, women were encouraged to be independent, responsible, and resourceful and monitor their breasts for changes (Wailoo, 2011). However, once they entered the medical system, they were expected to give up their independence and assume the sick role and submit themselves entirely to the authority of surgeons and doctors (Wailoo, 2011).

Keith Wailoo (2011) argues that women’s responsibilities for early detection in post-WWII America were shaped by the ideology of white middle-class womanhood. In considering “responsible white womanhood,” Wailoo outlines the ways in which women’s ability to be responsible or agentic subjects were constrained by the paternalistic treatment of female patients by physicians in the regime of medicalization. This study traces how dominant practices in the medicalized regime of breast cancer management reflected and responded to ideological constructions of white middle-class womanhood and functioned to safeguard and protect women’s delicate sensibilities, effectively constraining their ability to make informed choices about their bodies and health care. The practice of non-disclosure, he argues, was the cornerstone of this biomedical effort to ‘protect’ women’s femininity and delicate sensibilities. In effect, this practice entailed medical practitioners withholding information about diagnosis, prognosis, and cancer status from female patients. This information was often shared with the husband, or male family members, of the woman seeking treatment, who would be encouraged to be complicit in the deceit. As a result of this practice, women would often not be informed of their malignancy until after they awoke from the surgical removal of one, or both, of their breasts. Enabled by the norm of non-disclosure, these one-step
surgical procedures became dominant practice, reflecting the paternalistic attitude towards women within the medical system and the obedience demanded from women, as patients.

The popularity of the one-step treatment practice also rendered breast cancer as a discrete temporal experience. In effect, women could be sent to a surgeon for a biopsy and undergo a radical mastectomy under the same anesthesia and exit surgery ‘cured,’ without ever occupying the subject position of a woman with cancer (Wailoo, 2011). Klawiter asserts that, within the regime of medicalization, women with breast cancer could occupy only two temporal positions: the hopeless case or the cured woman (2008, p. 79); in either case, the subject position of the cancer patient dissolved soon after women submitted to medical treatment. The temporary subject position of cancer patient was highly individualized and was made visible and intelligible only within the confines of the hospital and through the patient-physician relationship (Klawiter, 2008). In the regime of medicalization, breast cancer patients were constructed as silent, obedient subjects who were encouraged by their doctors and families to keep their disease experience in the past and return to their (normative) lives as if nothing had happened or changed.

2.1.2 The Biomedicalization of Breast Cancer

Klawiter traces the emergence of a new regime of biomedicalization to the 1970s and 1980s. Broadly speaking, biomedicalization is an extension of medicalization (Zola, 1972) that captures the ways in which biomedical knowledges and practices have been transformed and extended by new technologies, and the interventions and subjective possibilities that they make possible and available to women (Clarke et al., 2003). Biomedicalization is fundamentally concerned with the maintenance, enhancement, and optimization of human health through the application of technoscience and biomedical knowledge (Clarke at al., 2003; Clarke and al., 2011). Further, Jennifer Fosket (2010) argues that one of the sites at which biomedicalization is most visible or prevalent in everyday life is through the increasing attention paid to the constitution of risk itself as a health problem that can, and should, be treated. Under the regime of biomedicalization, the lines between ‘risk’ and the state of being ‘at-risk’ for breast cancer and active
disease itself have increasingly become blurred. Similarly, Armstrong (1995) argues that the rise of “surveillance medicine,” and its associated technological practices of screening the population for risk factors, is intertwined with biomedicalization, and has resulted in a pervasive “problematization of the normal” (p. 395) whereby everyone is implicated in the process of inevitably becoming ill. Within this context, normal is no longer assumed to be an unproblematic or stable state of being, but rather, at all times, everyone is potentially harbouring some hidden signs of disease (Armstrong, 1995). In effect, the problematization of ‘normal’ or ‘health’ in this era of biomedicalization, and the intensification, and proliferation of surveillance and risk technologies, implicate all subjects in the process of eventually becoming ill, and render it impossible to not be ‘at-risk’ (Armstrong 1995; Clarke et al., 2011; Fosket, 2010). Klawiter argues that the regime of biomedicalization brought discourses and practices of risk to the forefront of breast cancer discourse, which fundamentally transformed the subjects of the medicalized breast cancer regime, and its associated practices of early detection, treatment, diagnosis, disclosure, and rehabilitation (Klawiter, 2008). The driving force of this regime was the introduction and institutionalization of mammographic screening technology. This technology extended the temporality of the breast cancer experience by making ‘risk’ for breast cancer knowable, calculable, and relevant to entire populations of asymptomatic adult women (Gardner, 2006; Reynolds, 2012).

The advent of mammographic technology and new norms of screening expanded women’s responsibilities for early detection by making the search for hidden (both palpable and non-palpable) signs of disease into a routine part of adult life (Klawiter, 2008). As a result, healthy and seemingly disease-free women were folded into the biomedicalized regime of breast cancer practices and subsequently transformed into both objects and subjects of screening and surveillance (Klawiter, 2008; Lerner, 2001). In contrast to the patient role privileged and invoked by the regime of medicalization, Klawiter argues that the integration of healthy and asymptomatic women into various screening practices expanded subjects of the breast cancer regime and resulted in the production of a “risk role.” This “risk role” complicated the previously clear distinction between women with the disease and women who were healthy by blurring the lines
between health and disease, producing a more fluid, ambiguous and blurred breast cancer continuum.

The blurring of lines between diseased and disease-free women was further exacerbated by the mammographic screening technology itself. Lerner (2001) argues that mammography did not simply reveal breast cancer or the ‘truth’ of the body, but instead produced information that required careful, skilled interpretation and classification by radiologists to render the findings intelligible. This interpretive process and the ambiguity of the information generated by the screening technology, contributed to the reconfiguration of breast cancer from an either-or diagnosis into a more fluid continuum marked by a number of ambiguous, non-threatening breast conditions and false positives (Reynolds, 2012). These conditions were frequently benign, but the identification of uncertain breast abnormality effectively produced a new population of women to govern through increased medical scrutiny or (unnecessary) medical intervention. As Klawiter observes:

For every woman recalled for additional testing who received a positive diagnosis, many more moved into ambiguous and uncertain positions along the breast cancer continuum. Perhaps their mammograms were not alarming enough to require additional diagnostic procedures but were suggestive enough to require intensified medical and self-surveillance – active watching and anxious waiting (2008, p. 101).

This marks a significant departure from the regime of medicalization where the female patient was kept in a state of ignorance and her identity as a person with cancer was temporary and explicitly linked to a diseased body. In contrast, within the regime of biomedicalization, illness is imagined before the disease is present, and the ambiguity of risk marks a central aspect of the breast cancer continuum. In effect, the diffusion of screening technologies such as breast-self-exams, clinical breast examinations, and mammographic screening throughout the 1980s produced a new ambiguous ‘risky’ subjectivity for healthy adult women who had previously fallen outside the medicalized
regime of breast cancer (Gardner, 2006; Griffiths et al., 2010; Lerner, 2001; Klawiter, 2008).

In particular, the normalization and routinization of mammographic screening practices and the identification of ‘risk’ dismantled the boundaries that separated women with the disease from women without the disease (Klawiter, 2008). The effect of this was to enroll all women as compulsory subjects along the breast cancer continuum by virtue of their new ‘risk role’ (Klawiter, 2008). However, the practice and value of mammographic screening has been, and continues to be, highly contested (Griffiths et al., 2010; Reynolds, 2012). For example, the recent Canadian National Breast Screening Study raised concerns about the effectiveness of the technology and the premise that underlies it, namely that early detection leads to improved outcomes (Miller et al., 2014). This study, among others, raises specific concerns about the potential harms of the technology, citing the prevalence of over diagnosis and overtreatment (Gotzsche & Neilson, 2011; Miller 2014; Reynolds 2012). Despite the controversy, breast cancer prevention in Canada and the United States continues to be centrally organized around the principle of early diagnosis and mammographic screening technology. Mammographic screening has become a “social obligation,” or a routine practice of surveillance that women are expected to accept and comply with, without question (Griffiths et al., 2010; McGannon et al., 2016).

The regime of biomedicalization and its extension of the breast cancer continuum to include asymptomatic women propelled a number of important shifts in the broader social discourses of breast cancer that, in turn, affected and shaped biomedical practices. A driving force behind this shift was patient-led and feminist health activism. In the 1980s, women affected by breast cancer began to organize and advocate for changes in the treatment practices of breast cancer and the sick role established under the regime of medicalization (Batt, 1994; Klawiter, 1999; Leopold, 1999; Lerner, 2001b; Moffett, 2007). In particular, feminist health activists deemed one-step surgical procedures and the absence of informed consent to be paternalistic and patriarchal practices, arguing that these procedures denied women the right to be informed of their diagnosis and actively participate in their treatment (Batt, 1994; Boehmer, 2000; Ley, 2009).
In Canada, in the late 1980s and early 1990s small groups of women affected by breast cancer began to publicly ask questions about biomedical practices and the treatment regimes of breast cancer. Batt (2017) argues that the effects of this organizing were both “startling” and transformative because women raised “questions about the disease and the practices in place to deal with it that had not been articulated before” (p.88). Out of these efforts emerged organizations such as the Canadian Breast Cancer Foundation, Breast Cancer Action, and the Burlington Breast Cancer Support Services, which became important sites of discourse that articulated new ways of thinking about the disease that was rooted in the experience of women themselves (Batt, 1994; 2017). The aim of this organizing was to create space for women to be treated as “resourceful collaborators in the shaping and using of knowledge” about breast cancer, rather than be constrained to the role of “passive, dependent, ‘patients’ lacking expertise” (Batt, 2017, p. 89). The effects of women’s breast cancer activism across North America during this period contributed to the transformation of physician-patient roles and relationships and created the conditions for the transformation of breast cancer patients into survivors (Batt, 1994; Klawiter 2008; King, 2006). Reflecting on this period of transformation, Klawiter writes that women were:

no longer anesthetized into silent submission to the will of the surgeon, breast cancer patients finally gained the right to ‘gaze back’ at their physicians and participate in their treatment as conscious, speaking, decision making subjects (2008, p. 109).

As living with breast cancer came to be discussed more publicly by women, the experience of breast cancer was also prolonged by the rise of rehabilitation services and support groups for women living with the disease. Before the 1980s, individualized rehabilitation service programs encouraged women to adopt the sick role and distance themselves from their experiences as breast cancer patients by viewing the disease as a limited temporal experience that they could and should leave behind (Batt, 1994). These individualized programs were gradually replaced with and complemented by support groups (Gardner, 2009). The structure of support groups - the very act of bringing a number of women with the disease together - challenged the script of the sick role and the
social relations of disease, which had been primarily characterized by silence and isolation (Batt, 1994; Gardner, 2009; Klawiter, 2008). Klawiter (2008) argues that support groups and the sharing of illness experiences facilitated the creation of a new and enduring sense of group identity among women with the disease. Support groups, in creating a social space for the sharing of experiences and knowledge of the disease with one another, created space for the formation of novel patient subjectivities (Batt, 1994; Gardner, 2006) and collective identification among women living with breast cancer (Boehmer, 2000).

The regime of biomedicalization was also marked by a dramatic expansion in biomedical treatment options after 1980 to include chemotherapy, radiation, modified mastectomies, breast-conserving surgeries and reconstructive surgeries (Leopold, 1999; Lerner, 2001). This increase in treatment options, alongside the introduction of practices of informed consent and the more egalitarian patient-doctor relationships, repositioned women with breast cancer as agents who had the capacity, as well as the responsibility, to make choices about their treatment and bodies (Gardner, 2006). At the same time that women’s agentic capacities as patients were expanding through increased access to medical knowledge, chemotherapy and radiation emerged as new treatment options, expanding the temporal experience of breast cancer, which now could stretch over the period of several months to a year (Klawiter, 2008). Under the regime of biomedicalization, when treatment came to an end, occupying a ‘high-risk’ status for the disease did not; nor, in many ways, did being a woman with breast cancer. Instead of returning to life as ‘normal,’ as subjects of the regime medicalization had, these women remained on the breast cancer continuum as risky subjects, who were currently well, but could never be considered ‘cured.’

2.1.3 Critical Perspectives on Risk

Since the 1990s, the breast cancer continuum, described by Klawiter (2008), has continued to expand as new surveillance technologies have made ‘risk’ for breast cancer increasingly knowable (e.g., through predictive genetic testing, chemoprevention), further blurring the boundaries between health and illness. In particular, critical health scholars have examined the proliferation of discourses on genetic risk and the ways in which the
discourse operates to further individualize health risk and women’s responsibilities to manage their risks for future disease (Dubriwny, 2013; Hallowell, 1999; Lippman, 1991; Petersen, 1997; Polzer, 2006; 2010; Polzer & Robertson, 2007; Robertson, 2001). This interest has coalesced around the development and implementation of predictive genetic testing technology, facilitated by the discovery of mutations in the BRCA1 and BRCA2 genes in the 1990s (Ford, Easton, & Bishop, 1993; Wooster, 1994), which, statistically speaking, confer increased risk for breast and ovarian cancer compared to the general population. The availability of predictive testing technology and discourses on genetic risk created new responsibilities for women with family histories of breast cancer to acquire specific knowledge about their genetic risk, with the acquisition of such knowledge emerging as an additional responsibility for women with family histories of breast cancer. Thus, genetic knowledge is figured as a prerequisite for women to make informed, agentic, and responsible ‘choices’ about their health in light of their breast cancer risk (Polzer 2006; 2010; Polzer and Robertson, 2007). Polzer (2010) argues that this framing of genetic knowledge is:

particularly seductive strategy of governing women’s health since, in taking active measures to become knowledgeable about health risks, women must necessarily rely on medical authorities and other health-related professions and disciplines (e.g., genetic counseling, epidemiology) that are invested in constructing and framing breast cancer risk (p. 72).

In this context, Dubriwny (2013) argues that the choices of women with confirmed defects on either the BRCA 1 or 2 genes are constrained and limited to specific ‘compulsory choices’ – namely to undergo a prophylactic mastectomy or engage in intensive practices of bodily surveillance and risk management (e.g., MRI screening, prophylactic chemoprevention). Ultimately, the forms of empowerment offered to women are restricted in ways that align with biomedical framings of breast cancer, producing a modern, neoliberal and post-feminist re-configuration of the passive patient role. The social and political implications of this configuration of ‘empowered’ health citizenship are significant, Dubriwny asserts that the empowered health subject:
Signals the solidification of biomedical empowerment as the primary means by which cancer can be prevented. This solidification of biomedical empowerment is particularly important because it leaves little space for discussing other means of preventing cancer, including reducing environmental toxins, which would necessitate larger-scale social – not merely individual action (Dubriwny, 2013, p. 64).

Significantly, critical health scholars have highlighted how the breast cancer survivors and pre-vivors, positioned as health consumer-citizen subjects, are embedded within a larger discourse of women’s health in alignment with neoliberal models of citizenship. This framing contributes to the increasing divide between women who can become ‘empowered’ through health consumerism, and compliance with biomedically sanctioned disciplinary practices and those who do not have the recourses to access such choices (Dubriwny, 2013; Polzer & Power 2016).

The proliferation of ‘risk’ detecting technologies has contributed to a greater blurring of the boundaries between being ‘at-risk’ for breast cancer and active disease by identifying new sources of risk and bringing the potential for disease into view, in the absence of embodied symptoms. Subjects of this extended risk regime are directed towards a wide range of risk management and potential treatment options and are incited to act as “(pro)active” managers of risk by reducing their risk of active disease (Polzer, 2006). In this context, critical health scholars have observed the production of a new category of illness subjects, the “pre-vivor” (Dubriwny, 2013; Löwy, 2010) to capture the experience of genetically at-risk subjects who respond to the call to take preventative risk-reducing action, such as undergoing a prophylactic mastectomy, before the emergence of signs of potential active disease. The blurring of the boundaries between risk and disease subjects operates to extend the breast cancer continuum, incorporating new groups of disease-free, but at-risk women into the field of survivorship bestowing asymptomatic women with new, life-long responsibilities for risk-reducing self-management.

Critical scholars have examined the increased individualization of responsibility for health and risk reduction in relation to neoliberal political rationality, to shed light on the
ways in which risk discourse has been shaped in ways that align with the aims of the neoliberal state. A number of feminist and critical health scholars have examined how surveillance technologies are implicated in the governance of women ‘at-risk’ for breast cancer and how these risk technologies shape women’s subjective and agentic possibilities (Dubriwny 2013; Fosket, 2010; Robertson 2000; Polzer 2006; 2010; 2016). Drawing on the theoretical perspective of governmentality, this body of scholarship has explored how such discourses of health risk operate as technologies of neoliberal governance that direct individual women towards ‘opportunities’ for the responsible management of individual risks (e.g., genetic, lifestyle) with the aim of producing autonomous, self-regulating citizen-subjects. This body of literature has highlighted how specific and emergent forms of breast cancer survivor subjectivity are shaped by, and align with, broader discourses of biomedicalization, postfeminism and consumerism, thereby drawing attention to the political dimensions of risk technologies and the forms of responsible citizenship that these constructions of breast cancer risk make possible and desirable.

In the Canadian context, Batt and Lippman’s (2010) concept of neomedicalization draws attention to the ways that the proliferation of risk discourse and risk-driven technologies are informed by and support neoliberal economic policies that aim to decrease public spending on health while stimulating economic growth (Polzer & Power 2016). They argue that neo-medicalization is a by-product of neoliberal policies that aim to minimize social spending and avoid over-burdening the Canadian publicly funded health care system. Neomedicalization captures the ways that responsibilities for risk management and bodily optimization have been shifted onto individual citizens through the expansion of ‘choice’ and the promotion of drugs, devices, and technologies to manage risk and stimulate economic growth (Batt & Lippman, 2010). Neomedicalization is a useful concept to understand the unique power dynamics of biomedicalization in the Canadian context where the individualized breast cancer risk detection and management technologies (such as predictive genetic testing) have emerged and gained prominence alongside population-level interventions aimed at the general population (breast cancer screening programs). This is reflected in the prominence of pharmaceutical chemoprevention regimes (i.e., tamoxifen) as an individualized prevention strategy
prescribed to healthy, but at-risk women to manage their risk of developing active disease (Fosket, 2010). The ironic side-effects of such preventative regimes, however, are increased risks for other disease and cancers, as the drug has been shown to have carcinogenic effects (Fosket, 2010). This approach to prevention “creates an almost circular pattern of risk and prevention where the treatment for one risk leads to new risks that will inevitably need to be treated. The profit-making possibilities are obvious, and spiraling patient careers are likely outcomes” (Fosket, 2010, p. 350).

Neomedicalization enables an understanding of how the consumption of health-related knowledge, technologies, products, and services are a central component of responsible citizenship, thus placing expectations on Canadian women to be informed, agentic health consumers who seek out and act upon knowledge about their health. As health consumer subjects, women are incorporated into a form of governance and self-regulation, whereby they are made responsible for securing and protecting their own health, regardless of the financial or personal costs of doing so. Contemporary discourses of breast cancer risk, genetic screening and health consumerism call women to become ‘empowered’ in relation to their own health by complying with recommendations, ultimately, constructing women as responsible for detecting cancer early or preventing it altogether (Gibbon, 2006; Gibson, Lee, & Crabb, 2015a, 2015b; McGannon et al., 2016; Sweeney, 2014). This responsibility echoes the public health discourse of ‘early detection’ from the 1950s but further intensifies women’s responsibilities by incorporating prevention, a lifelong endeavor that involves an extensive array of surgical and chemical risk reduction techniques. Further, within this context, both ‘at-risk’ women and women diagnosed with breast cancer are endowed with new responsibilities to account for (potential and future) ill health and reposition themselves as self-governing citizens who have control over their health and future risks.

In summary, the ways in which breast cancer has been understood as a disease and medically managed have undergone dramatic transformations in the past century. The critical perspectives reviewed above highlight how the development and implementation of new knowledges and technologies have expanded the breast cancer continuum through the identification of new risks, and the subsequent incorporation of new populations of
healthy women into regimes of surveillance and management as at-risk subjects. The transition between the regime of medicalization and the regime of biomedicalization fundamentally altered the subject positions made available to women with the disease and the relationship between women and their doctors. As discourses of health, citizenship, and breast cancer have shifted, women have purportedly gained increased access to knowledge about the disease, its risks, treatments, and their own bodies. As a result, women along the breast cancer continuum have been constructed as health consumer-citizens and granted the ‘freedom’ and responsibility to make choices about their health care and participate in a vast array of self-disciplinary practices in the presumed interest of risk reduction and optimization of personal and public health. While women’s experiences of breast cancer may appear to be dramatically different from the dark days of non-disclosure, silence, and radical Halstead mastectomies, critical scholars emphasize that the relationship between women and biomedicine remains constraining. Despite the proclaimed empowerment of today’s health consumer-citizen subjects, women’s choices about their health continue to be directed towards biomedical compliance. Echoing the discourse of early detection, women who fail to make the ‘right’ choices and suffer negative health outcomes or death continued to be constructed as responsible for their fates.

2.2 Feminist Narratives and Cultural Critiques

Alongside the transformations in biomedical understandings and management of breast cancer, public discourses of breast cancer have undergone similar, dramatic changes. Samantha King describes this discursive shift as a transition from a:

stigmatized disease and individual tragedy best dealt with privately and in isolation, to a neglected epidemic worthy of public debate and political organizing, to an enriching and affirming experience during which women are rarely ‘patients’ and mostly ‘survivors (2006, p. x).

The public prominence of images and narratives of women’s experiences of breast cancer have been central to the transformation and popularization of public breast cancer discourse. Literature, popular culture, public health campaigns, television talk shows, and
news media have all emerged as important sites for the production and dissemination of breast cancer survivorship discourse. In this section, I present a review of critical scholarship that has highlighted and explicated the social and political effects of popular discourses of breast cancer survivorship.

One of the first, and arguably most widespread, public discourses of breast cancer in North America was the news media coverage of the radical mastectomy performed on Betty Ford, the First Lady of the United States, in 1974. News of Ford’s diagnosis and immediate surgery was disseminated through numerous, incredibly detailed front-page newspaper articles in prominent publications such as the New York Times and the Washington Post (Clarke, 1999; Corbett & Mori, 1999; Dubriwny, 2013; King, 2006). This news coverage provided the public, for the first time, a window into the experience of breast cancer and provided the general public with knowledge of the disease, its etiology, methods of detection, and treatment regimes. The experiences of Ford and the women who followed her became access points for a public, yet intimate, look into and understanding of breast cancer and its impact on the lives of women. Dubriwny (2009) argues that the coverage of Ford’s diagnosis, treatment, and recovery gave rise to an “aestheticized” discourse of breast cancer survivorship that focuses on the life and death drama of the disease and women’s determination to survive, obscuring the horrific effects of the treatments and women’s constrained agency in their relationship with biomedicine. This framing of breast cancer survivorship continues to be highly visible in popular media (Clarke, 1999; Lupton, 1994; McGannon et al., 2016; Yardlon, 1997), and ultimately privileges biomedical perspectives, valorizing the medical technologies and research. In these glossy narratives of hope and survival there is little space for critiques of biomedical relations, or for concerns about the disease, the rate of occurrence and the effects of biomedical treatments (Dubriwny, 2009; Clarke, 1999; Lupton, 1994).

The publication of Ford’s breast cancer experience set off a wave of women’s writing on breast cancer that continues to this day. Numerous narratives of survival have been published by women, both famous and ordinary, producing robust interpretive frameworks that shape how we have come to understand both the disease and the women who survive it. Dominant narratives of breast cancer tend to represent illness as a
personal challenge to be to overcome by personal strength, willpower, and a re-dedication
to the project of health (Broom, 2001; Herndel, 2006; Stacey, 1997). Stacey’s (1996)
study of women’s cancer narratives found that most women’s narratives followed a
similar, distinct structure. Within this structure, women move from the position of
unexpected victim of illness to triumphant survivor (Stacey, 1996). The physical aspects
of illness are ignored or become transformed from sources of suffering to positive self-
knowledge that aid the author in self-transformation (Broom 2001; Herndel, 2006; Potts,
2000). Indeed, the survivor emerging at the end of these narratives is a newly wise
subject who appreciates the beauty of life, and who, most importantly, is able to take
charge of their life, and their health (Conway, 2007; Couser, 1997; Segal, 2008; Stacey,
1997).

A number of feminist scholars have expressed concern over the dominant narrative
structure of women’s autobiographical accounts of survivorship (Broom, 2001; Herndle,
2006; Potts, 2000; Segal, 2008; Stacey 1996; 1997). While stories of individual women
summoning the strength and courage to overcome a deadly disease may appear on the
surface to be a liberatory narrative, the political implications of such narratives are
anything but liberatory (Broom, 2001; Potts, 2000). In presenting illness as something
that individuals must overcome through willpower and personal strength, these narratives
suggest that individual women are responsible for their health, and implicitly their illness
and its outcome (Conway, 2007), dovetailing conveniently with neoliberal constructions
of breast cancer and breast cancer risk. This de-politicizes breast cancer, and casts death
from breast cancer as the product of individual failure and inability to manage one’s body
and life (Broom, 2001; Potts, 2000). In this context, Segal (2008) argues that “personal
breast cancer stories are one means of producing and maintaining ignorance about breast
cancer” (2008, p. 4). For Segal, women’s autobiographical writing about the experiences
of breast cancer functions as a technology of normalization that transform breast cancer
into an unremarkable experience, or what Ehrenreich (2001) refers to as a “normal
marker” of womanhood (p. 49).

However, among the catalogue of women’s writings on breast cancer are a subset of
political narratives that are anything but ‘normal,’ written by women who identify along
the queer spectrum (Jain, 2007a, 2007b; Lord, 2003, 2004; Lorde, 1980; Sedgwick, 1992; Stacey, 1997). These narratives actively challenge dominant framings of the disease and seek to position breast cancer as a collective and political issue. These narratives focus less on strategies of willpower and instead critique the ideologies of health and gender that delineate how women’s bodies should appear and behave (Lord 2003, 2004; Sedgwick, 1993), and ultimately seek to politicize breast cancer (Lorde, 1980; Lord, 2004; Jain 2007a, 2007b). One of the first, and most significant, feminist narratives of breast cancer survivorship was written in 1980 by Audre Lorde, a black, lesbian, feminist writer, poet, and activist. The Cancer Journals, in contrast to the majority of published breast cancer survivorship narratives, is a political text that sought to radically transform the conditions of breast cancer treatment and prevention. Lorde’s critique of the social, political and economic conditions of breast cancer is complemented by her argument for self-affirmation for women with breast cancer and a rejection of the dominant cultural and biomedical response to the disease.

Lorde was particularly critical of the medical and cultural pressures that women with breast cancer faced that forced them to immediately re-constitute themselves surgically or prosthetically as whole and feminine. Resisting cultural ideas that the loss of one or more breasts also resulted in the loss of women’s sexuality, and rendered them culturally insignificant, Lorde encouraged women to view their mastectomy scars as insignia of their suffering and survival, as a mark of warrior status. She rejected the silence and shame that surrounded breast cancer and forwarded her own survivor identity as a “fighter resisting:”

> It was very important for me, after my mastectomy to develop and encourage my own internal sense of power. I needed to rally my energies in such a way as to imagine myself as a fighter resisting rather than as a passive victim suffering [...] I believe it is this love of my life and self and the careful tending of that love which was done by women who love me and support me, which has been largely responsible for my strong and healthy recovery from the effects of mastectomy (1980, p. 73).
The survivor identity laid out by Lorde is one that is based on personal strength and resistance while also maintaining a critical consciousness that disrupts and challenges the dominant discourse of hopeful optimism, what King (2006) calls the “tyranny of cheerfulness.” In this vein, Lorde asserts that:

A clear distinction must be made between this affirmation of self and the superficial farce of “looking on the bright side of things.” Like superficial spirituality, looking on the bright side of things is a euphemism used for obscuring certain realities of life, the open consideration of which might prove threatening or dangerous to the status quo (1980, p. 73).

Lorde put forward an engaged and critical conception of survivorship informed by her personal experiences with breast cancer diagnosis and treatment. Her politically engaged survivorship narrative questions a number of issues that were rarely mentioned in public discourse, including the silence and isolation of women with the disease, activism that resists the cancer industrial complex, heteronormativity within cancer care, and the relationship between cancer activism, feminism, and anti-racist efforts. In so doing, Lorde’s work created space for feminist critiques of the breast cancer experience and the cancer industrial complex from both scholarly and literary perspectives. Lorde’s vision of survivorship, however, has not permeated popular discourses of breast cancer survivorship, in which survivorship has become intertwined with hope, optimism, and narratives of individual, personal transformations. The almost exclusive focus on the bright-side of women’s experiences with breast cancer in public discourse leaves little room for other, less positive aspects of the disease to be discussed, rendering certain aspects of the experience silent.

One exception to this is Barbara Ehrenreich’s (2001) Harper’s Magazine article, in which she describes her frustrations and anger with her breast cancer diagnoses and treatment, detailing the intense resistance she faced from other survivors when she articulated these feelings. Ruminating on her particular experience, and broader breast cancer culture more generally, she dismantles the idea that breast cancer awareness efforts have made breast cancer better for women, arguing that breast cancer culture and the survivor
identity are profoundly constraining for women experiencing the disease. Ehrenreich unravels the cheerful pink façade of modern breast cancer culture, characterized by pink-ribbon products, and endless awareness campaigns, and exposes the ways in which breast cancer is intimately connected to consumerism, the reification of femininity, and fundraising for expensive, but lucrative, pharmaceutical drugs. Centrally, Ehrenreich raises concerns about the ways in which public discourses of breast cancer and their alignment with corporate philanthropy have depoliticized breast cancer, relegating feminist concerns to the margins, and silencing dissent with a surplus of positive, upbeat messages.

The most troubling effect of the positive, pink wrappings of breast cancer culture, for Ehrenreich, is the way in which the “relentless bright-siding” operates to “transform breast cancer into a rite of passage,” and a “normal marker in the life cycle, like menopause or graying hair” (2001, p. 48). She argues that it is precisely this unremarkability of breast cancer and the separation of the disease experience from feelings of anger, fear, and injustice that render modern breast cancer culture so dangerous. In her view, the pink products, fundraising events and hopeful outlooks that women with breast cancer are directed towards, serve as a distraction designed to keep women’s attention away from the political and social injustices that underpin the disease and the ways in which it is researched and (mis)managed. She writes:

Everything in mainstream breast cancer culture serves, no doubt inadvertently, to tame and normalize the disease: the diagnosis may be disastrous, but there are those cunning pink rhinestone angel pins to buy and races to train for. Even the heavy traffic in personal narratives and practical tips, which I found so useful, bears an implicit acceptance of the disease and the current barbarous approaches to its treatment: you can get so busy comparing attractive headscarves that you forget to question a form of treatment that temporarily renders you both bald and immuno-incompetent (Ehrenreich, 2001, pp. 48–49).

Ehrenreich’s critique of breast cancer culture is just one of many critical perspectives (Batt 1994; Dubriwny 2009, 2013; Goldenburg, 2010; King 2006) that raises concerns
about the ways in which dominant framings of survivorship operate to constrain women’s possibilities for action by delegitimizing responses of anger, distrust and critical engagement and reinforcing both traditional femininity and paternalistic relationships with biomedicine.

Beyond narratives and popular media, another central site for the production of breast cancer survivorship discourse is philanthropic discourses and breast cancer cause-related marketing. Supported by numerous corporations and private citizens who seek to address the problem of breast cancer through the purchasing of products or donations of time or money, breast cancer fundraising campaigns and philanthropic physical-activity-based events are thriving forms of North American health consumer activism. Samantha King’s (2006) Pink Ribbons Inc. has emerged as a central, and significant critical sociological study of breast cancer culture in the United States. Drawing on her ethnographic examination of breast cancer “thons,” specifically the Susan G. Komen Foundation’s Race for the Cure, and using insights from governmentality theory, King illustrates how this event operates as a site for the production of particular forms of civic subjects and argues that participation in these practices of health consumerism has become a central aspect of responsible citizenship in the United States. King dismantles the popular notion that mass participation events, such as the Race for the Cure, are authentic, grass-roots movements or opportunities for meaningful social action, revealing how such events and the marketing strategies they employ operate to de-politicize breast cancer and support biomedicalized research agendas.

King’s work illuminates how practices of breast cancer philanthropy increasingly blur the boundaries between the state and the corporate world, as they each extend the interests of the other, promoting individual responsibility and consumption as appropriate and effective mechanisms to address social problems, enabling mass-participation events to come to be seen as sites of collective action. For King, the Race for the Cure is more than an exciting recreational activity or opportunity to wear a pink feather boa; it is a technology of governance that operates to produce particular kinds of subjects, knowledges about breast cancer, and forms of citizenship:
It is not simply the absence of a sense of collective political struggle from the Race for the Cure that deems it a site for the production of virtuous citizens, then, but also its emphasis on moral worth via individual responsibility and proper consumption. That is, by promoting early detection, consumption of Kellogg’s Wheat Bran Flakes, regular exercise, and volunteerism, the Race for the Cure and the discourses on breast cancer more broadly, work as a technique for the production of self-responsible consumer citizen (King, 2006, p. 46).

King demonstrates how breast cancer philanthropy and mass-participation events like the Race for the Cure have come to occupy a significant place in breast cancer culture and discourse and play a key role in shaping public perceptions of the disease, transforming the landscape of breast cancer research by directing tens of millions of dollars each year towards biomedical research. While corporate sponsorship has enabled breast cancer to become the disease with the highest funded research agenda in North America (Sulik, 2010), this prominence has come at a high cost – namely its activist potential. Maya Goldenberg (2010) argues that, while contemporary breast cancer activism and cure-oriented fundraising campaigns appear on the surface to be concerned with improving the conditions for women’s health, such “mainstream” campaigns actually operate to support and reinforce the status-quo through an “unquestioning support of the medical model” (p. 151). In effect, the current state of breast cancer organizing restricts women’s field of possibilities for participation and action to the consumer realm and the purchasing of supposedly socially conscious products (Goldenberg, 2010; Sulik, 2010). Such acts of consumerism are framed as ‘activism’ and have become central components of responsible citizenship (King, 2006).

Despite its limitations for achieving social change, these events and their messages of hope, optimism, and survival can be important and meaningful spaces for women affected by the disease. These mass participation events and their focus on celebrating women’s experiences with breast cancer have created the space and opportunity for women to form meaningful collective social identities as survivors (Goldenberg, 2010; King, 2006). These public events and their focus on celebrating women’s disease experiences “valuably exhibit a feminist commitment to redefining the meaning of
illness” (Goldenberg, 2010, p. 144). Further, in the face of overwhelming rates of breast cancer diagnoses, the ever-increasing population of survivors and the complexity of the problem of breast cancer, such events provide a highly palatable solution (i.e., fundraising) and present an opportunity for women to ‘fight’ against the disease.

However, the dominant discursive framings of breast cancer survivorship that permeate the pink-ribbon culture of these mass-participation events have significant exclusionary potential. Like Barbara Ehrenreich (2001), King argues that the optimistic discourse of breast cancer survivorship leaves little room for alternative, less positive, understanding of the disease and its effects on women’s bodies, or for critical analysis of the social, political and economic contexts in which the ‘fight’ against breast cancer is mobilized, thus leaving the ends served by such mobilization entirely unquestioned. The depoliticized, passive roles of the cheerful fundraiser that are made available for women in these spaces are particularly problematic for Goldenberg, who argues that:

> It hardly warrants mentioning that running, walking and campaigning for the cure will not end breast cancer. These activities raise awareness and funds that then can be put to use. Activists must concern themselves with and involve themselves with the details and not allow ‘campaigns for the cure’ to serve corporate interests under a pink wash of corporate responsibility rather than the needs of women (2010, p. 158).

Ultimately, critical scholars have argued that the construction of survivorship mobilized through philanthropic discourses functions as a form of governance that serves to maintain the status-quo through the support of the cure-oriented research, consumer capitalism, and the depoliticization of breast cancer as a social issue.

The cultural celebration of the survivor as a desirable, socially valuable identity is contingent upon women regulating their conduct in particular ways (i.e., towards optimism and hope), and upon their submission to, and support of, mainstream scientific knowledge and emerging biotechnologies. This view of survivorship folds women into the cancer-industrial complex through their unquestioning compliance with its logic; they are granted the responsibilities to explore treatment options within an acceptable range
and to share knowledge with other survivors but are discouraged from challenging the assumptions of biomedicine and its authority over the disease (King, 2006). As Goldenberg has argued: “while pink ribbon messages offer hope and optimism, it does so by suppressing many counterclaims, disputes, and ambiguities that surround the problem of breast cancer” (2010, p. 141). Despite its activist roots, modern culture of breast cancer survivorship is bound up with and inseparable from women’s efforts to shape biomedical research and practices and governmental policy. The bargains made to secure the corporate and political investments that transformed breast cancer into a worthy cause, propelling it into the spotlight, resulted in the relinquishment of the feminist principles underpinning the women’s health movement and the first wave of breast cancer activism, foreclosing the possibilities for critical engagement, patient empowerment and meaningful social change (Goldenburg, 2010; King 2006).

In summary, public discourses circulated through popular media, literature, cause-related marketing campaigns and other popular sites are central spaces for the production of discourses on breast cancer survivorship. Critical scholars have highlighted how these discourses are both enabling and constraining. These popular discourses provide a framework through which women can make sense of their experiences with the disease and shape how they can articulate their experiences and act towards their bodies. However, they are also constraining in that they present a limited framework that forecloses particular affective responses to the disease (i.e., anger and fear) in favour of other, more palatable affects (i.e., hope and optimism) that align with traditional gender roles for women and support the undisrupted continuation of the social, political, and economic order. The critical scholarship reviewed in this section interrogates the meanings, governing functions and political implications of dominant discourses that position breast cancer survivorship as a positive, enriching experience that provides women with an opportunity to re-make their bodies and lives. The work of these critical scholars reveals how such popular discourses of survivorship operate to normalize breast cancer and transform it into an unremarkable experience. Further, critical scholars have illuminated how ‘grass-roots’ and ‘activist’ mass-participation events, like Run for the Cure, support the depoliticization of breast cancer by promoting individual acts of generosity and consumerism, in support for cure-oriented biomedical research, as the
most effective way to address and respond to the high rates of breast cancer diagnoses, to the exclusion of other potential avenues of exploration or collective modes of response. Taken together, this scholarship highlights how popular discourses of breast cancer survivorship, like biomedical discourses, operate as technologies of normalization, disciplining and governing survivors in particular kinds of ways to support and reproduce dominant ideologies of gender, citizenship, and health.

2.3 Queer Interventions

In recent years, a small body of critical research has emerged that applies queer theory to scholarly work on breast cancer (Bryson & Stacey, 2013; Jain, 2007a; 2007b; 2011; 2013; Sedgwick, 1992; Stacey & Bryson, 2012). The works of the scholars within this emerging field highlight how the application of queer theory to the study of dominant and alternative discourses of breast cancer survivorship can illuminate the ambiguities and odd moments that are otherwise obscured. This critical perspective highlights how discourses of breast cancer survivorship are entangled with, and co-constituted by, discourses of gender, sexuality, and citizenship. In particular, scholars working from queer theoretical perspectives have highlighted how dominant biomedical and popular discourses of breast cancer survivorship render only certain experiences, types of subjects, and ways of being intelligible, and thus of social and moral worth.

Bryson and Stacey (2013) argue that the norms of recognition, for breast cancer survivors, are organized around normative logics that limit visibility to: “citizens who make healthy choices and manage risk,” or who articulate their experiences of breast cancer through “stories of reconstructed states of normality” (p. 197). Experiences or accounts of women with cancer that do not fit within these discursive parameters are rendered unintelligible and invalid. Bryson and Stacey argue that biomedical discourses of lesbian health are underpinned by heteronormative assumptions and life trajectories that do not map onto the lived experiences of many women. Breast cancer risk discourse, in placing primary emphasis on lifestyle risk factors associated with nulliparity and screening avoidance construct lesbians as a high-risk population. They argue that, through practices of “reification and institutionalization” (Bryson & Stacey, 2013, p. 201), lesbians as a “whole and legible kind of people” are constructed as irresponsible
citizens whose risky lifestyles contribute to their higher than average rate of breast cancer occurrence, obscuring the lived context in which these ‘risks’ emerge and are defined. Their work importantly highlights the ways in which dominant discourses and biomedical framings of risk are underpinned by reproductive norms that construct child-bearing as an integral part of womanhood and risk reduction.

Queer analyses of breast cancer survivorship have also explored the intimate entanglements of breast cancer with femininity and the ways that gender is constituted and inhabited. Eve Sedgewick (1992) reflects on her breast cancer diagnosis in White Glasses, relaying that her first thought was: “shit, now I guess I really must be a woman” (p. 202). In her examination of the ways that illness interacts with non-normative gender performance, Sedgwick illuminates the ways that medical regimes of management and the depoliticized cultural discourses of breast cancer both assume and require a feminine subject. Drawing on the metaphor of her white glasses, Sedgwick observes that the white frames, like the grim reality and horror of breast cancer, sink “banally and invisibly into the camouflage of femininity, on a woman” (1992, p. 203).

Reflecting on Sedgwick’s work in relation to her own experience of breast cancer as a queer woman, Jain observes that: “breast cancer demands a surrender to femininity and to mortality doled out by the female body” (2007a, p. 505). In her analysis of breast cancer culture and cause-related marking campaigns, Jain demonstrates how dominant discourses of breast cancer survivorship function as a technology of normalization that re-enforces and re-inscribes femininity on the survivor’s body, demonstrating how discourses on cancer survivorship are implicated in stabilizing and universalizing heteronormativity. While scholars writing from other critical perspectives, such as Dubriwny (2013), have explored the ways that femininity is re-inscribed through discourses of breast cancer risk, Jain’s queer perspective extends the purview of the analysis to illuminate the heteronormative underpinnings of dominant discourses on breast cancer survivorship and the material and structural inequalities experienced by queer women with breast cancer. This perspective thus enables: “a radical intervention into the ways in which gender is constructed and inhabited in relation to industrial capitalism and the distribution of one of its modes of suffering” (Jain, 2007, p. 506).
Queer analyses of breast cancer survivorship have also highlighted the temporal
dimensions of survivorship discourse. Stacey and Bryson (2012) suggest that temporality
is integral to the experience and identity of survivorship. They argue that cancer and the
biomedical management of the disease, particularly the processes of diagnosis, treatment,
and prognosis disrupt the “stabilizing fictions” that produce linear time, resulting in a
scrambled or warped temporality that disrupts the person with cancer from “any sense of
life’s proper path” (Stacey & Bryson, 2012, p. 6). They define survivorship as:

First and foremost a temporal relation – it speaks back to the endurance of a past
trauma and looks forward to a future that it wills into being through overcoming
adversity. Cancer survivorship is a statement in the present perfect (of having
survived) that speaks a desire for the future that it knows is uncertain (when does
remission become survival?). To survive is, by way of its etymology, to live
above, beyond or beside something; it refers to a “living longer than” that revises
previous expectations of time (Stacey & Bryson, 2012, p. 5).

Significantly, their work reveals the rich temporal dimensions of the breast cancer
experience and draws our attention to the assumptions about temporality that are
enmeshed within (hetero)normative constructions of breast cancer survivorship. Jain
(2013) also explores how temporality is threaded through cultural discourses of breast
cancer survivorship, illuminating the specific tensions, paradoxes, uncertainties, and
ambiguities that underpin survivorship, and unfold through the continuous temporal
“toggle between absent and present” (p. 222). In particular, Jain articulates how the
biomedical practice of prognosis operates to produce a scrambled and anxious temporal
state, a state she terms “living in prognosis:”

A prognosis seems like a fact if only a scrap of flotsam frenziedly bobbing in the
rapids of cancer treatment. But its stunning specificity (“34.7%”) shields the
bloodlessly vague platitude: in five years, you, yourself, will be either dead or
alive. The prognosis purees the I-alive-you-dead person with the fundamental
unknowness of cancer and gloops it into a general form of the aggregate. The
individual cookie cut from the dough is both prognostic subject and cancer object.
Living in prognosis severs the idea of a timeline and the usual ways we orient ourselves in time: age, generation and state in the assumed lifespan (Jain, 2013, p. 29).

For Jain, “living in prognosis” is a representational space that is unintelligible within conventional, linear temporal fields, and produces a sense of disorientation or disarticulation for those who occupy it. Her work highlights how institutional practices of oncology and other branches of the cancer industrial complex contribute to and shape the subjectivity of survivors.

This emergent body of critical literature demonstrates that there is much to be gained by applying the tools of queer theory to constructions of breast cancer survivorship, by illustrating how breast cancer is inextricably tied up with the (re)production of gender, temporal, sexual and citizenship norms. Looking at cancer survivorship queerly helps to unravel and examine critically how breast cancer discourse and culture is implicated in governing and shaping women’s bodies and lives through the imposition of particular temporal trajectories, and how these temporal trajectories are entangled with the reproduction of norms associated with gender, health, and sexuality.

2.4 Conclusion

In this literature review, I have described how breast cancer and breast cancer survivorship have been investigated from a variety of critical perspectives. This review illustrates the shifts in biomedical constructions of breast cancer over the course of the 20th century and demonstrates the ways in which shifting biomedical and popular discourses on breast cancer promote distinct forms of subjectivity for women with (or at-risk of) breast cancer, thus directing their conduct in ways that align with, and reinforce, hegemonic power relations across a variety of domains. I also reviewed how discourses of breast cancer risk have been shaped by neoliberal political rationality to further promote individualized forms of responsibilities for health and risk reduction. Within this framework, I illustrated how the breast cancer survivor, emerged within a regime of biomedicalization and subsequently became a popular and celebrated identity. I concluded this chapter by reviewing the contributions of critical feminist and queer
theorizations of breast cancer survivorship, which collectively illustrate how dominant discourses of breast cancer survivorship are implicated in the reproduction of a variety of sexual, gender, temporal and citizenship norms. In the next chapter, I describe the features of governmentality, my theoretical approach, and explain how I integrate insights from queer theory to attend to the temporal characteristics of survivorship as a governing discourse.
Chapter 3

3 Theoretical Framework

This study is guided by feminist Foucauldian perspectives and the insights of governmentality to examine how breast cancer survivorship discourse governs women through the specification of particular idealized forms of subjectivity and norms of conduct. The present study is also informed by insights from queer theory that enable a critical exploration of the temporal dimension of the forms of governance assumed through survivorship discourse. This framing, in bringing elements of queer theory in conversation with feminist Foucauldian perspectives, enables an analytic extension of the purview of governmentality.

A feminist Foucauldian approach pays attention to the projects, goals and theoretical perspectives of both feminism and the work of Michel Foucault. These two perspectives do not always fit neatly together and, as such, a feminist Foucauldian approach does not involve a dogmatic application of either theoretical perspective. Rather, it is a way of productively bringing together elements of each approach. To illustrate this, I will briefly outline Foucault’s concepts of governmentality and biopolitics. I will then detail the feminist critiques of, and interventions into, Foucault’s theoretical contributions to illustrate how these perspectives can work together to inform a critical analysis of breast cancer survivorship. Following my exploration of a feminist Foucauldian approach, I describe how governmentality and biopower operate within contemporary neoliberal societies focusing specifically on the transformation of citizenship responsibilities and the gendered implications of these transformations. In the second portion of this chapter, I detail how my theoretical framework is informed by insights from queer theory, and queer time specifically. I then describe how these theoretical insights can be productively used to further illuminate the temporal features of breast cancer survivorship as a governing discourse.
3.1 Governmentality

From the perspective of governmentality, government is defined as the “conduct of conduct” (Foucault, 1991), which can be understood as any action that aims to affect, shape or guide the comportments, behaviours or actions of individuals (Gordon, 1991). From this perspective, government is not a top-down action, but rather is multi-directional and occurs at multiple, simultaneous and interwoven levels (Dean, 2002). In this sense, government is not limited to the powers and practices of the state, but rather captures all practices and actions, both subtle and overt, that are implicated in shaping, directing and guiding the conduct of individuals and the population as a whole. In this sense, government is expansive, and power is exercised through an expansive set of practices, techniques, and technologies that are implicated in fostering the conduct of both populations and individuals. The practices of government, in this context, are dislocated from the workings of the state, and power is understood to be diffused and circulated through a variety of apparatus, policies, actors, institutions and individuals (Dean, 2002). Governmentality, as a critical perspective, enables an examination of the ways in which ‘freedoms’ and individual ‘choices’ are shaped and regulated at a distance from the state.

Foucault’s conception of power as a productive force underpins the theoretical perspective of governmentality. For Foucault, the productive potential of power is generated from its multi-directional and expansive exercise. Power, from this perspective, is not understood as only a repressive force exercised by the state, but, rather, is a fluid force that presupposes the capacity for action and resistance and circulates relationally through and among discourses, individuals, institutions, and groups (Foucault, 1991). As a network of relational forces, power is productive in that its collective operations produce and legitimatize particular ways of being and seeing the world, while obscuring others, generating both fields of possibilities and constraints for action.

One central way that power operates is through the circulation of discourses. Discourse in this sense refers to the ways that a phenomenon is spoken and written about within various institutional and public texts but also captures material aspects and practices
Discourse both reflects and produces prevailing cultural ideas and functions to shape collective perceptions and individual actions. In other words, how we come to think about ourselves, our world and our role within it are effects of relations of power/knowledge. Power not only produces particular ways of knowing the world, but also makes possible particular forms of subjectivity, or ways of experiencing and being in the world by inciting and directing conduct (Cheek, 2004). Subjectivity as a concept describes the ways of being in the world that are idealized, supported and made available in the social world through the proliferation of discourse (McLaren, 2002).

As an effect of power, discourse operates to produce particular objects, subjects and ways of thinking about the world and their position within it. Subjects are both products and effects of power. Practices of governance render particular forms of being and acting desirable, directing subjects towards them, inciting them to cultivate their capacities in particular directions through the application of disciplinary techniques, such as surveillance and self-discipline, with the aim of directing and fostering life in particular ways. For example, the cancer survivor is promoted as a desirable form of subjectivity to which women with cancer should aspire, while other forms of subjectivity such as the suffering patient or the angry patient are obscured and delegitimized through dominant discourses. Women with cancer are directed towards the survivor subjectivity and incited to take up the forms of conduct with which it is associated and thus participate in their own governance. In this formulation, government is exercised through the freedom of individuals to act upon themselves and others (Moore, 2013; Rose, 1999).

### 3.1.1 Biopolitics

For Foucault, power operates at a distance from the state to direct and foster life through two separate but overlapping poles: the anatomopolitics of the body, and the biopolitics of the population (Foucault, 1978). Anatomopolitics, as a modality of power, targets individual bodies and citizens as both “objects and instruments of its exercise” (Foucault, 1978, p. 170). As a set of practices and procedures, anatomopolitics is concerned with discipline, utility, and docility, endowing the individual body with specific capacities in the interest of producing particular forms of subjectivity. In contrast, biopolitics takes the population as its object of concern and focuses its mechanisms of power on life and its
conditions through the statistical management of health, propagation, mortality, and longevity (Foucault, 1978). Biopolitics draws upon and reconfigures the disciplinary technologies of anatopolitics through a series of techniques of power, deployed from both poles, designed to foster life and “make live” (Foucault, 2003, p. 247). Biopolitical knowledge of the population “makes it possible to analyze processes of life at the level of the population to ‘govern’ individuals and collectives by practices of correction, exclusion, normalization, discipline, therapeutization and optimization” (Lemke, 2005, p. 5). In this way, biopolitical strategies of governance are enabled by and through the disciplinary practices applied to individual bodies, and in turn re-shape these practices.

Biopower encompasses and captures a constellation of practices, technologies, and knowledges that seek to know, manage and optimize both the population and the bodies of the individual citizens through the production of norms. In this respect, biopower readily lends itself to the questions that concern population, life, mortality, longevity and their relationship to the conduct of individuals. Health from a Foucauldian perspective has been one key area of life targeted for the production of subjects and shaping of citizens, illuminating the inextricability of the body and subjectivity (Foucault, 1975; 1977; 1978). Discourses of health, as expressions of biopower, circulate to produce knowledge about concerns or dangers that affect both individuals and populations, thereby constituting health as an important point of connection between the body politic and individual citizens.

Biopolitics draws upon and informs techniques of disciplinary power by calling upon individual subjects to insert themselves into discourses of ‘life,’ whereby they are subjected to a variety of disciplinary techniques that shape and condition the capacities of the individual and their possibilities for acting and being in the world. It is through various mechanisms and techniques of power that life come to be known and the parameters of possibilities and constraints are produced, affirming particular forms of life (bodies and subjectivities). The biopolitical imperative to “make live” is productive in that it produces particular ways of being or living as possible and desirable (i.e., healthy) and orients the populations towards these forms of life, fostering life towards specific ends (i.e., productivity, reproductive). In the context of health and illness, biopolitics
“operates in such a way that only certain trajectories of life are encouraged or viewed as acceptable, generally, ones that incorporate biomedical rationalities into the governing of the self” (Ehlers & Krupar, 2014, p. 392). The present study is concerned with identifying and examining the specific trajectories of life that women are directed towards through biomedical and popular discourses on breast cancer survivorship.

3.1.2 Feminist Engagements

Analyses of power and its workings are central to the feminist project, which ultimately seeks to understand the dimensions and causes of women’s subordination to transform patriarchal and gendered social relations. Over the past thirty-years, Foucault’s conceptualization of power as a productive and relational force has been the subject of much debate among feminist scholars. In part, this debate stems from Foucault’s critique of the “repressive hypothesis” (1978; p. 17) or the notion that power is a negative force that operates solely through language, norms, and structures of the state; an assumption that underpinned many feminist theorizations of power. Specifically, Foucault’s theory of power called into question dyadic paradigms in which power was conceived as an instrument of domination exercised through repressive patriarchal structures that operate to support and secure men’s power over women (MacKinnon, 1987; Millett, 1971; Pateman, 1988). Feminist theorists, in turn, have extensively critiqued Foucault’s conceptualization of modern power, the absence of gender in his broader work (Deveaux, 1994; Fraser, 1989; Hekman, 1996; Ramazanoglu, 1993), and have questioned its appropriateness for feminist theorization. Further complicating this contested terrain, Foucault has been highly influential for post-structuralist feminists who argue that his work on governmentality and biopolitics offers an important resource for feminist theory (Bartky, 1990; Bordo, 1993; Heyes, 2007; Klawiter, 2008; McLaren, 2002; Polzer & Robertson, 2010; Power & Polzer, 2016; Sawicki, 1991).

Foucault’s conceptions of power and biopower have been utilized by some feminists to develop a more complex analysis of the relations between gender and power, avoiding the assumption that women’s oppression is a direct product of power held by men and wielded over women. Some feminist scholars have incorporated a Foucauldian notion of productive power whereby power circulates through and among the social body and is
exercised rather than possessed, to elicit more nuanced and complex understandings of power and its effects on women’s lives (e.g., Sawicki, 1991; Duncan, 1994; Connell, 2005; Azzarito, 2009). For example, Foucault’s notion of power as constitutive has facilitated the exploration of the complex ways in which women’s comportments, capacities, experiences, and subjectivities are constructed through and by power relations. Sandra Bartky (1990) and Susan Bordo (1993) have been particularly influential in this regard. Their Foucauldian studies on practices of aesthetic femininity, diet and exercise have been integrated into the feminist canon because they carefully illuminate the ways in which cultural norms of patriarchal societies are taken up by women to discipline their bodies in ways that converge with and reproduce normative ideals of femininity.

Despite many successful and useful applications, Foucault’s conceptualization of power as a relational, multidirectional and productive force is seen as problematic by a number of feminist scholars who argue that this understanding of power is totalizing and denies individual subjects the ability to exercise resistance (Hartsock, 1990). For these scholars, Foucault’s assertion that power circulates through all bodies and relations is troubling because it obscures the way that power is unequally applied or held by female subjects in a patriarchal system. However, I argue that this critique is misplaced because Foucault’s work does not suggest that power circulates throughout the social body equally, and thus leaves room for analysis of inequity. As Susan Bordo (1993) argues:

>This ‘impersonal’ conception of power does not entail that there are not dominant positions, social structures or ideologies emerging from the play of forces; the fact that power is not held by anyone does not entail that it is equally held by all. It is ‘held’ by no one, but people and groups are positioned differently within it. This model is particularly useful for the analysis of male domination and female subordination, so much of which is reproduced ‘voluntarily’ through our self-normalization to everyday habits of masculinity and femininity (p. 262).

Agency and feminism have had a complicated relationship, and many feminist analyses of power have also been charged with erasing women’s agency and rendering them victims (McNay, 2013). This tension within feminist theory has existed long before
Foucault’s work. For Sawicki (1991), Foucault’s account of discursively produced subjectivity does not introduce any new challenges into feminist theory, but rather highlights tensions that already exist:

Feminist praxis is continuously caught between appeals to a free subject and an awareness of victimization. Foucault suggests that this tension may be permanent, that both views are partially correct, and that living in this uncomfortable tension is an important catalyst for resistance and wariness (Sawicki, 1991, p. 104).

Sawicki (1991) further argues: “Foucault’s subject is neither entirely autonomous nor enslaved, neither the originator of the discourse and practices that constitute its experiences nor determined by them” (p. 104). Foucault’s focus on the ways in which subjects are constituted through and within discourses that shape and delineate the borders of subjective possibilities and rational agency points to the ways that agency is shaped, directed, and harnessed but does not erase the possibilities for resistance. While Foucault rejects the notion that resistance can be grounded in a pre-discursive subject or a self that exists prior to construction by power, he does not deny the possibility of resistance. To the contrary, Foucault argues “there are no relations of power without resistance; the latter are all the more real and effective because they are formed at the point where relations of power are exercised” (1980, p.142).

From my perspective, Foucault’s theoretical framework is extremely useful for a feminist project concerned with a nuanced analysis of the ways that gendered subjectivities are produced and reproduced. Despite the usefulness of Foucault’s account of power, many feminists have charged Foucault with androcentrism, and some have rejected his work on this basis (Diamond & Quinby, 1988; Hekman, 1996). While Foucault’s work is not concerned with gender, it is a mistake to reject it outright, as analytic perspectives of concepts of governmentality and biopower have much to offer feminism when it is applied through a feminist framework. A feminist Foucauldian framework enables scholars to identify and unravel the complex ways that gender, and other intersecting axes of identity such as class, race, and sexuality, are constructed, constituted and reinforced.
through discourse, thus allowing for a politicization and contestation of such constructions.

3.2 Governmentality in the Neoliberal Era

In order to critically consider how survivorship discourse functions as a mode of governance, it is necessary to understand neoliberal governmental rationality, our contemporary form of rule, and the how it has shaped the exercise of government. As an economic and political rationality, neoliberalism is characterized by practices that privilege and foster the autonomy of individual citizens by transforming the role of the state through strategies such as widespread deregulation and privatization, reshaping the contours of citizenship through the promotion of individualized practices of self-management and risk reduction (Inda, 2005; Rose, 2007). Practices of self-government, particularly the individualization of responsibility and the increasing moral obligation for risk management have emerged as exemplars of neoliberal techniques of management (Inda, 2005). Further, public health discourses and practices have been transformed by neoliberal political rationalities, adopting strategies and techniques of management that support the privatization of health, and the redistribution of responsibility for risk avoidance and management from the state to individual citizens, giving rise to new spaces and opportunities for intervention into private lives and conduct (Petersen, 1997; Polzer and Powers, 2016).

From the perspective of governmentality, neoliberalism is a form of rule that is characterized by the creation of spheres of freedom in which subjects are able to exercise a regulated form of autonomy. This regulated form of autonomy has been characterized as “entrepreneurial” (Rose, 1993). The entrepreneurial subject is a subject that is capable of engaging in effective care of the self, and the pursuit of strategies to mitigate or minimize the risk of adverse outcomes (e.g., ill health, poverty). As Petersen (1996) observes, “neoliberalism calls upon the individual to enter into the process of their own self-governance through the processes of endless self-examination, self-care, and self-improvement” (p. 48). The entrepreneurial subject is premised on the notion that subjects are free and able to participate in, and cultivate, the behaviours necessary to achieve health. This notion of choice is particularly important as it reflects on the moral capacity
of citizen-subjects (i.e., to choose health is a moral choice). However, ‘choice’ is complicated by and constructed within the landscape of neoliberal governmentality, which is characterized by policies that aim to reduce social and welfare programs, rendering the playing field increasingly uneven and equal. Thus, while ‘choice’ is often imagined to be accessible to all, this does not reflect the reality of heavily stratified neoliberal societies. Despite this, the notion of choice continues to be valued, as Greco (1993) discerns:

A health that can be ‘chosen’, however, represents a somewhat different value than a health that one simply enjoys or misses. It testifies to more than just a physical capacity; it is the visible sign of initiative, adaptability, balance, and strength of will. In this sense, physical health has come to represent, for the neoliberal individual who has ‘chosen’ it, an ‘objective’ witness to his or her suitability to function as a free and rational agent (pp. 369 - 370).

The rise of the entrepreneurial subject and the increasing emphasis on individual responsibility has contributed to the production of what Rose (2001) terms a “will to health,” or a new moral and civic imperative for individuals to secure, maintain and optimize their health. The emergence of the “will to health” and the related transformation of health into a fundamental and required life-long project of the individual has buttressed other social norms, including those relating to gender, and traditional feminine roles in particular. Moore (2010) argues that the citizen invoked within a neoliberal paradigm of health is not an ideal genderless subject, but rather is a quintessentially feminine subject. The responsibilities and attributes associated with the entrepreneurial health citizen such as: “body-consciousness, self-awareness, self-surveillance, a sense of the body being at once uncontrollable and in need of control… and the transformation of the body into a project” (Moore, 2010, p. 112) are attributes that have been historically associated with femininity, particularly within medical discourse, and have operated to constrain women’s possibilities for action and subjectivity. The alignment of healthy citizenship with femininity, for Moore, renders “health-consciousness,” and the body-work associated with risk reduction as an “ideal vehicle for the performance of femininity” (2010, p. 112), making visible the extensive
potential governing effects of the discourse. In this way, we can see how neoliberal strategies of governance that appear, on the surface, to be concerned with the optimization of life and reduction of risk are also implicated in the reproduction of femininity and gendered norms.

3.2.1 Individualized Responsibilities for Risk Management

Risk and the individual management of risk are central features of neoliberal forms of governance and the duties of citizenship within societies characterized by this form of rule. Risk society harnesses the biopolitical imperative to “make live” and optimize life by calculating and disseminating knowledge about the various dangers or perceived risks to human health and longevity in order to manage biological life in particular kinds of ways. In this way, the imperative to live optimally is one of the central organizing principles of modern neoliberal societies (Ehlers & Krupar, 2014). Rose (2007) describes how this imperative informs and shapes the self-governance of individuals who are called upon to “formulate life strategies, to see to maximize their life changes, to take actions or refrain from actions in order to increase the quality of their lives, and to act prudently in relation to themselves and others” (p.107).

The imperative for bodily optimization is significant for a scholarly consideration of cancer survivorship because risk is fundamentally future-oriented, concerned with predicting, and crafting, a particular vision of the future in which individuals manage their own risks for future illness, placing little to no burden on the state and publicly funded health care system. In the context of public health and health promotion, Ehlers argues that:

Risk represent those possible futures or outcomes that are seen to be undesirable and to be avoided. They are the possible futures that threaten the status quo; they are events or situations positioned as the ‘other’ of safety (Ehlers, 2016, p. 82).

The desired future, in this context, is one that is free from disease and in which citizens actively pursue (bodily) safety through participation in risk reduction strategies. This vision of the future, however, is underpinned by an impossible promise that falsely represents ‘risk’ as identifiable factors that are within the domain of the individual’s
control (e.g., diet, exercise, smoking, sun exposure).

In contemporary Canadian society, dominant discourses of health risk are shaped by an epidemiological paradigm that promotes particular truths, knowledges, and practices about diseases, their causations and treatments in order to improve population health. These paradigms not only shape how we come to think about disease, but are also embedded in governmental and scientific practices (Brown, 2007; Orsini, 2007). The dominant epidemiological paradigm, while aimed at the population, is informed by the biomedical model which locates the origins or cause of disease in the individual body and targets its etiological investigations at the genetic, hormonal and cellular levels (Rosse, 2000; Sweeney, 2014). This framing of disease aligns with and supports neoliberal governmental practices and the individualization of health.

In breast cancer research, disease causation is largely attributed to factors at the individual level such as diet, exercise, smoking, alcohol consumption, age at first parity, and genetics (Brown, 2007; Fosket, 2010; Sweeney, 2014). Approaches to prevention informed by this paradigm prioritize individual, responsible lifestyle choices, self-surveillance of the body, compliance with mammographic screening guidelines, and increasingly genetic testing chemoprevention regimes for those deemed to be at high-risk due to suggestive family histories of the disease (Sweeney, 2014; Fosket, 2010). The individualization of the responsibility for disease avoidance is communicated through prevention strategies that advocate the management of personal risk factors, framing breast cancer as a preventable ‘lifestyle’ disease, obscuring the social, structural, environmental and economic factors that influence the disease (Orsini, 2007). As I go on to illustrate in chapter 5, such individual approaches also extend into discourses on breast cancer survivorship and the management of remission, where individual lifestyle choices and responsible body management are increasingly emphasized.

Within this configuration of risk, the factors are standardized and grouped into arrangements from which experts calculate the riskiness of particular embodied subjects (i.e., women over 45 who smoke). However, the risk calculated through the process does not neatly map onto the level of the individual, and cannot predict the precise risk a
specific individual has for a specific undesirable outcome (e.g. breast cancer, heart disease etc.) (Gifford, 1986; Press et al., 2000). Thus, the relationship between individual risk and epidemiologically -derived risk knowledges are both complicated and highly unstable. Jennifer Fosket (2010) argues that despite the instability and precariousness of risk prediction at the level of the individual, risk factors are increasingly conceptualized as treatable health problems that can be managed. This is particularly problematic in the context of breast cancer prevention, as there is widespread controversy over, and uncertainty about, the causes of the disease, what cluster of factors may increase one’s risk of developing the disease, and what strategies can be employed to prevent the disease (Fosket, 2010). Indeed, our understandings of the causes of breast cancer are so tentative that is has been estimated that up to 75 percent of cases of breast cancer occur in women whose only known risk factor is increasing age (Madigan et al., 1995; Maura, 1998). This gap between known risk factors and the characteristics or features of women who do develop breast cancer highlights the uncertainty and instability of population-level risk factors for predicting disease occurrence at the level of the individual. Despite this, risk factors are often presented in ways that support the neoliberal shift towards individual responsibility, in effect, obscuring other modes of preventative action (i.e., government regulations over chemical carcinogenic and environmental pollutants).

While the etiology of breast cancer and its risk factors are uncertain and contested, the production of knowledges about breast cancer risk factors has continued to develop and circulate, often framed an uncontested ‘truths.’ Fosket contends that:

The translation of knowledge claims about breast cancer causation into specific actions in the realm of breast cancer prevention is both problematic and an increasingly politicized process leading to prevention choices that are underdetermined. The scientific data do not fully or clearly mandate any one choice, thus particularly opening up spaces for economic, political, and social factors to shape what are ultimately presented as scientific choices. That is, the difficulty is ascertaining what causes breast cancer in the majority of cases means
that decisions about prevention cannot be based on solid scientific knowledge of causality (2010, p. 334).

Given the current state of knowledge about breast cancer etiology and risk, and what remains unknown or undiscovered, it is impossible to effectively reduce risk for breast cancer at the individual level. The landscape of breast cancer prevention is uncertain, unstable and contested, and individual women have very little to no control over disease prophylaxis or recurrence (Fosket, 2010; Sweeney, 2014). Attention to uncertainty and ambiguity are thus significant considerations in the critical study of survivorship because they illuminate the precarious state and instability of the subject position of the survivor. The survivor is always at risk of recurrence, and can never be certain that they are, or will remain, disease free. Thus, a careful consideration of risk, risk management strategies and the temporal trajectory that they assume can shed light on how women with cancer are governed through survivorship discourse.

3.2.2 Neoliberal Citizenship and Health Consumerism

Within the context of state divestment from health and welfare safety nets and the increasing individualization of the responsibility for health, health has become constructed as an “unstable property, something to be constantly worked on” (Petersen & Lupton, 1996) particularly in light of unpredictable threats to health, such as breast cancer (Bell, 2013). The framing of health, in neoliberal societies, as a moral duty and lifelong obligation for individuals generates particular responsibilities and vulnerabilities involved in the production of ‘healthy’ and ‘responsible’ citizenship (Petersen, 1997; Petersen & Lupton, 1996; Rose 2007) and reconfigures how we think about the entitlements, responsibilities, and claims to the free market attached to citizenship (Rose, 1993). While the individualized pursuit for the achievement of health, may open up new opportunities for self-fulfillment and the achievement of symbolic social or moral status for some citizens (Crawford, 1980), there is significant exclusionary potential. Citizens who do not have the social and economic resources or do not desire to actively pursue health through the consumption of appropriate knowledge, practices, and technologies are excluded from the category of deserving and responsible citizenship and deemed
irresponsible citizens who place an unnecessary burden on the publicly funded health care system.

Neoliberal forms of governmentality are characterized by freedom and choice (Rose, 1996). Subjects of neoliberal regimes are empowered to make choices about their health from a range of options in the free market. However, these possibilities for action are constrained as individuals are directed towards particular choices that reduce risk and optimize health (Polzer & Power, 2016). Alternate choices, such as the choice not to engage in risk management strategies, are not readily accessible, socially acceptable and are “not morally equivalent” (Polzer & Power, 2016, p. 13). Freedom, in this context, can be seen to serve a regulatory function, operating through strategies of neoliberal governance to call upon citizens to engage in self-disciplinary practices that align with broader political and economic objectives, serving to support the increasing withdrawal of state support and intervention in health and social welfare (Petersen, 1997).

Within this neoliberal context, individual citizens have become constructed as ‘empowered health consumers’ who are free to seek out and make ‘informed’ choices regarding their own health and healthcare needs via the free market (Bell, 2010; Rose 2007). Decisions about healthcare products and treatments have become “a new form of buying” or a particular form of consumption that is reflective of the ‘lifestyle’ of the individual, and implicitly her morality and citizenship (Cheek, 2008, p. 980). Informed by her analysis of contemporary public women’s health discourses, Tasha Dubriwny (2013) argues that women are constructed as health consumers who are both vulnerable and empowered. This vulnerable empowered subject is produced through the alignment of neoliberal and postfeminist discourses and functions to support and reinforce the larger political project of neoliberalism and the related reification of traditional gender roles for women. The subjectivity of the vulnerable empowered woman emerges out of a western cultural and social milieu in which health is increasingly individualized and framed as a key feature of responsible, moral citizenship. Within this context, the subject’s relation to specific constructions of health risk renders her body vulnerable, consequently, she
becomes ‘empowered’ to take up risk management strategies (i.e., prophylactic mastectomy, screening practices) in order to abate her embodied vulnerability. This configuration of ‘empowerment,’ according to Dubriwny, is made possible through neoliberal framings of individual freedom, choice, and consumption. Further, the enactment of the vulnerable subject’s empowerment functions to support various aspects of the larger neoliberal political project, including the obfuscation of structural and material inequalities and the re-inscription of traditional gender roles (e.g., mothers, wives). The re-inscription of traditional gender roles operates insidiously, facilitated through postfeminist framings of empowerment that uproot the concept from its political and social context, transplanting empowerment into the realm of the individual. In this way, empowerment is transformed into a project of the self, reorienting women’s attention away from the social and towards their own bodies and capacities. This framing of empowerment operates to “consistently return women to the most traditional of gender roles: naïve daughter, passive wives and nurturing mothers” (Dubriwny, 2013, p. 25).

3.3 Temporal Inflections

The present study, guided by a feminist governmentality approach, is concerned with producing a nuanced understanding of how breast cancer survivorship discourse operates as a technology of neoliberal governance and identifying how the forms of subjectivity produced by the discourse operate within the larger neoliberal context to direct women towards particular norms of citizenship, gender, sexuality, and health. A secondary goal of this study is to explain how the theoretical perspective of governmentality can attend to temporality and how this sensitivity to temporality can illuminant new insights about the governing features of survivorship discourse.

An analytic focus on temporality enhances the purview of a governmentality perspective because the government of conduct is inherently concerned with the management of time, although this concern many not be explicitly articulated. Broadly speaking, within the rationalities of neoliberal governmentality and risk discourse, the future is typically conceived as something that is amenable to transformation – it is neither fixed nor inevitable. Undesirable potential futures that are marked by critical illness, disability or
death are constructed as alterable or preventable through interventions made in the present. In relation to disease and chronic illness, this is most frequently expressed through the discourses of risk and risk management, as I discussed in section 3.2.1. Underlying the discourse of risk management and related strategies is the belief that the uncertainties of the future can be eliminated through rational action and self-management in the present. The fundamental flaw in this logic as it relates to breast cancer is that the development of the disease is not always rational, and no amount of self-governance, exercise and healthy eating can ultimately guarantee a healthy future - the future and the body cannot be controlled with any degree of certainty.

As I explored in section 3.2.1., governmentality critiques of risk discourses highlight how constructions of risk direct subjects towards particular regimes of future-oriented regimes of risk reduction as a means to secure an optimal, healthy future. With the exception of such critiques of health risk discourse, governmentality analyses of health-related discourse do not typically consider the temporal dimensions of governance. However, subjects experience their bodies in and through time, and many practices of self-governance are concerned with time and the future specifically (i.e., risk reduction, disease prevention). The temporal structuring of our lives and conduct is taken-for-granted, and it often remains unnoticed until it is disrupted by an event - like a critical illness- that makes the embodied rhythms of time noticeable.

Governmentality critiques of risk discourse draw attention to the ways in which conduct is regulated by bringing (a particular kind of) future into the present. While this temporal trajectory can shed light on one way that survivor citizens are governed, the singular focus on this anticipatory temporal trajectory closes off the possibility that survivor citizens might also be temporalized in ways that reproduce and affirm other social, gendered, sexual, and citizenship norms. In order to consider the temporal dimensions of survivorship broadly within the present study, I draw on insights from queer theory in order to become attuned to alternative temporal orientations or trajectories that may be constructed and incited by breast cancer survivorship discourse. Such a perspective is advantageous for a critical analysis of breast cancer survivorship because other critical investigations have identified that the temporal landscape of survivorship is complex and
nuanced (Jain 2007a; 2007b; 2011; Stacey & Bryson 2012; Bryson & Stacey 2013). These studies indicate that the temporal dimensions of survivorship extend beyond/across/around the anticipatory future-oriented focus of governance that governmentality perspectives have illuminated, particularly with respect to risk discourse. I will outline some of these insights and describe their theoretical orientation in the following section. In so doing, I will highlight how the theoretical framework that guided this study enabled a critical consideration of how survivor citizens are temporally produced and oriented and explore in-depth the social and political implications of such orientations.

3.3.1 Queer Notions of Time

Theories of queer time suggest that time and temporality provide another lens through which we can critically examine how bodies are regulated and compelled towards particular trajectories of normality. A queer temporal perspective complements and extends a feminist Foucauldian analysis of survivorship by attending to the governing dimensions of temporality that fall outside of the future-oriented scope of risk. Using queer theory as a sensitizing concept enables my analysis to attend to kinds of temporal trajectories and orientations that survivor citizens are implicated in, further revealing the subtle and complex ways that survivor subjectivity is produced, and towards what ends.

Theories of queer time constitute a body of work that critically considers the production and reproduction of the future, the role of the future in reproducing heteronormative power structures, and how deviant and marginalized populations are rendered ‘futureless,’ both literally and figuratively, within these power configurations. This branch of queer theory imagines queerness as a site (rather than orientation) where the lines between the past and future created by heteronormative structures of social and biological reproduction can be diverted, broken off or redirected. Jack Halberstam (2005) articulates queerness in this sense as a site of “strange temporalities, imaginative life schedules and eccentric economic practices” which open up “queer relationships to time and space” (p. 1). Consequently, queer time captures “those specific modes of temporality that emerge within postmodernism once one leaves the temporal frames of bourgeoisie reproduction and family, longevity, risk/safety and inheritance” (Halberstam,
In this context, queer temporality requires new ways of thinking about time and space outside of linear or teleological narratives. A queer temporal perspective is skeptical of the optimism of futurity (the future will be better) as well as its temporal flow (linear, forward march of progress). This analytic perspective enables new ways of thinking about survivorship, as it provides tools to question and dismantle the optimism for the future that surrounds much of survivorship discourse and to attend to the reality of many women with cancer experience: there is no future.

Elizabeth Freeman’s (2010) concept of chrononormativity is particularly useful for my investigation. From a chrononormative perspective, time is not only a supposedly linear movement from past into future, but also a socially constructed rhythm that is lived within the body, experienced as natural and that produces a sense of belonging. These rhythms shape individuals into particular forms that enable them to participate in dominant forms of sociality. Bodies that can ease into the tempo are weaved into the fabric of dominant culture and rendered both intelligible and part of the production and reproduction of social life and capital. Chrononormativity leaves out or leaves behind the bodies that cannot be incorporated into the constructed temporal flow or timeline – whether it is due to poverty, race, disability, and sexuality (and perhaps illness/ inability to occupy a survivor position) (Freeman, 2010). According to Freeman, the discipline of “timing” creates and engenders a sense of “being and belonging that feels natural” (2010, p. 18). This process of temporal discipline extends beyond bodies of individuals and encompasses the management of populations in which individual bodies are synchronized not only with each other, mirroring similar goals and timelines, but also in ways that align with larger structural and institutional goals (i.e., capitalism), in effect naturalizing them. As Cosenza argues, “time frames daily habits, rituals, and routines in the name of ‘progress.’ It binds our bodies to the arbitrary schedules of capitalism, of heteronormative notions of family, of productive notions of reproduction” (Cosenza, 2014, p. 156).

In a chronobiopolitical (Luciano, 2007) society, the state and its institutions connect properly synchronized and disciplined bodies to narratives of movement and change, and teleological strategies of living such as marriage, reproduction, the accumulation of wealth, the cultivation of health etc., all in the interest of a (re)productive future - both
familial and national. A chronobiopolitical society in many ways is similar to or aligned with neoliberal political rationalities which are concerned with the production of self-disciplining, productive subjects in the interest of a healthier, wealthier future. The notion of ‘progress’ or moving forward towards a future that is secured by the personal and rational management of risk and the cultivation health, wealth and family is a central feature of the teleological timeline of western capitalism and neoliberal government. To this effect, Freeman (2010) argues:

in the eyes of the state, the sequence of socioeconomically “productive” moments is what it means to have a life at all…the logic of time as productive thereby becomes one of the serial cause-and-effect: the past seems useless unless it predicts and becomes material future (p. 5).

Indeed, the concept of ‘progress’ is imbued in western culture with meaning and value and is an object of desire to which subjects are incited to attach themselves. I see these notions of progress and a better future as particularly salient for critical health scholarship as so much of health promotion discourse is directed by discourses on risk towards the future and the achievement or improvement of ‘health’ for the future self (Lupton, 1995; Petersen, 1997; Petersen & Lupton, 1996). The focus on progress and the future are also reflective of the intensification of risk surveillance and management that is a central feature of biomedicalization (Clarke et al., 2010; Fosket, 2010; Klawiter, 2008). The detection and management of risk are future-oriented activities that are intended to direct subjects towards a specific kind of future, one that is healthy and productive. As Dubriwny (2013) reminds us, the future that women are directed towards through risk discourse are normative and marked by traditional norms of gender and sexuality.

The regulatory function of temporal trajectories extends beyond the disciplining of individual bodies and the reification of particular rhythms of life and operates to reinforce and reproduce a variety of social, political, and economic norms. Lee Edelman’s (2004) notion of “reproductive futurity” describes the mechanisms by which the heteronormative social order and the norms which characterize it are perpetually reproduced. Within the logic of reproductive futurism, the institution of the family and the practice of
heterosexual procreation are positioned as the vehicles by which the future is secured. The effect of this is to preserve “the absolute privilege of heteronormativity by rendering it unthinkable, by casting outside the political domain, the possibility of queer resistance to this organizing principle of communal relations” (Edelman, 2004, p. 2).

For Edelman, the vision of the future and its emergence are inseparable from the Child - the product of heterosexual reproduction and family. What Edelman’s work highlights are ways in which individual citizens are disciplined by a reproductive timeline and directed to engage in heterosexual familial formation in the interest of the future, and how such timelines enable the continuation and reification of gendered, sexual, temporal and other social norms.

In Chapter 2, I highlighted how scholarship that draws on queer theory reveals the rich temporal dimensions of discourse on breast cancer survivorship and draws our attention to the temporal assumptions embedded within (hetero)normative constructions of breast cancer survivorship. Drawing on this field of critical scholarship, I also described how dominant cultural discourses of breast cancer often focus on ‘recovery’ and celebrate the achievements of subjects who overcome their illness and move into a ‘healthy future.’ Indeed, the prevailing timeline of popular discourses of breast cancer survivorship is about moving towards a better future and self by engaging in a variety of disciplinary techniques, as well as orientating the mind towards a positive, optimistic outlook. This progress narrative, as Ehrenreich (2001) notes, forecloses any possibility that women with cancer might experience and dwell in negative affects and emotions, or that life might not be better, or may not continue at all. Lauren Berlant’s (2011) concept of cruel optimism sheds light on the social and political functions and implications of this attachment to hope and optimism within breast cancer survivor discourse. In the context of breast cancer survivorship, cruel optimism speaks to the impossibility of the promises (of survival and a better life) that are attached to promoted forms of survivor conduct (i.e., optimistic and positive) and provides a theoretical framework to understand the
ways that these attachments constrain the subject’s possibilities for action. Specifically, cruel optimism:

describes the relation of attachment to compromised conditions of possibility whose realization is discovered either to be impossible, sheer fantasy, or too possible, and toxic. What’s cruel about these attachments and not merely inconvenient or tragic, is that the subjects who have x in their lives might not well endure the loss of their object/scene of desire, even though its presence threatens their well-being, because whatever the content of the attachment is, the continuity of its form provides something of the continuity of the subject’s sense of what it means to keep on living and to look forward to being in the world (Berlant, 2011, p. 24).

Moreover, Berlant argues that cruelly optimistic attachments are actually obstacles that prevent the subject from flourishing. As such, the concept of cruel optimism can also attend to the social and political implications that attachments to undeliverable promises have for the women addressed by discourses of breast cancer survivorship.

In conclusion, insights from queer theory provide the tools to explore the many temporal elements and trajectories of breast cancer survivorship discourse. By attending to the hidden rhythms of temporality and the way that they structure and naturalize particular ways of moving through the world, queer temporal perspectives enable us to ask what functions the constructions of ‘normal’ bodily tempos and rhythms serve, how they align with asymmetrical power structures to direct bodies and energies in particular ways and to particular ends. Insights from queer theory support a critical analysis of our naturalized attachment to particular objects, ideas, and outcomes (e.g., health, future, optimism) and ask how these attachments function as a normalizing force to govern bodies and sustain power inequalities. Queer time also attends to the ways of living and being that fall outside of the normalized temporal order and provides us with the theoretical tools to think about the productive value of the subjectivities produced by survivorship discourse, such as the terminal or stage four woman with cancer. Applying a governmentality lens attuned to the possibilities of queer temporality to the study of
breast cancer survivorship discourse allows us to think about how the governance of the disease necessitates the imposition of particular temporal trajectories and how these temporal trajectories are entangled with the reproduction of other norms associated with gender, health, and sexuality. In the present study, I illustrate how breast cancer survivorship discourses incite women to govern their bodies through time and the objects they are oriented towards reveal new insights about how survivorship is inextricably tied up with the (re)production of gender, temporal, sexual and citizenship norms.
Chapter 4

4 Methodological Approach

The present study is concerned with mapping discourses of breast cancer survivorship in biomedical and popular fields in order to identify and describe the forms of subjectivity that are made possible and available to women and the forms of governance enacted. In Chapter 3, I outlined a flexible theoretical framework that combines Foucauldian theory, feminist theory and queer perspectives on temporality. I detailed how such a framework enables a robust, critical examination of the discursive construction of breast cancer survivorship, allowing for a specific focus on the constitutive elements of the discourse and the complex arrangements of power in which survivor subjects are entangled. In this chapter, I outline the central features of a feminist Foucauldian-informed critical discourse analysis, my methodological approach and describe its appropriateness for this study. I describe the specific research questions that guided this study and their alignment with my methodological approach. I introduce my discursive sites and provide a detailed description of my sampling techniques and selected texts. Following this, I elaborate on the iterative processes of data collection and analysis employed in this study and describe the central analytic choices made.

4.1 Critical Discourse Analysis

In this study, I employ a feminist, Foucauldian approach to critical discourse analysis (FCDA) to interrogate the assumptions, meanings, and absences in textual and visual discourses that communicate information about breast cancer survivorship. FCDA brings together critical discourse analysis (CDA) and feminist studies to advance critical, nuanced understandings of the complex and subtle ways that power operates through discourse and in relation to hierarchical and gendered social arrangements (Lazar, 2007). CDA is not a homogeneous method with a set of clearly defined tools and questions, but rather, it is a research program with numerous and multifaceted theoretical and methodological approaches (Wodak, 1999). Given the breadth and diversity of CDA approaches it is important to clarify, for the purposes of this study, how I use the terms discourse and how I approach the critical analysis of discourse. The specific approach
that I have adopted is informed by my theoretical orientations, my particular research questions and my subjective judgments about what aspects of survivorship discourse are both interesting and productive to consider. In the following section, I detail the central principles of CDA that underpin my methodological approach, explicating how these principles informed and shaped my processes of data collection and analysis.

My understanding of discourse is heavily influenced by the work of Foucault and scholars who take up his theoretical work. From this perspective, discourse can be understood as a set of possible statements or patterned way of thinking about a particular phenomenon that permeates textual, visual and verbal forms of communication, organizing how phenomena can be talked about and understood (Caldas-Coulthard & Coulthard, 1996; Kress & Van Leeuwen, 1996). Discourse is situated within and formed by wider arrangements of power, and operates to produce the conditions and possibilities of reality by delineating how we can think, speak about and access both the content and features of our social world (Cheek, 2004). Discourse has social and political effects; it produces and shapes possibilities for being, experiencing and acting. Discourse structures the limits of how a particular phenomenon (i.e., breast cancer survivorship) can be thought about, delineating particular ways of thinking as outside the boundaries, and thus rendered unintelligible (Rose, 2012). The effects of discourse are insidious such that what is possible to think about a particular thing at a particular historical moment appears to be both natural and normal – a true reflection of the thing itself.

The unremarkable and ‘natural’ appearance of objects constructed by discourse, for Foucault (2002), renders the careful examination and questioning of everyday, familiar discourse necessary in order to understand how the assumptions that underlie the discourse have been rendered invisible (Cheek, 2004). It is the assumptions that underpin discourses that facilitate the ‘naturalness’ of their appearance and the taken-for-granted character of the meanings they communicate and acquire. Such assumptions are not neutral or accidental, but rather are effects of the particular social and political conditions in which the discourses are embedded (Foucault, 2002). Thus, in order to interrogate the meanings and effects of discourse, it is imperative to articulate the broader social and political context in which it occurs and the ways that the discourse operates to construct,
affirm, challenge or disqualify particular ways of knowing and being (Jager, 2001; Jager & Maier, 2009). Analyzing discursive frameworks from a Foucauldian perspective enables researchers to investigate the following broad questions: what rules order the kinds of statements that can be made about a particular thing?; what is constructed as valid knowledge in a particular place, time and space and what is constructed as false?; how does this knowledge arise and how does it circulate and reproduce?; and, how does this knowledge shape society in particular ways? (Jager & Maier, 2009, p. 34).

Discourses of phenomena, like breast cancer survivorship, do not exist and operate isolated from other discourses; they slot into the scaffolds of larger discursive frameworks, supporting and enabling the ordering of reality in certain ways (Cheek, 2004, p. 1142). Discourses are not monolithic and uniform. Rather, there are a number of possible discourses for each aspect of reality (i.e., breast cancer survivorship) that offer different ways of thinking and speaking about the phenomenon. The discourses may overlap or diverge from one other, compete or co-exist with varying degrees of prominence and influence. Typically, one discourse will emerge as dominant, appearing as a natural, way of thinking about and understanding a particular phenomenon, to the exclusion of other possible ways of thinking. The prominence of particular discourses over others is not happenstance, rather, in keeping with Foucauldian theory, it is an effect of power / knowledge (Cheek, 2004) and the socio-historical context in which it is situated (Jager & Maier, 2009).

Discourses produce subjects and reality. They are both socially constitutive and socially conditioned, in that they function to reinforce, reproduce and or challenge the unequal relations of power that order our social world through the ways in which they position subjects (e.g., women) and represent various phenomenon (e.g., health) (Fairclough & Wodak, 1997). The socially consequential effects of discourse combined with the often taken-for-granted acceptance of dominant framings make discourse a particularly important site for critical scholarly inquiry. Mapping the ways that discourse operates to shape our thinking about particular aspects of reality (e.g., cancer survivorship), and the ways in which this thinking is an effect and operation of power, draws attention to the constructed nature of the phenomenon, revealing the possibilities of alternative ways of
thinking and understanding. A critical examination of how contemporary discursive constructions of breast cancer survivors and survivorship are constituted and shaped by larger social and political discourses can thus contribute to the forging of an epistemic space in which alternative ways of understanding, speaking about and acting towards women who continue to live after acute breast cancer can be imagined and enacted.

As Cheek (2004) has argued, CDA can best be understood as an approach rather than a predetermined or prescriptive method. There are no step-by-step guides to follow. The approach is flexible and is customized to reflect and work in tandem with the theoretical framework of the researcher and her analytic interest (Jager & Maier, 2009; Wodak & Meyer, 2009). Broadly speaking, a Foucauldian approach to critical discourse analysis is characterized by the critical interrogation of the following: 1) the complex relations of power in which discourses are situated; 2) the productive and value-laden nature of language; 3) the constitutive effects of discourse particularly in relation to how meanings, objects, and subjectivities are produced; and 4) the partial and situated nature of reality (Ainsworth & Hardy, 2004; Cheek, 2004; Jager & Maier, 2009; Laliberte Rudman & Dennhardt, 2015). Further, critical discourse analysis is underpinned by a commitment to ‘critical’ analysis in that it is attentive to the broader sociopolitical contexts in which discourse is embedded and the real-world injustices and inequalities that it supports, reinforces and / or challenges (Laliberte Rudman & Dennhardt, 2015).

My application of CDA is also informed by feminist theory and a feminist commitment to the interrogation of gender and sexuality. While CDA is guided by an understanding that social practices are both reflective and constitutive of discourse, the discourse of gender is not always explicitly considered within CDA. A feminist CDA approach reflects the understanding that social practices and knowledges, far from being neutral, are shaped by assumptions about gender, as well as other constructed categories such as race, class, and sexuality. The aim of FCDA is thus to make visible the complex, subtle and explicit ways that power relations and taken-for-granted gendered assumptions are discursively produced, negotiated, sustained and challenged (Lazar, 2007). FCDA as a methodological approach is well suited to a critical study of breast cancer survivorship because it illuminates how discourses on health and disease are not neutral, but rather, are
sites for the production and reproduction of assumptions about gender, sexuality, race, and citizenship.

4.1.1 Research Questions

Consistent with the theoretical framework and methodological approach that inform this study, the following research questions guided this study:

Central questions:

- What forms of subjectivity and conduct are made possible and idealized by contemporary discursive constructions of breast cancer survivorship?
- What kinds of temporality / temporal relations are assumed by these discursive constructions?

Secondary questions:

- How are gender, sexuality and other forms of difference (e.g., age, race, class,) communicated and constructed through these discursive constructions?
- How are discourses of risk articulated in relation to discourses of survivorship? How do they co-constitute and potentially transform each other?
- What kinds of survivor citizens are imagined and towards what kinds of futures are they compelled, propelled or incited towards? What kinds of conduct are survivor citizens incited to engage in?
- How are ideas about futurity and time expressed in different discursive genres of breast cancer survivorship? How are these temporal dimensions related to particular constructions of subjectivity?
- What forms of subjectivity are obscured within the discursive conditions of possibility?

4.2 Discursive Sites

In order to critically consider what forms of subjectivity are made possible and idealized by contemporary discursive constructions of breast cancer survivorship, I examined and compared two unique sites of discourse production on cancer survivorship: (i) Springer’s Journal of Cancer Survivorship aimed at healthcare practitioners and cancer survivors
and (ii) promotional texts of breast cancer survivorship, produced by a Canadian-based philanthropic organization and aimed at breast cancer survivors and the general public. These sources of discourse production were selected to enable analytic comparison of how survivorship is constructed by, and for, different audiences, highlighting the ways in which survivorship discourse is shaped by the broader contexts in which it is situated.

The Springer Journal of Survivorship, first published in 2007, provides an appropriate and interesting data source because it is the first, and currently only, academic journal that takes cancer survivorship as its primary focus. As a data source, the Journal provides ample opportunity (over 380 articles on breast cancer survivorship, specifically) to examine how discourses of breast cancer survivorship are constructed, and the types of subjectivities that are assumed and made available within this new sub-set of biomedical knowledge production. Furthermore, as the journal attempts to constitute itself as the site of ‘legitimate’ expertise on survivorship, and is explicitly directed towards practitioners and survivors, an analysis of articles published within the Journal provides an interesting opportunity to discern how this site of knowledge production functions as an entry point for the governance of breast cancer survivors.

The purpose and scope of the Journal of Cancer Survivorship is situated within the context of increasing cancer survival rates, noting that within the United States alone, there are currently 13 million cancer survivors (Springer, n.d.). This population, from the perspective of this journal, is a medically underserved and under-researched group that constitutes a “worldwide concern.” The international journal seeks to fill this gap by providing a ‘legitimate’ site for health information for survivors, and a forum for evidence-based research on cancer survivorship. The editor-in-chief of the Journal, Michael Feuerstein, positions himself as both a medical professional concerned with the study of survivorship and a cancer survivor himself. Since 2006, he has published a wide range of academic and popular texts on the topic of cancer survivorship (e.g., Feuerstein, 2007a, 2007b, 2007c, 2009b; Feuerstein & Harrington, 2006), including a Handbook of Cancer Survivorship that is directed towards a lay population.
As a site of knowledge production, the Journal claims to disseminate evidence-based knowledge concerned with improving the understanding of adult cancer survivors and their unique medical needs. The Journal presents international qualitative and quantitative research produced from a variety of disciplinary perspectives including kinesiology, physiotherapy, nursing, occupational therapy and behavioural science. Purportedly, the research published within the Journal is centrally concerned with improving the quality of life of adult cancer survivors and mobilizing evidence-based research into better professional practice. Within this discursive site, cancer survivors are configured as a specific medical population with significant unmet health care needs, particularly as they relate to the continued management of their recovering bodies. Throughout the Journal, managed survivorship care is forwarded as a new and important site for professional expertise; ripe for the application of robust, evidence-based research and the implementation of interventions informed by a variety of allied health professionals.

Through this site of discourse, the study and care of survivors is, in essence, constructed as an ‘emerging’ science and the field in which epistemological investment holds the potential to transform and improve the lives and bodies of adult cancer survivors.

To provide an interesting source of analytic comparison, my sample of promotional texts consist of print and video material created by The Canadian Breast Cancer Foundation (CBCF) for their popular, annual fund-raising event - the CIBC Run for the Cure. The CBCF and the CIBC Run for the Cure have been selected as sites of investigation for this project because they are key Canadian sites for the discursive production and proliferation of knowledge about breast cancer survivorship. The CBCF, founded in 1986, is currently the largest charitable funder of breast cancer research in Canada. The primary fund-raising vehicle for the foundation - the CIBC Run for the Cure - was first held in 1992 and has since become the largest, single-day, volunteer-run breast cancer fundraising event in Canada. The Run is currently held in 63 communities across Canada and attracted 97 040 participants in 2016, raising over 17 million dollars, (CBCF, 2016). The Foundation’s website proudly describes itself as “the leading organization in Canada dedicated to creating a future without breast cancer” (CBCF, 2016), raising over 360 million dollars in the name of breast cancer research, funding 1 400 community and scientific research grants in its 30-year existence.
The Foundation maintains a strong public presence, both online and offline, through wide-spread advertising campaigns (e.g., websites, billboards, bus shelter ads, television, radio, YouTube, Facebook etc.,) directed towards awareness and fundraising. The widely popular CBCF and the Run for the Cure are the most public and recognizable ‘face’ of breast cancer in Canada. The public popularity and prominence of the event are reflected each October in the countless favourable articles that appear in newspapers across the country each fall praising the philanthropic work of the organization and the participation of ordinary Canadians in the worthy event.

4.3 Sampling Techniques

Taking the Springer Journal of Cancer Survivorship and the promotional materials produced for the CBCF’s Run for the Cure as my discursive sites, I applied a range of selection criteria to generate two manageable samples. I first limited the temporal scope of the materials to a nine-year window between 2007 and 2016 to capture the full publication trajectory of the of the Journal of Cancer Survivorship and a broad range of Run for the Cure promotional campaigns. This temporal range was selected to enable a comparison and to track how the discourse changed over time, while also capturing contemporary dimensions of the discourse.

To generate a manageable sample of articles published in the Springer Journal of Cancer Survivorship, I first conducted a keyword search within the Journal’s database using the keywords “breast cancer” and “survivor.” This search returned 388 articles. To narrow down this initial sample, I reviewed each abstract alongside my research questions to determine their appropriateness. Articles that substantially addressed or focused on breast cancer, survivorship and temporality broadly were set aside for inclusion into the preliminary sample. Through this process, a total of 60 articles were identified. Each of these 60 articles was entered chronologically into a spreadsheet according to date published. I also recorded the length, the type of analysis (qualitative or quantitative) and the relatedness to the primary research question. To sample articles proportionally according to the date published, every third article was selected for inclusion generating an initial sample of 20 articles. Applying CDA techniques, the initial sample was analyzed to generate an understanding of the general content and features of the Journal
as a discursive site. Drawing on this preliminary analysis, I identified, in consultation with my Advisory Committee, a number of interesting features of the emerging discourse that warranted further exploration. To do so, the sample was expanded by an additional 20 articles (See Appendix A). These articles were purposefully sampled based on their relatedness to the emerging questions so as to enable an exploration of these points of interests.

In contrast to the easily accessible digitally archived journal issues and articles, the promotional materials produced for the Run for the Cure are ephemeral artifacts. In order to generate a robust initial sample, I pursued a number of search strategies. I first contacted the CBCF to inquire whether or not they had an archive of promotional material. This line of inquiry did not prove fruitful. I then conducted a number of digital searches on the various web pages associated with Run for the Cure and CBCF to capture any static or video advertisement content. The majority of the promotional materials were located on the Facebook and YouTube pages for the organization. I also conducted dozens of broad digital searches for promotional materials locating some static advertisements in the online portfolios of graphic designers and marketing professionals. Finally, I reviewed a local archive of print, Canadian women’s magazines (Flare, Chatelaine, and Canadian Living), focusing specifically on the issues published in October (breast cancer awareness month).

In total, 54 advertisements were located through the various search procedures. These advertisements were organized in a table, by year and type (i.e., print or video) the sample included at least one advertisement for each year across the sample span (2007 – 2015), although the sample was most dense for 2011 – 2014. The initial sample was composed of 24 print ads and 32 video/television ads. To generate a manageable sample, I applied purposeful sampling techniques, reviewing each of the advertisements to assess how they related to the research questions guiding the study. Advertisements that: 1) represented survivors or survivorship in some way; 2) spoke to, or represented the future, time and temporality in some way, and; 3) communicated or represented difference (i.e., race, gender, age etc.,) were selected for inclusion. When multiple advertisements from the same campaign (in terms of year and theme) met the inclusion criteria, not all texts
were included in the sample. In these cases, the texts that best fit all three criteria were selected (this usually came down to the inclusion of difference) to enable a diverse sample. This resulted in the sample of 24 advertisements (see Appendix B).

Many of the campaigns included in the sample featured both print and video advertisements produced for the same campaigns and communicated similar ideas. Through the analysis process, I found the promotional videos to be much richer and more complex sources of discourse. As a result of this richness, my discussion and description of the video materials in Chapter 6 is more in-depth and nuanced than that of the static ads. Mindful of this difference, the static images have been incorporated into the analysis wherever possible and I frequently refer to static advertisements that correspond to video materials.

4.4 Analysis Approach

Consistent with the tenets of CDA and qualitative data analysis more generally (Cheek, 2004; Fairclough & Wodak, 1997; Jager & Maier, 2009; Wodak, 1999), my analysis was concerned with identifying the main discursive constructions of survivorship and the subjectivities they engender by engaging in multiple close readings of these texts. Emerging myself in the text, I critically considered the use of rhetorical devices, metaphors, images and other textual strategies in order to explore the links between discourse and broader social and political structures (Caldas-Coulthard & Coulthard, 1996; Fairclough & Wodak, 1997). In this section, I provide a detailed description of how my analysis processes were constructed and enacted, highlighting the alignment with both my theoretical framework and the guiding principles of CDA.

CDA is a multilayered, process that employs and combines various linguistic tools and methods of deconstruction to engage in a multi-level analysis of texts across a range of foci (Jager & Maier, 2009). Methods of deconstruction do not aim to uncover the hidden, ‘true’ meaning of a text, but rather, aim to unsettle the text and make visible the implicit meanings, assumptions, ideological perspectives, binary oppositions and absences within a text that are not visible at first glance (Cheek, 2004.) The content and meanings of a text are situated within its form and organization, and as such, CDA must attend to both
what is said and the ‘texture’ of the texts (Fairclough, 1995). In order to examine the ‘texture’ of my selected texts, I developed a theoretically informed analysis sheet for each sample to systematically guide my reading drawing on the model offered by Laliberte Rudman and Dennhardt (2015) (see Appendix C). Analysis sheets function to guide rigorous readings of the texts that are both informed by theory and that push beyond the superficial context of a text to interrogate its form, and how it functions to produce both content and social meaning (Fairclough, 1995). My analysis sheet incorporated three types of questions: (i) linguistic tools to aid in the deconstruction (i.e., meaning, form, rhetorical devices) and prompts to investigate the absences within the text; (ii) theoretically informed questions that aligned with my theoretical framework and; (iii) questions that were informed by my specific research questions (Laliberte Rudman & Dennhardt, 2015). These questions were consistent across samples, and an additional set of questions related to the visual elements of the discourse were added to guide my reading of the CBCF promotional materials to include an additional set of questions (see Appendix C, 1b) (Rose, 2012).

Guided by my analysis sheets, I engaged in an iterative process of data collection and analysis grounded simultaneously in the texts, analysis sheets and the analytic memos I produced throughout the process. This process was emergent and developed continually in response to the findings generated and the emergent questions (Fairclough & Wodak, 1997; Phillips & Hardy, 2002). Throughout my engagement with the texts, I kept my theoretical framework and analytic focus on subjectivity and temporality in the forefront of mind, while also maintaining a degree of epistemic flexibility to consider and pursue findings that challenged the boundaries of this framework. This process was immersive. I examined each sample separately and spent a considerable number of months reading, reflecting upon and re-reading the data, identifying, testing and refining the themes to reflect the content represented within each text. In the following section, I will situate myself as a researcher in relation to my chosen topic of study and will then provide an in-depth description of the analysis process.
4.4.1 Reflexivity

There is no consensus regarding the quality criteria within the broad methodological approach of critical discourse analysis (Wodak & Meyer, 2009). Part of the difficulty stems from the epistemological assumptions that underpin CDA, as the aim is not to uncover the ‘truth’ about a text or to generate the most ‘accurate’ reading. Instead, the goal of CDA is to produce a comprehensive, theoretically informed and empirically grounded reading of a body of texts that draws attention to, and questions, the taken-for-granted assumptions embedded within and reproduced by the texts (Cheek, 2004). The results of a critical discourse analysis are informed by the interaction between the texts and the analyst. Texts are open to multiple readings, with each possible reading uniquely shaped by the theoretical framework, experiences, and knowledge of the analyst. My interpretations are uniquely informed and shaped by my interaction with the texts, my particular existing knowledge, experiences, and values.

Within much critical social science research, and feminist research in particular, the practice of reflexivity - the practice of critically considering how one’s personal experience impacts the processes of analysis and data interpretation - is employed to maximize the quality and reliability of research (Mauthner & Doucet, 2003; Mauthner, Parry, & Beckett, 1998). As part of my reflexive process, I located myself in relation to the subject of inquiry by clarifying my personal interest and investments in the study of breast cancer survivorship and identifying what assumptions and experiences I bring with me to the research. I became interested in breast cancer survivorship in 2011 when my mother, a ten-year cancer ‘survivor,’ was diagnosed with stage-four cancer and given only a few months to live. My mother joked that after ten years of healthy eating and rigorous to exercise, she was so full of cancer that even if the surgeons could remove it, she would end up looking like a sieve (very few people found this funny). My mother was very angry about her diagnosis and felt that she had been misled by her doctors into giving up life’s pleasures (i.e., sugar, coffee, alcohol, chocolate) with the false promise of continued life.

I spent a lot of time with my mother throughout her final illness and took up the role of her primary caretaker. I learned more about cancer diets, iatrogenic effects of various
drugs, compression socks, and how to tie an attractive headscarf than I ever anticipated. I spent numerous summer evenings sitting on the back deck with my mother, talking about her appointments and often awkward encounters with nurses, doctors, and well-meaning friends. It became clear to me that within our small suburban community hospital there was considerable a lack of resources for women who could not be survivors; furthermore, there was no social script to engage with stage-four women for whom there was no hope. Friends, health care professionals and strangers alike did not know what to make of my tiny, but angry mother who refused to be the proverbial elephant in room – she was dying and would do so out in the open, bare-headed and make-up free. She wanted to have open conversations about the side of cancer that we don’t like to talk about, the immense suffering, horror, pain, and death.

Prior to 2011, I inhabited the pink-washed survivor world. I annually attended and participated in The CIBC Run for the Cure in Toronto and Relay for Life in Oshawa, Ontario. I had more pink ribbon t-shirts than I knew what to do with. This was mostly coloured by my early experiences with cancer. My mother was first diagnosed with breast cancer in early 2000 and was given a very poor prognosis. After participating in an extremely intensive experimental chemotherapy and radiation program at Princess Margret hospital in Toronto, my mother was given the all clear by her doctors in 2001. Family and friends celebrated her almost miraculous recovery. In many ways, I remember my mother being the model survivor. She often talked about how breast cancer had changed her life and given her the impetus to reorganize and reprioritize her time. She reduced her work hours from 70 hours per week to 50 hours and began to practice yoga (dragging me along, despite my disastrous lack of coordination). She signed up for a gym and started cutting out processed foods, caffeine, alcohol and sugar from her diet. She joined a book club and started spending more time with her friends. She started gardening zealously. She was continually on the verge of joining a dragon-boat team. She would tell anyone that would listen that she was a much better and happier person post-cancer.

Throughout my short 28 years, I have vicariously experienced both sides of the survivor coin – the bliss of survivorship and renewed life, and the dark reality of pain, suffering,
and invisibility. During the writing of this thesis, I have myself, been interpolated into a ‘high-risk’ screening group by virtue of my suggestive family history, enrolled in a compulsory biomedical regime of screening and surveillance (waiting and watching).

Through all of this, I have become and remain fascinated with cultural scripts of survivorship and ideas about how women with cancer ought to conduct themselves. I have been angry about the lack of resources and discourses to account for, and attend to, stage-four women. I have been annoyed by the positive, cheerful images of breast cancer survivorship that seem to appear everywhere, particularly in October. I have cried desperately with friends over the new diagnoses of loved ones. I have voraciously consumed cultural products created by women with breast cancer, particularly those that seek to shift the script of cheerful survivorship. But most of all, throughout this process of investigation and cultural consumption, I have realized that cancer, and particularly, breast cancer survivorship permeates our culture; it touches many women and shapes how they think about their families, bodies, and futures – it is almost impossible to escape. I am the first to acknowledge that my fascination is not neutral in any way and is greatly shaped by my experiences as a child and young adult. What brings me to this particular research is a desire to understand, beyond my own experiences with my mother, the discursive constructions of survivorship, how women are governed through survivorship and the social and political implications of such constructions. I want to understand outside the frame of my own narrow framework of experience what survivorship means and how it calls women to inhabit their bodies and their world.

4.4.2 Analysis Process

Following my data collection, I prepared my samples for analysis. For the CBCF sample, this involved transcribing verbatim the audio from each video advertisement, recording the specific web locations of each video and print advertisement, and saving a copy of each file for reference. The transcripts, print images, and video files were the data analyzed in this sample. I followed a similar process for the Springer Journal sample: I recorded all the bibliographic information for each article included in the sample and saved a digital copy. Once my archives were prepared, I embarked on the analysis process and examined each sample separately over approximately a 10-month period.
To ensure rigor in my analysis, I have followed the guidelines for quality forwarded by Ballinger (2006) and Laliberte Rudman & Dennhardt (2015). These guidelines include four criteria: coherence, systematic and careful research conduct, convincing and relevant interpretation and accounting for research reflexivity (Ballinger, 2006; Laliberte Rudman & Dennhardt, 2015). These guidelines informed my specific, four-step systematic process of analysis (see figure 1).

For both discursive domains, the first cycle of analysis involved an intensive process of immersing myself in the texts. I engaged in practices of close reading, during which I used an analysis sheet to record broad, descriptive reflections of each article. I inserted both quotes and summary notes from each of the articles into the data analysis sheet. Each article in this cycle was read several times, with each reading attending to different aspects of the texts such as overall content, function, or prominent rhetorical devices and linguistic strategies. The purpose of this round of reading was to gain an understanding of the content, underlying intention and prominent themes of the texts. I also recorded my initial thoughts about the text through detailed analytic memos, particularly as they related to the similarities and differences between the texts. The intention behind the broadness of my notetaking was to keep my possible interpretations of the text open at this early stage of the analysis.

The notes and analysis sheets produced informed the second cycle of reading. In this round, I read and re-read each text alongside my preliminary thoughts, and my theoretically informed questions, further immersing myself in the data. This closeness with the data enabled me to reflect upon and refine my preliminary thinking about the descriptive and analytic themes I had identified while remaining grounded in the data. In writing my memos, I reflected on the specific portions of the text, unpacking the specific language and rhetorical strategies to access the underlying and deeper meanings. I drew on my analysis sheets to start mapping the discourse, sketching the outline of central threads and general features of the content and meanings communicated. At this point, I organized my preliminary findings into a summary document in which I focused on producing a comprehensive summary that captured the content and prominent
Figure 1: Analysis Process
themes within the texts and the linguistic strategies and other rhetorical devices through which they are communicated.

At this point in the analysis process of the Journal of Cancer Survivorship sample, I had identified a number of questions that emerged from my readings of the initial 20 articles. These questions were primarily concerned with the difference between quantitative and qualitative research articles published within the Journal and the ways in which aging survivors were described and constructed. To address these specific questions, I employed purposeful sampling techniques and selected an additional 20 articles for inclusion that specifically addressed the emerging questions. At this point, I isolated the 20 purposefully sampled articles and repeated cycle one and two, following the same processes described above. Additionally, I wrote analytic memos reflecting on my questions, the content of the new texts, strategies used to communicate the content and tracking the points of alignment and diverge with the previously sampled texts. I incorporated these findings into the summary document prepared in cycle 2. Once this stage was completed, I moved onto the third cycle of analysis with all 40 articles.

In the third cycle of analysis I read the texts alongside the preliminary themes and discursive threads that I identified in the second cycle and employed them as sensitizing concepts in my re-reading to ‘test’ my interpretation and see if they could be substantively sustained with textual examples. In this cycle, I attended closely to the data and drew on specific examples to explicate the themes and discourses in a written summary that mapped the sample as a discursive field. At this stage in the process, I focused on systemically mapping how the different foci and levels of analysis are analytically related to each other (Fairclough, 1995), and describing the strategies employed within the text to convey particular meanings. This involved a considerable amount of writing analytic notes, free-writing, theoretical reflection and data extraction. I returned to my summary document created in cycle two, and revised it to reflect the central discursive threads, the function and constructions of ‘truth’ in the sample as a whole, and to flesh out the types of subjectivities the discourse produced. The revised summary document for each sample was presented to and reviewed by the members of my thesis committee who offered feedback regarding the strength of my evolving
interpretations and the evidence I drew on to explicate them. The feedback received was incorporated into the revised draft produced in the fourth cycle of analysis.

In the fourth and final cycle of the analysis, I read the texts against each other repeatedly in order to generate an understanding of the points of convergence and divergence amongst the texts. I paid particular attention to the similarities, repetitions, contradictions, variations, and absences with respect to the content, function, and form. In this round, I tried to get a sense of how the discursive threads that I identified and described in the previous document either worked together or did not work together, constituting a larger discursive framework of breast cancer survivorship. For example, for the Journal sample, I read the discourse of chronic survivorship alongside and against the discursive threads of bodily optimization and decline to understand how they interacted with each other and identify points where they diverged from or reinforced one another. I followed this process with all of discursive threads identified for each sample, in so doing, I mapped how the specific discursive constructions overlapped and worked to produce a larger, central discourse of breast cancer survivorship. Using this map, I then organized my findings into three thematic sections for each sample. The three thematic sections reflect my research questions and were clustered around my central analytic concerns of subjectivity and temporality. The additional discursive threads identified that were interesting but did not speak to the key analytic concerns of the study, dropped away, thus keeping the findings in line with my research questioned. Using these thematic clusters are organization devices, I revised and refined the summaries produced in the previous round. This draft of my findings focused specifically on explicating the forms of subjectivities that were produced and the kinds of conduct and temporal trajectories that survivors were directed towards. Each revised summary was reviewed and approved by the members of my thesis committee.

In the two chapters that follow, I present the final results of my analytic writing.

**Chapter 5**, *Chronic Survivorship: new risks, intensified responsibilities* outlines the findings that emerged from my analysis of the Springer Journal of Cancer Survivorship.  

**Chapter 6**, *Running for the Future: intimate connections and gendered responsibilities* describes the results of my analysis of the CBCF promotional materials. Each chapter is
organized around three central discursive constructions: in the first portion of each chapter I describe the landscape of each discursive field and outline the general features of the content communicated within it; the second section of each chapter forefronts the forms of breast cancer survivor subjectivity that are constructed within each discursive field; while the final section maps the temporal dimensions of the discourse and illuminates the types of temporal trajectories that are produced and assumed. While I have attempted to separate these two analytic foci, temporality and subjectivity are inevitably interwoven throughout the findings chapters.
Chapter 5

5 Chronic Survivorship: New Risks, Intensified Responsibilities

In this chapter, I trace how breast cancer survivorship is constructed in the Journal of Cancer Survivorship and consider the implications for the emergence of new survivor subjectivities. First, I outline the ways in which the Journal of Cancer Survivorship claims ‘survivorship’ as a legitimate scientific object by establishing survivors as a specific population in need of expert advice, and how survivors’ unmet needs are levied to create space for new professionalized regimes of care. I then examine how this particular construction of survivorship produces a new course of illness – that of chronic survivorship – and map the ways in which this new trajectory transforms the biomedical management of post-treatment women, producing new practices of diagnosis, treatment, and life-long management. I draw particular attention to the ways in which chronicity and temporality are intimately interwoven in the discourse and the particular idealized trajectory of survivorship it promotes. Tracing this idealized trajectory, I explore the expanded temporal boundaries of survivorship and how this expansion enables deeper entanglements of seemingly asymptotic and healthy women into an increasingly complex and expansive regime of survivorship.

Turning specifically to the new subjects of this regime – Chronic Survivors\(^4\) – I consider how women who have survived cancer are interpolated into particular regimes of discipline and self-care, highlighting the new spaces for governance and self-governance that are produced. While this chapter illuminates the contours of the dominant discursive framing of survivorship within this text, it is important to emphasize that the Journal does not speak in a monolithic voice; this discourse is produced through the editorial clustering of interdisciplinary ideas, approaches, and articulations of survivorship. Within this diverse assemblage, there are numerous points of divergence and tensions.

\(^4\) In both findings chapters, I use capital letters to identify specific forms of subjectivity that emerged from the data. I will discuss each of these forms of subjectivity in Chapter 7.
Throughout this chapter, I illuminate these moments of tension, highlighting the interplay between the discourse of what I term ‘biomedical survivorship’ and the broader, socio-cultural mandates that shape how survivors and survivorship are conceptualized and approached.

5.1 Constructing Survivorship as a Scientific Object

The production of survivorship as a scientific object and the related professionalization of survivorship care occurs through an interrelated cluster of discursive strategies. Firstly, a specific definition of survivorship is forwarded. This definition is informed by biomedical understandings of the body and a reformed disease trajectory of cancer. The definition is situated in the context of “evidence-based” research and stripped of any subjective, socio-cultural meanings connected to popular understandings of survivorship. Secondly, specific “unique problems” and “unmet needs” are attached to the newly identified condition of survivorship. Thirdly, a new patient category and population is delineated to capture survivors identified through the newly established, and purportedly objective, criteria. The biomedical survivor is constituted as a particular subjectivity that can be classified, identified, and to which specific kinds of behaviours, responsibilities, and experiences are attached. Finally, the construction of the survivor as a defined, scientific object and particular biomedicalized subjectivity produces a new field in which biomedical and other forms of professional expertise can be claimed and applied.

Discursively, the biomedicalization of the experiences and trajectories related to survivorship operates to promote particular subjects and regimes of management and care. A variety of biomedical and allied health professions are incorporated into these regimes as a range of experts charged with the responsibilities of addressing the unmet needs of survivors through knowledge dissemination and patient direction. Thus, control over the management of survivorship is spread across a broad range of experts who claim to have knowledge of this new identity and chronic condition. The proliferation of biomedicalized survivorship through this site of knowledge production propels the professionalization of survivorship care by producing and reproducing more experts who can create knowledge about survivors and survivorship. In the following section, I will trace the Journal’s positioning of itself as a site of professional expertise, explicating the
discursive processes through which the construction of survivorship as a biomedical object is produced.

5.1.1 Staking Claims, Forging a Scientific Definition

In the Journal, survivorship is incrementally established as a scientific object through a variety of discursive strategies that function to highlight its objective or ‘true’ properties while simultaneously peeling away subjective, popular and socially constituted understandings of survivorship. The vast majority of the research published in the Journal is quantitative. Within the sample, the quantitative research is peppered with references to rigorous scientific research methodology, the reliability and objectivity of specific measures, references to evidence-based practice and the statistical significance of the findings. Further, several quantitative articles included in the sample positioned qualitative methods, and patient-reported outcomes in particular, as unreliable sources of knowledge when contrasted to the reliability of scientific or technological measurement such as heart-rate monitors and digital activity trackers. These discursive strategies draw on larger scientific discourses of objectivity and methodologies as a way to legitimize survivorship as a scientific object and new knowledge regime. Particularly prominent within the sample are references to the discourse of evidence-based research and practice. The evidence-based practice movement occupies a prominent position in behavioural and healthcare disciplines and shapes the ways in which knowledge is produced, valued and taken-up in these fields of practice. In particular, references to evidence-based practice are invoked in the reported debates surrounding the establishment of an objective definition of survivorship.

In contrast to evidence-based research, current popular and non-scientific definitions of survivorship were contested for their shifting and subjective boundaries of inclusion. Establishing a consensus regarding the inclusion and exclusion criteria for survivorship as a scientific category emerged as a “critical” task in the Journal, and as integral to establishing and justifying a scientific claim over the field of survivorship. The importance of this task is described in an editorial published in the first edition of the Journal:
New definitions of what constitutes a cancer survivor have emerged over the years. Survivors have been *variously defined* as those first diagnosed with cancer to those living with a cancer diagnosis for 5 years or longer. The family has also been considered as survivors in definitions [...] Each of the existing definitions of and perspectives on cancer survivorship has their purpose (e.g., policy-related, disease statistics accounting, adjustment/coping, and advocacy). However, none of them, including the one this Journal will use, provide an evidence-based definition of survivor or survivorship. These will emerge as the field does [...] *there is a critical need for an evidence-based definition* using population health data related to those living following a diagnosis of and treatment for cancer (Feuerstein, 2007b, pp. 6–7).5

The multitude of definitions of survivor and the various purposes they serve are problematized for their subjective nature and relationships with particular interests (e.g., facilitating coping). In the context of competing interests, an “evidence-based definition” rooted in objective, population health data is positioned as the only definition that can reflect the ‘true’ nature of the phenomenon. However, the status of survivorship as an emerging scientific field hinders this pursuit because the necessary evidence required to assemble such a definition does not yet exist. The dearth of scientific evidence and the “critical” need for it are thus levied as a justification for the existence of Journal and its purpose as a site for the production and dissemination of knowledge that is evidence-based:

This Journal will help to facilitate this more comprehensive understanding, one that is based upon sound epidemiological, etiological and clinical research [...] as more evidence-based descriptions and understanding of the challenges facing cancer survivors emerge, many of the problems faced can hopefully be prevented or, at

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5 In both findings chapters, I have added italics in the quotations for emphasis to draw attention to the discursive constructions.
least, more effectively managed than at present (Feuerstein, 2007b, p. 7).

As this quotation suggests, the Journal was conceived as a key site for publication of scientific research that will establish the objective parameters of survivorship and, in so doing, will illuminate the problems associated with survivorship and enable the development of effective, evidence-based practices of care. Despite the lack of specific scientific evidence, the editor-in-chief proposes a “working concept in transition” that sketches tentative boundaries of survivorship and the Journal as a research forum:

Survivorship is a *working concept in transition*; a way to organize a body of knowledge that will improve over time and ideally impact the health and well-being of those diagnosed with and treated for cancer […] the *Journal of Cancer Survivorship: Research and Practice* will focus on populations and individuals with a diagnosis of cancer who have completed primary treatment for cancer. *It is well recognized that there are survivors who continue with “treatment” or management and that it may be unclear when primary treatment ends.* This Journal will consider these cases as survivors as well […] As evidence accumulates regarding *adult cancer patients following primary treatment until the end of life*, a more complete definition of cancer survivorship will emerge (Feuerstein, 2007b, p. 6)

The “working concept in transition” locates the origins of survivorship in the moment that primary treatment for acute cancer ceases. Despite the stated desire to forward a concrete definition, Feuerstein acknowledges that the boundaries of primary treatment are ambiguous and potentially “unclear.” The borders sketched around survivorship are thus blurred by the porous and overlapping boundaries between primary treatment and survivorship care. The end of “primary treatment” and the “end of life” are positioned as the temporal bookends of survivorship, suggesting that, as a scientific phenomenon, survivorship is uniquely temporal and relies on particular moments to distinguish itself from acute cancer and ascertain its existence.

This emphasis on establishing evidence of survivorship based on objective scientific criteria is reflected within the sample; seven articles reviewed were dedicated entirely, or
in part, to establishing an “evidence-based” definition of survivorship through the shedding of subjective meanings and inclusion criteria. Underpinning this research was a rejection of popular, institutionally-endorsed and non-objective definitions of survivorship (e.g., Susan G. Komen Foundation, American Cancer Society) and a problematization of their public prominence, particularly in relation to the ways in which such definitions shape how the general public comes to imagine survivorship and survivors.

The term has been greatly embraced by the media and advocacy groups with the surge in “success stories,” especially of “celebrity” survivors and, in recent years, by researchers and policymakers. Despite the recognized importance and popularity of the term “cancer survivor,” there is generally a lack of consensus about how it should be defined. Inspection of the literature shows that there is presently a variety of definitions, each one formulated differently to define the user’s area of interest. For example, there are those who have expanded on Mullan’s definition to include family, friends, and caregivers as they are also affected by the cancer diagnosis [...] over the past decade, there has been considerable debate over as to when an individual with a cancer diagnosis becomes known (or seen) as a cancer survivor (Cheung & Delfabbro, 2016, p. 2).

In summary, competing definitions of survivorship were identified as being socially constituted by different stakeholders such as fundraising bodies and popular media for a variety of different social and financial purposes disarticulated from objective truth.

Kelly et al., in their article, *Living post-treatment*,\(^6\) problematized the lack of consensus regarding the definition of survivorship, and charged the “larger literature and advocacy community” with producing “a confusing mix of “survivors,”” thereby shaping the public’s perception of survivors (p. 159). These authors attribute this “confusing mix” to the non–scientific expansion of the category of survivorship from individuals who have completed treatment for acute cancer to incorporate others including: the recently

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\(^6\) Titles of the Springer journal articles are indicated by italics
diagnosed, those currently undergoing active treatment and friends and family members of those currently living with cancer (Kelly et al., 2011, p. 159). Kelly and colleagues traced the multiple boundaries of survivorship as defined by various cancer organizations and fundraising bodies in a table, which is reproduced below as Table 1:

**Table 1: Definitions of Survivorship, (Kelly et al. 2011)**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Definition of a Survivor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Susan G. Komen Foundation</td>
<td>Survivor: a person with a confirmed breast cancer diagnosis. Co-survivor: family, friends, healthcare providers or colleagues who are there to lend support from diagnosis through treatment and beyond.</td>
</tr>
<tr>
<td>Livestrong/Lance Armstrong Foundation</td>
<td>Survivor: anyone battling cancer. A survivor might be the person diagnosed, a spouse, a child, a parent, a friend or any caregiver</td>
</tr>
<tr>
<td>National Cancer Institute</td>
<td>Survivor: a person with cancer from the time of diagnosis until the end of life.</td>
</tr>
<tr>
<td>National Cancer Institute’s Office of Cancer Survivorship</td>
<td>Survivor: a person with cancer from the time of diagnosis, through the balance of his or her life. Family members, friends, and caregivers are also impacted by the survivorship experience and are therefore included in this definition.</td>
</tr>
<tr>
<td>American Cancer Society</td>
<td>Survivor: defined by each individual. Each individual has the right to define his or her own experience with cancer and considers a cancer survivor to be anyone who defines himself or herself this way, from the time of diagnosis throughout the balance of his or her life.</td>
</tr>
</tbody>
</table>
Survivor: a person who was diagnosed with cancer and others affected by the diagnosis, such as family, friends, and caregivers.

Survivor: an individual diagnosed with cancer from the moment of diagnosis and for the balance of life

The ways that the term survivorship is used by philanthropic or cancer support organizations are critiqued throughout the Journal for their broadness and non-specificity. Such critiques, forwarded in these articles, together with the editorial approach of the Journal operate to establish the need for an evidence-based definition by discrediting popular definitions and reinforcing biomedical or scientific definitions. This is visible through the various iterations of boundaries of inclusion and exclusion that exclude subjective knowledge such as personal experience or self-identification as valid criteria of survivorship. For example, Kelly et al., contrast the inclusion criteria of the organizational definitions outlined in Table 1 (see above) with that of the “standard medical definition” which includes only “individuals who remained disease free for a minimum of 5 years” (2011, p. 158). The popular, non-medical definitions were critiqued for their broadness, and the inclusion of “non-survivors,” which these authors viewed as muddying the concept of survivorship for both the scientific community and the public at large.

While a “standard” medical definition was upheld by Kelly et al. as an objective measure, this specific definition was not operationalized in any of the studies included in the sample. In practice, most studies utilized the “working concept” forwarded by Feuerstein (2007) to determine their inclusion criteria. The criteria of inclusion and exclusion established in the study methodology were relatively consistent across the sample,
effectively constituting women who have been diagnosed with DCIS\(^7\) or stage I – III breast cancer, completed primary treatment and are currently disease free as breast cancer survivors.

### 5.1.2 Transforming Everyday Lived Experiences into Symptoms

Another central discursive strategy invoked to construct survivorship as a legitimate field of scientific study was the articulation of various “unmet needs” related to improvements in treatment and survival rates, and thus a growing population of “survivors.” In the Journal, unmet needs were often linked to the side-effects of breast cancer treatment, such as fatigue, pain, and depression and were constructed as problems that required a response or solution from the allied healthcare professions. The necessity for a professional response to such problems was demonstrated through frequent references to the large and growing nature of the population of cancer survivors:

Due to earlier diagnosis and improved treatment, the 5-year relative survival rate for all types of cancer combined is 66%. Current estimates are that *more than* 10.8 *million* persons living in the United States are cancer survivors. Excitement about this progress has been accompanied by *a myriad of questions about the unmet needs of long-term survivors* and interventions that may assist them (Bloom et al, 2008, p. 191).

The discursive construction of unmet needs functions to transform affective responses to the everyday embodied experiences of breast cancer (e.g., fear, anxiety) into urgent symptoms associated with survivorship that demand biomedical and allied health solutions and attention. For example, Thewes and colleagues describe “fear of recurrence” as the most common unmet need and a “chronic problem:”

The need for help with fear of cancer recurrence (FCR) is the *most commonly reported unmet need* with *one quarter to one-third* of cancer survivors reporting

\(^7\) Ductal carcinoma in situ (DCIS) describes a non-invasive or pre-invasive form of breast cancer.
*moderate to high levels of unmet need* for help with FCR. Fear of cancer recurrence which has been defined as “the fear that cancer could progress or return in another part of the body” can be a *chronic problem* for some survivors. Breast cancer survivors are particularly vulnerable to FCR (Thewes et al., 2015, p. 68).

Positioning fear of cancer recurrence in this way functions to bring “FCR” into being as a pressing and significant symptom (with its own acronym!) that requires a biomedical response. Simard et al., further enliven FCR as a legitimate medical condition by describing its complexities:

*FCR is not simply an emotional factor (e.g., fear or anxiety); it is a multidimensional construct.* In these formulations, the patient’s emotional reaction (e.g., fear) can be the result of interpretations and cognitions of the threat of cancer released by the perception of internal cues (e.g., physical symptoms) and/or external cues (e.g., television shows about cancer). This fear can lead to dysfunctional behaviors, including anxious preoccupations, avoidance, and excessive checking, leading to an increased fear response (Simard, Savard, & Ivers, 2010, p. 361).

In stating that FCR is not simply fear or anxiety, FCR is positioned as a symptom or sign of clinical abnormality that departs from a normal affective register and that requires medical authority and professional knowledge to understand, diagnose and treat. FCR is not seen an affective response to embodied experience of disease, but rather a pathological condition that speaks to the subject’s failure to respond to the condition of survivorship appropriately. The framing of FCR as a pathological condition is supported by the description of the potential negative outcomes and side effects that are associated with it (e.g. “dysfunctional behaviors,”) which are described in medical language that denotes urgency and seriousness (i.e., “anxious preoccupations,” “excessive,” and “increased fear”). Taken together, these strategies construct FCR as a serious and legitimate unmet need of cancer survivors who require assistance from various allied medical health professionals.
Although fear of recurrence was often the focus of articles that assessed the unmet needs of survivors, unmet needs described in the Journal were expansive and extended beyond pathological experiences of “fear” to include a variety of physical, mental and psychosocial aspects of everyday life. Through these descriptions of various unmet needs and their effects on survivors’ lives and bodies, survivorship is established as a field of care that expands beyond the borders of biomedicine and the physical body, incorporating other allied health professions into the regimes of care to attend to the emotional, psycho-social and behavioural dimensions of survivorship. This expansion is evidenced by research published from a variety of professional perspectives (e.g., physiotherapy, occupational therapy and psychologists) that propose specific contributions that the discipline or profession can make to address the unmet needs of cancer survivors.

In contrast to the pathological perspective described above, qualitative research presented within the Journal focuses particularly on highlighting the broader contours of the field of survivorship, drawing attention to women’s affective and emotional experiences and responses as a way to illuminate the various aspects of daily life affected by survivorship. These aspects of daily living extended far beyond physical or psychological parameters to include financial and social impacts of survivorship. It is important to note however, that the qualitative research presented within the Journal was still informed by positivist thinking, rather than offering a critical perspective. This is visible in the following excerpt, that describes unemployment, length of time taken to return to work, and work performance as unmet needs of survivors:

Cancer survivors typically suffer from impairments in physical and psychosocial functioning, which may last several years after treatment. Consequently, 1.5 years after diagnosis, only two-thirds of cancer patients have returned to work, and the rate of unemployment is significantly higher in cancer survivors when compared to non-cancer controls. Additionally, work performance, e.g., the ability to perform and complete work accurately, is often lower than before diagnosis (Groeneveld, de Boer, & Frings-Dresen, 2013, pp. 237 - 238).
In a different way, this example highlights social withdrawal, difficulties concentrating and coping with social situations as symptoms of survivorship:

This study’s findings demonstrate that social situations are a challenge for some cancer survivors related to their capacity to concentrate on the content of certain conversations. This claim has been substantiated by others. In addition, researchers have found that some breast cancer survivors who reported cognitive changes also reported changes in social relationships and possible withdrawal from social functions. Some participants explained that participation in certain social interactions had changed because of adjustments in their personal priorities. In addition, anticipated cognitive difficulties in certain social situations coupled with fatigue and the overall impact of the cancer experience impacted women’s interest in participating socially (Boykoff, Moieni, & Subramanian, 2009, p. 10).

The “impairments in physical and psychosocial functioning” identified by researchers thus extend the boundaries of survivorship as a condition through a vast array of effects of the disease, ranging from memory loss, inability to concentrate, unemployment and reduced income. This problematization of cancer survivorship highlights the broad impact of breast cancer on women’s everyday lives beyond treatment and extends the terrain for professional intervention.

### 5.1.3 Epistemological Tensions

In an interpretive context in which survivorship is constructed as a distinct biomedical condition, qualitative accounts of survivorship presented within the Journal highlight important tensions that surface in the discourse, marking instances where lived experiences of survivorship and survivors’ own understandings of their bodies and lives diverged from the promoted, biomedical configuration. This can be seen in three of the qualitative articles sampled, which problematized the validity and utility of a definition of survivorship based solely on population evidence-based data and dislocated from ‘subjective’ lived experience. Specifically, the qualitative accounts questioned how an objective evidence-based definition could seek to improve the care and quality of life of
survivors if such a definition did not account for how survivors understand their own illness experience and trajectory.

*Evidence-based practice for cancer survivorship care should begin with finding out what the terms mean to these individuals and their thoughts on its significance* (Cheung & Delfabbro, 2016, p. 2).

Understanding how cancer factors into people’s self-concept throughout the life course is *important for designing effective, patient-centered* programs that acknowledge diverse experiences and expectations and possible changes with the passage of time (Smith et al., 2016, p. 1).

This research did not question the legitimacy of survivorship as a medical and scientific object, but rather advocated for survivors’ experiences to be viewed as valid knowledge integral to the shaping of the scientific study of survivorship. Within this divergent discursive thread, survivors themselves were positioned as important sources of information about survivorship, and as vital to the formation of an accurate definition of survivorship.

The qualitative research sampled positioned and problematized the proliferation of survivorship as a popular identity imbued with rich layers of social, symbolic and affective meanings. Taking women’s lived experiences as their epistemological standpoint, this research questioned whether the popularization of survivorship, and the identity of breast cancer survivor in particular, accurately mapped onto, or reflected, how women who had survived cancer understood themselves. Specifically, in comparison to the scientific framing of survivor outlined in the previous section, this divergent discursive thread explicitly questioned the desirability of the survivor identity and the willingness of women to take up this identity post-treatment. For example, one qualitative study was concerned with self-identification as survivors among people who had received a cancer diagnosis in the past. Reflecting on their data, the authors conclude that:

*The concept of being a “survivor” is complicated […] Although we are unable to determine the direction of association among all of the factors associated with
considering oneself a survivor, it appears the concept of identifying with the term "survivor" is multifaceted and not uniformly endorsed by patients who have had cancer (Jagielski et al., 2012, p. 456).

In another similar qualitative study that explored the impact of the experience of cancer on women’s lives post-illness, the researchers found that:

*The impact of a cancer diagnosis on one’s sense of self is neither pre-determined nor universal, but rather individually and socially constructed.* Individuals’ sense of self and definition of the meaning of having cancer are constructed through the process of composing and sharing cancer experiences and expectations within a specific social context (Smith et al., 2016, p.1).

These articles challenge the assumption that underpins the dominant configuration of biomedical survivorship – that people who have survived acute cancer uniformly understand themselves as survivors and will continue to do so for the “balance of life” (Feuerstein, 2007b, p. 7). Fundamentally, a biomedical model of survivorship requires the existence and buy-in of a patient population. In articulating survivorship as a “complicated” identity that is “not uniformly endorsed” (Smith et al, 2016), the divergent discursive thread questions both the utility and the ‘truth’ of the evidence-based definition of survivorship that the Journal seeks to promote. Further, in constructing survivorship as a multifaceted concept that reveals something about how subjects understand themselves in relation to their social worlds, these articles re-entangle the identity of the survivor with the social and cultural meanings that are stripped away in the articles that enforce evidence-based definitions.

Given the complexity of survivorship as a socially shaped and contextualized identity, several qualitative researchers questioned the appropriateness of applying a scientific, evidence-based definition to the population of post-treatment women without considering the potential negative and unintended consequences this may produce.

People with cancer who do not consider themselves survivors may experience confusion, resentment, or feel excluded from programs directed at survivors […]
As clinicians and health care systems move forward with the development of survivorship research, programs, and resources, it is important to be aware that not everyone who has been diagnosed with cancer considers herself a survivor. Those who do not may not avail themselves of programs and resources directed at survivors (Jagielski et al., 2012, p. 456).

It may be that both researchers and healthcare professionals need to rethink when using terms such as cancer survivor and cancer survivorship because not only do these terms perpetuate an image of happiness and success, not all of those who may seek treatment for cancer may necessarily wish to embrace the term and benefit from it (Cheung & Delfabbro, 2016, p. 11).

These articles illustrate how patient non-compliance and rejection of survivor status and survivorship care regimes arise as potential outcomes through the privileging of scientific definitions of survivorship to the exclusion of all other ‘subjective’ understandings. Taking seriously the inescapable interplay between scientific discourses of survivorship and the larger social and cultural mandates that shape how survivorship and survivors are imagined and approached, this divergent discursive thread highlights the potential consequences that arise from an attachment to ‘objectivity’ and evidence-based conceptions of survivorship and that exclude survivors as valid sources of knowledge. While the qualitative accounts of survivorship diverge from the dominant discursive construction, they share important points of commonality. Specifically, both seek to question broader, popular conceptions of survivorship and to uncover and forward the ‘truth’ about survivorship as an epistemological object. The tensions between these discourses arise from their conflicting epistemological understandings and what type of evidence is constituted as credible (i.e., objective science or women’s lived experiences) and of scientific value. These tensions map onto larger scholarly debates regarding the value of quantitative and qualitative research and their respective ability to produce or reveal the ‘truth’ about a particular phenomenon.
5.2 Survivorship as a Chronic Condition

A key aspect of the discursive strategy to claim survivorship as a uniquely biomedical object and domain of scientific inquiry is the differentiation and separation of survivorship as a condition from that of acute cancer. The construction of survivorship as a unique condition is enlivened through two specific strategies: 1) reconstructing cancer as a disease with two distinct, linear temporal trajectories - acute and chronic, and 2) producing a new form of subjectivity and risk role for women who occupy the chronic trajectory. As an effect, breast cancer survivorship is transformed into a disease-like state that is characterized by particular forms of vulnerability that give rise to a novel risk role with a discrete set of promoted responsibilities for women who have completed primary treatment for breast cancer.

5.2.1 Inherently Risky Subjects and Risk Management Failures

There are frequent moments of slippage in the discourse where the boundaries between risk and disease and the present and anticipated future are blurred, drawing attention to the tenuous temporal space occupied by biomedical survivorship. This temporal blurring is brought into sharp relief in the editorial published in the inaugural issue:

It is important to remember that survivors remain patients. They can experience a number of health challenges and threats to health, overall well-being and function [...] while certain cancer survivors are symptom-free, highly functional and simply go about “business as usual” years after diagnosis, there are many who continue to experience challenges. Even those who fall into the enviable “problem-free” category, require high-quality follow-up care for preventive health maintenance, potential recurrence and late effects of treatment (Feuerstein, 2007a, pp. 2-3).

The many challenges that confront the cancer survivor are not simply a continuation of problems experienced during treatment but represent unique problems in the trajectory of the experience with this illness as the survivor transitions from the acute to the chronic dimensions of illness (Feuerstein, 2007b, p. 6).
Feuerstein forwards a construction of survivorship as a chronic, treatable health problem that both *exists* and requires biomedical management in the absence of active disease or symptoms. In this construction, the completion of active treatment, a marker of the endpoint of the acute phase of cancer, no longer signals a return to health and the termination of the sick role. Instead, this marker is transformed into a moment of transition and the starting point of survivorship, chronicity and the advance of a new patient trajectory.

Significantly, this new disease trajectory does not require the presence of “problems” or “symptoms,” only the potential of, or risk for, their future emergence. This invocation of a chronic survivor trajectory does not map onto dominant biomedical understandings of chronicity, which typically signals the persistence of disease or symptoms, conjuring their existence far into the indeterminate future. Instead, biomedically configured survivorship is a perpetual state of *risk*, a chronic condition that is brought into being by the *potential* for adverse effects or disease (re)emergence in the future.

The incorporation of “problem-free” survivors into the trajectory of chronicity is justified by the uncertain/unknown risks associated with biomedical treatment regimes for acute cancer and the unknowable future (i.e., recurrence, side-effects etc.) it gives rise to:

> With many known persistent medical and non-medical problems, breast cancer is now recognized as a form of chronic condition, with many unknown after-effects from treatment. A vast array of international research indicates the extreme impact that cancer can have on quality of life, self-esteem, family roles and everyday functioning. This suggests the need for an effective model of care to address the long-term consequences accompanying cancer survivorship (Loh et al., 2013, p. 332).

The “unknown after-effects” of biomedical treatment and the attendant potential for “persistent” problems to infiltrate and affect various domains of patients’ lives suggests

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8 The word “chronic” emerges from the Greek “chronos” which simply refers to the passage of a length of time. It is in this etymological sense that *chronic* is invoked in the discourse of survivorship; to designate the lasting, persistent and recurring nature of the condition rather than the symptoms.
that chronicity is an iatrogenic effect. Survivorship takes its shape from the variously embodied echoes of acute disease the and iatrogenic effects of biomedical treatments for acute breast cancer. In this configuration, survivorship as a condition is an unexpected outcome of the medical management of acute breast cancer that becomes re-enlisted into the biomedical regime through which it was produced. It is, thus, both an effect of, and an object for biomedical management.

Cures, silver bullet or otherwise, are entirely absent from the discourse of chronic survivorship. Instead, cancer is framed as a disease that, with the aid of biomedicine, can be temporarily banished from the body. The unstable, tenuous state of remission – or survivorship – is revealed by the frequent positioning of recurrence as an event secured on the horizon of the future. Recurrence is an inescapable risk of survivorship, a specter that continually haunts the possibilities of the future. Again, this risk is framed as an iatrogenic product associated with “earlier diagnosis” and “longer survival” rates:

Due to earlier diagnosis and improvement in cancer treatments, cancer survivors are living longer after an initial diagnosis of cancer. *Cancer is often considered a chronic illness rather than a life-threatening disease.* However, with longer survival after initial diagnosis, *the number of cancer survivors experiencing disease progressions such as a recurrence, a metastasis or a new tumor could also increase.* Survivors of a first primary cancer have an *increased risk* of up to 50% of developing subsequent primary cancers (Thong et al., 2009, p. 164 - 165).

Discussions of risk within the text are often coupled with statistics about increased survival rates. As suggested in the passage above, while medical progress has brought about an increasing population of survivors and a higher probability of surviving the disease, survival comes at a cost: increased risk for future disease. The construction of breast cancer survivorship as a chronic condition transforms how biomedicine is organized and practiced in relation to the possibility for future disease, thus extending the temporal scope for possible interventions. The linear temporal trajectory of chronic survivorship is characterized by both the impossibility and inevitability of an end to the risk role; there is no possibility of recovery or return to a ‘normal’ life trajectory. The
survivor subject is bound by the inescapable risks of both recurrence and the increased, lifelong risk of developing a secondary cancer. Chronicity and risk are entangled in the discourse, together providing the discursive justification for the biomedical management of survivorship care. Recurrence is not the only risk attached to survivorship; it forms just one link in the chain of risks. This chain of risks is composed of various symptoms that can be experienced by survivors (e.g., fatigue, anxiety, weight gain) as well as any factors identified at the population and individual levels that signal an increased possibility for future disease (e.g., bone density, BMI). Effectively, biomedical survivorship is constituted as a risk condition that arises from the clustering of particular types of calculable risks and the related predicted emergence of future disease.

In alignment with the production of biomedical survivorship as a chronic risk condition, survivors are constructed as inherently risky subjects – that is, by virtue of their already failed bodies, they are always already in danger of a variety of future negative health outcomes. The list of these outcomes is expansive and includes physical, psycho-social, emotional (e.g., “fear,”) problems and “other needs,” such as sexual problems:

After completing treatment, patients require surveillance to not only detect cancer recurrence, but to also identify and manage some of the long-term and late side effects of breast cancer treatment including lymphedema, pain syndromes, neuropathies, osteoporosis, menopausal symptoms, cardiovascular problems, and development of new cancers to name a few. In addition, cancer survivors may have a wide range of physical, psychosocial, and other needs related to the cancer and its treatment that may extend many years beyond completion of treatment (Kukar et al., 2014, p. 199).

Not inconsequential numbers of survivors have reported lingering effects of their treatment, especially menopausal symptoms, arm and chest wall problems, weight gain, cognitive impairment, sexual difficulties with partners, problems with obtaining and maintaining health insurance, and fears of recurrence. Almost a third of the women continue to report psychological distress, primarily depression (Bloom et al., 2008, p. 191).
The increased risk for survivors to develop other diseases or conditions, particularly lifestyle-related disease was emphasized. Further, the non-compliance of survivors with lifestyle-related health recommendations (in particular increased exercise and reduced fat consumption) are pinpointed as key sources of this increased risk.

Despite promising advances, cancer survival is associated with the presence and persistence of treatment-related side-effects, as well as increased risk for cancer recurrence, cardiovascular disease, diabetes, osteoporosis, and functional decline. *Lifestyle factors including regular physical activity, a healthful diet, and weight control have been shown to ameliorate both the short- and long-term effects of cancer treatment, as well as promote and sustain good health and are embedded as part of internationally consistent guidelines for cancer survivors. Nevertheless, the majority of cancer survivors fail to meet established guidelines for physical activity, diet, and weight control (Goode et al., 2015, p. 661).*

*Breast cancer survivors are at increased risk* for cancer recurrence and mortality, as well as developing lifestyle-related chronic conditions such as cardiovascular disease and diabetes. Engaging in healthful behaviours, in particular, regular physical activity and eating a healthy diet is important for reducing risk of such adverse outcomes. Cancer organizations around the world recommend cancer survivors engage in regular physical activity at a moderate intensity for at least 150 min/week; eat a healthy diet that is high in vegetables, fruits, and whole grains; and achieve and maintain a healthy body weight. However, *the majority of breast cancer survivors fail to meet these guidelines* (Spark et al., 2013, p. 74).

The implied individual failure of survivors to manage the constellation of risks associated with survivorship is explicitly highlighted in the passage above which admonishes the failure of the “majority of breast cancer survivors” to comply with recommended activity and diet guidelines, despite knowledge of their increased risk. This failure is further problematized by the authors who note that, as a population, survivors are less compliant with diet and exercise recommendations than the general public:
When post-intervention maintenance is assessed, less than half of physical activity and/or dietary intervention trials achieve successful maintenance. The maintenance success rate [for survivors] is smaller than the 72% reported for physical activity and dietary intervention trials in the general adult population (Spark et al., 2013, p. 78).

This failure of survivors to adhere to expert recommendations is framed as particularly problematic because of the increased riskiness of survivors – that is, it is assumed that survivors should be more responsible than the general population because of their increased likelihood for negative health outcomes. Positioning the riskiness of survivors in this way lends urgency and legitimacy to the intervention and lifestyle modification programs that are promoted throughout the Journal, which become positioned as both necessary and beneficial. The central message is that survivors are at risk and cannot or will not manage their risks without the help and knowledge of experts. Breast cancer survivors are constructed as subjects who, by virtue of their survival of disease, occupy a continuous risk-role, yet also fail to responsibly and effectively manage their at-risk bodies. This construction supports the positioning of survivors as a particularly risky biomedical population that is in need of new and potentially intensified forms of expertise, surveillance and chronic care and gives rise to a new survivor subjectivity – the chronically ill survivor.

5.2.2 New Risks, Intensified Responsibilities

The compulsory enrollment of women who have survived breast cancer into a new subjectivity - the chronically ill subject - facilitates the exposure of survivors to new discourses of self-management and new responsibilities of risk reduction. The invocation of this new subjectivity locates survivors within larger public and clinical discourses of risk and chronic illness in which patient care is framed through the language of individual risk management and lifestyle change. Such framing is highly visible in the journal, which outlines lifestyle modification and risk-reducing choices as central responsibilities of chronically ill subjects who are expected to shoulder the responsibility for their present and future wellbeing.
One quantitative study, *Objectively measured physical activity and cognitive functioning in breast cancer survivors*, provides an example of how discourses of lifestyle risk are invoked through a biomedical language of treatment in order to re-frame survivorship as a state of being chronically ill that is marked by risk and individual responsibility to manage risk. The purpose of this particular study was to scientifically determine, how “specific doses” of exercise can be “prescribed” to “free-living” (i.e., non-medically supervised) survivors in order to improve the cognitive impairments that many survivors experience post-treatment. Within the findings, body mass index (BMI) is discursively linked to cognitive impairments and lack of physical activity - linking survivorship care to an established discourse of obesity.

*Obesity is a modifiable lifestyle factor* that has been associated with higher rates of cognitive impairment in non-cancer populations and has been associated with time spent in MVPA [physical activity] in interventions and epidemiologic surveys. In the current study, we identified BMI as an effect modifier of the relationship between MVPA and information processing, such that the relationship was stronger among heavier women […] *Findings suggest that heavier breast cancer survivors, who are at an elevated risk of cognitive impairment because of their body weight, may benefit from physical activity interventions for enhanced cognition* (Marinac et al., 2015, p. 235).

Marinac and colleagues emphasize that lifestyle risk factors such as BMI are *modifiable* and result from the personal choices of survivors (i.e., choices not to exercise and to consume high-calorie diets). The study links the “modifiable lifestyle factor” BMI with cognitive impairment, suggesting that the link between the two may be causal, in alignment with the construction of survivorship as an interrelated chain of risk factors. Implicitly, this study positions “heavier” survivors who fail to “modify” their lifestyle risks as responsible for any cognitive impairment they may experience after treatment is ended. Left unexamined, are the potentially life-limiting, iatrogenic effects of biomedical treatments for breast cancer and the possibility that post-treatment women may not be able (physically or otherwise) to engage in the promoted lifestyle practices.
Survivors’ responsibilities to be informed about and manage risk is also visible in the “shared-care model,” which was described by one team of researchers as an optimal framework for delivering “survivorship care.” This framework requires post-treatment women to be both informed about and active in the planning and delivery of their long-term care. The researchers describe the competencies that survivors must have in order to effectively participate in this model of care and the consequences of any competency deficiencies:

Survivors’ require confidence in their ability (i.e., self-efficacy) to manage, coordinate, and advocate for their survivorship care […] Deficits in any one area, for example having a survivor who is neither well-informed nor participatory in their survivorship care planning, can ultimately impact on their long-term health outcomes. Research evaluating the most effective communication strategies for delivery of survivorship care plans is an important area of future investigation (Casillas et al., 2011, p. 376).

Perhaps in light of these “deficits” in survivor care “competencies,” some studies suggested that survivors, as chronically ill subjects, required careful monitoring and surveillance by experts. For example, texts described survivors as “free-living” – that is, as unmonitored subjects, equipped with expert advice and recommendations, but who resist compliance with biomedical authority to address their risks and “deficits” (Marinac et al., 2015). This double framing of survivors as risky and irresponsible (i.e., free-living and non-compliant) is deployed to support the need for a particular type of expert-monitored behaviour modification program (see section 5.3). The chromic survivor is constituted in the discourse as a subject that is at once dependent on biomedical advice and in need of both close management and self-directed, responsible action. Importantly, in framing post-treatment women as chronically ill the discourse anticipates failure and irresponsibility of survivors to manage risk and their continuing need for biomedical management and direction.

In alignment with a neoliberal framing of health, risks associated with survivorship in the Journal for Cancer Survivorship are predominantly located in the individual body and are
attributed to lifestyle or individual choices. In the study sample, risk is never discussed as being environmental or social in nature, and the social determinants of health are absent. This can be seen in one study that investigated the relationship between diet and fatigue in breast cancer survivors. In this article, the authors identified the consumption of “empty calories” as a “significant” risk for fatigue in survivors (George et al., 2014, p. 684).

In this large breast cancer survivor cohort, post-diagnosis diet quality was inversely and independently associated with all dimensions of fatigue. The dietary guidelines for Americans aim to provide a dietary pattern that, if followed, could reduce risk of major chronic disease. This study provides new evidence on how adherence to both US diet and physical activity guidelines is associated with lower behaviours severity and sensory aspects of cancer-related fatigue (George et al., 2014, p. 696).

What is overlooked in this configuration are the life-limiting, iatrogenic effects of chemotherapy and radiation that contribute to and produce fatigue in the first place. Framing the adoption of healthy eating guidelines as a solution to reduce the severity of survivorship-related fatigue (and future risks for chronic illness) forwards an individualized model of survivorship that obscures the complex social and economic contexts in which individuals’ consumption choices are shaped and constrained.

Within the sample, a number of researchers (Alfano et al., 2007; George et al., 2013; Marinac et al., 2015) were concerned with tracing present problems or symptoms of survivors to sources of ‘risk’ in their past (i.e., smoking, sedentary behavior etc.) These sources of risk were always located within body or lifestyle of the individual. Employing a ‘backward’ looking gaze, specific biological and behavioural characteristics of women prior to diagnosis were examined for evidence to explain the disease outcomes experienced by survivors in the present crafting a linear relationship between individual behaviours in the past (i.e., high-fat diet) and the emergence of adverse events or outcomes in the present. The ‘backward’ looking gaze is imbued with moral assumptions about the irresponsibility of women to effectively manage their lifestyle risks. However,
the linear logic of this approach was problematized by a number of qualitative studies that diverged from linear risk logics (i.e., Boykoff, Moieni, & Subramanian, 2009; Groeneveld, de Boer, & Frings-Dresen, 2013; Hahn et al., 2013; Miller, 2012).

For example, Laura Miller’s qualitative study of survivors’ experiences with uncertainty highlighted a number of moments where linear risk logics did not map onto the experiences of survivors, highlighting the limits of risk as an interpretive framework. One participant described her frustration in trying to understand why she was diagnosed with breast cancer at a young age, despite the absence of known risk factors: “‘How did I get it? [I’m] 37 1/2. There’s no history of breast cancer in my family. I’m a healthy person. I exercise; I eat right, all this kind of stuff. So, I’m like, ‘Huh?’” (Miller, 2012, p. 434). The above participant references common risk factors associated with breast cancer such as age, family history, and lifestyle, and then casts doubt on the predictive quality of these risk categories. In this example, the woman’s own experience, age, family history, and lifestyle are positioned as sources of uncertainty because they do not explain or shed light on her development of cancer. In this way, the subject’s past lifestyle is reconstructed as unreliable through the condition of the present because the anticipated outcomes of past risk management efforts do not map onto embodied condition of the present (breast cancer treatment and survivorship).

5.3 Governing Survivors

As I reviewed in the previous section, Chronic Survivor subjects are incorporated into a complex biomedical regime in which risk for future disease is searched for, anticipated and brought into the present, and various ‘normal’ aspects or features of everyday life are transformed into symptoms. The positioning of these mundane features as symptoms and signs of (potential) future pathology enables the promotion of anticipatory action and bodywork practices to reshape and intervene into the possibilities of the embodied future. The responsibility for risk reduction is partially shifted onto individual Chronic Survivor subjects who are constructed as responsible to seek out and take up expert advice and biomedical knowledge as part of an anticipatory strategy of risk management. This strategy is centrally concerned with the conditions of the future, which is imagined as something that survivors should be both concerned about and motivated to optimize
through their actions in the present, in light of their (assumed) past failure to responsibly manage risk.

5.3.1 Governing through Self-Management and Anticipatory Action

The idea that survivors should engage in anticipatory, self-management strategies is evidenced in the sample by a number of articles that introduce interventions designed to ‘train’ survivors to care for themselves in ways that align with biomedical advice. To map how the Chronic Survivor is constructed as a self-managing, anticipatory subject, I detail one specific program as an example of the ways in which patient education is used as a disciplinary technology to direct survivors to conduct themselves in particular ways to incorporate particular habits and practices of self-surveillance and risk reduction.

The 2013 study, *Effectiveness of a Patient Self-Management Program for Breast Cancer as a Chronic Illness*, describes an intervention designed to cultivate specific forms of “effective” and “proactive” survivorship conduct, with the aim of training women to live “effectively” with breast cancer (Loh et al., 2013, p. 338). Effective living with breast cancer is described by the study authors as the result of engaging in various self-management techniques in daily life (e.g., banishing negative thoughts, adopting positive thinking, engaging in exercise, maintaining a healthy diet). In this study, participants were required to attend a number of information and skills workshops designed by the researchers. These workshops were peer-oriented in nature and women were partnered with a “buddy,” whose dual role involved peer support and peer monitoring (they were actively encouraged by the researchers to report on the adherence of their partnered participants to the modeled behaviours):

Participants were assigned to one member of the group, based on a similar experience […] they were encouraged to lend support to each other and to *report to the group* if their buddy was not able to attend subsequent session, and what or how they have provided support to their respective buddies in this journey (of health after breast cancer) […] *these women shared and were exposed explicitly to how other women managed their intrusive thoughts, or how to talk to their fearful young child about their loss of hair or illness*. During the discussion, *the exercise*
required them to reflect and pick up positive behaviour which they can apply in their situation, based on the success stories heard from other women (vicarious model). An example of self-management behaviour required of the participants included knowing how to conduct breast self-examinations (or be breast aware), and they were paired up to practice with their “buddy” using an evaluation checklist to feedback to each other (Loh et al., 2013, p. 332).

Significantly, this intervention was based on modeling desired forms of conduct that were promoted as the correct or healthy way to be a survivor. This can be clearly seen in the activity described above where women are instructed to “reflect and pick up on positive behaviour” described by the “model” survivors and apply it to a role-playing scenario. Throughout the training workshops, participants’ behaviours and conducts were directed in particular ways through the dissemination of knowledge (i.e., positive thinking strategies, exercise recommendations) and the adoption of these desired behaviours was subjected to peer surveillance and evaluated according to prescribed guidelines (i.e., evaluation checklists). The activities described above reflect, construct and disseminate a model of disciplined survivorship that promotes individual responsibility and intensive self-management.

Among the various responsibilities of survivorship is a duty to be knowledgeable about breast cancer, its treatment and the unique condition of survivorship. The duty to be knowledgeable was visible in the majority of the articles sampled to some degree but is most clearly visible in the discussion of survivor training programs in which the cultivation of knowledge about breast cancer and health is an explicit and integral component. For example, a second training program, designed by Bloom and colleagues (2008) also focused on increasing women’s knowledge about breast cancer. Five specific knowledge domains were identified across programs: 1) treatment options and the risks and benefits of each; 2) possible symptoms and management strategies; 3) expert advice on lifestyle (i.e., exercise, diet, ideal body-weight, breast self-exams); 4) how to communicate effectively with health professionals; and 5) how to “fight” negative thoughts and cultivate a positive attitude. The significant knowledge component of the training programs described is reflective of the idea that proper survivorship includes a
duty or responsibility to know and understand expert advice. Compliance with this duty is framed as *empowering* for survivors as subjects within a chronic disease regime and health consumers to make the *right* decisions (or to be self-managing survivors) and act in ways that reduce their risks and protect their future health. In this way, the program, through the translation and dissemination of expert knowledge and the modeling of *correct* survivorship, makes the expectation of self-management for survivor subjects both possible and feasible.

The duty to be knowledgeable about survivorship requires both active and continuous effort on the part of the survivor throughout the rest of her life. The intervention designed by Bloom is composed of three, six-hour information workshops intended to “renew” survivors’ motivations and desires to make lifestyle and behavioural changes in the interest of “protecting” and “enhancing” “their health and quality of life in the present and in the years ahead” (Bloom et al., 2008, p.192). This intervention sheds further light on the various topics about which survivors are expected to be knowledgeable and how their conduct is directed towards particular actions. In the quote below, Bloom describes the components of a workshop concerned with diet and exercise. In the text, we can see how expert knowledge is combined with directed action in order to *train* survivors to take up the desired behaviour:

In the first workshop, *an exercise physiologist spoke about the importance of weight-bearing physical activity, gave examples of weight-bearing exercises, and led the women through a 30-min exercise session using exercise stretch bands.* At lunch, the women discussed ways to increase exercise in their daily routines and the importance of healthy eating […] In the second workshop, all of the women received *a personal assessment by the exercise physiologist and an exercise prescription.* In addition, women exchanged information about barriers to regular exercise and techniques they had found useful in increasing their exercise. In the third workshop, *the exercise component was again reinforced by further exchange of exercise “progress reports.” The fitness instructor also led them in exercises during a break* (Bloom et al, 2008, p. 194).

This model combines expert information, directed action, and peer group discussion of strategies to achieve the desired comportment, and was followed in all three target intervention areas (healthy eating, exercise, patient communication). This intervention is disciplinary and based on repetition and incrementally builds on the desired knowledge
and skills through the use of particular tactics, such as the discussion about the importance of physical activity, the “practice” of physical activity, the provision of “exercise prescriptions,” exercise progress reports, and instructor-led exercise. This type of embodied practice aims to transform women into *ideal survivor subjects* through the repetitive modeling of ideal conduct, effectively resulting in a literal incorporation of survivorship ideals.

This model of survivorship training renders the desired action, behaviour or lifestyle change as the only *rational* option for a survivor citizen. The desired behaviour or piece of knowledge is presented and repeated a number of times in this intervention, while possible barriers or resistance to the practice are dismissed through superficial discussions of how to incorporate the change into the subject’s life. Through this model, and the perspective of the sample more broadly, it becomes incomprehensible that a survivor would *choose* to ignore expert advice and not take up the desired action. Barriers to incorporating particular activities or taking up particular knowledge are presented as trivial, or something that can be overcome simply by chatting about strategies with peers over lunch. In this way, barriers are constructed as individual (i.e., time management) rather than systemic (i.e., social class). The discourse constructs survivors as having a duty to know and understand expert advice and then to act on this advice, implementing it into their own lives, and overcoming any barriers to doing so. These workshops are a reflection of how survivors are constructed as subjects who are particularly risky, “below average” in compliance with lifestyle guidelines and thus in need of expert guidance and training. The intensity of this intervention and the rigorous training and repetition they demand also suggests that survivors are subjects who must be held to a higher degree of responsibility than the average citizen for their health.

In alignment with the construction of survivorship as a chronic condition imbued with ever-present risk, the programs discussed above position the responsibility of survivors to engage in the promoted forms of conduct as a life-long and continuous project. This idea can also be seen in, *Physical activity and/or dietary interventions in breast cancer survivors*, in which the authors emphasize that “the adoption of healthy lifestyle behaviours is important following breast cancer diagnosis; however, it is the *maintenance*
of these behaviours that are critical to the long-term survival of women with breast cancer” (Spark et al., 2013, p. 80). The idea about the “maintenance” of desired behaviours (i.e., following diet and exercise recommendations) can be seen in a number of articles throughout the Journal and is reflective of the idea that survivorship is a life-long project and obligation that involves continuous and relentless disciple and self-management of the body.

5.3.2 Technologies of Normalization and Optimization

In the previous sections, I described how post-treatment women are constructed as a population of at-risk, chronic patients in need of medical scrutiny, surveillance, and training. The construction of breast cancer survivors as a population of chronic patients positions the continuation of life-limiting symptoms and the recurrence of acute cancer as outcomes that can, and should, be avoided through continuous and active management of the body. In this section, I describe how the construction of chronic survivorship invites and necessitates new interventions directed towards the normalization and optimization, of survivors’ bodies and comportment. These interventions were concerned with both normalizing the present condition of the survivor’s body and optimizing her future health through anticipatory risk-management strategies. Ultimately, this discursive construction functions to locate the symptoms of survivorship within the individual body and attribute their existence and severity to lifestyle choices, rather than exposure to chemotherapy, radiation, and other biomedical treatments.

Underpinning the construction of breast cancer survivorship as a manageable and optimizable condition is the assumption that the disease and its trajectory are securely within the realm of scientific expertise and biomedical knowledge, rendering its potential outcomes as both predictable and amenable to intervention. Positioning survivorship in this way interpolated chronic survivor subjects into new evidence-based regimes of risk management that function as technologies of normalization and optimization. Underpinning these regimes is a classificatory system that systematically identifies particular ‘symptoms’ and ‘risks’ associated with survivorship using specific calculable measures (e.g., body fat ratio, BMI, bone density) that are then used to judge and assess survivors’ bodies in relation to a less risky norm – one the approaches or achieves the
status of ‘healthy.’ These symptoms and risks of survivorship identified in the Journal included, physical and affective aspects of survivorship (e.g., fear, stress, confidence). Each individual risk factor within this regime becomes the basis for classifying survivors’ bodies, and survivors themselves, as being either ‘at-risk’ or normal and is operationalized to promote specific interventions (e.g., exercise programs, diets) in order to bring the survivor’s risk measurements into line with the established norms and ‘healthy’ ideals. This practice of risk profiling operates as a normalizing technology, producing new standards for survivorship, understood as both a subjectivity and chronic illness trajectory.

The Journal’s investment in producing new norms for survivorship comportment is suggested in the publication of research that advocates for the importance of establishing scientific measures of ‘normal’ survivorship against which a population of survivors will be compared:

The American Society of Clinical Oncology has recently released guidelines for the assessment and management of anxiety, depression, pain, and fatigue for cancer survivors that emphasize the evaluation of the psychosocial, lifestyle and functional long-term and late effects of cancer and its treatment. A brief measure that identifies the scope of problem areas that can be experienced by an individual cancer survivor is a goal of quality care […] there is a need, even in the context of formal navigation, for approaches that can efficiently, reliably and validly identify common problem areas for cancer survivors that have clear implications for triage to resources in general and/ or specific health care providers (Todd, et al., 2015, p. 138).

As suggested by the quote above, the published guidelines produced by the American Society of Clinical Oncology are concerned with the “assessment, management and evaluation” of “long-term and late effects” of breast cancer and its treatments. The development of such guidelines suggests that the American Society of Clinical Oncology has determined levels of “pain, fatigue, anxiety, and depression,” that can be categorized as normal, and subsequently, levels or experiences of these phenomena that are outside of
normal, problematic and thus clinical. So, while these embodied or affective experiences of breast cancer survivorship have long been identified as common experiences and discussed in various survivor narratives, they are transformed in the Journal into clinical side-effects that should be experienced in particular ways (i.e., degrees and severity) and should be modified if they are experienced in ways that fall outside of the prescribed norm.

The establishment of particular norms of survivorship through the practice of risk profiling is captured in the study described above. This particular research is concerned with formulating and testing a measure that could be applied in the clinical setting to reliably, and accurately, assess and identify the severity of specific risks or ‘problems’ experienced by individual breast cancer survivors. What is particularly interesting about this study is the output of the measure developed – the Cancer Survivor Profile. As shown in Figure 2, this profile makes it possible to visually “identify where an individual cancer survivor’s score falls along some continuum. A specific score on the profile informs the provider and survivor where her score fell relative to the group of breast cancer survivors used in the standardization procedure” (Todd et al., 2015, p.145).

Figure 2: My Cancer Profile, (Todd et al., 2015).
The profile measures a variety of mental and physical phenomena including: stress, feeling down, fatigue, fear of recurrence, pain, body image, cognitive function, social function, sleep, sexual function, work productivity, unhealthy diet, healthy diet, physical activity, patient-provider communication, health information/knowledge, health care confidence and financial strain. We can see in Figure 2 that each of these phenomena is measured in relation to a presumed norm and, based on a survivor’s measurement in any one of these areas, the physician is instructed to: 1) encourage the survivor to “maintain” the behaviour; 2) monitor (“watch”) the behaviour or phenomenon; or 3) intervene (“act”) in order to modify the behaviour or phenomenon and bring it into acceptable/“normal” levels.

Significantly, the list of phenomena covered by this profile is expansive and encompasses a wide variety of aspects of life from sleeping habits, to workplace productivity and social function, which previously were outside the purview of survivorship care. The output of this profile, and the colours used to mark abnormal levels that require action, literally and visually mark the areas in which the survivor departs from an established norm, thus alerting the health care provider to the particular types of interventions that each survivor requires in order to achieve normality. This measure and its output profile operate as a technology of normalization by establishing/reinforcing normal and expected ways of being a survivor in terms of health, experience, symptoms, emotions, and physical function, against which individual survivors can then be measured. This normalized construction of survivorship locates survivorship as an object within the realm of biomedical expertise, promoting its construction as a condition that can be accurately and reliably controlled and managed through the application of evidence-based practice. This normalized construction of breast cancer survivorship operates to invoke a sense of authority and legitimacy, and to obscure the various elements of biomedical uncertainty that continue to puncture this emerging scientific field. While the dominant discourse of survivorship presented in the Journal functions to obscure these elements, there are moments where various biomedical uncertainties are acknowledged; moments that question the legitimacy and accuracy of the promoted regimes of care and management. These points of tension frequently emerged in qualitative articles that presented narrative accounts of survivorship which
draw attention to the interplay between the discourse of biomedical survivorship as an interpretive frame and the complexities of everyday lived experience. One narrative account featured in, Sources of uncertainty in survivorship, described lymphedema, an iatrogenic effect of acute cancer treatment, as an uncertain, unmanageable and unpredictable condition that was outside of her control.

The lymphedema is an ongoing uncertainty. Is it going to get worse? Is it going to eventually disable me? Will I have an elephant leg that will make mobility a problem? Will I get infections? I think the main thing is coming to grips with the fact that I don’t really know what’s going to happen. I don’t really know. It’s not a stable thing (Miller, 2012, p. 345).

The instability of the symptoms that she describes, in tandem with her assertion that the condition is both unstable and unpredictable, does not map neatly onto the normalizing construction promoted within the dominant discourse. Instead, her account gives the impression that lymphedema is outside the realm of biomedical control and effective intervention. Accounts of biomedical uncertainty were also clustered around qualitative accounts of women’s experiences of post-treatment cognitive change, or “chemo-brain.” These accounts typically described women’s challenges in gaining biomedical recognition of their contested condition and access treatments:

[My oncologist] noticed that I wrote on my hand, my notes, and he said, “what are you doing that for?” And I go, “you guys did this to me. I don’t have my memory anymore.” He goes, “well, do you think you have chemobrain?” I said, “yeah...does it go away? Does it get better? Does it get worse? What’s the deal?” And he says, “we really don’t know.” And I think that’s the case. I think they really don’t know. That’s why nobody’s sending you anywhere [for treatment] (Boykoff, Moieni, & Subramanian, 2009, p. 228).

A number of qualitative accounts presented in the Journal drew attention to the debates around claims of biomedical authority and expertise over the field of survivorship. These accounts point to the limits of a scientific framework of survivorship for understanding and responding to the lived experience of the ongoing and long-term effects of cancer
treatment in everyday life, drawing attention to the ways the framing of survivorship as a ‘new’ and unique condition operates to mask the uncertainty that accompanies the ‘success’ of biomedical treatments for acute cancer.

5.3.3 Returning to Normal

Underpinning the construction of survivors as chronically ill subjects whose risks are amenable to intervention was the assumption that ‘normal’ is an identifiable state of the body and that this state is achievable for all bodies. Taken for granted in this configuration is the idea that cancer survivors are ‘normal’ before the advent of illness, and that the survivor is able to return to this state of being – that is, that she has not been fundamentally changed or altered by cancer and its treatments. This positions survivorship along a teleological trajectory that is characterized by the completion of active treatment, leaving the cancer experience behind and moving forward through the embodied, risky state of survivorship in which the normalization and optimization of the body and its functions are prioritized. The survivor’s configuration as a subject who is called to respond to and account for their various embodied changes is visible in a 2009 editorial that describes Feuerstein’s first encounter with survivorship care:

The team at UCLA placed greater focus on my current and long-term health as someone who had very invasive treatment for brain cancer and wants to be as healthy as possible. While an oncologist coordinated the evaluation, I was also seen by an endocrinologist, nurse specialist, and social worker, and was given a comprehensive evaluation and realistic intervention options. I felt that I was on the right track. It was a relief. This evaluation provided me with a better sense of my current general medical condition, potential late effects, well-being, and the need to re-establish health behaviors as someone who went through treatment for brain cancer. I received a new medication that turned out to be more effective in helping my mood, fatigue, and weight loss efforts, a better perspective on how to manage my hearing loss, and a renewed sense for the need to and guidelines for changing key health behaviors. A vitamin D deficiency was also identified and a plan to mitigate this was initiated. What cancer survivor wouldn’t want something like this? Action steps you can take […] it is very important for all of us to realize
that many cancer survivors don’t want to simply accept a “new normal.” Instead, they want their “old normal” back or to return as close to “normal” as possible. Some may even want to go beyond their “old normal” (Feuerstein, 2009, p. 3).

Within this account, the “new normal,” or the altered embodied state of the survivor is problematized as an unacceptable and irresponsible state of being. The various symptoms and embodied experiences that mark this state such as “fatigue,” “weight gain,” “hearing loss,” and poor mood are positioned as amenable to transformation. This transformation is enabled through the seeking out of advice from many types of experts and taking up this knowledge to inform individual behavioural change via “action steps.” Survivorship is thus framed as an opportunity to correct the mistakes or ignorance of one’s past and to take one’s health seriously by seeking out and adopting expert advice and modifying one’s consumption and habits. Underlying this approach is the assumption that survivors are rational subjects who are free, unconstrained and able choose their own health destinies, and that, once informed, they will make the ‘right’ choices to the exclusion of possible alternatives in the realms of diet, habit, and activity. Those who knowingly, and thus willfully, choose otherwise are not worthy of survivorship status; their choices are positioned as illegitimate. The discourse implies that despondency or unwillingness on the part of survivors to choose ‘correctly’ and change their lifestyle can be willfully overcome with medical knowledges and expertise. Absent from the discourse is any acknowledgment that survivors, as subjects, are positioned differently in social relations of power and their social and economic conditions that shape both their lifestyle choices and health histories.

Bodily optimization interventions and responsible self-action are positioned as mechanisms that render it possible for the motivated, self-managing survivor to achieve their previous bodily state (the “old normal”), or even go beyond this state to cultivate an optimal state of being. Feuerstein, the editor-in-chief, is himself interpolated into the discourse as an Optimizing Survivor subject – a self-governing, responsible chronic subject – presenting a model of what is possible and achievable through adherence to the biomedical model of survivorship. The risk discourse that underlies the normalizing regime of care thus operates to project an illusion that survivors’ health outcomes and the
avoidance of remission are achieved via responsible consumption and self-management of the body.

While the majority of the research presented in the study sample positions returning to ‘normal’ as both desirable and possible for survivors, moments of tension were present in the discourse where it was acknowledged that such a return may not be possible or desirable. In particular, narrative accounts of women’s experiences of survivorship featured in qualitative articles often highlighted a sense of disarticulation from, or being out of step with, the normalized (white middle-class) life course they had occupied before their illness. This disarticulation was illustrated as a permeant relocation to an alternative, abnormal timeline. For example, one woman described feeling as if she had fast-forwarded through her life-course, and was now, as a survivor, experiencing life as a person much older than her chronological years:

What I have to do sometimes is have my son come over and pay my bills. Can you imagine? It really makes me feel bad…I’ve been so independent and here I am at 55 years old and I can’t pay my bills. And the money’s there (Boykoff, Moieni, & Subramanian, 2009, p. 227).

In sharp contrast to the Optimizing Survivor described by Feuerstein, this survivor described a sense of feeling unable to manage her life and return to the roles that she once occupied and rituals that demonstrated her financial success and self-sufficiency (paying bills). Instead, she has been transformed, against her will, into a more dependent subject that required the help of her adult son to manage tasks of daily living. This survivor’s temporal trajectory was altered, accelerated and catapulted forward, rendering her closer to decline and to the loss of independence, foreclosing the possibility of her return to ‘normal.’

5.3.4 The Specter of Decline

As I have illustrated in the previous section, the self-managing Chronic Survivor is propelled towards the trajectory of bodily optimization, a trajectory that is promoted within the discourse as the responsible and correct path for survivorship. While the
Optimizing Survivor was a prominent and idealized form of subjectivity, it was not the only one present in the discourse. Accounts of decline and dependency were threaded through the discourse, producing other, less desirable, subjective possibilities for survivors; that of the at-risk survivor and the Decliner. The Decliner was invoked in the discourse as a failed subject that is beyond redemption and biomedical intervention. She is locked into a downward trajectory of decline, disability, and death. In contrast, the at-risk survivor subject is located at the crossroad between the trajectory of optimization and decline, her ultimate path dependent on her actions and willingness to responsibly manage her body and risks.

This subject is still redeemable and is incited to take up the responsibility for her own health. A particular sub-type of the at-risk subject emerged in the discourse – the aging survivor - whose biological aging intensifies her risk, responsibilities and the magnitude of the potential devastating, negative outcomes of her failure. This subject is located on the boundary of irreversible decline. In the following sections, I will trace the ways in which each of these subjectivities are constructed and consider the kinds of conduct they promote.

The ideal active risk-reducing patient who complies with various technologies of normalization and optimization was frequently contrasted with the figure of the non-compliant, risky patient, who was invoked throughout the discourse to highlight the perils of unmanaged survivorship. This subject – the Decliner – appeared frequently throughout the Journal serving as the subject of a cautionary tale in which their failure to manage their chronic condition resulted in a variety of long-term effects that detrimentally affected their quality of life in a variety of domains. Decliners are positioned as subjects who are beyond intervention and redemption and operate as the failed subjects of a biomedical regime of survivorship. Their decline was frequently attributed to the persistence of a number of modifiable risk factors (e.g., lack of exercise, high BMI, comorbid condition) and the irresponsibility of survivors to engage in recommended lifestyle change. As objects of scientific study, Decliners, and their particular characteristics were drawn on to inform the development of interventions for future survivors identified as being at risk of decline. The Decliners are invoked as
subjects of a cautionary tale, the core message of which is that proper management and interventions could have improved their outcomes.

As I have discussed in the previous section, within the Journal, risk is constructed as having a particular temporal relation, in which risk factors operate as predictive technologies that anticipate the emergence of disease in the future. In this configuration, the origins of the disease can be explained and traced to a degree through scientific examination of past risk factors. Decliners were examined through this backward-looking gaze, and researchers sought to locate origins of decline within the individual body through the close examination of the features and characteristics of this population, isolating particular characteristics as predictors. Looking backward to the past to explain the dimensions of the present, these researchers ultimately determined that what separated the Decliners from normal (i.e., recovering) survivors and Optimizing Survivors were individualized factors. In particular, this group was described as “significantly less educated, less likely to exercise, more likely to have [a comorbid condition], and a higher BMI” (Sehl et al., 2013, p. 24). Significantly, these factors are all individualized and associated with the social determinants of health (e.g. class and race), however, there is no mention of the potential social nature of these differences in the discourse, and instead, these factors are positioned as the outcome of individual choice, and thus modifiable.

The idea that the risk factors for decline are modifiable is demonstrated in this article’s conclusion where it is reasoned that because persistent decline (i.e., being a Decliner) is predictive of “poorer 10-year survival” (i.e., death) in breast cancer survivors, future research should be directed to determining whether lifestyle-based intervention could improve the survival outcomes for individuals determined to be at risk for “persistent decline.”

Physical activity and health education interventions have been shown to improve physical performance scores in sedentary older adults at risk of disability. Further research should address whether exercise interventions that improve physical function or diet and smoking cessation interventions have an impact on patterns
of decline in physical functioning specifically in older cancer survivors (Sehl et al., 2013, p. 30).

We can see here how insights gained from the backward-looking gaze (i.e., declines are less likely to exercise and have higher BMIs) were used to shape possible interventions (e.g., exercise interventions) to intervene into the future outcomes of new patients and to prevent decline. This conclusion ties decline with individual factors and offers individualized solutions to prevent future Decliners, eliding any possible investigation of systematic or social explanations for the physical decline in this particular population. In tying individual lifestyle to decline, this conclusion also provides practitioners with possible strategies or ways to manage survivors who are conceptualized as being at risk of decline.

Another article, Physical activity, long-term symptoms, and physical health-related quality of life among breast cancer survivors, also employed the backward-looking gaze to determine how survivors’ pre-cancer exercise patterns contributed to their post-cancer outcomes and function. The hypothesis of this study was that the long-term side effects of cancer treatment may be ameliorated, reduced or prevented by physical activity before diagnosis, and that lack of physical activity may be able to explain why some survivors experience serious and long-term side-effects. The study is introduced by reviewing the literature on long-term side-effects and listing all of the possible long-term problems that may occur and the serious impact that they may have on survivors’ lives.

Physical activity is one factor that may modify risk of these problematic long-term physical symptoms. Physical activity among healthy people has been linked to improvements in many of the same physical and psychological symptoms that are problematic among cancer survivors. Further, according to the “buffering model,” physical activity before diagnosis can “build up” a patient’s physical status to begin cancer treatment in the best possible condition which should minimize problematic symptoms (Alfano et al., 2009, p. 117).

Physical activity is positioned as a protective activity that “builds up” the subject’s physical resilience before cancer diagnosis and treatment, and thus protects the physically
active (optimizing) subject by “minimizing problematic symptoms.” Implicitly in this configuration, physically active subjects are rewarded for their efforts with minimal side-effects, and sedentary subjects are rendered unprotected, and thus vulnerable to all of the possible side-effects. The backward-looking gaze of these researchers seeks to explain why survivors experience different severities or degrees of side-effects by looking to the behaviour and actions of the subjects before they were diagnosed with cancer.

We might expect a history of physical activity to be associated with reduced severity of cancer-related symptoms (e.g., fatigue) because physical activity in non-cancer samples is associated with reduced severity of similar symptoms … Our results suggest that women with higher levels of pre-diagnosis sports/recreation activity, especially vigorous activity, may be better able to be physically active in their daily lives (e.g., climb stairs, walk several blocks) after breast cancer treatment (Alfano et al., 2009, p. 125).

The hypothesis of the study is that physical activity serves a protective function and subjects with “higher levels of pre-diagnosis sports/recreation activity” will have better post-cancer outcomes. Based on these findings, vigorous physical activity (not household activity, or moderate activity) is constructed as having a protective function that shields the cancer patient from negative side-effects during treatment, producing a better health outcome. This framing has the effect of placing responsibility or blame on individual women for their negative outcomes post-cancer, as they failed to ‘protect’ their health and engage in healthful behaviours before diagnosis. This framing further separates the physical burdens and suffering of survivorship from the treatment modalities themselves and links them to the pre-cancer behaviours and lifestyles of survivors. The message within the discourse is clear, survivors who experience serious side-effects do so because they did not ‘protect’ their health and engage in expert recommended behaviours before their illness. The problem of significant or life-limiting side effects are dislocated from the treatment themselves, which are left unquestioned and assumed to be infallible. The issue of prevention, or the development of less toxic treatments is skirted entirely. Rather, the burden is placed on individuals who are called
to optimize their bodies and develop physical resiliency before the advent of breast cancer.

Aging and older survivors were positioned in the discourse as a particularly risky, vulnerable population in need of intensified, and specialized resources and care. In particular, this population was problematized as being at an increased risk of “decline” and positioned on the cusp of the downward trajectory of decline. This construction of older survivors is enlivened through intertextual references to the larger discourse of population aging and the “graying of America,” and contextualized by references to the increasing age of the baby boomers and the related projected increase in cancer diagnosis, and thus survivors, in the near future.

Women 65 years and older (“older”) constitute 55% of the three million U.S. breast cancer survivors and will account for a greater absolute number and proportion of survivors with “the graying of America.” This older survivor population often has age-related declines in functioning and reserve, increasing levels of comorbid illness, and diminished social and economic resources (Faul et al., 2014, p. 628).

The problematization of the increasing age of the population aligns with the discursive construction of survivors as a large and growing population, supporting a key argument for the establishment of the Journal, and the field more broadly (see section 5.1). The prediction that the patient population of breast cancer survivors will increasingly be composed of ‘older’ women functions to heighten the urgency around the biomedical problem of unmanaged survivorship because of the various forms of “age-related decline” that this population is anticipated to experience. In the context of “decline” across a number of domains in terms of both health and access to resources, the lack of biomedical management for older survivors becomes particularly problematic, due to the already ‘at risk’ nature of this population and the ever-present threat of further decline and dependency.

The intensified risk role of aging survivors is explicated in several articles included in the sample which warned about increased risks of: long-lasting and severe iatrogenic effects
of treatment, co-morbid complications, general physical and cognitive decline, confusion, inability to follow treatment care plans, poor follow-up care and inadequate resources to participate in a healthy lifestyle relative to younger survivors. The expansive, risk producing interaction between biological aging and breast cancer survivorship described within the discourse operates to produce new spaces and possibilities for the biomedical and self-management of older women. Older women who have survived breast cancer becomes constituted as particularly risky subjects with intensified responsibilities for compliance with biomedical management and self-management in the interest of warding off decline and dependency.

Functional decline emerged as a particular risk factor in the discourse that signaled the survivor subject’s position on the downwards trajectory towards the irreversible Decliner subjectivity. Several of the articles related to aging or older survivors were concerned with assessing and measuring functional decline for the purposes of predicting and reducing the risk of falls, fracture, fragility, disability, and death in older women. This assessment of functional status was not present in articles concerned with survivors under the age of 65 and suggests that functional status is an area of survivorship management specific to older women.

The prevalent problematization of functional decline within studies of older survivors is in alignment with larger discourses in the biomedical field of geriatrics. As a specific field of medicine and research, the measurement and monitoring of the physical and cognitive function of aging person is a central feature of the field which is underpinned by the assumption that the chronological passage of time produces inherent risks for the body. Intertextual references to discourses of geriatric medicine can be seen throughout the discourse of aging survivors.

Older breast cancer survivors are particularly vulnerable, as cancer and its treatments usually co-occur with comorbid conditions that have an impact on functional status […] The rate of functional decline is dramatically accelerated in patients over the age of 65 years with cancer, and older cancer survivors report more functional impairment than individuals who have not had cancer (Sehl et al.,
We conclude that decline in self-reported PF-10 (high rates of functional decline) that persisted over 2 years following breast cancer diagnosis was predictive of poorer 10-year survival in older breast cancer survivors. Future research should determine whether early recognition of decline in physical functioning can prospectively improve survival outcomes, and coordination of care between primary care physicians and oncologists may optimize management of comorbid conditions (Sehl et al., 2013, p. 30).

Within the discourse, the persistence and degree of functional decline experienced by survivors become important predictors of their survivorship, and the assessment of functional status thus comes into being as a new aspect or site of survivorship care and management for this sub-population. In describing functional decline as “dramatically accelerated,” in older survivors, and in linking accelerated and persistent decline with “poorer 10-year survival,” functional status is brought into being as an important indicator of survival, and physical functioning becomes constructed as an aspect of life that requires assessment and management for older survivors. The failure to manage one’s functional status results in an accelerated trajectory of decline, dependency, and death.

Beyond the prediction of survival, the physical functioning of older women was also positioned as important within the discourse because of the association with function decline, falling, injury and disability. One study described older breast cancer survivors as being at an increased risk of functional limitations and falls, which have potentially “serious consequences” including “fracture,” “disability and death.”

Women who have had breast cancer are significantly more likely to fall and to report more functional limitations than women who have not had cancer. Falls are strongly associated with fractures in older adults and can have other serious consequences including disability and death. About one-third of older adults who fall will require assistance with activities of daily living after a fall, and over half (58%) of those persons will need help for more than 6 months. In addition to falls,
declines in physical functioning can also threaten independence and changes associated with aging appear to be accelerated in breast cancer survivors (BCS) [...] In subgroup analyses by cancer type, older BCS were more likely to report a functional limitation, such as difficulty walking up and down stairs or doing heavy household chores, than cancer-free peers (Winters-Stone et al., 2012, p. 189).

The functional vulnerability and riskiness of older breast cancer survivors were also positioned as problematic because falls, fractures and functional decline in older women are associated with a loss of independence and the need for increased assistance resources. In effect, constructing older breast cancer survivors as being at risk for accelerated aging, and the non-valuable Decliner subjectivity with which it is associated.

*Older BCS [breast cancer survivors] face many challenges in maintaining a healthy body composition and optimal physical functioning due to the combined effects of cancer treatment, aging, and reduced physical activity. Cancer treatment is associated with loss of bone mass, loss of lean body mass, and increases in body fat, changes that are worsened by aging and inactivity. These body composition changes place older BCS at higher risk of obesity-related disease, breast cancer recurrence, frailty, and fractures. For example, older BCS is 30–50 % more likely to report an inability to do daily activities requiring physical strength compared with older women with no cancer history (Dobek et al., 2014, p. 304).

Falls and disability share overlapping risk factors that typically increase with age. Muscle weakness, altered gait, and instability are independently associated with increased fall risk and lower functional capacity for performing daily tasks such as lifting objects. Age-related sarcopenia leads to muscle weakness that is linked to poor balance and falls. Cancer treatment can cause muscle wasting that does not reverse in recovery and when combined with deconditioning and fatigue that can accompany treatment, may place older BCS [breast cancer survivors] at greater risk of falls and functional decline than women without cancer (Winters-
In both examples above, the interacting effects of aging (e.g., muscle weakness, poor balance, loss of lean body mass, loss of bone mass) are described as being “increased” and “worsened” by the cancer treatment which places older survivors at an increased risk for decline. This relationship was explicated throughout the discourse, in which the increased risks of older breast cancer survivors are entangled with the discourse of biological aging; in this sense, the effects of biological aging are positioned as being accelerated or exacerbated by breast cancer and its treatment. The symptom burden of older survivors is magnified by the ways in which acute cancer treatments interact with the biological aging process to amplify the negative effects of both processes, speeding up the trajectory of decline in older women.

The progressive relationship between biological aging and acute cancer was also drawn on as evidence to demonstrate the expanded field of survivorship inhabited by older adults. Biological processes of aging were described to highlight the diverse and unique complications experienced by older survivors. The condition of frailty, in particular, was invoked to illustrate complex health problems that result from the “convergence” between acute cancer and biological aging.

*Frailty is a condition that compromises a person’s capacity to respond adequately to both physical and psychological stressors, exposing the individual to a worsening of his/her health status.* […] The limited evidence on the topic suggests that older cancer survivors may present an increased likelihood of being frail or disabled when compared with older adults without cancer background (Perez–Zepeda et al., 2016, p. 2).

The definition of frailty provided is broad and ambiguous. The definition provided gives the impression that frailty is a descriptive term that refers to a state of vulnerability rather than a clinical condition with a specific set of diagnosable criteria. However, frailty is transformed and legitimized as a ‘condition,’ through the scientific description of its biological pathways and interactions with the molecular characteristics of aging. Similar to survivor, frailty as a condition is characterized by risk and the potential for unspecific
future negative health outcomes.

The association between cancer survivorship and frailty in older adults may be explained through several pathways, including the presence of iatrogenic damage (sequels of the adopted interventions) and residual chronic conditions due to cancer and aging. In other words, these individuals are dealing with the interacting effects of the biological and physiological changes of aging, multimorbidity, and the effects of the cancer and its treatments. Biological aging is characterized by genetic instability, DNA repair imbalance, telomere shortening, epigenetic alterations, altered nutrient sensing, protein instability, mitochondrial dysfunction, cellular senescence, stem cell exhaustion, altered intercellular communication, and inflammation. These biological changes can lead to an overall decrease of the homeostatic reserve and subsequently to proneness to adverse outcomes. Such changes characterize frailty as well, and these challenges would certainly include the effects of cancer and its treatments, which seem to have lasting effects should the individual reach old age […] Compared with the young individual in whom such changes may produce a premature aging syndrome, in the older adult, these effects are superimposed with the age-related changes leading to frailty (Perez–Zepeda et al., 2016, p. 5).

It is through scientific discourses and references to “genetic instability, DNA repair imbalance, telomere shortening, epigenetic alterations, altered nutrient sensing, protein instability, mitochondrial dysfunction,” etc., that frailty becomes constructed as a condition that can be clinically managed and evaluated. This interweaving of discourses of biological aging and various risk-conditions associated with survivorship, such as frailty, was present in most of the articles concerned with older women. This discourse frequently employed technical, scientific language to explain the interactions between aging and conditions of survivorship, and this language functioned to bestow legitimacy on the interactions (i.e., this is scientific ‘fact’), and to justify the increased surveillance and management of older breast cancer survivors. Significantly, this discourse also functions to transform everyday aspects of life and embodied experience associated with aging (i.e., frailty, decreased muscle mass, decreased mobility) into conditions associated
with survivorship, effectively expanding the biomedical field of survivorship.

The combined effects of aging and cancer treatment are mobilized within the discourse to provide justification for the development of resources and interventions that correspond to the increased riskiness of older survivors and to assist older survivors to engage in self-management.

In 2011, the first generation of baby boomers will reach 65, and the aging of this generation will contribute to a projected doubling of cancer survivors by 2050. Developing safe, effective, and translatable interventions that optimize function and quality of life specific to older cancer survivors is an important area for future work (Winters – Stone et al., 2012, p. 197).

The article also described the “forces of aging” as posing a “unique challenge for survivorship care,” particularly because older women are more likely to have health concerns in addition to cancer survivorship and may “need to monitor adjuvant hormonal therapy, manage multiple symptoms and medications, and coordinate care delivery by multiple physicians” (Faul et al., 628). The complication of survivorship by the effects of aging within the discourse produces a need for the development and testing of “test geriatric-centered care plans specifically targeting late effects, comorbidities, and other symptoms that affect the functioning of older adults” (Faul et al., 634). This need is further justified by the construction of older survivors as a vulnerable population that cannot manage the complexities of survivorship care or effectively self-manage without expert assistance:

Survivorship care can be further complicated if older patients are confused about their cancer treatment history, recommended follow-up care, or how to manage their multiple illnesses. Older patients may also misattribute modifiable symptoms to “normal aging” or believe that their symptoms are not treatable, leading to under-reporting during follow-up visits (Faul et al., 2014, p. 628).

Describing older women as “confused,” unable to comprehend and manage their follow-up care and symptom burden, functions to position this population as in need of expert
advice to guide them towards the correct choices and actions and away from the trajectory of decline. Older breast cancer survivors are incorporated into a regime of increased surveillance and management due to their increased riskiness and their perceived limited ability to enact their responsibilities of self-care. The stakes for this group of survivors is high, as they are positioned as occupying a tenuous space on the trajectory of survivorship with the specter of decline and death permanently affixed to the horizon.

5.4 Conclusion

In this chapter, I have described how breast cancer survivorship is constructed as a unique chronic condition that requires life-long biomedical and self-management. I outlined how post-treatment women, including non-symptomatic women, are incorporated into a new regime of chronic survivorship characterized by biomedical and professional management and directed self-care in the interest of risk reduction. I also identified the Chronic Survivor, the Optimizing Survivor and the Decliner as specific forms of subjectivity that emerged in this discursive field.

Further, I highlighted the discursive strategies through which cancer survivorship was secured as a domain of scientific expertise. I outlined the ways in which the Journal constructs survivorship as a unique and chronic condition, the effects of which extend beyond the realm of biomedicine that requires the specialist knowledge of a variety of allied health professions. To enable this construction, the long-term iatrogenic effects produced by biomedical cancer treatment were discursively transformed into ‘symptoms’ and attached to the condition of survivorship. Examined through a technoscientific and biomedical framework, these symptoms were interpreted as signs of disease or dysfunction and configured as problems to be addressed through biomedical intervention. I also described how this novel construction of survivorship was brought into being and made possible by the biomedical management and treatment of acute cancer, producing a complex relationship in which biomedicine is both managed through its targeting of iatrogenic effects, and utilized to manage survivors themselves.
Finally, I concluded this chapter by describing the anticipatory temporal trajectories assumed by the discourse of chronic survivorship and how such trajectories orients subjects towards strategies of normalization and bodily optimization. I also outlined how the trajectory of decline was invoked in the discourse to highlight the consequences that result from the failure of individual survivors to take up promoted strategies of risk reduction and normalization.

In the next chapter, I present the results of my analysis of a sample of promotional materials for the Run for the Cure and outline the specific forms of breast cancer survivor subjectivity constructed by discourse.
Chapter 6


In this chapter, I present the three central discursive constructions that emerged from my critical discourse analysis of promotional materials produced for the Canadian Breast Cancer Foundation (CBCF) annual Run for the Cure Event. In the first portion of this chapter, I will describe the field of breast cancer survivorship that is constituted through the sample and highlight the discursive strategies that operate to incorporate women into the field. In the second portion of this chapter, I will turn my attention to the temporal trajectories of survivorship constructed through the sample. In particular, I will outline how breast cancer is invoked as an interruption that threatens the structure of the nuclear family and expected heteronormative life-course. I will also describe how the figure of the child is invoked to promote a particular form of anticipatory action in the interest of the child’s reproductive futurity. In the final section of the chapter, I turn my attention to the ways in which survivorship is constructed as a new, subjective category that functions to bring women back into traditional gender roles, extending the responsibilities of women to care for themselves and those they love in ways that align with traditional female gender roles. In addition to women’s expanded responsibilities of care, I will also describe how participation in the Run is incorporated into the duties of both survivorship and responsible citizenship more broadly. Finally, I will trace how the construction of the Run, as an event, shifts across the discourse from a ritual of loss to a celebration of both survival and the preservation of the nuclear family. To contextualize and ground these discursive constructions, I first outline the discursive structure produced by the sample of promotional materials.

6.1 Constructing the Discursive Field of Survivorship

When placed in chronological order, the promotional materials produced a particular discursive structure with its own temporal markers and pattern. Within this pattern, 2011, the 25th anniversary of the CBCF, emerged as a pivotal moment in the discourse that marked significant shifts in the constructions of survivorship and the CBCF itself. The
narrative and the kinds of messages and meanings communicated in the early years of this sample (2007 – 2010) were dramatically different, and arguably even oppositional to the ideas communicated after 2011. In order to illustrate how 2011 functions as a pivotal moment in the Canadian public discourse of breast cancer survivorship, I will outline the distinct features of the three 2011 promotional videos; *The Beginning, Voices of Breast Cancer* and *Creating a Future Without Breast Cancer*. Then, I will briefly describe the central themes of the promotional materials published before and after 2011. This comparison will provide a meaningful context and grounding for the subsequent, in-depth discussion of the specific discursive constructions that were produced in the sampled promotion materials, in which I highlight these discursive shifts where it makes sense to do so.

The CBCF’s 25th anniversary was marked by the release of a trilogy of promotional videos that craft a particular narrative about the CBCF and its role in Canadian society and culture. Combined, the thirteen-minute narrative positions the CBCF as a Foundation with activist roots guided by a singular aim – to save and lengthen the lives of women with breast cancer through the financing of biomedical and scientific research. This pursuit and the survival of women, we are told, are made possible by the expertise of CBCF and the researchers to which they are connected.

The first video in the series, *The Beginning* (4 minutes), is composed of spliced clips of close-up interviews with each of the four founding members: Nancy Paul, Bette Johnston, Michelle Levy and Dr. Richard Hasselback. These sutured excerpts form a particular origin story of the organization that begins with a retelling of Nancy Paul’s “vision to create a Foundation that would focus on breast cancer research.” Throughout this story, the CBCF is styled as a volunteer-driven, grass-roots organization started by a small group of community-engaged citizens – the ‘movers and shakers of the city’- for the purposes of making *public* the problem of breast cancer and the lack of funding available for biomedical research. Bleak descriptions of the dark ages of breast cancer, marred by death and silence, are juxtaposed with descriptions of the activist work of the CBCF and the struggle of the founding members to insert the disease, its impact on women, and the need for funds to conduct cure-oriented research into public and political discourse. The
work of the CBCF is credited with bringing breast cancer out of the ‘closet’ and ushering in a new “public profile” of the disease through “education and advocacy,” unshackling women from shame and enabling them to survive and thrive after a breast cancer diagnosis. The video concludes with Nancy Paul praising the public for supporting the Foundation and urging them to: “keep going, keep doing what you’re doing because the only thing that matters are the lives that are saved and the lives that are lengthened.”

Significantly, no information is provided about how the CBCF has contributed to “saving” and “lengthening” women’s lives or improving the material conditions of breast cancer.

*Voices of Breast Cancer*, the second video in the series, surveys and accounts for the conditions of breast cancer and survivorship in the present moment. As a narrative, this video functions to highlight both the progress made by the CBCF and to expose the work that remains to be done. This five-minute video is composed of confessional interviews with five individuals affected by breast cancer: four women who have received a breast cancer diagnosis, one of whom is stage 4, and one widower of a woman who has died from breast cancer. Each of the interviews captures a unique, intimate perspective of survivorship, highlighting the various ways that the uncertainty of survival transforms and interrupts the lives of women with breast cancer and their families. The narratives do not neatly map onto dominant discourses of breast cancer survivorship, discussed in *Chapter 2*, in which breast cancer is positioned as a ‘gift’ that positively impacts and alters the life and self of the survivor. Instead, the narratives highlight the devastating impact that breast cancer can have on the lives of women and their families, laying bare the uncertainty surrounding breast cancer diagnosis, remission, and continued survival. Through the narratives, breast cancer is constructed as an unpredictable disease that can affect anyone at any time, can return at any time, and from which women can, and do, die. Alongside the construction of breast cancer as an unpredictable disease, the CBCF is positioned as a guiding organization that benevolently provides an opportunity for women to “manage” or cope with the uncertainty of survivorship. Participation in the CBCF is described as a way for women with breast cancer to create a “lasting legacy” for themselves and to help others by working towards the goal of “ending” breast cancer.
The mechanism through which participation contributes to this goal is left unstated, as is any information about how this goal might be achieved.

The final video, *Creating a Future Without Breast Cancer*, describes the current and future directions of the biomedical research funded by the CBCF, foreshadowing the development of a biomedical cure as the inevitable conclusion. The video is composed of a number of interview segments with Canadian researchers and oncologists and culminates with a series of close-up images of smiling researchers, survivors and founding members of the CBCF. The first section of the video constructs breast cancer as a complex, multi-faceted disease, or a puzzle that must be unraveled and solved through the application of science by researchers with “overlapping but distinct interests and expertise.” This construction presumes and speaks to the public’s desire for a cure to be found “right away,” and highlights the naivety of this desire by illustrating the complexities of breast cancer. Despite such complexity, the narrative firmly locates the problem of breast cancer within the realm of biomedical and scientific expertise. In the second section of the video, the researchers’ progress is highlighted through technical descriptions of the “next phase of research.” These descriptions coalesce around the development of individualized treatment plans that provide the “best fit for a given patient.” Finally, the interviews conclude with the researchers sharing their visions for the future of breast cancer research. Significantly, these visions do not include the eradication of breast cancer or the development of prevention strategies. Instead, the imagined future of breast cancer in this video is one in which women “no longer need to fear” breast cancer because science would be mobilized to “fight against” and “conquer” it. This hopeful promise for the future is visually emphasized by a series of quick, close-ups of smiling survivors, CBCF founding members and researchers, the complete cast of characters featured in the 25th-anniversary videos.

Taken together, the 25th-anniversary narrative constructs breast cancer as a complex scientific problem that must be addressed through the application of science and the direction of funds towards biomedical research and a disease that poses a universal but uncertain risk for women. The Run and the personal generosity of individual citizens are positioned as the vehicle through which a “future without breast cancer,” will be brought
into being. The videos function to legitimize the CBCF’s status as an important Canadian Foundation dedicated to the cause of breast cancer. Hope and faith in biomedicine and science are emphasized, and current advancements are deployed to signal the inevitable development of a ‘cure.’ While little information is provided about how the work of the Foundation has contributed to “saving” and “lengthening” the lives of women with breast cancer, oblique references to success and heady promises for the future are levied to persuade the viewer to continue to participate by raising funds and purchasing sponsored commodities.

6.1.1 Overview of the Discursive Structure of the Sample

From 2007 – 2011, participation in the Run is generally constructed as an action of remembrance and a way for Canadians to collectively commemorate women and families affected by breast cancer. In part, this is enabled through visual references to women who have died from breast cancer, either through the depiction of spectral forms (e.g., ghostly figures) or by emphasizing their absence (e.g., the motherless child). Material objects are also used to memorialize women who died, for example, one multi-year campaign centered around painted running shoes that feature the names of women affected by the disease. Depictions of survival or living survivors are rare in the materials published within this window.

Before 2011, breast cancer was presented as a problem that affects all Canadians, and a problem that Canadians have a civic responsibility to respond to. In part, this was conveyed through the deployment of specific phrases in print advertisements that called the viewer to “unite with all Canadians” or “unite with the people around you” by participating in the Run. Four specific mantras were used in these campaigns: “we’re all connected;” “who are you running for?” “some women run it every year;” and “give generously.” “Who are you running for,” appeared most frequently in the promotional materials, followed by “we’re all connected.” The placement of these mantras alongside images that highlight the affective, familial and civic connections of Canadians functioned to constitute breast cancer as a force that forges links between citizens. The 2008 and 2009 print campaigns clearly invoke this idea through images of various
Canadians physically connected to one another by a large pink ribbon alongside the slogan: “we’re all connected.”

Generally, these ads are oriented towards the past (e.g., remembering those who have died) or the present (e.g., acknowledging bereaved family members). Several ads feature references (either visual or textual) to women who have died from breast cancer (i.e., wives, mothers, friends), and position the memory of these women as a compelling reason to participate in the Run. The affective dimensions of breast cancer are particularly emphasized through (visual and textual) references to mothers and wives that have left small children and young husbands behind. Significantly, these ads often feature men and male children participating in the Run on behalf of the living or dead female members of their family affected by breast cancer. Depictions of men and boys impacted by breast cancer are rarely present as focal points in ads after 2011, which focus primarily on female survivors themselves.

The meanings attached to participation in the Run for the Cure shift in the promotional materials published after 2011. Whereas participation in the pre-2011 materials is constructed as a way to connect with others and commemorate those affected by breast cancer and women who have died in particular, after 2011, participation is constructed as a way to celebrate survivors and highlight women’s triumphs over the disease. Images and narratives of young, vibrant women who have survived the disease proliferated in these materials, shifting the overall tone to celebratory optimism.

The promotional campaigns published after 2011 were rich data sources with respect to both the content and sheer amount of advertisements. Proportionally, most of the preliminary sample of 56 advertisements were published within this period (40 of 56). Fourteen ads (6 print, and 8 videos) published from 2012 to 2016 were included in the sample. It is also important to note that some discursive threads present in the earlier campaigns persisted throughout the materials after 2011. The most prominent of these threads was the construction of breast cancer risk as an uncertain but universal threat. The universality of breast cancer risk and the uncertainty that marks its etiology and onset
persist throughout the later campaigns by highlighting the vulnerability of all women to the disease, with a particular focus on young healthy women.

The slogan “we’re in this together,” continues to be used throughout the latter part of the sample, but the meanings attached to the slogan are transformed. In particular, references to a collective and calls to “unite” with “all Canadians” are no longer present. Instead, the slogan “we’re in this together,” becomes attached to the constructed universality of breast cancer risk. Despite the wide application of breast cancer risk to the population at large, the response to this problem becomes individualized. Instead of inciting people to connect with those around them and participate on behalf of all Canadians, the discourse calls viewers to participate in the interest of specific individuals to whom they are intimately connected. While the meanings attached to participation shift, the focus on fundraising for biomedical research remains.

The shift towards an intimate and more individualized construction of the rationale for participation in the Run occurs alongside a new focus on the promotion and celebration of individual survivors. The survivors highlighted are typically youthful, beautiful and vivacious, and their narratives often attribute their survival to their personal strength, optimism, and individual efforts. Particular advertisements also connect the survival of individual women to the Run as an event and the specific fundraising efforts of their friends and family members. Additionally, a new focus on individual women who participate in the Run as volunteers appear, and their specific contributions to the cause of breast cancer fundraising are highlighted ascribing a survivor celebrity status. This portion of the sample was marked by an intense focus on the future and the potential future impact of the disease. Participation in the Run was ultimately constructed as an action that has the potential to ensure the protection of the future generation, and the mechanism by which a ‘future without breast cancer’ can be secured.

6.2 Survivorship as National Unity

Before 2011, participation in the Run is configured as a way to facilitate and enable social connections between and among Canadian citizens for the purpose of highlighting, and collectively responding to, the national problem of breast cancer. To this end, breast
cancer is constructed as a deadly disease with consequences that extend to and affect all Canadians. This construction emerges most clearly in the 2008 and 2009 print advertising campaigns that depict a super-size version of the iconic pink ribbon—a symbol that marks breast cancer fundraising efforts and products— that visually connects Canadians to one another, symbolically communicating the connections forged by the disease.

For example, one 2008 print advertisement (figure 3) features nine squares, black and white photographs of eleven diverse women and men arranged around a central text box. These individuals are connected to one another by a large, continuous pale-pink ribbon that encircles each of their faces, forming an interconnected chain around the page. The central text box reads:

Breast cancer affects Canadians from coast to coast. On Sunday, October 8, 2008, unite with all Canadians in the Canadian Breast Cancer Foundation Run for the Cure. Be part of the largest single-day volunteer-led fundraising event dedicated to creating a future without breast cancer (CBCF, 2008).

The text calls the viewer to envision their connection to other Canadians by virtue of their shared citizenship. The image of the interconnected pink-ribbon chain suggests that the experience of breast cancer is something that both

Figure 3: Connect with Canada, CBCF
encompasses one’s personal life and bonds strangers together via their common experience. This connection is not based solely on the disease itself but is also informed by the broad impact of breast cancer on the families and loved ones of women who receive a diagnosis. This is suggested by the inclusion of men and children in the advertisement, which highlights familial and intimate connections. In foregrounding affective connections, all Canadians are interpolated into the problem of breast cancer by virtue of their relationships with women, emphasizing that we all know and care about someone who has been diagnosed with the disease. Breast cancer is positioned as a national problem that “affects Canadians from coast to coast” (CBCF, 2008). Thus, the viewer is called to act, as a citizen, upon their responsibility to “unite with all Canadians,” and be “part” of “the largest single-day volunteer-led fundraising event dedicated to creating a future without breast cancer” (CBCF, 2008). The call for the reader to “be part” of the fundraising event, strongly invokes participation in the Run for the Cure as a duty of good citizenship and a reflection of the responsibility of citizens to “unite” in the pursuit of a cure. Breast Cancer is cast as a collective problem that affects the body politic and that can and should be addressed collectively by citizens, through acts of personal generosity and participation in the Run, an event styled as a meaningful site of collective action.

The discursive positioning of participation in the Run as a mechanism to facilitate social connections was a consistent thread in the promotional campaigns released from 2007 to 2010. Within these materials, survivors were called on distinctly, and yet similarly to the public at large, to participate in the Run and foster social ties with others impacted by the disease. This is highlighted in a 2009 print advertisement, Breast Friends (see figure 4) that featured a black and white photo of a group of seven women standing in a field, clad in uniform for the “Breast Friends” dragon-boat team. The women are enfolded in the loop of a pink-ribbon, the ends of which extend outward, beyond the frame of the image seemingly endless. The text above the image reads: “We are all connected,” and invites the viewer to “unite with the people around you for the Canadian Breast Cancer Foundation CIBC Run for the Cure” (CBCF, 2009). Brought together by their common disease experience, these women communicate their survivor status through their team name (“Breast Friends”) printed on their uniforms. Standing together with pink-ribbons
insignia proximately displayed on their chests, the Breast Friends operate as symbols of unity, strength, and survival.

In the print ads published between 2008 and 2010, the Run is consistently constructed as a philanthropic event that enables a large number of Canadians to “come together” in the name of a worthy cause - fundraising for biomedical, cure-oriented breast cancer research. These campaigns produce affective connections between and among Canadians facilitated by the common disease experience by emphasizing the ways in which breast cancer touches the lives of all Canadians. Thus highlighting the expansiveness the disease and positioning breast cancer as a national, and collective problem. In this way, participation in the Run becomes a way that Canadians can demonstrate good citizenship by acting on behalf of others in the interest of the national interest. This call to “unite,” and “connect” with other citizens through participation in the Run disappears from the discourse after 2010.

6.2.1 Intimate Articulations of Survivorship

In 2011, calls for participation in the Run begin to be attached to more individualized and intimate articulations of breast cancer survivorship. Breast cancer emerges as a disease that is communicated and transmitted through intimate or familial relations with
deep roots in personal, private and familial spheres. The first traces of this shift emerge through a new focus on both survivors and affected family members as *individuals* with unique stories and experiences. In both the print and video materials, the focus on individual women and their narratives of survival construct a window into the intimate experience of survivorship that invites viewers to imagine the experience for themselves. The targeted focus on individualized accounts of survivorship constructs survivorship as a problem that affects specific individuals and their families, producing new affective meanings of survivorship that eclipse previous understandings of survivorship as a national, collective problem. The individualization of the affective field of breast cancer survivorship effectively reconfigures the responsibility for participation in the Run from an act of civic responsibility into an act of caring for those that we love.

This shift towards an intimate and individualized focus on breast cancer first emerges in a 2011 print and video campaign that ran until approximately 2013 featuring personalized white New Balance running shoes. Significantly, this campaign also marks a shift towards an increasingly explicit commodification of survivorship and the connection of survivorship in the CBCF sample to commercial, physical fitness promoting products such as New Balance running shoes. The painted and bedazzled sneakers featured in the ad campaign are customized to acknowledge and celebrate individual women affected by breast cancer and are also promoted as accessories to be worn at the Run. This can be seen in the 2012 print ad, *Auntie* (Figure 5), which features a single New Balance sneaker painted yellow, with delicate white tree branches and small blue birds. In the center of the shoe, painted in white stylized letters is the word “Auntie.” Underneath the shoe, printed in white the question: “Who are you running for?” appears in bold white letters. The rhetorical structure of this question both presumes the reader is already a participant in the Run and invites them to create their own running shoes to celebrate or memorialize someone they love. These personalized running shoes are not only stylish accessories for the Run, but also a figured as a way to communicate one’s commitment to good citizenship via consumption and philanthropic participation.
This idea of creating personalized, survivor sneakers was centrally featured in a 2011 television advertisement for the Run produced in partnership with the Canadian Television Network (CTV). This campaign is a response to the slogan “who are you running for?” and follows three young women revealing the intimate connections behind their personalized running shoes. The video draws on confessional techniques as a strategy to create a sense of intimacy with the viewer. This technique is highly visible in the first scene, which takes place in the bedroom of a young woman whose mother died of breast cancer. The camera is focused in on a white, new balance sneaker, partially covered in bright yellow paint. On the side of the sneaker “mom” is painted in gray, looping letters. The camera zooms out to reveal a black and white photograph of a young girl with her mother sitting next to the shoe. Their faces are pressed together, and their lips are pursed as if they are blowing kisses at the camera. As the camera continues to zoom out, a young, white woman enters the frame. She is sitting, painting the sneaker in pastel bedroom. Staring at the viewer, the young woman confesses, “I lost my mother to breast cancer. It runs in my family.”

In the next scene, a young woman with dark curly hair reaches towards a pair of pale pink, painted new balance sneakers. On the side of the pink shoes, is darker pink lettering that spells out the name “Kate.” (figure 6) The woman slings the sneakers over...
the shoulder of her pink Run for the Cure t-shirt (indicating her status as a survivor) and turns to face the camera. Gazing at the viewer she states: “today I’m celebrating being four years cancer free. I’m running so my step-daughters will never have to fight this disease.”

Figure 6: Run for the Cure, CBCF & CTV

A third and final pair of sneakers comes into focus. These sneakers are painted hot-pink with bright pink artificial flowers glued onto the toes. The laces have been replaced by bright pink ribbons and are in the process of being secured onto the foot of a blonde, middle-aged woman. On the side of the sneaker in silver cursive writing is painted “Saleema.” Looking directly at the camera, the woman reveals: “my best friend was only 36 when she was diagnosed.”

What this campaign accomplishes through its specific focus on three individual women and their personal experiences with breast cancer is to illustrate how survivorship is articulated through affective ties and intimate relations with the self, family and friends. These intimate relations are communicated through explicit visual and textual references to familial connections and commitment to friends, the use of intimate language (i.e., love, mothers, daughters), as well as references to the obligations that become attached to the potential, if not inevitable, exposure of ourselves and those that we love to breast cancer. The invocation of the familial connections between women, in particular mother-daughter relations, function to position participation in the Run as an extension of the
socially constructed responsibilities bestowed on women to care for their families. It becomes a moral imperative to run on behalf of those we love. In this way, participation in the Run and the consumption of particular goods (i.e., New Balance sneakers) are configured as aspects of responsible citizenship, and modes of conduct that helps to preserve intimate or familial connections.

Beyond the call to purchase and decorate sneakers, participation is connected to acts of good consumer citizenship. Viewers are invited to “walk, run and give generously,” an invitation that connects the act of participation to philanthropy and personal generosity. The call to give generously is unsurprising considering that the overarching purpose of the Run is to raise funds for the CBCF and breast cancer research. The attachment of personal generosity to physical activities, such as running and walking functions to imbue these actions with a particular kind of morality. Personal generosity, volunteerism, and philanthropy in contemporary Canadian culture are constructed as aspects of good citizenship and as desirable ways that individuals can demonstrate their personal morality. The attachment of generosity to participation in the Run operates to support the discursive positioning of running as the ‘right’ and moral thing to do.

The idea that participating in the Run is the ‘right way’ to respond to the unavoidable exposure of those we love to breast cancer is more fully realized in a 2015 promotional video, In this Together. The title of this video conjures similar meanings to the earlier images of national unity and collective responsibility; however, the content firmly situates the affective scope of breast cancer within the realm of intimate relations. The opening titles of this three-minute video inform the viewer that four prior participants in the Run for the Cure were invited to be part of a documentary and were subsequently invited to view the screening at a local theatre. The title fades, revealing a predominantly Caucasian crowd of middle-aged men and women settling into their seats. The theatre lights dim, and the black and white documentary fills the screen. Two young women with dark hair and light brown skin come into focus. They wear black sundresses against a white background. Gazing out at the viewer, they describe their motivations for joining the Run for the Cure, emphasizing that: “it feels nice to know that we could be making a difference.”
Our mom was actually diagnosed with breast cancer when we were little. For the first year after she passed away, we were kind of like, sitting around, like okay well you can’t really do anything to bring her back, but you can do something to fight it, so we joined the Run for the Cure (CBCF, 2015).

Their confession positions love for their mother and their desire to ‘fight’ against the disease that claimed her life as their inspiration for participating in the Run, and participation is constructed as a mechanism to channel their grief and loss into meaningful action. In this video, the stories of loss shared by four ordinary women position participation and personal generosity as rational responses to the profound loss of a loved one. In contrast to the unproductivity of unchanneled grief, participation is configured as a way to transform overwhelming grief into productive, philanthropic action that meaningfully contributes to the ‘fight’ against breast cancer by raising funds for biomedical research.

These emotional, video confessions lay bare the deeply significant intimate and familial relationships that connect women to those they love, highlighting the devastating losses that occur when these relationships are severed or threatened by breast cancer. *In This Together* promotes participation as the ‘right way’ to respond when someone you love has been affected by breast cancer. This response channels women’s emotions and grief into productive, but individualized action (i.e., fundraising), and also communicates the importance of the intimate connection by configuring participation as a gesture of love.

Intimate and familial relations are specified and emphasized during this time period of CBCF discourse as important connections through which breast cancer comes to matter, producing new responsibilities for women to act in particular ways (i.e., participating) to protect those we know and love.

What I draw attention to here is the way that the promotional materials deploy individualized and intimate narratives/stories to construct breast cancer as an individualized problem that affects women and their families, rather than a national or civic problem that affect the body politic as a whole. Presenting breast cancer as an individualized problem and directing their energies towards participation in the Run as a
way to channel grief over the loss of loved ones to breast cancer and forecloses the possibilities and opportunities for people to direct their anger and grief towards other forms of collective social and political action.

Instead, women are directed towards one response only: fundraising for biomedical research. This response is positioned as a powerful and meaningful action that has the potential to enact change and save lives. The ‘heroic’ potential of women’s participation is highly visible in the dramatic conclusion *In This Together*. In this conclusion, it is revealed that each member of the crew is a breast cancer survivor and all members of the audience have been ‘touched’ by breast cancer. In one of the final scenes, the director Mary Wall turns the camera on herself. Taking a deep breath, she confesses: “the research that comes from the funds that are raised is there to help save people and I’m here because of the people that have run in the past … thank you” (CBCF, 2015). An image of the audience fills the screen. They are standing on their feet clapping and cheering for the participants in a deafening show of gratitude (figure 7). The closing titles roll, inviting the viewers to join the Run as the logo for the Canadian Breast Cancer Foundation and the CIBC Run for the Cure appears, the “Cure” portion of the Run’s logo is quickly replaced by a scrolling list of the names of survivors (e.g., Molly, Nalie, Sarah, Heather) featured in the various promotional materials, reminding the

![Figure 7: In This Together, CBCF](image)

Cancer Foundation and the CIBC Run for the Cure appears, the “Cure” portion of the Run’s logo is quickly replaced by a scrolling list of the names of survivors (e.g., Molly, Nalie, Sarah, Heather) featured in the various promotional materials, reminding the
viewer of the individual women affected by the disease and the Foundation’s efforts to find of a cure, before finally returning to, and resting on “the Cure.”

In this video, the emotional grief-laden confessions of the women and their despair over the real or potential loss of their loved ones contrasts sharply with the overwhelmingly positive, enthusiastic and celebratory response of the large audience and survivors themselves. The audience’s assent and approval of the women’s decisions to mobilize their anguish by participating in the Run is communicated through their vigorous applause and joyful, emotional response. Further, the staggering number of survivors in the audience serves as a powerful image that testifies to the effects of biomedical research and treatments that have enabled them to live. Through this contrast, the individual act of participation is constructed as having the power to enact change in the field of breast cancer survivorship, protecting women and their intimate connections to others. The powerful imagery functions to legitimize the construction of participation as the rational and responsible response to breast cancer and entrench biomedical research as the way to enact change.

6.2.2 The Universal Woman at-Risk

Alongside the increasing focus on the affective experiences of individual survivors and those who are left behind, a particular kind of woman emerges as the face of survivorship after 2011. The women selected to represent survivors in the CBCF promotional materials are young, conventionally attractive, vivacious, thin, white and exude a sense of vitality. These survivors appear to be women that represent and reflect the ideals of womanhood in Canadian society and reflect the idealized visions of health, beauty, youth, and fitness. What is significant about the use of these women and their experiences to represent breast cancer survivorship are the very the attributes that make them ideal women (i.e., their health, beauty, and youth), do not align with representations of sickness and disease. In other words, the physical perfection of these women, and the sense of health and vitality that they radiate is culturally imagined providing a measure of protection from disease.
For example, in the 2016 promotional video *Julia*, we can see how the physical attributes and appearance of the survivor are used to communicate ideas about breast cancer and women’s vulnerability to the disease. The brief thirty-second video is largely silent, and

![Image](image.png)

**Figure 8: Julia, CBCF**

Julia, the woman around which the video is centered never speaks, but the way that she is depicted communicates a number of ideas about breast cancer. The video begins with a close-up of Julia, who appears to be in her late thirties. Julia has long blonde hair, an unlined face, and fashionable purple framed glasses. She stands outside, with her head tilted slightly backward and her eyes closed. The sun is illuminating her face and bright blonde hair; her face is relaxed – she looks happy and peaceful. Birds can be heard chirping in the background. The scene is idyllic. As the video progresses, we see Julia walking along a white-sand beach in front of calm blue water hand-in-hand with a handsome, middle-aged man. Julia’s colourful sundress and hair are artfully blowing in the wind. The serene scene and image of the beautiful and happy couple calls to mind advertisements for luxury Caribbean vacation packages.

Towards the end of the video, the narrator reveals that Julia has been diagnosed with breast cancer and is just one of the sixty-eight Canadian women who receive a diagnosis each day. As her diagnosis is revealed to the viewer, Julia stands in the driveway of a large brick home on a tree-lined street. She is embracing two young, blonde girls who beam up...
at her. Behind this heart-warming maternal scene, a large group of adults stands in front of her garage. They are all wearing custom-made white t-shirts with “Run for Julia” printed on them; some hold signs featuring Julia’s picture. Adopting these tools associated with activism and protest, the group has gathered to declare their intention to respond to Julia’s diagnosis by participating in the Run on her behalf.

Julia, in this video, is depicted as living the ideal, heteronormative middle-class Canadian life, signaling the importance placed by these promotional materials on the preservation of the heteronormative family structure (see section 6.3.1). What is significant about this is that Julia possesses everything that is constructed as culturally desirable. She is a beautiful, youthful, feminine woman, has a handsome husband, two beautiful children and a large house in the suburbs. She is surrounded by supportive friends and family. She is vibrant, youthful and engages in healthful pursuits such as walking. Julia has ‘it all’ she is the woman that we should aspire to be – and she has breast cancer. These two ‘truths’ about Julia run up against each other incongruously. Julia appears to be young, healthy, fit and happy – attributes which are culturally imagined to offer a measure of protection against disease, but even these attributes could not protect Julia from breast cancer. The idea that Julia, the ideal woman, is not safe from breast cancer, functions to dismantle the viewer’s assumptions about the protective shields that the appearance of youth and health offer against disease and challenge the notion that breast cancer is a disease of older women. Drawing attention to the survivor status of young, healthy and fit women, like Julia, serves to highlight the failure of these coveted attributes to guard women from the breast cancer, ultimately positioning every woman as potentially vulnerable. In essence, these images communicate the message that if these young, vibrant and healthy women can be affected by breast cancer, then we are all at risk. We could become one of the sixty-eight women diagnosed each day - no one is safe from breast cancer.

The construction of breast cancer as a disease that penetrates the protective shield provided by youth, health and vitality is a consistent thread throughout the sample. This idea is explored in the 2011 promotional video, *Voices of Breast Cancer*, which features the narratives of two breast cancer survivors under 40, a group that accounts for
approximately 5% of diagnoses (Canadian Cancer Society, 2016). Both survivors, Marcie and Cristie, are white, fit and conventionally attractive. They both describe their lives before breast cancer as happy and carefree. Marcie’s account of her breast cancer diagnosis, in particular, reveals the way that the construction of the disease is underpinned by a sense of universal vulnerability. Marcie, despite mentioning her significant family history of breast cancer that “goes way, way back,” describes her diagnosis at thirty-two as completely unexpected:

I think it’s very easy for people and just natural to take things for granted. *I had perfect health up until the incident*… even when we hear about bad things like breast cancer diagnoses happening to other people, *you don’t really think that it can happen to you, and then it does*… Suddenly, for me anyway, *I was just aware of how anything can happen to us at any time*, and I know that it did take a breast cancer diagnosis for me, even with a family history of breast cancer that goes way, way back. I still don’t think that I really, really, really felt that it could happen to me, certainly not at 32. *I don’t think I’m alone in needing such a big wake-up call to really get it* (CBCF, 2011).

In this narrative, Marcie reveals how her youth, and “perfect health,” provided her with a (false) sense of protection from breast cancer, and despite her family history, she didn’t feel like “it could happen to” her. Her unexpected breast cancer diagnosis disrupted her sense of invulnerability to disease and served as a “big wake-up call,” that “anything can happen to us at any time,” making clear that we are all vulnerable to breast cancer. Marcie’s narrative captures the way that the ubiquity of breast cancer is constituted in the CBCF survivorship discourse. Her narrative suggests that her diagnosis was not a result of her own individual specific risk factors (i.e., family history), but rather, an outcome of a seemingly uncertain (i.e., anytime), but universal (i.e., anyone), vulnerability to breast cancer. She directs her “wake-up call” to the audience calling upon viewers to reflect on their own vulnerability to the disease and the potential of its emergence at any time. Such a “wake-up call” disrupts the idea that youth and perfect health can protect the viewer from breast cancer; breast cancer permeates everyday life and has the potential to affect any woman without warning at any time.
This idealized representation of breast cancer survivors produces particular ideas about breast cancer and the ways that the disease should be responded to. The intense focus on the (unlikely) diagnosis and triumphant survival of youthful, healthy-appearing, beautiful women function to constitute the figure of the Universal Woman at-Risk who communicates the universal vulnerability of women to the disease. The images of young, healthy cancer survivors sharply disrupt the idea that youth is a care-free time free from disease, shattering the notion that the cultivation of “perfect health” offers a protective shield from the disease. In disarming the protective promise of youth and health, the discourse alters dominant cultural conceptions of the life course, which is characterized by linear notions of health, disability, and death. Instead, these narratives foreground the potential for disease, disability, and death to puncture the everyday experience of health as the possibility of the emergence of breast cancer is always present. The probability of becoming one of the “fifty-eight” women diagnosed each day is ever looming, incorporating all women into the field of breast cancer survivorship.

Through this construction of universal vulnerability, breast cancer is discursively constructed as a ubiquitous and inevitable part of modern Canadian life which cannot be completely prevented through individual, health-promoting actions effectively positioning breast cancer as a disease that is outside the realm of prevention, and an occurrence over which individuals have no secure measure of control. The absence of prevention within the discourse was particularly striking in the 2011 promotional video, *Creating a Future Without Breast Cancer*, which charts the biomedical and scientific developments that have resulted from the research funded by the CBCF. In this five-minute video, the researchers and oncologists interviewed make no mention of primary prevention which raises a number of questions about the “future without breast cancer” they both promise and predict will be ushered into existence. Instead of primary prevention, the researchers emphasized individualized biomedical approaches to treatments including; radiation beads, genetic-based treatments, and pinhole surgeries. The focus on treatment implicitly positions future breast cancer occurrences as inevitable, unavoidable outcomes that can be made manageable and survivable through biomedical advances. The researchers emphasized that the goal directing their research was to make “breast cancer a disease which women no longer need to fear,” stressing that they do not
see breast cancer as “something that we just have to live with,” but rather that “it’s something that we can fight against, something that we can conquer” (CBCF, 2011). Dismissing the possibility of prevention at an individual or population-based level, this video positions breast cancer occurrence as an inevitable feature of modern Canadian life. While breast cancer may be inevitable, biomedical research offers up the promise that the disease can be ‘conquered,’ overcome, and disarmed. The promised future is one where the disease experience of breast cancer is stripped of its horror and suffering, transformed by biomedical treatment advances into an expected, unremarkable, nonthreatening marker on the trajectory of Canadian women’s lives.

In the absence of prevention, the field of breast cancer survivorship is expanded to accommodate all women, as potential future survivor subjects, who are made responsible for acting in particular ways in the interest of the(ir) future. Within the sample, these responsibilities involve participating in the Run for the Cure and actively fundraising for biomedical breast cancer research. Returning to the 2016 video Julia, we can see how this responsibility is laid bare. As the narrator reveals that Julia is one of the sixty-eight Canadian women diagnosed with breast cancer each day in Canada, she addresses the viewer, posing the question: “so what can we do?” The narrator calls upon views to “keep running,” “because we are all changemakers when we run” (CBCF, 2016). Rather than focusing on prevention at the population or individual level, women are called to take up the mantle of ‘change making’ by raising money for the CBCF. Participation in the Run and personal generosity in this context enact changes in the field of breast cancer by supporting and facilitating cure-oriented research, which is figured as the only rational response to the problem of breast cancer.

6.3 Tracing the Temporal Trajectory of Survivorship

Within the CBCF sample, the temporal dimensions of survivorship were highly visible. The conditions of the future are of primary concern, and the conduct of all women, and of survivor subjects in particular, are directed towards the securement of a future without breast cancer. The discourse calls on women to act now in the name of the future by participating in the Run for the Cure and raising funds to support biomedical research. Intimacy and relations with others, particularly children, are used to persuade women to
participate in this civic duty. The survivor subjectivity constructed within the promotional materials is a subject situated in and propelled towards a particular temporal trajectory – that of the heterosexual, reproductive life course. Her motherhood or potential as a future mother is constructed as being central to her value as a citizen and is also drawn on to direct her conduct towards participation in order to secure the future for children. In the following section, I will trace the heterosexual, reproductive life course towards which survivors and women more broadly are directed, demonstrating how intimate relations are drawn on through visual and textual references to the family, and children, in particular, to support the construction of participation in the Run as a duty of citizenship. I will also focus specifically on the ways that children are constructed within the discourse as future-survivor-citizens whose futures (and future families) are at-risk of being disrupted or severed by the emergence of breast cancer.

6.3.1 Interrupting the Heteronormative Life Course

As discussed in the previous section, breast cancer and survivorship are constructed as intimate problems that affect and interrupt families. The potential of breast cancer to disrupt and potentially dismantle heterosexual, nuclear families is highlighted through the juxtaposition of breast cancer with significant moments in the heteronormative life course such as marriage, pregnancy, and childbirth. The disruptive potential of breast cancer is enlivened by the stark contrast between life events such as marriage, that are typically associated with achievement, happiness, and futurity, with the uncertainty and ambiguity that accompanies cancer survivorship. The uncertainty and ambiguity of survivorship figure centrally in the 2011 print advertisement Brian (figure 9). Notably, the advertisement itself is ambiguous. The frame of composition features the cropped torso of a white man dressed in blue jeans and a casual beige button-down shirt. The man’s identifying features are located outside of the frame, effectively anonymizing him - the headless torso could belong to any white adult man. In the image, Brian cups a New Balance (sponsored) sneaker in one large hand, while the other holds a small paintbrush poised over the sneaker. Bottles of paint and out of focus photographs are visible on top of his wooden workbench. The sneaker, prominently located in the center of the image, has been painted in a delicate, swirling teal, yellow, purple and black pattern, and the
name ANNE has been painted in large, black letters on its side. Underneath the eye-catching image is printed: “Who are you running for?” Below, in slightly smaller font is printed: “Brian’s wife was diagnosed with breast cancer the day before their wedding” (CBCF, 2011).

The interpretation that is invited suggests that Anne is Brian’s wife and that he is participating in the Run on her behalf in acknowledgment of her breast cancer experience. The outcome of this diagnosis is left open, reflecting the uncertainty of breast cancer survivorship. The viewer is unable to discern whether or not Anne has survived, and thus whether Brian’s participation in the Run is a memorial or celebratory act. Notably, the diagnosis of Brian’s wife, Anne, occurred alongside a central milestone in the heteronormative trajectory – marriage - and the advent of Anne’s new responsibilities as a wife. The achievement of this important milestone and the progression of the heteronormative life course (i.e., marriage, reproduction, and parenting) for Anne and Brian is disrupted, threatened by the diagnosis. Thus, the promises of the future for Anne and Brian as a married heterosexual couple are threatened and potentially foreclosed.

The composition of this ad is particularly significant because the anonymizing of Brian’s image creates a sense that this torso, and by extension this story,

Figure 9: Brian, CBCF
could belong to any man. Brian could be anyone, and anyone could have their family interrupted and thrown off course by breast cancer at any moment, even at a pivotal milestone of the heteronormative life course.

*Brian* functions to highlight the ways in which the ubiquity of breast cancer and the at-risk status of all women effectively threatens the stability and structure of the nuclear family through the loss or injury of wives and mothers. In this way, breast cancer is constructed as a particular problem of and for the nuclear family. The deployment of the slogan “who are you running for?” alongside the depictions of Brian alone in the frame, highlights the absence of his wife, and the incompleteness of the heterosexual pair. This absence is particularly important in relation to the life course marker identified in the text (i.e., marriage), which marks the extension of women’s responsibilities as wives, and (presumably) future mothers. These responsibilities include a duty to nurture and care for the family, and Anne’s absence makes clear that these responsibilities have been interrupted, left potentially unfulfilled. Brian’s life is further interrupted as he is left to take up these responsibilities alone, in addition to the new responsibility for participating in the Run on behalf of Anne. The interruption, termination, or reassignment of the responsibilities of care are positioned as one of the outcomes of breast cancer, an outcome that negatively affects families.

The construction of breast cancer as a threat to families and the fabric of Canadian society is rendered urgent through an intense focus on the heteronormative nuclear family, and the potential for a diagnosis to disrupt or destroy the family unit. This is illustrated in the 2014 promotional video, *In Her Shoes*, which follows the experience of one woman’s forcible entry into survivorship. This video is shot through a point of view, or the first-person perspective, which allows the viewer to access the perspective of the subject and ‘see’ through the lens of the camera and experience events as they unfold through the ‘eyes’ of the central character. The use of this first-person perspective is important in this context, because it allows the viewer to witness and, to a degree, experience the constructed intense emotional impact that a breast cancer diagnosis has on this imagined family.
The video begins inside of a clean, modern kitchen. It is a weekday morning, and the family is preparing for their day. A pre-teen girl with long red hair is standing at the kitchen counter, she smiles broadly as her mother enters and reminds her to bring her textbook, presumably getting ready for school. Her husband, a handsome, middle-aged, man passes her a freshly poured cup of coffee, touches her on the arm, and kisses her cheek before leaving for work. This performance of the family’s weekday, morning ritual constructs the family as an ideal, middle-class, heterosexual, nuclear family. The woman, whose eyes we are seeing through, appears to have it all: she is a mother, a wife, and lives in a home with a beautiful modern kitchen.

However, in the next frame, this image of the ideal family is shattered by her breast cancer diagnosis. The viewer, through the eyes of the woman, is called to bear witnesses to the devastated faces of the husband and daughter as they learn the news. Close-ups of the husband’s crestfallen expression and the daughter crumpled, and tear-streaked face fills the screen proving an empathetic response to their suffering. Dramatic instrumental music swells in the background. Throughout the rest of the two and half minute video, the viewer witnesses the daughter’s and husband’s reactions to the various stages of the woman’s breast cancer experience.

Figure 10: In Her Shoes, CBCF
The daughter is a central focus of the video, and close-ups of her crying, distressed face are peppered throughout. The intense grief and sadness of the daughter remind the viewer that this ideal family has been interrupted by breast cancer and that this young girl could soon be a motherless child. The viewer is also invited to bear witness to the experience of breast cancer treatment, the countless shots of IV drips, bleak hospital corridors, gurneys, green hospital bedding, and endless pill bottles, are interspersed with flashbacks or memories of the daughter running outside in the sun, laughing with her long red hair streaming behind her. These constructed memories appear to motivate the woman to endure and survive her seemingly endless treatment sequestered in the austere walls of the hospital.

Finally, as the woman is wheeled down a bleak hospital hallway on the gurney, her gaze upon the ostensibly infinite white ceiling tiles, a light engulfs the frame. Suddenly, the viewer is transported into the bright light of day, outside a large brick home. The door opens, and the woman walks into a surprise party. The clean, modern house is decorated with pink balloons, and a “welcome home” banner is strung up over the stairs. The focus of the woman is not on the party; instead, it is locked onto the smiling faces of her husband and daughter who runs to embrace her. This happy reunion scene closes with a close-up shot of a pink Run t-shirt, a symbol of her survivor status, marking her return to the family. The joyful image is replaced by a white background and text that reads: “We’re closer to a future without breast cancer, but we can’t stop now” (CBCF, 2014), suggesting that participation in the Run is the way to secure the future and restore the subject’s and the family’s place in the expected heteronormative life-course.

At first glance, this first-person perspective video appears to be designed to transport the viewer into ‘the shoes’ of a woman diagnosed with breast cancer, to convey the harsh realities of medical treatments, and the bleakness of the experience, garnering compassion for women undergoing treatment. However, when we take a closer look, the trajectory of active, breast cancer treatment does not appear to be the central focus. Instead, the disease experience functions as a backdrop to highlight the intense emotional interplay between the members of the family in response to this crisis. This is made clear through the concentrated focus on the emotional reactions of the daughter, and the
prolonged depictions of her tear-streaked face. Through the first-person perspective, the viewer is called to bear witness to the devastation of the young girl who is faced with the potential loss of her mother, and the husband who may lose his wife. The interruption of this family is made more significant through the contrast of these deeply, unhappy moments with the joyful interactions of the family in the kitchen on the morning of the diagnosis. Similar to the advertisement featuring Brain, this contrast illuminates the uncertainty of breast cancer and survivorship, emphasizing that the disease can puncture any moment of the life course, no matter how ideal one’s life may be, reinforcing the idea that complete protection or security is illusory.

Through the perspective provided by this video, the viewer is interpolated into the effects of breast cancer and is called to reflect on the impact that breast cancer might have on their own families and loved ones. Affect is mobilized throughout the video to position breast cancer survivorship as a problem of families, and to promote the duty of citizens to engage in responsible breast cancer survivorship by participating in the Run for the Cure. The woman’s responsibility to participate is invoked the moment she passes the threshold into survivorship, stepping into her welcome home party where she is handed her pink Run t-shirt, and called to do her part. The slogan “we’re closer to a future without breast cancer, we can’t stop now,” works to persuade by positioning a “future without breast cancer,” and a future where children are protected from the potential loss of their mothers as both possible and within reach, offering up the body of the survivor as proof of the progress made. Emphasizing that “we can’t stop now,” the discourse produced by the CBCF ads offers up the promise of this future in exchange for continued participation in the Run and support of the CBCF. Drawing on and highlighting the way that breast cancer diagnosis interrupts and devastates families, the discourse positions participation in the Run for the Cure as an act of protection or insurance for the family and an investment in its future. Further, the focus on mothers and motherhood calls on and extends to the responsibility of mothers to protect their families and shield their children from harm, enfolding participation into the duties of motherhood.

The construction of breast cancer as a disruptive force was coupled with narratives describing how women actively repaired their interrupted lives through various rituals of
survivorship. One way that the interruption of breast cancer was repaired was through the restoration of the body and mind. The challenge of repairing the self and one’s position on the expected life course was constructed as part of the personal journey of survivorship, a task that is presented as one that women must approach head-on. This is illustrated in the narratives of Cristie, a survivor in the 2011 promotional video *Voices of Breast Cancer*. Cristie is a young, white woman, who appears to be in her early thirties. She is a striking woman with short, curly, dark-hair and artful makeup. Gazing at the viewer, Cristie describes the ways that her cancer diagnosis and experience have altered her “outlook” on life, and her embodied experience of the world through her bodily changes:

Life now is definitely different, I have different hair, my body is different, my outlook on life is different. People often talk about sort of your life being, you know, cancer's the gift wrapped in sandpaper, and I feel that. Some other people talk about it being a gift period. It gives you sort of a deeper appreciation for your life. I already appreciated my life, I was a really happy person, and I still hope that I am a happy person. *I’m sort of a work-in-progress right now.* I’ve been out of treatment for, active treatment for about a year now, and *it’s definitely a journey that you go through. I have more good days than bad days and definitely less bad days that I used to have.* So, *I just kind of keep putting one foot in front of the other and trying to get where I want to be and that’s to reclaim my life* (CBCF, 2013).

In this passage, Cristie positions cancer as an *interruption* in her life and life-course. She describes herself as a “really happy person” who “appreciated” her life before her diagnosis and rejects the dominant discourse that breast cancer is a “gift” that functions to invite reflection and appreciation for one’s life. Instead, Cristie describes her life, post active treatment, as a “work-in-progress,” with the end goal of reclaiming her life. The positioning of her life as something which she has to “reclaim” reveals the self-work that underpins survivorship in this discourse, as the act of reclaiming is an active process in which a subject works to “obtain the return of” something once possessed, but lost, by bringing it “under cultivation” (Oxford English Dictionary, 2016). The number of “good
days” in comparison to “bad days,” is used as a measure of progress through which her efforts to “reclaim her life” are marked and judged. Significantly, the “journey” in this narrative is constructed as an active process in which the survivor envisions where she wants to ‘be’ or what kind of life she wants to cultivate, and takes actions over time to achieve (i.e., “putting one foot in front of the other.”) Importantly, the active component of this process reveals how survivorship is constructed not as a status or subjectivity that is conferred onto the woman after the completion of active treatment, but rather is an outcome or result of various rituals of individual effort and perseverance, and a status that must be maintained through the subject’s direction of her body, life, and conduct. These rituals of repairing the body and mind, of resolving the interruptions produced by the uncertainty of a breast cancer diagnosis are one way that survivorship is enacted within the discourse.

6.3.2 Threatening the Future through the Child at-Risk

As I have shown in Section 6.2.2, the construction of the Universal Woman at-Risk and the discursive positioning of breast cancer risk as an all-encompassing threat interpolate all women into the field of breast cancer survivorship, transforming the disease into a normal and expected feature of modern Canadian life. As subjects of the discourse, all women are called to take up the duty of participation in the Run as a response to the threat of breast cancer and demonstrate their commitment to securing a future without breast cancer. The construction of participation as a duty is enlivened through frequent references to and depictions of children who are at-risk for a future interrupted by breast cancer. The expectation for women to participate in the Run neatly align with and reproduces/reinforces discourses of traditional femininity and female gender roles, placing prominence on women’s responsibilities to protect and care for their families. The preservation of the nuclear family and the protection of loved ones (in particular children and husbands) is a constant thread throughout the CBCF ads and becomes a particularly intense focus of the campaigns published after 2011. Alongside this intensified focus on familial responsibilities, the temporal field of breast cancer survivorship is expanded and extended forward in-time to incorporate children as
citizens-in-the-making. The intense focus placed on children and the possible conditions for their futures are highly visible in the 2013 print and video promotional campaign, *Run for the Future*. This print and video campaigns is centered around the confessions of children who narrate their own reasons for participating in the Run, detailing the various impacts of breast cancer on their projected future lives and families. In contrast to their childlike appearance, their narrations are delivered through adult language and speech patterns producing a jarring effect.

The temporal dimensions of this expansion of breast cancer survivorship are evident in the first video Delia, which features a pre-teen girl. Delia sits on a twin bed in front of frothy lace curtains in a pastel bedroom. She gazes at the viewer with a serious expression and matter-of-factly responds to the unasked call “who are you running for?” by stating:

I’m proud of my daughter. As a toddler, she was strong and confident, so of course, when she was a teenager, we argued a lot (sigh)... But, she grew into this woman who could accomplish anything. Now, it’s my turn to be strong for her. *Now that she has breast cancer. I’m running for my daughter* (Delia, 2013).

![Figure 11: Delia, CBCF](image)

Delia’s narrative is bewildering. She speaks from her location in the present, as a pre-pubescent girl, about a future that has yet to be realized. The temporal tensions in her
narrative are highlighted through the juxtaposition of the image of Delia, a girl still in the midst of childhood, with her seemingly impossible narration of the future-present (i.e., her daughter’s breast cancer diagnosis) and the invocation of a past in relation to her future that has yet to come (her entrance into motherhood and her daughter’s childhood), producing a strange, distinctly non-linear temporality. Incongruously, the future that she projects in the present casts her as the mother of an adult daughter, a daughter whose future existence is inevitably marred by breast cancer. Notably, there is no room for an alternate possibility in the language used to describe this future, as breast cancer is described as being a property of her daughter, something that she “has,” not something that “could” occur; the imagined daughter’s fate has already been set in motion, as has the imagined mother’s response. Again, breast cancer is positioned as an expected and inevitable experience of being a woman, a disease that is certain to strike in the future. Furthermore, breast cancer becomes constituted in this ad campaign as a threat leveled against women who have yet to come into existence, but who are nonetheless interpolated into the expected experience of breast cancer and the field of survivorship by virtue of their future womanhood. The second video in this series, Sean, invokes a similar disorienting temporal trajectory (figure 12). Sean is a blonde-haired boy who appears to be about 7 or 8 years old and is pictured sitting on a swing in a park. He is not a particularly handsome child, and with his slightly bucked teeth and large protruding ears, he is decidedly average. His image could easily be replaced by another ordinary child, perhaps even the child of the viewer. Sean, gazing seriously at the viewer, states:

I love my wife. We met in fourth year on campus. It was love at first sight; she'd say second sight. We got married not too long after graduation. Last October we got the bad news. The doctor found a lump in her breast. I'm running for my wife (CBCF 2013).

Sean’s account also produces a disorienting temporality through his narration of an anticipated future in the present. The first portion of his narrative maps neatly onto an idealized, anticipatory life trajectory marked by heterosexual romance, advanced education, and family formation. This trajectory is reflective of the dreams and aspirations that many heteronormative, Canadian parents and families hold for their
children – the reproduction of the nuclear, heterosexual family and the cultivation of a middle-class life.

![Image of a young boy]

Figure 12: Sean, CBCF

Sean’s idealized life trajectory, however, is disrupted and thrown off course by the appearance of breast cancer and the threat of losing his wife. The viewer is left unaware of what the outcome of his future wife’s breast cancer will be, highlighting the uncertainty that underpins breast cancer as a disease and the unpredictability of its threat to continued life. Regardless of the outcome of her illness, the predicted emergence of breast cancer in Sean’s future threatens to curtail his anticipated, heteronormative life trajectory through the uninsurable exposure to disease. Sean is faced with the prospect of losing his wife, whom he fell in “love with at first sight,” years before he will meet her. His fairy-tale, campus romance and predicted heterosexual family are threatened before they can even be realized. Presented as pre-determined, Sean’s future has already been interrupted by breast cancer by virtue of the universality of breast cancer and the threat that it poses to all women, present and future.

The figure of the child who narrates futures interrupted in these promotional materials operates as a powerful discursive strategy that unsettles the viewer and incites action. The representation of the child who orates the inevitable threat of breast cancer in their future produces an uncanny effect; their mannerisms and adult-like speech are strange, yet
familiar. The children visually appear as ‘ordinary,’ in that there is nothing remarkable about their appearance. They are dressed in commonplace, nondescript clothing (plain t-shirts, a cardigan, and a windbreaker) that one would expect to see in an elementary school classroom or at a playground, and the children are situated in places where one would expect to find children (playground, bedroom). The unremarkable appearance of Delia and Sean serves to render them as a visual placeholder for the ‘average’ Canadian child. Effectively, Delia and Sean are each invoked as a ‘universal child.’ This figure, like the figure of the ‘universal woman’ functions to communicate the ubiquity of risk and the expansiveness of vulnerability to breast cancer. However, the universal child-at-risk is distinct from the universal woman at-risk in that its invocation incorporates both male and female children into the field of breast cancer survivorship, highlighting their mutual vulnerability. While female children are rendered vulnerable through their bodies - the eventual sites for disease emergence - male children are presented as being made vulnerable through their assumed intimate connections to future female partners. Further, unlike the universal woman at-risk, and her attainment of the coveted statuses of beauty, health, and vitality, the universality of the child at risk is communicated not through the child’s exceptionality, but rather through their unremarkability and ordinariness. The children presented as at-risk in this campaign could be the child of anyone, and thus everyone. The figure of the universal child-at-risk operates, in this campaign, to magnify the threat of breast cancer and to heighten the urgency for action, signaling to viewers the inevitably threatened futures of the children they have, know and love, appealing to their civic duties to Run to protect the futures of the children of the nation.

However, the familiarity communicated through the figure of the ordinary child is disrupted and subverted when the children begin to speak. Both the way that the children speak, and the contents of their speech comes across as strange and jarring because they convey a seriousness and maturity that is distinctly unchildlike. While the appearance of Delia and Sean is childlike, the nature and tone of their speech interpolate them into adulthood, thus erasing the carefree pleasures associated with childhood, effectively incorporating them into the responsibilities of adulthood. In this way, the children are positioned as having grown old before their time, maturing too fast and experiencing the world through an accelerated timeline. The grim narratives of the children demonstrate
what is at stake for the future of both themselves and the nation. The paradoxical configuration of the unchildlike child is disturbing because it highlights the way in which the inevitability of breast cancer punctures the protective shield of childhood, resulting in children’s forced incorporation into survivorship discourse as disciplined subjects who are called to act responsibly and run on behalf of the imagined futures of those that they will (should) love. This unsettling configuration of the child works to disturb the viewer through the subversion of cultural expectations of childhood, heightening the urgency for intervention into a predicted future.

6.3.3 Running for the Future

The anticipated future severance of the heterosexual nuclear family is also communicated in Elijah, a print advertisement for this series, which juxtaposes the image of a half-smiling, boy with brown skin and curly hair with the bold statement “I’M RUNNING FOR MY WIFE,” printed in white, childlike capital letters. Elijah, like Sean, is interpolated into the field of breast cancer survivorship through his intimate connection to women in the future-present, and the anticipated diagnosis of his future wife. Elijah, Delia, and Sean function as powerful discursive figures and draw on a discourse of intimacy to communicate the threat of breast cancer and its projected impact on future generations. The references to relations with intimate others (e.g., wife) are highly visible in these campaigns, such as Sean’s declaration of love for his future wife, and Delia’s assertion of pride in her future-daughter. These sentiments not only make clear the

![Image of Elijah, CBCF]

Figure 13: Elijah, CBCF
significance of these intimate relationships to Elijah, Sean, and Delia but also function to invoke emotion in the viewer by referencing their own intimate connections, inviting the viewer to reflect on those that they love and to consider running on their behalf. In effect, the viewer is incorporated into the field of breast cancer survivorship.

The intimate relations of survivorship are also visible conclusions of the video advertisements in this series. Both Sean and Delia conclude with a static image of the child’s frowning face making the unhappiness of the child impossible for the viewer to escape. Text appears across the lower portion on the child’s face that reads: “RUN FOR THE FUTURE, A FUTURE WITHOUT BREAST CANCER.” The stark contrast between the child’s unhappy face and the hopeful promise of “a future without breast cancer” is striking. In this image, participation in the Run is privileged as a solution to curtail or prevent the unhappiness of the child, and an opportunity to craft a future in which they, and their imagined families, are protected from the disruption of breast cancer. Participation is not just a mechanism to intervene in the future of this particular child, but the future of all children. The call to “run for the future,” alongside the figures of children whose futures are at-risk, operates to mobilize and responsibilize the viewer through their own intimate connections to act in the interest of protecting those that they love from future harm. Participation in the Run becomes configured as a way to protect (heteronormative) families of the future generation from the interruption of breast cancer and the uncertainty of survivorship.

Figure 14: Sean, CBCF
6.3.4 Ambiguous Biomedical Promises

After 2011, the construction of the future as ambiguous emerged as a particular discursive strategy to encourage participation on the Run. The intense focus on the future emerges in the 2011, 25th anniversary promotional videos where the promise of “a future without breast cancer” is connected to continued participation in the CBCF’s fundraising venture for the first time. This connection is forged through multiple references to the scientific advances that have resulted from research funded by the Foundation, with these advances mobilized to provide evidence of the increasing scientific mastery over the disease and signal the proximity of the promised, imagined future.

The promise of a future without breast cancer is highly visible in the first video of the series, *The Beginning*. This video concludes with Nancy Paul, a central founding member of the CBCF urging viewers to: “keep going, keep doing what you are doing, because the only things that counts are the lives that are saved and the lives that are lengthened” (CBCF, 2011). In her plea, Nancy Paul connects the personal generosity of individuals and their continued participation in the Run to improved outcomes in the lives of women with breast cancer, whose survival is levied as evidence of progress and “changemaking.” This strategy of persuasion is also visible in the 2014 print advertisement, *Every Mom* that features the image of a young survivor in a pink Run t-shirt with her smiling

![Figure 15: Every Mom, CBCF](image-url)
daughter, whose arms are wrapped around her. They gaze at each other, smiling, in a perfect moment of maternal bliss.

Next to the image in bold pink text reads: Sign up to let every mom know how much she’s loved. The following text appears below:

When you take part in the Canadian Breast Cancer Foundation CIBC Run for the Cure, you are helping to fund education and advocacy programs as well as ground-breaking research. *We’re closer to a future without breast cancer, but we can’t stop now. Join us on Sunday, October 5th* (CBCF, 2014).

The juxtaposition of this maternal image with text that suggests that the woman’s survival and this moment with her daughter have been made possible by the CBCF and the research and programs that they fund. In this way, the text communicates the likelihood of a “future without breast cancer” through the body of the breast cancer survivor and her continued life, which serve as evidence of the ‘progress’ made through biomedical research. Such evidence is positioned as proof that a “future without breast cancer” is not only possible but is within reach and will be brought into being through continued individual acts of personal generosity.

This hopeful vision of a future where breast cancer can be conquered by biomedicine contrasts starkly with the anticipated futures featured in the 2013 *Run for the Future* campaign. As I discussed in section 6.3.2 the print and video advertisements in this campaign feature ordinary appearing children who forecast a future in which they themselves, or their future family members (daughters, wives) are inevitably marred by a breast cancer diagnosis followed by an uncertain and unknowable outcome (will diagnosis result in death or life?) The predicted bleak futures, and the forecasted emergence of breast cancer in the bodies of girls yet to cross the threshold of womanhood, functions to highlight the interrupted, and potentially foreclosed future possibilities of the children and their imagined families. However, the austerity of the predicted future is tempered by a sliver of hope that offers the tantalizing possibility that the future might yet be otherwise. This thread of hope emerges in the dual slogan and promise: “RUN FOR THE FUTURE, A FUTURE WITHOUT BREAST CANCER.”
Similar to the 2011 anniversary videos and the 2014 print advertisement discussed above, the promise of a “future without breast cancer” is made available, and rendered possible through the act of participation in the Run for the Cure.

Despite the interpolation of all women and children into the field of breast cancer survivorship, the promises for the future levied by participation in the Run is imbued with hope and optimism. This promise is, however, marked by ambiguity and is suspended in a complex temporal arrangement that blurs the boundaries of the future and the present. The ambiguity threaded through the Run for the Future campaigns operates as a powerful discursive strategy that produces an empathetic response in the viewer in order to promote continued participation in the Run. This discursive strategy can be traced within one of the print advertisements for this campaign, 38th Birthday (figure 16). In this ad, the face of a pre-pubescent girl with a mousey brown pony-tail is framed against a blurry background of swirling technicolor. Her relaxed face, neither smiling nor frowning, is the central focus of the image. Underneath her lips, “I’M RUNNING FOR MY 38TH BIRTHDAY,” is printed in white font, mimicking uneven child-like writing. The text is bordered by the slogan “RUN FOR THE FUTURE: A FUTURE WITHOUT BREAST CANCER.” The text and image communicate a number of ambiguous ideas about the future. The 38th birthday of the child stands out as a significant moment, one whose meaning is left open. The viewer is invited to question whether the marker of the
38th birthday refers to the date of her future breast cancer diagnosis, a date marking an increase in her risk for breast cancer, the date on which she partakes in the Run as an investment in her own future, or all of the above. Indeed, the child’s statement of why she is running, like the promises uttered by Sean, Elijah, and Delia, demonstrates her commitment to do her part by investing in her future in light of such temporal ambiguity. The specific reason offered as the motivation for her participation is located in the future and is unknowable in the child’s present moment. The child’s promise to run in response to an imagined, yet unpredictable future occurrence is reflected in the slogan “Run for the Future,” and the imperative expressed by this campaign for the viewer to participate now in the interest of the future.

The ambiguous construction of the future threaded throughout the Run for the Future campaign functions as a powerful discursive strategy. The discursive strategy of ambiguity is invoked to invite the viewer to imagine for themselves how the pre-determined breast cancer will affect and shape the child’s possibilities for the future. In dwelling on the curtailed possibilities of the child, a tension is produced through the contrast between the innocence of childhood and the interruption of the child’s future possibilities heightening the urgency for action in the present. Importantly, the unstated, open and undetermined outcomes of the pre-determined diagnoses are never revealed in the advertisements. Instead, the ambiguity that surrounds the future of the child and their future families functions to position breast cancer as an inevitable yet unpredictable threat for the future generation, a threat for which the injurious effects cannot be calculated and to which adult citizens have a duty and moral responsibility to respond to – by running.

### 6.4 Responsibilities and Rituals of Survivorship

In the previous section, I outline how the general public, and women in particular, are targeted by the CBCF promotional materials as citizens who have the responsibility to invest in and protect the future of the nation’s children. This responsibility includes acts of personal generosity, the support of biomedical research, and participation in the Run for the Cure. In this section, I will focus specifically on how survivors of breast cancer are targeted by this discourse, outlining the new responsibilities they are called to take up in order to demonstrate their commitment to life. I will trace how participation in the
Run features centrally into this responsibility and has become configured as a ritual of life.

6.4.1 The Duty to Survive Well

Within the CBCF promotional materials, a particular type of survivor subjectivity emerges – the Resilient, Fit survivor. The Resilient, Fit survivor has a number of attributes that are implicitly and explicitly credited with enabling or assisting her survival of the disease. In particular, this survivor is physically fit and demonstrates both physical and personal strength. She is determined, possesses the perseverance to work for and achieve her goals by demonstrating mastery over her body and life. In taking action, she also takes chances, pushes herself and her body and is not deterred by failure. Within this discourse of survivorship, there is a focus on the capacities and capabilities of individuals while silence surrounds suffering and bodily limitations. The possibility that women might experience bodily limitations or side-effects produced by biomedical treatments for active breast cancer is glaringly absent. Instead, this subjectivity constructs survivorship as a symbol of personal strength and a reflection of the survivor’s morality, personal fortitude, and persistence to endue breast cancer and biomedical treatments.

One way the duty to survive well and the fitness of survivors is communicated in the sample is through the athletic clothing, running shoes and Run for the Cure t-shirts frequently worn (and presumably purchased) by survivors. These athleisure items function as cultural symbols that communicate the survivors’ moral commitment to bodily fitness, discipline and participation in the Run. The prominence of athleisure clothing and accessories in the promotional materials highlight the ways in which discursive constructions of survivorship overlap and intermingle with discourses of consumerism and consumption. As a result, the survivor subjectivity promoted by the CBCF is produced through active, and continuous performances of both the conspicuous consumption of health and fitness products and the disciplined management of the body and mind.

This subjectivity appears in narratives of several survivors (e.g., Nalie, Julia) featured in campaigns between 2011 and 2017. Georgina, a survivor featured in two, 2013 print and
video advertisements is a particularly striking invocation of the novel subjectivity of the Resilient, Fit survivor. She is featured as part of the #onenewthing campaign, which positions the act of trying new, challenging physical activities as an opportunity for women, and survivors, in particular, to demonstrate their physical and mental strength, and their commitment to self-management. The campaign promises that trying one new physical activity “can mean everything” for women (#onenewthing, 2013). Each ad in this campaign features a different woman trying a new, challenging activity like high-diving, paddle boarding or tennis, and then discussing the experience of overcoming the specific physical and mental challenge in relation to her survivorship.

Georgina’s Story is unique because Georgina is the only visibly ‘older’ survivor included in the sample of promotional materials. Georgina is a thin, white woman in her sixties. She is small in stature and her short, gray hair is artfully styled. She wears large, funky jewelry and stylish, casual clothing and sleek athletic wear throughout the video. While Georgina’s age separates her from the typical, youthful survivor featured in the promotional materials, her generally fit body and pursuit of challenging physical activities, such as paddle boarding and dragon-boat racing, demonstrates her commitment to the maintenance of bodily youthfulness and vitality.

Figure 17: Georgina's Story, CBCF
The opening scene of *Georgina’s Story* shows Georgina paddling with her dragon-boat racing team in an expanse of choppy, blue water (figure 17). In a voice-over, Georgina introduces herself: “My name is Georgina and I am a mother and a wife, and a daughter, a dragon boat paddler and I am a breast cancer survivor. That’s who I am” (CBCF, 2013).

Georgina’s articulation of her identity positions her foremost as “a mother, a wife, and a daughter,” emphasizing her commitment to the institution of the family, highlighting the centrality of these traditional roles to her understanding of herself as a subject and to the CBCF’s construction of survivorship. Of secondary importance is her identity as a “dragon boat paddler” and physically fit disciplined subject. In foregrounding these aspects of her identity, Georgina’s account positions her status as a breast cancer survivor as a subjectivity that co-exists and supports the other aspects of her identity, rather than challenging them. Georgina’s subjective operates as a powerful re-inscription of traditional female roles by decisively dissociating breast cancer survivorship from any mention of feminism or activism. The use of Georgina to position the Resilient, Fit Survivor as one who is first, a wife and mother highlights the way in which this popular construction of survivorship functions to bring women back into traditional gender roles in modern Canadian society.

While Georgina’s age separates her from the other survivors spotlighted in the promotional materials, her high level of physical fitness demonstrates her commitment to youth and the pursuit of health. In describing her experience of survivorship, Georgina draws on her participation in dragon boat racing and forges connections between survivorship and sport by highlighting the common physical and mental discipline required to succeed:

> Part of my experience is this dragon boat team, which is *a powerful reminder of what you can do after a diagnosis*. Every woman on that team has had breast cancer, every woman is strong. *It might seem like it impossible, but we all did it, and paddling strong*. Maybe not always winning every race, but really a great team of strong women (CBCF, 2013).
Georgina’s account connects her participation in the challenging sport, and her commitment to “paddling strong,” thereby overcoming the physical and mental challenges to the ‘strength’ that is required to survive breast cancer. Participation in sport signals the strength of the survivors to physically direct their bodies and their determination to persevere in the face of physical and mental challenges. Centrally, her narrative constructs breast cancer diagnosis and the process of surviving as an opportunity to reassess and remake one’s life and to demonstrate one’s strength of character. This commitment is in alignment with larger discourses of neoliberal citizenship and the ‘duty to be well,’ (Greco, 1993) which calls on individual citizens to take responsibility for their bodies, lives, and health and to act to make the best of oneself.

Georgina’s status as a breast cancer survivor is also credited with strengthening her mental resolve, making her a stronger, more capable person. She describes how her participation in various physical activities has enabled her to see herself as a woman who is capable of achieving anything:

*Cancer actually changed my life in a very positive way.* Probably lots of people say that. It’s a strange thing, it makes you appreciate your life. My personal life, my work life, my everything, the way I looked at the world changed. You can’t really fail after that. Everything is living, everything is life, everything is success because you didn’t die. *Anything I think of that I really want to do, then I just make sure that I get it done.* I don’t want to be dying some time thinking I wish I’d done this. I’m never going to feel like that. I’m going to have done everything. *You can always find a way, if there is something that you really want to do, you find a way and you do it* (CBCF, 2013).

In Georgina’s narrative, survivorship is positioned as a source of empowerment that enables her to take control of her body and desires by setting goals and determinedly pursuing them, refusing to accept failure. This *carpe diem* approach to life, inspired by her critical illness, and the ‘success’ of not dying is commensurate with biomedicalization and serves to render Georgina’s life, body and mind as projects to be
continuously worked on and improved. Her life, body, and mind are not constructed as static states to be maintained, but rather are sites of opportunity that can be worked on to “find a way” to achieve her desires. In this way, Georgina’s survivor subjectivity appears to be in-motion or a continual work of progress, transforming her body and capacitates into sites for the achievement of success. Reflecting on her paddle boarding experience, Georgina positions herself as a curious, adventurous subject who seeks continuous self-improvement and challenge. Her active, learning-focused life and pursuit of youthful physical activities do not align with cultural assumptions about older age as a time for decline and dysfunction. In light of her illness experience in the past, and the unspoken threat of disease re-emergence, Georgina takes up a ‘duty to survive well’ in order to ward off disease recurrence and to demonstrate her ongoing commitment to life and health through her active engagement in the management and optimization of the self. The approach to survivorship forwarded in Georgina’s campaign, combines positive thinking and optimism with the qualities of intense personal strength, determination and a desire to cultivate the best life, and body, for herself. This attitude is credited with making “all the difference.”

Figure 18: Georgina's Story, CBCF
Georgina's Story highlights the ways in which the body of the breast cancer survivor and her capacities are configured as a site for the achievement of continued success, signaling her morality, responsibility, and worthiness with respect to her survival and health. The portrayal of Georgia’s intense commitment to body and self-work are informed by her illness and subsequent survival and shed light on the ways in which constructions of survivorship, situated in the larger discursive context of the ‘will to health’, connect ideas of health to morality, responsibility and good citizenship. In other words, to survive becomes a continuous, active process, and subjects, like Georgina, are called to perform their survival through relentless self-management and self-improvement.

6.4.2 Survival of the Fittest

The prominence of cultural symbols of physical fitness within the discourse is not surprising considering that the function of these materials is to elicit participation in a five-kilometer race. However, the physical fitness of the survivors communicates more than their ability to participate in such an event; it also functions to signal their ‘fitness’ as both citizens and survivors. In other words, the fit body and ability to complete the five-kilometer run stand in as signs of moral character, determination, and discipline, characteristics that are connected to the emergent construction of survivorship and the duty to survive well. This is clearly illustrated in the 2015 print and video campaign focused on Nalie Augstin, a young breast cancer survivor, in which the Run is invoked as both physical challenge and metaphor for survival. The 2015 promotional video, Nalie’s Story, focuses specifically on her experience participating in her first Run for the Cure as a young woman with active breast cancer. Her narrative highlights the ways that personal characteristics of perseverance and strength are ascribed to survivorship. The video opens with a close-up of Nalie, a young, beautiful, woman with light brown skin and a pixie haircut. She is sitting in front of a window, and the reflection of the light highlights her shimmering pink lip-gloss. Her sparkling cosmetics, beaming smile, and laughter emphasizing her effervescence, youth and vitality.
She appears very much alive and vibrant. Wearing a t-shirt from the Run for the Cure, she describes how her experience of breast cancer at twenty-four was mirrored by her participation in the 5-kilometer Run:

The 5k to me is kind of a metaphor to my entire journey of having to get by each treatment, each step, you past the first the first kilometer, it’s really hard because you are just starting. Then you pass the second kilometer, things get easy, and then the last three and four are the hardest but you’ve got to keep pushing and pushing and pushing and then you finally cross it and you realized like wow, I made it. You know, and I think that’s what really represents me and trying to like get through breast cancer and make it to the end until I’m cancer-free (CBCF, 2015).
This comparison of the experience of active breast cancer to a 5-kilometer race is striking because the completion of a race is a goal that can be achieved through a personal commitment to arduous training. She credits individual effort, perseverance, and the strength to keep “pushing” through the “hardest” parts of the Run with enabling her to survive the disease. This moment of “wow, I made it,” is visually captured, and a bald-headed Nalie in a white Run t-shirt is shown crossing the 5K finish line with her arms raised in a victorious pose (figure 20). The white t-shirt is a significant visual marker because it communicates that at the time of the race, Nalie was not yet a survivor, she was simply a participant. At the event, pink t-shirts are awarded to breast cancer survivors to communicate their status and celebrate their survival. This makes her crossing of the finishing line even more significant, as this moment and her victorious stance mark not just her completion of the race, but her passage into survivorship.

![Figure 20: Nalie’s Story, CBCF](image)

The image of Nalie crossing the finish line is a potent image of strength and determination. The physical and mental strength that is required to propel her through both of these journeys casts participation in the Run and survival as accomplishments that can be achieved or cultivated through individual action, determination and strength.
Significantly, the sample also connects the act of participating in the Run, and the physical effort required to complete the 5-kilometer race, to the survival of breast cancer linking women’s actions, characteristics and capacities to their disease outcomes while also forging connections between participation in the Run and survival of the disease. In this way, the act of participating in the Run becomes a metaphor or ‘practice’ site for the journey of breast cancer, a journey that all women may be called upon to make by virtue of the universal risk of breast cancer. Participation is thus configured as a way to practice or cultivate the necessary skills and strength required for the breast cancer ‘journey.’

In the context of the universal threat of breast cancer, the use of youthful, vibrant, smiling women engaging in physical fitness as representations of the ‘face’ of the breast cancer survivorship supports the construction that breast cancer as an unavoidable, but survivable, disease. While survival is depicted as a feat of strength, and an accomplishment that requires perseverance, determination, and fitness, survival is not assumed to be the eventual outcome of breast cancer. In the sample, breast cancer is also configured as an unpredictable disease whose outcomes cannot be accurately predicted, determined, or completely controlled through the application of biomedicine. The limits of biomedicine are acknowledged and are made visible through the stories of women who have died or are dying from the disease. The acknowledgment of the limits of biomedical knowledge and the degree of uncertainty that continues to mark breast cancer and survivorship operates to heighten the urgency of action and the necessity for continued fundraising to support biomedical research.

The urgent need for action is clearly communicated in the 2011 promotional video, *Voices of Breast Cancer*, which features the stories of two young breast cancer survivors, a stage-four woman, and the widower of a woman who has died from breast cancer. Following the stories of triumphant survival offered up by Marcie and Cristie (see section 6.1.4), Gail, a middle-aged woman with short, blonde hair and quirky black glasses shares her experience with breast cancer (figure 21). Unlike Marcie and Cristie, Gail does not appear youthful and vivacious; instead, she gazes out at the viewer with a serious expression. Gail reveals that she is not a survivor, she is stage-four, and her future is not filled with hope and possibilities for self-improvement. She positions herself
as a woman that is “surviving,” and highlights her discomfort with the uncertainty that ultimately underscores breast cancer as a disease.

I’m not crazy about the word survivor because I’m surviving. I’m not a survivor. Survivor makes it sound as though it’s something that’s in the past, and I do think that everyone who has a breast cancer diagnosis and is treated for breast cancer is surviving, you know, in many cases it comes back. In my case, it didn’t have a chance to come back, it was already - it was already spread (CBCF, 2011).

Gail’s account contests the construction of survivorship as a challenge that individual women can overcome with personal strength and determination. She makes note of the unknown etiology and trajectory of the disease in her body, emphasizing that “in many cases, it comes back,” and that when her cancer was discovered, “it was already spread,” erasing the possibility of breast cancer becoming a part of her past.

The acknowledgment of the uncertainty of breast cancer, and its ability to spread, re-emerge and take the life of those that are “surviving” operates to produce a double construction of the survivor. On the one hand, the survivor, represented by the image of Nalie crossing the finish line, emerges as a symbol of perseverance, individual determination and a beacon of hope for the future, illustrating that breast cancer may be overcome and survived. On the other hand, Gail’s narrative and the references to women

Figure 21: Voices of Breast Cancer, CBCF
who have died that are peppered throughout the promotional materials serve as reminders that the disease can be and remains unpredictable and deadly, underscoring the urgency for action in the present.

Gail’s account of ‘surviving’ counters Nalie’s narrative of entry into survivorship through individual determination and perseverance, thus puncturing the idea that surviving breast cancer is within the realm of personal control, making clear the impossibility of this promise. However, her account also operates alongside the dominant discourse, functioning to highlight the deadly threat of breast cancer and the limits of current biomedical knowledge, in order to emphasize the need for continued research. In so doing, the impossibility of Gail’s survivorship operates to render participation and personal generosity as a moral and responsible choice.

6.4.3 The Run as a Ritual of Survivorship

As promotional materials, the print and video advertisements function primarily to elicit participation in, and financial support for, the Run for the Cure - the central fundraising vehicle of the CBCF. In light of this function, it is not surprising that participation in the Run emerges as a central feature of the discourse. Participation, however, is not a static construction or idea within the discourse, but rather is attached to a number of different ideas and meanings throughout the promotional trajectory that function to shape participation as the ‘right’ thing to do. The meanings attached to participation across the duration of analyzed promotional materials also invoke and reflect different conceptions of survivorship that are informed by distinct temporal logics and configurations. In the promotional materials published before 2011, survivorship is constructed as an uncertain, unstable subjectivity through the representation, acknowledgment, and commemoration of women who have died from breast cancer in the past. This fore-fronting of death signals the impossibility of guaranteeing survival and contributes to a construction of survivorship that is underpinned by uncertainty and precarity. In this discursive construction, participation in the Run is connected to the past and functions dually as a memorial and philanthropic act.
We can see how participation is connected to memory and philanthropy in the way that breast cancer deaths are invoked in two advertisements from a 2007 print series. The first advertisement depicts a middle-aged white man and his young son wearing white Run t-shirts as they run hand-in-hand along a paved lake-side trail. They are surrounded by clusters of middle-aged women running in white and pink t-shirts. The father and son stand out not only because they are the only male figures in the image, but because of the appearance of a translucent, pale pink woman figured alongside them. This ghostly figure is depicted mid-stride clad in athletic pants and a Run t-shirt with her long hair pulled back into a pony-tail. She is smiling and looks wistfully over her shoulder at the father and son. The spectral woman completes this ideal nuclear family while simultaneously signaling the aberrance of its form. The way in which the apparition is figured mid-stride, running alongside the father and son functions to explain their participation in the female-dominated event. The spectral woman is a visual placeholder for the mother and wife rendered absent, lost to breast cancer.

Above the eerie scene, “Some women run it every year,” is printed in pale pink lettering. The lower portion of the ad is augmented by a mock white runner identification card complete

Figure 22: Some Women, CBCF
safety pins. The card features the pale pink Run for the Cure logo, event details, and the call to “walk, run and give generously.” Below, nestled between the logos of corporate sponsors including Revlon, New Balance and Ford, “who are you running for?” is printed in pale pink font. What is striking about this advertisement is the way in which the breast cancer survivor is figured. The pale pink spectral woman running alongside the father and son signals at once both death and survival, communicating and embodying the uncertainty that underlies the subjectivity of breast cancer survivorship. Two readings are possible here. The obvious reading is that the spectral woman is merely a ghost, survived by her husband and son. However, a second reading is suggestive of the ghostly woman’s status as a survivor, which is communicated by her pink form, the same shade as the pale pink t-shirts that are used to identify the living survivors in the image and at the Run.

Paradoxically, the spectral woman’s translucent pink body confers and communicates her survivor status to the viewer, while simultaneously acknowledging her death from breast cancer. This figure of the spectral breast cancer survivor starkly contrasts with images of the triumphant, vibrant and living survivors that have come to represent the breast cancer survivor in popular Canadian culture, such as Nalie or Georgina. Depicting the breast cancer survivor as a literal ghost of herself functions as a powerful visual reminder of the uncertainty of breast cancer survivorship and unsettles the imagined connections between survivorship and life. Further, her ethereal appearance next to the solid materiality of her husband, son, and the other runners lay bare the human impact of breast cancer on those the left behind.

The figure of the spectral survivor and the way in which her embodied form is represented also sheds light on how the Run as an event is constructed as a ritual of loss. The positioning of the apparition alongside, and in sync with, the running father and son visually completes the triad, producing an image of a once but no longer complete nuclear family. This strange familial configuration communicates the idea that participation in the Run is a way to invoke and engage with the memory of loved ones lost to breast cancer. The act of running, for the father and son, is thus positioned as a way for them to run alongside the memory of the wife and mother made absent by breast cancer. Alongside the text, “some women run it every year,” her Run for the Cure t-shirt
suggests that the event is a particularly important ritual of loss performed in memory of those who have lost their lives to the disease.

The spectral survivor also makes an appearance in the second advertisement in this print series. In this ad, a middle-aged, white woman is depicted running along a tree-lined street as part of the Run. She is flanked by a number of other white women attired in black running pants and white and pink (i.e., survivor) t-shirts. Alongside her, matching her stride and mirroring her bodily comportment, is a translucent pink woman. The scene is uncanny as the appearance of the pair is strikingly similar – they can only be differentiated by the colour of their t-shirts (one white, one pink) and the slight difference in the length of their hair. The spectral survivor, positioned alongside the fleshy materiality of the living, running woman is unsettling, not just because it points to death, but because of the strong physical similarities between the women. The spectral woman is the mirror image of the living runner - she is both the same and yet different. She functions as a ghostly twin, her apparition haunting the living runner, a constant reminder of the potential proximity of breast cancer and the uncertainty of survival.

Figure 23: Some Women 2, CBCF
The rhetorical slogan “who are you running for?” aids the interpretation of this image, suggesting that the ghostly woman may represent a close female relative, possibly a sister, who has lost her life to breast cancer. The severed intimate connections between the women help to explain the living woman’s participation in the race as an act of memory for the woman lost. In this context, the act of participation in the Run is figured as a commemorative act and a way to invoke and honour the memory of women who have lost their lives to the disease. The uncanny similarities of the two figures also serve to highlight the vulnerability of this woman and implicitly all women to the disease – reminding the viewer that their protection from, and survival of, the disease cannot be guaranteed.

In summary, the figure of the spectral survivor is powerful and functions to communicate a number of ideas about survivorship and participation in the Run for the Cure. Significantly, her translucent pink apparition forefronts the reality that breast cancer can and does result in death, visually emphasizing that the outcome of survivorship is not always life. In representing women who have lost their lives to breast cancer, the campaign places both the uncertainty of survivorship and the left behind – the human cost of breast cancer– in the spotlight. Positioning participation in the Run as a memorial or commemorative event serves two purposes. Firstly, the annual occurrence of the run, and the textual reminder that “some women run it every year,” positioning the Run as an annual memorial event and an annual ritual of loss. Such positioning functions not only as an attempt to position the Run as an important national event but also obscures the primary function of the Run as a fundraising venture.

As an annual event, the Run for the Cure is also incorporated into the rituals of repair described in section 6.2.1., whereby women engage in particular forms of action in order to restore their life course, in light of the disorientating, and disruptive effects of breast cancer. Rituals of repair are intimately connected to the Run for the Cure and the CBCF and are thus constructed as a key part of survivorship within the discourse. While repair as a verb describes the processing of restoring a breach or bringing together that which has been separated (Oxford English Dictionary, 2010), as a noun, to make one’s repair refers to a gathering or assembly of people at a specific place or site which a person visits.
or travels to habitually. In this sense of repair, the Run for the Cure, as an annual event, and happening can be seen as a site of a pilgrimage undertaken as part of the rituals of survivorship. Turning back to the 2005 video, *In Her Shoes* that I discussed in section 6.3.1 we can see how the Run functions as a symbolic ritual of survivorship and repair. In this video, the woman’s active disease experience is concluded with the gift of a pink Run for the Cure t-shirt. The pink shirt marks her entry into survivorship and confers her into the Run as a member, a survivor. This membership, however, comes with a new responsibility and requires action and effort on the part of the woman; she must run and participate in alignment with the ‘duty to survive well’. It is not enough to have survived the disease, one must also re-enact the journey of survival through endurance and the completion of the race.

The configuration of the Run as an event to which survivors make their repair is also visible in the 2015 promotional video, *Nalie’s Story*. As part of her narrative, Nalie describes her journey towards survivorship as a 5km race, blurring the experience of her survival of the disease with that of her participation in the race. In this way, the completion of the race and her survival are entangled, interconnected and inseparable. The annual occurrence of the event and its familiar traditions (i.e., pink shirts, the survivor tent, survivor celebration breakfast etc..) enable the Run to function as an annual temporal marker of survivorship, and participation in the Run thus functions as a renewal

![Image](image.png)

*Figure 24: In Her Shoes, CBCF*
of membership into survivorhood, offering up the possibility that this moment of repair can be renewed and experienced, again and again.

In summary, the Run for the Cure as an annual event is constructed across the discourse as an important ritual and part of survivorship. As I have illustrated, the meaning of this ritual changes across the discourse; while in the earlier promotional material it is attached to ideas of loss, commemoration, and memorial, it becomes reconfigured as an event to celebrate life, strength, and survival in the later promotional materials. While the meanings of the Run as a ritual, and the kinds of survivor subjectivities that the ritual invokes (e.g., spectral survivors, vibrant thrivers) change, the idea of the run as an event, happening or place that is intimately connected to survivorship remains constant. The shift in the discourse towards the celebration of survivors in the present enables other rituals of life outside the Run to come into being. These rituals of life capture and reflect new moments or temporal markers of survivorship that are enabled by the CBCF and the biomedical research funded by the organization. These new temporal markers function in tandem with the ritualization of the Run to assert and entrench the constructed position of the CBCF as an important Canadian philanthropic organization that promises to deliver a future without breast cancer.

In constructing particular moments and potential experiences of survivorship into rituals of life, the discourse operates to reorient the temporality of breast cancer and survivorship by disrupting expected timelines or outcomes (i.e., breast cancer recurrence or death), inserting in their place new temporal markers (i.e., five-year survival markers). Within the discourse, these temporal markers function as evidence of the women’s lives that have been lengthened or saved and are offered up as proof of progress purportedly made possible by the work of the CBCF and biomedical research. These temporal markers reflect new significant moments in survivorship, moments that are interconnected with CBCF and its goal of improving biomedical treatments for breast cancer.

One such temporal marker is brought into being through the aptly titled 2013 video The Moment. The Moment, a silent seventy-second promotional video that follows a couple’s experience during a dramatic, medical consultation. The consultation is presented as a
serious affair. Seated across from a white coat wearing doctor, in an office lined with framed degrees the couple wear serious, neutral expressions. Deep, dramatic instrumental music swells in the background, heightening the lack of speech, rendering the scene uncomfortable and conveying the sense of foreboding. The silence, dramatic music, and the unstated context of the interaction operate as a discursive strategy rendering the interaction ambiguous. This discursive strategy calls on the viewer to draw on their interpretive resources and understandings of breast cancer and survivorship to make sense of the unfolding scene. These interpretations are made in response to a highly dramatic presentation of a clinical encounter.

In the first frame, the doctor is shown reviewing a series of x-rays and reports. His face is blank and expressionless as he focuses on his task. An ordinary appearing white, middle-aged woman sits across the desk from him. Her appearance is plain, she has a bare face, dull, slightly frizzy brown hair and is wearing a shapeless cardigan. Her husband sits next to her, clad in a denim shirt and blue jeans. They are an unremarkable, white, middle-aged couple. They appear to be waiting nervously, and alternate between looking intently at the doctor and worriedly at each other. The husband reassuringly rubs the arm of his wife. Over the slow, instrumental music the doctor begins to speak wordlessly, gesturing at the couple. In the absence of sound, the viewer is left to study the expressions and imagine the content of the conversation. The woman’s face fills the frame, her chin wobbles, and her face crumples as her eyes fill with tears. The doctor holds up the x-rays and points to the image. The woman begins visibly crying, her hand covers her mouth. She closes her eyes and bends over, hugging herself while sobbing.

This interaction in the doctor’s office, the x-rays, the solemnness of the expressions, and the visceral emotional reaction of the woman, are familiar hallmarks of medical representations of breast cancer in popular culture and direct the viewer to conclude that “the moment,” being depicted is the moment of diagnosis. Diagnosis is the anticipated and assumed narrative to explain the drama of the unfolding scene. This reading of the scene is disrupted, however, when the woman suddenly looks up, removes her hand from her mouth and smiles broadly. White text appears over the image that reads: “Catherine just learned she’s been breast cancer free for five years.” The text remains on the screen.
for a few seconds, enabling the viewer to absorb its meaning, while Catherine smiles and looks at her husband in the background.

Figure 25: The Moment, CBCF

The image is replaced by text that reads: “Let’s run for more moments like this. Run for a future without breast cancer.” This video subverts the anticipatory trajectory of breast cancer, in which an emotional, tear-filled scene in a doctor’s office signals only the delivery of bad news, such as a diagnosis or recurrence. Instead, this emotional moment between a woman, her husband, and her doctor, is reconfigured into a celebratory moment of survival, and a moment of triumph. The passage of the five-year maker is brought into being as a temporal marker that can be anticipated and incorporated into women’s compulsory entry into breast cancer survivorship, and a new ritual of life made possible by the CBCF.

6.5 Conclusion

In this chapter, I presented the findings of my CDA of the selected sample of promotional materials produced by the CBCF. Throughout this chapter, I described the specific forms
of subjectivity that emerged in the discursive field – the Universal Woman at-Risk, the Child at-Risk and the Resilient, Fit Survivor.

I also traced the significant discursive transitions that occurred across the promotional campaigns from 2007 to 2017, highlighting how the construction of breast cancer shifted from a national problem to that of an individualized and intimate problem. I further described how the latter construction of breast cancer as a problem of individuals and families was articulated through references to intimate others, in particular, the figure of the Child at-Risk. Drawing on these intimate connections, I demonstrated how breast cancer survivorship was constructed as a problem that is best responded to by individuals on behalf of those that they love and is framed as a duty of good citizenship.

I also described how the discourse constructs breast cancer as a universal, inescapable aspect of Canadian life that threatens the future of all women and children. In contrast to the Chronic Survivor subject and Decliner produced in the Springer Journal, I detailed in this chapter, how the survivor subject imagined by the CBCF promotional materials produces the figure of the Universal Woman at-Risk. Further, I outlined how the youth and beauty of the Universal Woman at-Risk were invoked to emphasize the vulnerability of all women to the disease and promote participation in the Run. I also described how the discursive construction of breast cancer as an inescapable threat to all women ultimately positioned breast cancer survivorship as a problem that could only be addressed through participation in the Run and the financial support of biomedical, cure-oriented research. In the final section, I outlined the subjectivity of the Resilient, Fit Survivor and described how she enacts the ‘duty to survive well’ by demonstrating her bodily and civic fitness through participation in the Run.

In the chapter that follows, I draw on the theoretical perspective of governmentality to highlight the governing features of the specific forms of subjectivity that I identified in Chapter 5 and Chapter 6. I also return to my analytic interest in temporality to explicate how the discursive imposition of a particular temporal trajectory of survivorship that is characterized by a moral imperative to live and think towards the future operates to reify particular gendered, sexual, and civic norms.
Chapter 7

7 Governing Women Through Survivorship

This study empirically and theoretically analyzes how discourses of breast cancer survivorship are constructed within professional and popular fields of knowledge production. In this thesis, I used critical discourse analysis methods informed by Foucauldian, feminist, and queer theoretical perspectives to analyze a sample of texts, published in the Springer Journal of Cancer Survivorship and by the Canadian Breast Cancer Foundation, to elucidate a more complex understanding of how discourses of breast cancer survivorship effectively privilege and exclude particular forms of subjectivity and temporal trajectories. In this chapter, I return to theoretical notions of governmentality and queer temporality to discuss the forms of subjectivity I identified in each of these discursive fields, and to illustrate how discourses of breast cancer survivorship operate as a technology of neoliberal governance that invokes particular constructions of responsible and healthy citizenship, gender, and the future in order to direct the capacities and conduct of women affected by the disease, and the population at large, towards normative ideals. I explicate the intricate workings of neoliberal practices of governance and the expansive citizenship duties that women with breast cancer and women more broadly are called to take up through these discourses of breast cancer survivorship. The findings of my study raise concerns regarding the specific ways that breast cancer survivorship discourse, and the forms of subjectivity it inspires, are shaped in relation to neoliberal political rationalities and contemporary anxieties about women’s bodies, as well as their social and political roles. As I go on to explore, the forms of subjectivity idealized in these discursive fields charge post-treatment women with the duty to ‘survive well,’ cultivating particular forms of bodily and civic fitness that dampen survivors’ resistive potential and encourage complicity with traditional forms of femininity and gendered responsibilities.

In the previous two chapters, I presented the findings of my critical discourse analysis. In Chapter 5, I described the three central forms of subjectivity produced in the Journal of Cancer Survivorship, drawing particular attention to the construction of the Chronic
Survivor, the Optimizing Survivor, and the Decliner. Each of the discursive framings of survivorship circulated within the Journal endorse active, responsible citizenship and risk management practices for post-treatment women, inciting them to respond to their moral obligations to ‘achieve’ and optimize their health through individualized actions. Centrally, the discourse incites health professionals to view post-treatment women as subjects who should respond to their embodied vulnerability by engaging in disciplinary practices to cultivate and optimize their bodily fitness. In Chapter 6, I outlined three forms of subjectivity produced in the Run for the Cure discourse. Specifically, I identified the Universal Woman at-Risk, the Child at-Risk, and the Resilient, Fit Survivor. These forms of subjectivity are connected by a central concern with the securement of a particular future marked by a continuation of the heterosexual, nuclear family. In order to secure this future, the discourse ultimately calls all women, and those with whom they are intimately connected (i.e., family, friends), to demonstrate their civic fitness by participating in the Run for the Cure.

In the first portion of this chapter, I apply a governmentality framework to consider how the forms of subjectivity I identified in Chapters 5 and 6 operate to direct women’s conduct in ways that align with traditional femininity and reflect the neoliberal individualization of responsibilities for health and wellness. I argue that the Chronic Survivor and Universal Woman at-Risk are each a unique configuration of what Tasha Dubriwny (2013) calls the “vulnerable empowered woman,” a form of subjectivity that I described in Chapter 3. In the following section, I trace the specific contours of these vulnerable empowered subjectivities produced in each discursive field of survivorship, highlighting the particular ways that women’s subjective possibilities and parameters for agency are shaped by the meanings assigned to survivorship. Drawing on my findings, I consider how these unique articulations of vulnerable empowerment both deepen and complicate our understandings of how women are imagined and represented by, and incorporated into, survivorship discourse, and highlight the social and political effects of these imaginings. In particular, I draw attention to how an analysis that attends to issues of affect and temporality reveals new insights into how these forms of vulnerable empowered subjectivity operate to reproduce sexual, gender, temporal, and citizenship norms, revealing the overlapping and deeply intertwined effects of power.
In the second portion of this chapter, I apply a theoretical lens attuned to queer temporality to consider the temporal and affective dimensions of the discourse, highlighting how the imposition of a particular temporal trajectory characterized by a moral imperative to live and think towards the future orients survivor subjects towards particular forms of anticipatory action. Drawing on my findings, I explicate how breast cancer survivorship discourse governs post-treatment women, and the population at large, by assuming and requiring the imposition of specific temporal trajectories that are underpinned by heteronormativity and ageism, and operates to support the reproduction of gender, sexual and citizenship norms. I conclude this chapter with a brief reflection on the productive potential of a governmentality framework that is attuned to notions of queer temporality and describe the new insights into governing techniques that I generated using this approach.

7.1 Chronic Survivorship

As a site of knowledge production and dissemination, the Journal of Cancer Survivorship brings into being both breast cancer survivorship as chronic illness and the Chronic Survivor as a governable subject. In Chapter 5, I demonstrated how breast cancer survivorship is constituted as a permanent, chronic risk condition through the clustering of particular types of calculable risks, the predicted emergence of future disease(s), and the increased bodily vulnerability assigned to women after they complete treatment for breast cancer. Post-treatment women are incorporated into a (compulsory) patient population and transformed into subjects of a complex biomedical regime in which risk for future disease is searched for, anticipated, and brought into the post-treatment present. Within this regime, responsibility for risk reduction is shifted onto individual chronic subjects who are constructed as being empowered to take up expert advice and biomedical knowledge as part of an anticipatory strategy of risk management and bodily optimization. While iatrogenic effects of biomedical treatments for breast cancer are the ‘symptoms’ targeted by this regime, the potential life-limiting effects of these treatments are obscured and discounted as barriers that might prevent the subject for participating in promoted form of action. Ultimately, the discourse of chronic survivorship is a technique of neoliberal governance that calls post-treatment women to act upon their bodily
vulnerability, take up the responsibility of risk reduction and body optimization and (re)constitute their identities as responsible and moral citizens.

The Chronic Survivor can be understood as a particular biomedicalized form of vulnerable empowered subjectivity that illuminates how power, understood as a productive force, is at once both enabling and constraining. The framing of the subject’s vulnerability as ‘chronic’ functions to intensify and expand the field of risks in which the subject is situated, thus opening up new possibilities for a broad range of professional interventions and producing new opportunities for self-management. While her options for action may appear to be expanded, the field of agency in which the Chronic Survivor is situated is constrained, as she is directed towards particular choices (i.e., expert informed interventions) and away from others (i.e., doing nothing). These choices are not offered as morally equivalent options; making the wrong choice (e.g., doing nothing) renders the subject responsible for any negative health outcomes and secures her construction as an irresponsible Decliner and failed subject. Clarke et al.’s (2003) framework of biomedicalization is useful to show how the inescapable constellation of risks that characterizes survivorship as a chronic condition magnifies the vulnerability of the subject in particular ways, producing lifelong responsibilities for self-management. Through my critical reading of this biomedicalized framing of chronic survivorship, I illuminate the ways in which the body of the survivor is transformed into a new terrain for the demonstration of both responsible citizenship and femininity.

As I reviewed in Chapter 2, biomedicalization is characterized by a pervasive “problematization of the normal” (Armstrong, 1995) in which asymptomatic bodies are increasingly situated as being at perpetual risk of disruption by the emergence of disease, thus implicating everyone in the process of eventually “becoming ill” (Petersen, 1997). The heightened attention to bodily vulnerability for post-treatment women is enabled through technological innovations that expand the purview of the biomedical gaze, rendering new problems related to the management of breast cancer (e.g., iatrogenic effects such as pain and fatigue) and the risk of breast cancer recurrence as visible, knowable and predictable, thus “opening up a space of future illness potential” (Armstrong, 1995, p. 400). As a form of biomedicalized subjectivity, the Chronic
Survivor is brought into being by and through biomedical interventions. She is an iatrogenic subject; an unexpected outcome of the ‘successful’ medical management of acute breast cancer. Survivorship – her condition – is produced through the clustering of side-effects, symptoms and long-term effects of breast cancer treatment, which are re-packaged as unique symptoms. These symptoms are then targeted by a new regime of biomedical and professional management that seeks to optimize her body and reduce her risk of future illness. As I will show in this chapter, optimized survivorship is a relentless and endless pursuit that only intensifies as the subject ages.

The Chronic Survivor occupies a tenuous temporal space in which the future embodied state of the subject is unknowable, and the re-emergence of illness is always on the horizon. As a permanent subject of the biomedical regime, the Chronic Survivor redefines the breast cancer continuum identified by Klawiter (2008) by expanding it beyond its former ‘endpoint’ – the completion of treatment. The Chronic Survivor’s permanent residency upon this expanded continuum is justified by her inescapable and incalculable risk for future ill health. As I described in Chapter 5, the Journal articles included in the sample construct survivorship as an unpredictable condition that is shaped by various unknown factors and effects that result from the exposure to biomedical treatments for breast cancer. It is precisely the ambiguity and uncertainty that informs survivorship, as a subjectivity and regime of biomedical management, that renders it a fertile ground for biomedicalization.

As a site of knowledge production, the Journal is primarily directed towards physicians and other health care practitioners who provide care for post-treatment women. The ways in which breast cancer survivorship and survivor subjects are constructed within the journal shape, and are shaped by, professional modes of perception and the clinical gaze, which are highly biomedicalized. The biomedicalized risks associated with chronic survivorship are framed as pressing and treatable health problems in the absence of active disease. This construction of survivorship starkly demonstrates that, within biomedicalization, the presence of active disease or the manifestation of symptoms suggesting disease is no longer necessary – ‘chronic’ survivor subjects persist despite this absence. The compulsory enrollment of post-treatment women into this new subjectivity
as chronically risky subjects facilitates their exposure to new discourses of self-management and new responsibilities for risk reduction, as evidenced by the numerous interventions and training programs promoted within the Journal. The responsibilities for risk-management associated with chronic conditions are intensified because the subjects of this regime are already presumed to be irresponsible. That is, their breast cancer diagnosis is taken as evidence of their failure to effectively manage their risks in the past. This logic is highly visible in the discourse, particularly in the studies that interrogate the survivor’s past behaviours and lifestyle prior to diagnosis to explain the severity or persistence of her post-treatment symptoms. As a spoiled or failed subject, the Chronic Survivor is called to demonstrate her commitment to self-governance through new, post-treatment risk-management practices in order to remake herself as a good citizen. In light of her prior failure, the Chronic Survivor is rendered even more responsible for risk management than her pre-diseased, at-risk counterparts.

While risk is a highly salient component in the lives of all women located along the breast cancer continuum, my findings demonstrate that framing survivorship as a chronic condition produces new responsibilities for women that extend beyond practices of screening or surveillance. As with all subjects of risk discourse, the Chronic Survivor subject is incorporated into a complex biomedical regime in which risk is searched for, anticipated, and brought into everyday life, transforming new features of the everyday into sources of potential danger (i.e., food consumption choices, thought patterns and responses to stress). However, as a post-treatment subject, the Chronic Survivor is interpolated into the liminal space between remission and recurrence, rather than the liminality of risk and disease occupied by subjects at-risk for breast cancer (i.e., pre-vivors). By virtue of her prior diagnosis and the risks for future illness attached to her post-treatment condition, the responsibilities attached to the risk role of the Chronic Survivor are intensified. Her particular vulnerability propels action as she is directed towards extensive practices of self-management and bodywork to ameliorate her risks for recurrence.

Such action is presented as a project of empowerment that offers up the tantalizing promise of control over her embodied future and post-treatment possibilities. Similar to
the governing functions of risk discourse generally, the assumption undergirding breast
cancer survivorship discourse is that once survivor subjects are aware of the risks (their
vulnerability) and the actions promoted to ameliorate them (i.e., lifestyle modification)
they will become empowered to engage in the expected conduct. However, as Dubriwny
(2013) makes clear, there is nothing empowering about a ‘compulsory choice,’
particularly when that choice requires women to be complicit in a paternalistic
relationship with biomedicine. As a particular form of vulnerable empowered
subjectivity, Chronic Survivors are responsibilized to take up expert advice, biomedical
knowledge and self-manage their newly identified risks within a designated field of
action.

This route to ‘empowerment,’ significantly, is dependent on women directing their
bodies and conduct in ways that align with promoted biomedical treatment regimes.
Actions located outside of this field are not interpreted through a lens of ‘agency,’ but
rather are read as misguided, uninformed, or irresponsible. For example, in the Journal,
post-treatment women who did not comply with prescribed risk reduction strategies (i.e.,
specific diet and exercise plans) and engaged in ‘risky’ behaviours such as eating high-fat
food and abstaining from exercise, were consistently framed in the research as being ill-informed, unaware subjects who are in need of both education and biomedical guidance.
The possibility that women might exercise their agency and choose to engage in
pleasurable practices, such as drinking alcohol, and eating high-fat foods are rendered
invisible by the discourse. Further, making the ‘wrong’ choice has significant
implications as the burden of responsibility for ill-health or recurrence are shifted on
individual subjects and rendered as evidence of failure to self-govern.

As citizen-making technologies, the disciplinary practices of risk reduction and
responsible self-care promoted by the Journal produce particular kinds of docile,
gendered citizens whose responsibilities support feminine ideals related to embodiment,
comportment, and consumption. This is highly visible in the ‘training’ programs I
described in Chapter 5 (see section 5.3.1), which deploy disciplinary strategies (e.g.,
repeatedly modeling desired forms of behaviour such as positive thinking and physical
activity, peer surveillance) to idealize regimes of normalizing and optimizing bodywork and mental work in order to cultivate a desirable form of survivor subjectivity.

These forms of bodywork reflect Moore’s (2010) observation that neoliberal framings of healthy citizenship and the practices of ‘body-consciousness’ through which it is enacted, are deeply gendered and operate to re-signify femininity on the body. As the practices of body-consciousness (i.e., diet and exercise) promote particular moral ideals that associate health with a thin body and feminine conduct (demonstrated through restrictive consumption practices), Moore argues that women become “doubly-subject” to the disciplinary practices deployed through discourses of health (p. 112). In this way, disciplinary techniques such as intensive risk reduction strategies operate insidiously under the banner of ‘health’ to render women’s bodies both docile and feminine. This docile femininity emerges in the Journal’s intense emphasis on diet and exercise regimes, which aim to restrict women’s consumption of food through low-calorie, low-fat diets, and re-shape the body through vigorous physical activity, ultimately producing a smaller, leaner, fitter female body. The feminine docility endorsed by the interventions published in Journal also sought to train the mind of breast cancer survivors through their emphasis on encouraging post-treatment women to engage in “positive thinking” (Loh et al., 2013), a finding which resonates with my later discussion in section 7.3 of the role of affect in the governance of post-treatment women.

The pervasive focus in the Journal on the physical bodies and consumption practices of survivors also resonates with the work of feminist scholars who have produced rich analyses of the ways in which discourses of fitness, diet, and bodily management operate as normalizing strategies to produce docile, slender bodies by directing women’s attention towards their bodies and away from other possible pursuits (Duncan, 1994; Bartky, 1990; Bordo 1993; Roy, 2008). Bartky (1990), for example, argues that while the overt aim of disciplinary practices of diet and fitness is to produce a particular aesthetic ideal, the covert function and ultimate effect of these practices is the social and political disempowerment of women. Susan Bordo (1993) describes the cumulative effect of these strategies as the “tyranny of slenderness,” and argues that it is one of the most “powerful “normalizing” strategies of our century” (p. 85). These normalizing
strategies are deeply intertwined with notions of morality and citizenship, rendering the shape and size of women’s bodies as symbols of the condition of the soul. The slender, fit, female body has come to represent self-control and the ability to effectively suppress desires and passions, both sexual and gastronomic (Bordo, 1993). A central component of hegemonic femininity is women’s suppression of desire and their restricted consumption of various resources (i.e., food sources, health care dollars, state resources) (Urla and Swedlund, 2007). This requirement for self-control is intensified for Chronic Survivors, who are called to (re)establish their moral integrity in light of their prior breast cancer diagnosis. My findings suggest that the (bourgeois) body that is cultivated through survivorship can be read as a site on which achievements of self-discipline, regulation, morality, citizenship, and femininity are (re)established, measured and communicated. Becoming an ‘empowered’ survivor subject in this context is thus entangled with, and inseparable from, disciplinary practices of femininity and responsible consumption.

7.2 Universal Vulnerability

In Chapter 6, I described how the promotional materials produced for the Run for the Cure construct breast cancer as an inescapable feature of modern Canadian life and an inevitable aspect of womanhood that threatens the conditions and possibilities of the future. The significant threat posed by breast cancer and need for urgent action was communicated through an intense focus on youth and youthful bodies and on women’s roles as mothers and wives, reflected in the figures of the Universal Woman at-Risk and the Child at-Risk. In this section, I focus on the Universal Woman at-Risk and consider how this form of subjectivity operates as another unique form of vulnerable empowerment. Like the Chronic Survivor, the form of empowerment that the Universal Woman at-Risk is directed towards is individualized and operates to support and re-enforce biomedical control over the disease and its research agenda. While the Universal Woman’s opportunities for empowerment are positioned in the discourse as being both liberatory and socially transformative, I suggest that, like the Chronic Survivor, these opportunities are located within a constrained field of possibilities that foreclose forms of action that disrupt or challenge the continuity of hegemonic sexual and gendered norms that characterize contemporary Canadian life. As a technology of governance, I argue
that this popular discourse of breast cancer survivorship calls women to demonstrate their ‘fitness’ across moral, national, reproductive, familial, civic, and bodily domains. In so doing, the discourse produces particular kinds of female citizens with expanded responsibilities for care and giving, reshaping the contours of citizenship and redefining what constitutes legitimate and meaningful forms of social and civic action.

In Chapter 6, I illustrated how the intense focus on the diagnosis and survival of youthful, healthy-appearing, beautiful women in the CBCF promotional materials constitutes a Universal Woman at-Risk. As a form of subjectivity, the figure of the Universal Woman at-Risk functions as a symbol of national urgency and positions breast cancer as a social problem that must be responded to through conspicuous acts of personal generosity expressed in running for the cure. The proliferation of images of young, seemingly healthy cancer survivors enacts a cultural disarmament, disrupting the idea that youth is a time of protection from disease and that the cultivation of ‘perfect health’ offers a protective shield against the disease. Through this discursive severing of youth from the expectation of health, breast cancer survivorship discourse alters cultural conceptions of the life course such that the possibility of disease, disability, and death puncture the everyday, effectively incorporating all women into the unavoidable field of breast cancer. Through the construction of breast cancer as a ubiquitous social problem and an expected part of modern Canadian life, the scope of responsibilities associated with the discourse is extended temporally and socially to include all women by virtue of their universal vulnerability (i.e., biological womanhood) as well as those to whom women are intimately connected.

In the previous section, I drew on Dubriwny’s concept of the vulnerable empowered woman to illustrate how the empowerment of the Chronic Survivor produced in the Springer Journal is contingent on adherence to biomedicalized regimes of risk reduction, reflecting the extensive gendered responsibilities for risk management that have become part of neoliberal citizenship. In this section, I describe how the (expanded) responsibilities of survivorship articulated in the CBCF discourse support another aim of neoliberal citizenship – the securement of the national (re)productive future. Returning to Dubriwny (2013), I show how the empowerment of the Universal Woman at-Risk is
fulfilled through particular citizenship practices that reinforce traditional femininity and demonstrate her commitment to the nation and her family. Further, I demonstrate how the expansiveness of the discourse operates to extend the field of survivorship by incorporating additional (healthy) actors into practices and responsibilities of civic fitness. Specifically, the responsibilities of civic fitness invoked by the CBCF discourse are individualized and reflect the post-2011 discursive framing of survivorship as a problem of families and children. Women are addressed by this discourse primarily as mothers (or future mothers) and are called to act as guardians of personal, familial and national health by participating in practices of personal generosity and physical fitness. Women are constructed in this discursive field as gaining access to both empowerment and responsible citizenship through this form of protective action and the support of the biomedical research agenda that the CBCF endorses.

What is distinct about the Universal Woman at-Risk is the way in which the breast cancer risk is configured as an inescapable aspect of her biological womanhood. As I described in Chapter 6, the lifestyle interventions associated with risk management and individual control over prevention are almost entirely absent within the promotional materials for CBCF. With the exception of the 2012 #onenewthing campaign that featured Georgina, the construction of breast cancer survivorship is dislocated from biomedical frameworks and risk logics (despite the CBCF’s unwavering support of biomedical research). Instead, the CBCF draws on and circulates a view of breast cancer survivorship that is informed by intimate knowledges and relationships. The experiences of individual women and their (constructed) stories of unexpected diagnosis and triumphant survivorship form the primary body of evidence in this discursive construction of breast cancer survivorship. Through the narrative presentation of this intimate evidence, breast cancer is framed and presented to the public as an unpredictable disease that threatens the everyday lives of all women by puncturing and effectively disarming the protective shields of youth and health. Importantly, this construction of survivorship re-shapes and re-defines the field of agency in which this vulnerable subject’s empowerment can be enacted. The choices that she is directed towards are distinct from that of the Chronic Survivor and informed by an entirely different paradigm of risk in which breast cancer risk is ubiquitous. Women’s inescapable risk and her constructed connections to other
survivors and at-risk subjects propel them, and those they love, to participate in philanthropic practices that harness their agency towards biomedical ends through the financial support of cure-oriented research.

While on the surface the actions and choices made available to the Universal Woman at-Risk appear to be quite different than those of the Chronic Survivor, the endorsed forms of action within these discursive fields operate similarly to reinforce biomedical research agendas, solidify women’s compliance with biomedical regime and authority, and re-inscribe traditional femininity. Discourses of motherhood and care shape the ‘choices’ that the Universal Woman at-Risk is oriented towards. In particular, the participation of the Universal Woman at-Risk in the Run, conceived as a form of civic action, is consistently figured within the promotional materials as an act she has undertaken on behalf of and for the benefit of others - namely her children or future children –never explicitly for herself. Women’s participation is configured as a gesture of love for others, as evidenced by the long-term slogan “who are you running for?” This is captured visually in the Run for Nalie and Julia campaigns where women gather to Run for the Cure in t-shirts bearing the name of their suffering loved one. It is through such representations of selfless, civic-minded actions that the Universal Woman’s empowerment is achieved.

In addition to advertising the Run for the Cure, the CBCF promotional materials offer women one particular form or site of ‘empowerment’ – the possibility and promise of a future made fulfilling through the cultivation of a heterosexual, nuclear family. Motherhood and the nuclear family are centrally represented in the promotional materials and frequently positioned as the apex of women’s desires. As I discussed in Chapter 6, survivors were overwhelmingly represented alongside their families or with their children, making the dire absence of other representations of survivors outside of familial connections (i.e., as professionals, as vibrant individuals) highly visible. These findings support Dubriwny’s assertion that the choices made possible and available to the vulnerable empowered subject are both crafted “to appeal to a woman’s sense of empowerment and yet reify one of the most traditional aspects of being a woman: motherhood” (Dubriwny, 2013, p. 57).
In addition to reinforcing marriage and motherhood as women’s primary object of desire, the results of my study suggest that survivorship discourse is intimately bound up with the reproduction and reconstitution of femininity across a variety of domains. That breast cancer survivorship is connected to femininity is perhaps unsurprising given that breast cancer is culturally understood as a disease that “attacks women at the bodily site where notions of femininity intersect” (Lupton, 1994, p. 73). Breast cancer wounds femininity through the iatrogenic effects of its biomedical treatments (e.g., baldness, loss of the breasts), which disfigure and remove cultural signifiers of femininity and sexuality from women’s bodies. A key function of breast cancer culture and survivor discourse more broadly has been to encourage women with breast cancer to normalize their appearance as soon as possible after treatment so that they can present privileged forms of femininity and make themselves visible not as ill persons, but as feminine and whole (Batt, 1994; Carter, 2003; Lorde, 1980). The survivor, as represented by CBCF, is normative in all areas outside of illness; she is wholly feminine and entirely unthreatening. In the sample of advertisements I reviewed in Chapter 6, the breast cancer survivor is constructed as white, heterosexual, and middle-class with a balanced bust line, the physical signs of her illness are carefully disguised with cosmetics and prosthetic devices (Carter, 2003; Cartwright, 1998). The Universal Woman is one such survivor; she is a subject that is produced through disciplinary practices of femininity.

A number of scholars have identified how the stylized, feminine appearance of the breast cancer survivor functions to reinforce norms of femininity (Batt 1994; King, 2006; Ehrenreich, 2001). However, less attention has been paid to the ways in which the forms of conduct incited by breast cancer survivorship discourse (e.g., participation in fundraising), and the rationale underpinning these forms of conduct, also operate to reify traditional gender and citizenship roles. The results of this study further our understanding of the normalizing effects and implications of breast cancer survivorship discourse by highlighting how the effects extend beyond the body and into the citizenship and familial roles and duties of women, firmly securing women’s return to traditional femininity through gendered responsibilities. To illustrate this, I return below to the subjectivity of the Resilient, Fit Survivor and the modes of conduct that she is oriented towards.
In Chapter 6, I identified the subjectivity of the Resilient, Fit survivor and described the ways in which her body and physical capacities are configured as sites on which her morality, responsibility, good citizenship, and health are communicated. I highlighted how the physically fit bodies of survivors and their narrative accounts of determined survival function to signal their ‘fitness’, physically and as citizens. The Resilient, Fit survivor is an entrepreneurial subject (Greco, 1993) who responds to the call to ‘make the best of oneself’ through her continuous commitment to intense practices of body-work and self-work (i.e., engaging in and completing mentally and physically challenging tasks). My analysis of Georgina and Nalie in Chapter 6 illustrates how this form of subjectivity is constructed as a form of individual accomplishment and civic participation in an era of hyper-individualism where health is defined as a personal, obligatory moral achievement (Crawford, 1980). These practices align with neoliberal political rationality and shed light on the ways in which this survivor subjectivity, situated in the larger discursive context of the ‘will to health’ (Greco, 1993), gives rise to a new duty for survivors – the duty to ‘survive well.’ Like the responsibilities bestowed on the Chronic Survivor, ‘surviving well’ is an active process and women are continually called upon to perform practices of self-management as a demonstration of their physical, moral, and civic fitness.

Situated within the context of neoliberal models of citizenship I described in Chapter 3, I argue that the Resilient, Fit survivor presented in the CBCF promotional materials, and her accounts of self-determination, willpower, and discipline, communicates her concern for the self and the body as objects of both discipline and anxiety within a moralized framework of self-governance, enabling her to be constituted (and seemingly constitute herself) as an ideal neoliberal citizen. Crawford (2004) contends that the pursuit of health through rational calculation has become attached to ideals of citizenship because it reflects the subject’s commitment to re-calibrate her conduct in response to the anxieties, insecurities, and danger she encounters. The conduct of this subject is not informed by her desires; it is rather shaped by her commitment to live optimally. The expectation for the survivor to optimize her body and life through self-management and bodywork practices is a thread that runs through both discursive fields I analyzed. This suggests that there is a consistent duty to survive well across the popular and professional
survivorship discourses that is bound up with gendered ideals of ‘fitness’ across bodily, moral, and civic domains.

Like the Chronic Survivor, the survivor subjects constructed in the CBCF discourse are both vulnerable and uncertain. In the CBCF discourse, the female body and its inescapable vulnerability are constituted as a state of uncertain embodiment, particularly for the survivor whose bodily vulnerability has already been exposed by the unexpected threat of breast cancer. In the context of this vulnerability, the body of the Resilient, Fit survivor can thus be seen as a ‘natural’ terrain for the demonstration of responsible citizenship through disciplinary, bodywork practices (i.e., running) that are linked to the production of a lean, fit physical body, a physicality that communicates the moral worth of the subject and her commitment to self-discipline and femininity (Bordo, 1993).

Engaging in physical activities such as the Run for the Cure operates in the promotional materials as a central site of moral transformation and civic participation of survivor subjects. Running, as a form of physical participation, is constructed as an opportunity for survivors to redeem themselves morally and to become civic role models for others. As others have noted, fitness has become an increasingly important commodity that signals both the morality of the subject and her civic fitness. Samantha King (2006) has described how ‘thons,’ such as the Run for the Cure, provide an opportunity for citizens to demonstrate their morality, generosity and civic fitness by “running well.” Imagery of the physically fit body, and narratives of the self-disciplined Resilient, Fit survivor’s survival and continued health are positioned as the product of her responsible choices and evidence of her status as an autonomous and worthy citizen.

The subjectivity of the Resilient, Fit survivor builds on the notion that the female body is a site upon which one’s success and mastery over the unruly self are to be displayed. The self, for the Resilient, Fit survivor, is a project to be worked upon, improved and optimized, reflecting a “makeover framework,” (Ehrenreich, 2001) that neatly aligns with consumer culture, youth culture, and hegemonic femininity. Through this lens, breast cancer survivorship can be read as a ‘makeover opportunity’ where subjects abdicate their previous, spoiled identities as ill subjects, cultivating enhanced emergent identities as Resilient, Fit survivors. This makeover framework resonates with the biomedically
driven regime of optimization that Chronic Survivors are propelled towards in the Journal of Cancer Survivorship. Both of these processes are configured as opportunities for women to re-make themselves as proper, responsible citizens in light of their ‘spoiled’ identities as women who have been diagnosed with and treated for breast cancer.

In the CBCF promotional materials, this reinvention of the self is inextricable from participation in the Run, the raising of funds for biomedical research, and the consumption of pink-ribbons products (e.g., New Balance running shoes, pink-ribbons products). Thus, the Run for the Cure, as a site of moral transformation, civic participation, and reinvention of the self, operates as a technology of governance to produce self-governing subjects through its intimate connections to consumer culture, the ethics of personal generosity, and the imperatives of biomedicine. Neoliberal political rationality, as Rose et al., (2006) contend, governs individuals through their freedom by displacing the need for active governmental control and directing their own conduct in desired ways under the guise of self-fulfillment and agency. The self-discipline of the Resilient, Fit survivor subject and her commitment to bodywork practices, in the context of neoliberal citizenship are constructed as authentic self-fulfillment and empowered action.

In Chapter 6, I described how breast cancer survivors were overwhelmingly represented as youthful subjects. In the sample of promotional materials, I analyzed, representations of post-menopausal women are almost entirely absent, relegated to the edge of the survivorship imaginary as bodies that fail to matter. Based on my analysis of Georgina, the only ‘older’ woman in the CBCF sample, my findings suggest that the fields of agency in which the vulnerable empowered woman’s choices are shaped and constrained are further intensified when the subject is disarticulated from youth. In contrast to the youthful, vibrant Universal Woman at-Risk, Georgina cannot and is not represented as a mother alongside her young children (or even a grandmother alongside her grandchildren) who require her continued care and love. Georgina does not have the same trajectory of possibilities (sexual, reproductive and otherwise) ahead of her; instead, her future holds the inevitability of aging, bodily decline, and possible state dependency. Representations of young (or future) mothers are read as compelling sites for public and
corporate investments, whereas the possible imminent loss of older women does not compel an outpouring of public generosity. Given this, and in light of my findings, I suggest that the worthiness of older survivors as morally fit citizens and sites of investment must then be demonstrated in other ways – through their pursuit of active, and healthy aging through the rigorous enactment of a Resilient, Fit Survivor subjectivity.

Turning back to the single, but powerful, representation of an ‘older’ survivor in the Run for the Cure promotional ads, I suggest that Georgina’s subjectivity as Resilient, Fit Survivor is shaped in relation to neoliberalism and contemporary western anxieties about the economic and social effects of an aging population (Asquith, 2009; Rudman, 2006). Georgina emerges as an ideal aging, survivor citizen who responsibly manages her risky body in the pursuit of never-ending youth, agency, and function, thereby distancing herself from the specter of decline, disease, and state dependency. She is the Janus face of the ‘Decliner’ subjectivity that emerged in the Journal of Cancer Survivorship, that is, the survivor subject who fails to self-manage her risks and optimize her physical existence and suffers the consequence of physical decline. In contrast to the Decliner, Georgina’s narrative of optimization constructs the duty to survive well distinctly from the other campaigns featured in the CBCF sample in the way it details the individual, risk-reducing efforts made by an older survivor to protect her health and achieve survivorship. In her video, Georgina describes the various intensive forms of bodywork she engages in to maintain her bodily fitness (dragon boat racing, running, walking, paddle boarding), these forms of activity are positioned as moral work that she performs in response to her prior illness and continued vulnerability as an aging breast cancer survivor. As I described in Chapter 6, the increased responsibilities for self-management and risk-reducing bodywork are highly visible in the images of Georgina who is viewed paddling a dragon boat, walking along a boardwalk, and paddle boarding in the early morning light. Georgina’s narrative does not communicate the responsibilities associated with breast cancer survivorship with images of athleisure clothing and exhortations to Run for the Cure. Rather, these responsibilities are performed in multiple realms of physical activity in which Georgina defies both breast cancer recurrence and old age.
The ageism that underpins this construction of Georgina as a survivor subject makes it clear that the characteristics of dependency and bodily decline - culturally associated with ‘oldness’ - are not characteristics associated with responsible citizenship. I suggest that, Georgina’s conspicuous participation in rigorous physical activity demonstrates both her bodily and civic ‘fitness’ as an older survivor. In signaling her active pursuit of bodily optimization and the maintenance of her independence, Georgina as an older woman and breast cancer survivor, becomes intelligible as a responsible and moral citizen. Through her visible commitment to remaining healthy (and thus not place undue burden on the state,) Georgina is constructed as a compelling site of investment, one that is worthy of public generosity. Her representation as an entrepreneurial survivor subject reproduces the exclusionary, neoliberal myth that anyone, despite their age, health status, and bodily ability, can reach for and achieve ideals of health, survivorship, and citizenship.

7.3 Governing Through Hope

Thus far, I have put my findings into conversation with governmentality theory to show how the biomedicalized discourse of breast cancer survivorship in the Springer Journal of Cancer Survivorship operates as a technology of governance to constitute post-treatment women as chronically vulnerable citizens who express their ‘empowerment’ through participation in intensive regimes of bodywork and self-regulation. I have also described how the survivorship discourse produced by the Run for the Cure promotional materials draws upon intimate knowledges and experiences to construct breast cancer as an inevitable and inescapable feature of modern Canadian life. Through the use of the visual representations and constructed narratives of survivors and young women at-risk for the disease, breast cancer is constructed as an urgent national problem to which individual Canadians, particularly women and mothers, have a duty to respond. In this section, I return to the queer theoretical framework I described in Chapter 3 to consider how the affective and temporal dimensions produced within both discursive fields operate to extend domains of governance through the imposition of a particular temporal trajectory that is characterized by a moral imperative to live and think towards the future.
7.3.1 Impossible Promises

As I described in section 7.1, the presumption that the post-treatment, survivor body is a site of continued risk produces a particular kind of liminal subjectivity for the Chronic Survivor who is located between recovery and recurrence. The persistent invocation of the body’s potential for disease recurrence in the discourse positions sanctioned practices of risk management as the solution to bodily vulnerability and an uncertain subject position. Individual practices of self-management and bodily control are configured as the pathway to safety and optimal life. However, within the discourse, the limits of risk reduction are often obscured, and the promises of improved function and futures are foregrounded in ways that, I argue, are cruelly optimistic. Lauren Berlant (2011) describes cruel optimism as the:

Relation of attachment to compromised conditions of possibility whose realization is discovered either to be impossible, sheer fantasy, or too possible, and toxic. What’s cruel about these attachments, not merely inconvenient or tragic, is that the subjects who have X in their lives might not well endure the loss of their object/scene of desire, even though its presence threatens their well-being, because whatever the content of the attachment is, the continuity of its form provides something of the continuity of the subject’s sense of what it means to keep on living and to look forward to being in the world (p. 24).

For the breast cancer survivor, continued survival and the promise of a future that is both healthy and livable are the promises offered by technologies of risk and individualized strategies of risk management. These promises are affective in that they are marked by hope, which operates to obscure the impossibilities of such promises and functions to direct the survivor subject towards the self-management strategies (i.e., through behaviours promoted in the training programs) purported to usher in the desired conditions of the future. According to Elhers and Krupar (2014), hope:

 carriers a utopian promise; it offers possibilities of a ‘not yet,’ a ‘to come,’ and an imagining of life otherwise […] hope is invoked as an incantation, under
conditions of uncertainty; it is an insistent affirmation of the ability to effect change (p. 386).

In relation to the discourse of chronic survivorship, hope operates to direct the subject towards the management of the present in the name of the future and as a response to the subject’s particular embodied vulnerability and the ever-present threat of cancer’s re-emergence. Undeniably, the attachment to hope, survival and the future come with costs. As Jain (2011) argues, “the attachment to hope saves us from the dirty work of really looking at what is being survived and how” (p. S46).

I suggest that, within the discursive field of chronic survivorship produced in the Journal, risk management strategies and the promise of future safety are what attaches the survivor subject to hope. Hope operates to affirm particular ‘truths’ about biomedical authority, expertise, progress and its ability to save, optimize, and enhance human life. In this context, hope “conditions conduct and produces biomedical subjects in line with the biopolitical imperative to ‘make live’” (Ehlers & Krupar, 2014, p. 393). The survivor’s attachment to hope and optimistic orientation towards biomedical regimes obscures biomedical uncertainty in the contested field of breast cancer survivorship, affirming her commitment to fulfill her biomedical obligations (i.e., through compliance with expert advice). Hope is thus enabled by, and enabling for, the biomedical management of survivorship. It affirms belief in the potential of biomedicine by directing attention towards the promise of technological progress and bodily optimization and away from under-examined social and political contexts of disease, and unexplored possibilities for population level prevention strategies. Beyond the practices of risk-management this attachment to hope and the biomedical promise of renewed life foreclose possibilities for survivors’ critical engagement with the biomedical practices, research agendas, and expensive, but highly profitable, pharmaceutical inventions.

In the context of the pervasive “fear of recurrence” identified by the Journal, an attachment to hope can be read as a strategy that enables post-treatment women to continue to live in the context of their embodied vulnerability and continued uncertainty. The ‘actionable’ nature of lifestyle risk factors, read through a lens of biomedicalized
hope, may provide a comforting set of strategies by which women can regain a sense of control over their uncertain bodies and lives. Despite this comforting potential, two important questions arise: What are the costs of such an attachment to hope? And what alternative ways of coping and flourishing are obscured? To begin to understand the costs of hope, I first turn my critical attention to discourses of individualized risk that prevail in the Journal. The risk factors identified within the discourse as ‘actionable’ and ‘modifiable’ are located within a contested biomedical terrain. The salience of risk and the importance bestowed on its promised predictive powers within the realm of breast cancer has been critiqued by a number of scholars. Press et al., (2000) for example, suggest that the meanings of breast cancer risk for women in contemporary western culture can best be understood through a carrot vs. stick metaphor:

The ‘stick’ is American women’s profound fear of breast cancer and the increasing sense that they have that their own bodies are the source of cancer danger; the ‘carrot’ is the ironic promise that increased certainty and control can be achieved through the provision of probabilistic risk information including genetic susceptibility testing (p. 238).

The contrary affects of fear and hope comprise the stick and carrot within discourses of breast cancer risk and contribute to the production of a “risk spiral” in which each identified risk prompts the calculation of other potentially connected risks (Press et al., 2000). Within neoliberal political rationalities, risk factors are increasingly seen to be located within the bodies and selves of subjects and are articulated through a framework of individual responsibility. Further, individualized risk knowledges optimistically promise that a degree of ‘safety’ can be achieved through a set of practices and behaviours, and the prognosis of chronic survivorship is incalculable and ever changing according to the subject’s relation to the constellation of risks through which her chronic condition is produced. While projects of risk quantification may appear to offer certainty by rendering bodily vulnerability increasingly knowable and calculable, this appearance obscures the uncertainty that underlies the translation of risk from the population to the specific individual. The costs of this illusory certainty are high and transfer the burden of responsibility onto individual women to mitigate risk, despite the fact that “identifying
and eliminating a factor associated with increased cancer risk does not necessarily translate into disease prevention” for individual women (Fosket, 2010, p.335).

As I discussed in Chapter 5, there is little acknowledgment that risk is a contested terrain within the Springer Journal sample I analyzed, which is dominated by claims of ‘evidence-based knowledge,’ statistical significance and objective fact, effecting a slippage between risk and result, choice and destiny. Within the biomedicalized configuration of survivorship, individualized lifestyle risks are identified as actionable and risk reducing behaviours (i.e., exercise prescriptions) are promoted as effective, protective actions. In this configuration of risk, responsible chronic subjects purportedly gain a measure of control over their bodies and attain an unspecified degree of security with an unknowable frame of reference. However, there is no compelling (i.e., 70%, 90%) guarantee in risk reduction that can be reliably attached to the many practices and forms conduct that the Chronic Survivor is incited to take up. In other words, despite the promised protective effects, it is impossible to know what, if any, effect the consumption of particular foods, the engagement in specific forms of physical activities, the reduction of stress, and moderate consumption of alcohol will have on any specific woman’s future health. The cruel optimism of the promises offered by individual risk reduction strategies privileged in the Journal is that the subject’s attachment to hope operates as an obstacle that prevents the subject from flourishing (Berlant, 2011) and finding her own meaningful strategies to navigate and respond to the uncertainty of survivorship.

In other words, the intensive regimes of bodywork that Chronic Survivors are directed towards require that significant discipline, commitment, time, and energy be directed towards the body and its regulation, and away from other possible endeavors and pursuits. The cruelly optimistic regime of chronic survivorship does not guarantee better health, longer life, or the prevention of recurrence; however, it does guarantee that paternalistic relationships with biomedicine are deepened, extended and prolonged. Significant costs arise out of the Chronic Survivor’s compulsory acceptance of and compliance with biomedical treatment regimes and bodywork practices. Firstly, these practices offer up promises of future health and control over bodily vulnerability that are both cruelly optimistic and undeliverable. The survivor’s attachment to hope operates to
firmly position biomedicine and technoscience as ‘in control’ of the problem of breast cancer, transforming survivorship into a condition that can be managed and extended by biomedical knowledge and expert advice, and despite gaps in biomedical knowledge about the disease and limited evidence to demonstrate the utility of this approach at the individual level.

Secondly, Chronic Survivors, by virtue of their prior ‘failure’ to effectively manage their risks (as evidenced by breast cancer diagnosis), are constructed by individual risk rationalities as particularly accountable to manage their risks and (re)constitute their identities as good citizens. Positioning continued survival and the achievement of (optimal) health as outcomes over which Chronic Survivors have individual control and responsibility renders the existence and consequences of the iatrogenic effects that result from biomedical treatments both invisible and insignificant, ultimately constructing cancer recurrence or the emergence of future disease as a failure on the part of individual women. Further, within the discourse, the possibility of recurrence in women who engage in the prescribed, extensive risk-reducing practices is rendered unintelligible; illness can only be understood as a product of individual irresponsibility. There is no room within this individualized risk framework for women who have eagerly complied with risk reduction to maneuver and make sense out of their situation when breast cancer recurs. Given the potential for the blame and responsibility of recurrence and disease progression to be placed on the shoulder of individual women, we might then reasonably ask, where is the empowerment in this equation?

In addition to reinforcing biomedical regimes of breast cancer survivorship care and obscuring the underlying uncertainty associated with the liminal state of survivorship, the Chronic Survivor also operates to reify the discursive exclusion of ‘irresponsible,’ non-self-regulating women from citizenship categories. The Chronic Survivor, as a vulnerable empowered subject, is embedded within larger discourses of women’s health that align with neoliberal models of citizenship that operate to obscure increasing material and structural inequality. Within this context, there is a deep divide between women who can become ‘empowered’ through compliance with biomedically sanctioned disciplinary practices and those who cannot afford to direct their energies, time and other
resources inwards toward their bodies and selves. The Chronic Survivor, like other vulnerable empowered subjects, is embedded within structural and material inequities. Thus, the ability of the Chronic Survivor to achieve empowerment and ‘thrive’ is located in her ability to access and participate in the promoted activities and forms of health consumerism (both knowledge and products). The exclusionary potential of the discourse is significant and women who cannot, or do not want to, engage in these disciplinary practices are deemed responsible for any negative health outcomes or instance of cancer recurrence. At the same time, the numerous lifestyle recommendations and disciplinary practices promoted within the discourse are dislocated from the demands and constraints of women’s everyday contexts that are shaped by structural factors and social determinants of health. In effect, this simplifies the ‘choice’ equation to a matter of morality and citizenship rather than ability, resources and desire on the part of the individual.

7.3.2 Anticipatory Trajectories

The Journal and the discourse of chronic survivorship it produces operate as a regulatory biopolitical tool that targets survivors as a population and orients them towards the optimization of life in particular kinds of ways. As a body of knowledge, the Journal provides a way to regulate an entire population of post-treatment women (a large and growing population as we are so often reminded in the Journal) that has itself emerged as a direct effect of biomedical interventions for acute breast cancer. The Journal targets a variety of practitioners and health care professionals who are called to ‘treat’ Chronic Survivors and direct them towards strategies and practices of self-management. These practices are regulatory as they aim to cultivate the bodies and capacities of post-treatment women in particular kinds of ways, producing and promoting certain trajectories as ideal (i.e., behaviours that purportedly lead towards bodily optimization) and rendering other trajectories (e.g., not getting better - staying the same, or decline) unintelligible, undesirable, and morally reprehensible. The biopolitical imperative to affirm and secure optimized survival through the duty to survive well is productive; it aims to build the capacities of survivors along particular anticipatory trajectories,
orienting them towards their bodies in a regulatory fashion and shaping their possibilities for future life in particular ways.

Drawing on the dichotomous subjectivities of the Optimizing Survivor and the Decliner, described in Chapter 5, I explore how temporal trajectories assumed by the discourse operate as technologies of governance that direct survivors’ capacities and orientations towards life in an anticipatory, future-oriented manner. The Optimizing Survivor is an ideal, active risk-reducing subject who complies with various biomedical interventions and technologies of optimization with the aim of producing a body and self that is healthier and fitter than before diagnosis. In Chapter 5, I described how this subjectivity was taken up and promoted by the Editor, himself a cancer survivor, as the ideal form of enterprising survivorship. The Optimizing Survivor was frequently contrasted with the figure of the non-compliant, risky patient – the Decliner - whose invocation functioned to highlight the perils of unmanaged survivorship. The Decliner is a doubly failed subject of risk management - she did not learn from her diagnosis and treatment and continues to eschew her responsibility to engage in self-management. As a result of her irresponsibility, she is located on a downward trajectory, speeding towards decline, dependency, the loss of her agency and ultimately, death. In contrast to the downward spiral of the Decliner, the Optimizing Survivor is located on an anticipatory temporal trajectory that reaches towards a healthier, functional and productive future. This future-oriented trajectory is enacted by the risk-reducing conduct of the Optimizing Survivor who responds to her duty to survive well and is made visible by various scientific measures of her bodily fitness (e.g., BMI, bone density). This form of subjectivity was consistently held up as the model of responsible and moral survivorship in the Journal. This trajectory orients subjects towards the future and invokes the biopolitical imperative to ‘make live’ (optimally). As a form of power, the fostering of particular trajectories of life has the “authority to force living not just to happen but to endure and appear in particular ways…where living increasingly becomes a scene of the administration, discipline, and recalibration of what constitutes health” (Berlant, 2007, p.756).

The temporal trajectory of the Optimal Survivor is situated within a complex affective arrangement produced through the overlapping of hope, anxiety, and uncertainty that
underpin the moral imperative to think and live towards the future. The future is the driving force in this trajectory and it delineates the contours of the present and conditions how the subject can inhabit it. In orienting her conduct towards the future, practices of anticipatory living shape the possible conditions in which the future can unfold but do not guarantee the emergence of its desired form. Focusing her attention and action towards her body and the cultivation of risk ameliorating lifestyle, the Optimizing Survivor fosters some possibilities for the future (i.e., a fit body, a reduced risk burden) and forecloses others (i.e., the enjoyment of the present, the pursuit of pleasurable, non-risk reducing activities). Anticipatory orientations colour the present by shaping how subjects can think about and respond to problems (e.g., body limitations, desires, material conditions of their lives) by shifting attention away from the embodied present (i.e., what would fulfill me in the now?) and towards the future. The result of such an orientation is “the production of possible futures that are *lived and felt* as inevitable in the present” (Adams et al., 2009, p. 248). This affective dimension is essential as it is through the *living and feeling* of anxiety, fear, and vulnerability that are conjured by visions of an anticipated future (i.e., cancer recurrence) that urgency to act in the *now* is generated. Hope is, thus, harnessed as a speculative, regulatory technology to drive action in the name of the future.

As I have already discussed, the future oriented-actions that are driven by hope are rooted in knowledge of individualized risk factors. The privileging of these forms of action and practices of bodily optimization as the strategies through which a healthy future can be secured, reinforces the idea that breast cancer prevention is best achieved through the actions of individuals. The absence of primary prevention in the Journal further supports the individualization of the responsibility for prevention. Further, as I discussed in Chapter 5, the quality of current biomedical treatments for breast cancer was unquestioned by the research published in the Journal, and despite the widespread acknowledgement of iatrogenic effects there were no calls for research into better or improved biomedical treatments. The underlying message of the Journal is that it is not the responsibility of biomedicine or the state to safeguard individuals from illness, or to develop less toxic and harmful treatments. Rather, it is the responsibility of the individual
to prepare the body for potential illness to optimize their chance of survival, and ability to ‘survive well.’

In summary, the temporal and affective dimensions of survivorship discourse operate to orient and mobilize subjects towards the future secured by biomedicine and anticipatory modes of action. The temporal and affective underpinnings of the biomedical survivorship discourse I have identified align with the aims of neoliberalism and the biopolitical imperative to ‘make live’ and optimize life. As particular features of survivorship discourse, temporality and affect further constrain the agentic field in which women negotiate their bodies and lived experiences of survivorship by supporting the transfer of responsibility for preventing illness onto individuals. What is covered over in this pursuit of safety, however, is fallibility of biomedical knowledge, the contestations around the predictive quality of individual risk factors, and the very real possibility of recurrence and death - despite the subject’s diligent participation in anticipatory regimes of action. Further, in responsibilizing survivor subjects to secure their own health and ward off cancer recurrence, the entire possibility or question of primary prevention is skirted. Instead, the large and growing population of survivors are transformed into permanent patients and compliant subjects of biomedical management.

7.3.3 Civic Constraints of Hopes

The attachment of hope to biomedical practices, regimes and research agendas is a common thread across the discursive fields. Whereas the Chronic Survivor is made hopeful through her enrollment in individual regimes of risk management, the Universal Woman at-Risk is made hopeful through her enlistment in the Run and practices of fundraising. The actions are future-oriented and attached to the promise of a better future, “a future without breast cancer,” brought into being by the promise of a biomedical discovery. Similar to the biomedical discourse advocated by the Journal, hope is attached to biomedicine in the CBCF promotional materials through persuasive discursive strategies of scientific progress, advancement and the inevitably of scientific discovery. This is highly visible in the slogan I discussed in Chapter 6: “we are closer to a future without breast cancer: we can’t stop now,” and the persistent call for the viewer to “run for the future,” alongside images of children who are invoked as future citizens.
Underpinning these slogans and the larger discourse is the assumption that individual investments of money, hope, and faith in the biomedical project will inevitably lead to the discovery of a cure that will make life better for future generations. The Run, as a site of investment and technology of hope, forwards the promise that a future without breast cancer will be realized and that individual acts of personal generosity can and will make a difference. Because of its allure, this promise is cruelly optimistic.

As a vulnerable, empowered subject, the Universal Woman at-Risk produced in the CBCF ads is compelled to make only one (compulsory) choice - to participate in practices of personal generosity by directing her energies toward the raising of funds and the training of her body to successfully and triumphantly complete the race. This choice is located within a constrained field of agency in which women are ‘empowered’ to act in ways that support biomedical research agendas, but not to provide input into or otherwise engage critically with questions of research priorities, prevention or treatment. This paradox of empowerment constitutes a key tension of modern breast cancer culture (King, 2010). As I illustrated in Chapter 6, there is no mention of specific research agendas or the types of research questions that women themselves would like addressed in the discourse. Indeed, there is little transparency in the biomedical research arrangement: there are few avenues for women to ask questions about the types of research funded, what types of research (i.e., environmental, primary prevention) are not being pursued, and what effects, if any, the funded research has had in the lives of Canadian women. Further, the contested nature of the biomedical knowledge etiology of the emergence, recurrence and severity of any particular breast cancer is entirely absent from the survivorship discourses I examined in this study. Both the biomedical and popular discursive fields positioned current biomedical approaches to the study of the disease and regimes management as infallible and unquestioned. The possibility that alternative perspectives, approaches, and avenues of research (i.e., environmental causes, prevention etc.) might yield important knowledge is deflected.

While participation in the Run is positioned as the route to empowerment for women and survivors, I suggest that the subject’s attachment to biomedical hope and the cultivation of particular forms of civic and bodily fitness instead deliver compliance and docility.
The field of agency in which this vulnerable empowered subject is situated is highly constrained. She is ‘empowered’ to answer the call to dutifully participate in the Run, to train her body, and to raise money to support biomedical research; however, her abilities to enact an agentic relationship in this context are limited – despite the CBCF’s slogan that positions participation as a ‘changemaking’ action. While participation is presented to women as a technology of empowerment, in effect, it functions to reinforce the paternalism of biomedicine and solidifies biomedical control over breast cancer research. Critical engagement with breast cancer research and treatment are literally configured as outside of a survivor’s possible fields of action. Thus, to be empowered is to be compliant, to unquestionably accept the limited information and cruelly optimistic promises of a better future that frame and support the biomedical research agenda.

The results of my discourse analysis suggest that the Run for the Cure operates as a technology of neoliberal governance that legitimates particular forms of civic participation and citizenship for breast cancer survivors while obscuring other possible ways of responding. As a technology of citizenship, the Run harnesses affect – hope, fear, and grief - and women’s desires to transform the material conditions of breast cancer and directs the energies of citizens towards acts of personal generosity. The energies of women are directed away from the social and material contexts in which their lived experiences of risk and illness are situated, and instead, are directed inwards towards their individual bodies and capacities. While the overt aim of the disciplinary practices promoted within the discourse may be the cultivation of a civically and physically ‘fit’ female body, the covert function is the political disempowerment of women (Bartky, 1990; Duncan, 1994). The stagnated state of women’s breast cancer activism in Canada is supported through these actions that are ironically styled as a meaningful form of collective, civic action – touted by the CBCF as ‘changemaking.’ The discourse, through its persistent focus on participation and biomedical fundraising, forwards a singular and decisive response to how the problem of breast cancer is best addressed, socially and personally.

The Run for the Cure and its discursive construction of survivorship is also implicated in and reflects the re-configuration of citizenship and civic participation in the consumer
era. In her study, King (2006) argues that, as a form of civic action, participation in breast cancer ‘thons’ and the purchasing of cause-related products can be read as a form of consumer citizenship in which political sentiments are expressed individually, through one’s personal donations of time and/or money and purchases of specific products. As King suggests, this form of civic action is a reflection of political shifts away from public collective action via demonstration or dissent and towards the individualization and depoliticization of breast cancer that enabled its meteoric rise into a ‘dream cause’ for corporate sponsorship. In the Canadian context, the duty to participate in the Run for the Cure, and the duty to survive well more broadly, are intensified in light of the responsibility of citizens to avoid (over)burdening the publicly funded healthcare system. Optimal living and the achievement of health are integral components of civic responsibly and fitness in this context.

The depoliticization of breast cancer survivorship is in part enabled by the idealized form of survivor subject constructed within philanthropic spaces; her femininity, optimism and beauty functions to make breast cancer into a palatable product and site of investment that is “blissfully without controversy” (Goldman, 1997, p. 70). Significantly, this discourse of survivorship has achieved prominence at the precise cultural moment where there are more women living after a breast cancer diagnosis than ever before. This discourse functions to suppress the resistive potential of women living post-treatment to engage in alternative forms of political action or survivorship subjectivity, such as those envisioned by Audre Lorde. In effect, the radical potential of this population is suppressed through specific disciplinary practices that operate to bring women back into line with traditional gender roles. Within this depoliticized context, the empowerment offered to survivors can be read as a cruelly optimistic promise of neoliberalism.

7.3.4 Intelligible (Reproductive) Futures

In Chapter 6, I trace how the representations of the Run for the Cure shifted from a demonstration of national unity and collective action into an individualized, hopeful act informed by women’s intimate attachments. In this latter configuration, the importance of participation is articulated through repeated references to the future of Canadian families and its children in particular. The promotional materials drew on particular
forms of intimate evidence such as representations of mothers with breast cancer and children who themselves have been incorporated into (future) suffering by virtue of their imagined connections to women with the disease (i.e., future wives, children, mothers). As a citizenship practice, participation in Run articulates the subject’s commitment to the nation by protecting and preserving women’s traditional roles and responsibilities (i.e., motherhood) as well as the formation of the nuclear family - the site through which new citizens are produced and nurtured.

As I illustrated in my analysis of the CBCF print and video advertisements, personal generosity and participation in the Run are disarticulated from any sense of anger or injustice at women’s suffering, the high-rate of breast cancer diagnoses, and the devastating effects of biomedical treatments on women’s bodies and lives. Instead, women’s suffering is articulated through concerns about the potential effects of breast cancer on the family and children; in effect, their suffering is intimately connected to and enlivened by femininity and traditional feminine roles. In this construction, women’s lives come to matter – their suffering comes to invoke personal generosity - through their connections to family and children. In this section, I will return to these intimate, familial connections to describe how the future-orientated trajectory of reproductive womanhood contours the governance of both breast cancer survivors and women more broadly.

The centrality of the heterosexual nuclear family in the CBCF’s vision of the Canadian nation and future was highly visible in the Run for the Future multi-media campaign and the figure of the Child at-Risk that I described in Chapter 6. The figure of the Child at-risk is a citizen-in-the-making, who, tragically, due to the forecasted illness of someone they love (a daughter, a wife, they themselves), has been interpolated into survivorship discourse. The Child at-risk is intimately connected to heteronormativity and reproductive futurity as evidenced by the way that breast cancer is positioned as placing future nuclear families at risk (e.g., through the projected potential loss of a young wife and young women of reproductive age). The forecasted impact of survivorship on (future) families and relationships functions to incorporate boys into the field of risk through their assumed intimate connections to women. In this way, participation in the Run for the Cure is configured as not just a strategy to protect girls and future women,
but all children and by extension the future. The responsibility of citizens to ‘run’ is emphasized by the children’s assertion that they are themselves ‘running’ as future citizens- in-the-making in the interest of their anticipated heterosexual futures and families.

Beyond the Run for the Future campaigns, intimacy is strategically deployed across the promotional materials through numerous representations of heterosexual familial connections. Of particular prominence were the intimate connections between mother and child, which were positioned across the campaigns as the intimate connections through which breast cancer comes to matter. In the promotional materials, the problems of breast cancer are made visible through a heterosexual paradigm in which the threat is reduced to the image of the motherless child and the grief-stricken husband. Women’s subjecthood in the discourse is thus tied to her (future) family, it is through her connections to these others – child and husband - that she becomes recognizable and valuable as a citizen. The survivor subject privileged in the CBCF materials reveals nothing of herself; she is void of any dreams, aspirations or accomplishments outside the sphere of marriage and the family.

The attachment of survivorship to the heterosexual nuclear family reflects Lauren Berlant’s (1994) argument that the conditions of women’s citizenship are increasingly attached to reproduction and ideas of the national future. Importantly, within this discourse, the imagined national future that women are charged with bringing into being is one that does not belong to them - instead, the future toward which women are propelled is a circular narrative of birth, marriage, motherhood, and death. Reproduction and motifs of national future are central features of the survivor discourse. The Child is figured prominently, and the potential of the Child being rendered motherless is a driving force in the drama of breast cancer, heightening the urgency for action and public generosity.

The centrality of the child in this discursive genre of breast cancer survivorship enacts the child-centric “reproductive futurism” that Lee Edelman (2004) asserts underlines the heart of heteronormative culture and politics (p.21). Reproductive futurity and its
intensive focus on the Child facilities the reproduction of society itself without
difference, and, in so doing, upholds and reproduces gender, citizenship, sexual, and
temporal norms. I suggest that the pervasive invocation of the Child at-Risk (of a severed
nuclear family) within the CBCF discourse signals that the future worth protecting is a
heteronormative future, re-inscribing women’s traditional roles and flattening the
subjective possibilities of the breast cancer survivor to that of the mother of the nation.
Within this context, participating in the Run for the Cure becomes styled as an
investment in the child and in the reproductive future of the Canadian nation.

The homophobic implications of this imagining of the future are clear. The vision of the
future “without breast cancer” promised through the CBCF discourse is a heterosexual
future in which women’s citizenship value is derived from motherhood. This vision
aligns with the configuration of women within a temporal trajectory characterized by
reproductive futurity. In her feminist reading of Edelman, Grahovac argues that:

> What is concealed in the sentimentalized figure of the “Child” is then a deeply
homophobic and conservative investment in the preservation of a heteronormative
social order rather than an enabling future. A woman’s reproductive body is,
again, fundamentally implicated, as there can be no ‘Child’ without a mother. Her
position is that of a mere reproducer of the conditions for the future of the other.
Her journey is always already known and thus robbed of an open future pregnant
with the multitude of imaginable alternatives to pursue (Grahovac, 2013, pp. 4 -
5).

For Edelman (2004), the fantasy of the child as innocent “futurity” and as the object for
which sociality is organized operates to discipline bodies that exist outside the bounds of
reproductive, heteronormative, and patriarchal norms. Thus, in order to be rendered an
intelligible, productive subject (i.e., a body that matters) within the social imaginary,
citizens must be operative members of reproductive futurism, and do their part to ensure
that culture is repeated without difference. In this schema, women without children, queer
women, women who channel their energies into projects outside of motherhood are
absent, unintelligible and non-valuable members of society. Erased are the possibilities
for women to be seen and valued as generators of potentialities beyond the realm of reproduction, motherhood, and family.

The survivor subjectivity constructed within the promotional materials for the CBCF is a subject firmly situated in reproductive futurity. Her motherhood, or potential as a future mother, is central to her value as a citizen about whom we should care and whose future we should attempt to secure by participating in the Run for the Cure. Glaringly missing from this discourse are survivors who are single, queer, childless by choice, or women for whom a career or intellectual pursuits are of primary importance. The absence of women who exist outside the boundaries of heteronormative and patriarchal norms speaks volumes; these are women whose lives and futures are not worthy of public or personal investment. These women are not visible as citizens within the CBCF’s construction of the survivor and its imaginings of the Canadian nation.

Within the discourse of reproductive futurity, the exclusion of women who do not fulfill their reproductive obligations is facilitated through the privileging of particular temporal trajectories. Temporality is a central mechanism of governance and temporal norms are intimately entangled in the corporal and governmental regulation of women’s bodies. Dana Luciano’s (2007) concept of “chronobiopolitics” captures the ways that the state and its institutional apparatuses attach narratives of progress, future and linear, forward motion to the bodies of citizens. According to Luciano (2007) only bodies that are temporalized in particular ways that align with normative life trajectories (e.g., education, productive, paid full-time work, marriage, childbirth) can become visible as citizens. Bodies that follow alternative, non-normative trajectories are rendered unintelligible and are cast aside. Within a chronobiopolitical context, women are temporalized in ways that direct them towards domestic and reproduction trajectories – “cyclical time,” – in which they are rendered valuable through their reproductive potentiality and the continuous renewal of the social order (Luciano 2007; Freeman 2010). Cyclical time supports the linear progress of normative society and prevents its rupture. The cyclical temporal orientation of the survivor subject renders the subject intelligible, valuable and worthy of public acts of generosity. Within the Run discourse, her subjectivity is flattened, reduced
to her reproductive contributions or potential future contribution. She is a vehicle for, rather than a subject of, the (promised) future of Canadian nation state.

The insidious ways in which breast cancer survivorship discourse operates to discipline survivors, and women more broadly, in ways that align with and reinforce sexual, moral, civic and reproductive norms has significant effects. The discourse operates to suppress the radical potential of survivorship (Jain, 2011; 2007; Lorde, 1980) and the possibilities for women who have endured horrific material conditions of breast cancer to disrupt norms of femininity, and feminine compliance with biomedicine in particular.

7.4 Conclusion

In this chapter, I interpreted the findings of my study through the theoretical framework of governmentality and described how popular and biomedical discourses of breast cancer survivorship operate as technologies of neoliberal governance that invoke specific constructions of responsible, healthy, and gendered citizenship. I identified several key forms of survivor subjectivity that emerged from my findings: the Chronic Survivor, the Optimizing Survivor, the Decliner, the Universal Woman at-Risk, the Child at-Risk and the Resilient, Fit Survivor, and described their governing features. Despite the differences in their articulations, the forms of survivor subjectivity identified in this study share common characteristics: they are highly individualized, bestow significant civic responsibilities, and they orient women in and towards their bodies via disciplinary practices of hegemonic femininity. The aggregate survivor subject that emerges from this study is vulnerable, empowered and hopefully oriented towards the future. She is made vulnerable by her body and her experience of acute illness, and she responds to her exposed vulnerability by engaging in anticipatory actions that promise to deliver a livable future. In her pursuit of safety and empowerment, she is expected to extend her compliant relationship with biomedicine and become a particular kind of feminine, docile, civic subject. She does not express anger, frustration or worry about the material conditions of breast cancer; instead, she turns her focus inwards towards herself, her body and her capacities. Her response to the problem of breast cancer and her bodily vulnerability is highly individualized. She is not visible as a member of a large and growing population of women affected and maimed by breast cancer who makes demands for changes to
breast cancer research; rather, as a survivor, she comes to represent her own individual success and responsibility through the optimization of her biological and civic fitness. She is an ideal, an impossible standard against which post-treatment women, and women more broadly, are measured.

Drawing on theoretical insights of queer temporality, I have also critically examined the temporal and affective dimensions of survivorship as a governing discourse. I have argued that temporality and affect are intricately entangled in discourses of survivorship and shape the subjectivity of the survivor and the forms of conduct she is directed towards. I have shown how ‘hope’ is invoked through particular discursive strategies and incantations of risk and danger to direct survivors towards the promise of safety and security offered by biomedicine. The practices of citizenship and the modes of subjectivity made available and desirable through breast cancer survivorship discourse harness affect, particularly women’s fears of disease, decline, and death and their hope for a livable future, for themselves and those they love, to propel subjects towards practices and forms of action (i.e., risk reduction, support for biomedical research) that promise to intervene into and transform the conditions of the future. These practices are ultimately, I argue, cruelly optimistic. They offer promises that are impossible to deliver and significantly constrain the agentic possibilities of its subjects. The limited modes of empowered action promoted for survivors obscure, if not foreclose, possibilities for survivors to find their own meaningful responses and modes of flourishing in relation to, not in spite of, their bodily vulnerability and everyday lived experiences of uncertainty.

While the effects of these hopeful attachments ultimately threaten the wellbeing of the subject by preventing her from finding her own way of surviving and addressing the problem of breast cancer, on the surface, these practices appear to be empowering, meaningful and consequential. They provide a comforting response and feeling of productive action in the face of the uncertainty of breast cancer and the conditions of one’s own future. It is precisely the attachment to hope and the promise that the future might be otherwise – made better and more livable – that makes these practices so enduring, compelling, fertile for consumption, and particularly resistant to dissent. In the face of biomedical and bodily uncertainty, hope for the future offers the survivor
something to hold onto, to help her continue to live in and be oriented towards the world. We must continue to ask critical questions about the costs of hope and optimism in survivorship discourse, to push beneath the cheerful wrapping and promises of empowerment in order to expose the material, social and political effects that arise from breast cancer survivors’ enduring and compliant relationship with biomedicine.

A secondary aim of this study has been to illustrate the importance of affect and temporality for governmentality theory. The results of my critical discourse analysis illustrate that the government of survivorship conduct involves the temporalization of subjects and their orientation towards specific trajectories of the future. As I have shown in Chapters 5 and 6, the government of survivorship conduct is inextricably bound up with futurity and the cultivation of particular forms of future life through anticipatory action. My analytic focus on temporality draws attention to the ways in which the anticipatory temporal trajectory invoked through survivorship discourse shapes the management of subjects beyond ‘risk’ and ‘risk reduction’ strategies. Specifically, my analysis highlights how discourses of survivorship temporalize and orient subjects in ways that ensure the continuation of gendered, sexual, and civic norms and the reproduction of hegemonic society. Further, my analysis also makes clear that the discourses of survivorship produced within these professional and popular fields are informed and marked by ageism, ableism, heterosexism, and reproductive futurity, thus suggesting that, within neoliberal contexts, only certain bodies and forms of suffering matter and only certain women are recognizable and intelligible as breast cancer survivors.

The theoretically informed interpretation of breast cancer survivorship discourse that I have articulated is based on a sample of articles published in the Journal of Cancer Survivorship and promotional materials produced for the CBCF Run for the Cure. These are just two of the many sites for the production of discourses on breast cancer survivorship, and thus my interpretation cannot, and does not, claim to present an overarching or complete framework of contemporary breast cancer survivor subjectivity. There are numerous other sites of knowledge production that contribute to the broader discursive field of breast cancer survivorship, and which could, and should, be subject to
further investigation. These include: public health campaigns, personal blogs, autobiographical accounts of survivorship, alternative care webpages and blogs and feminist breast cancer activist blogs and organizations. A critical examination of these sites of discourse would provide interesting opportunities to consider how the forms of subjectivity identified in this study align with or diverge from the configurations of survivorships that are circulated within alternative discursive sites.

The results of this study suggest some clear directions for future research and leave me with a number of lingering questions. In this analysis, I have described the forms of breast cancer survivor subjectivity that are constructed and promoted within two distinct sites of knowledge production. However, given my focus on professional and public constructions of breast cancer survivorship, this study cannot speculate how women with breast cancer interpret, take up and/or resist these discourses and forms of subjectivity, nor can it identify alternative conceptualizations of breast cancer survivorship. This was, however, an original aim of this study. The preliminary design of this study included a third discursive genre – women’s narratives of breast cancer survivorship – in order to provide insight into how women narrate and negotiate their lived experiences of the disease in relation to professional and popular discursive ideals of survivorship. However, this third genre dropped away from the study after the richness of the texts sampled from the first two genres became apparent. An exploration of this genre remains a priority for my future research. Critically examining women’s narratives of survivorship from a theoretical perspective informed by governmentality would provide nuanced insights into the ways that post-treatment women navigate the forms of breast cancer survivor subjectivity that I have identified in the present study. Such an examination might also generate an understanding of alternative forms of survivor subjectivity that were not present within the popular and professional discourses examined in this study. Further, I am left with lingering questions about how women who continue to live after breast cancer diagnosis and treatment understand and experience the temporal dimensions of survivor subjectivity and how they are oriented towards the future. In-depth narrative interviews with post-treatment women could provide rich insights into the embodied experiences of their temporal (dis)orientations
and also provide an understanding of how women negotiate the anticipatory risk trajectories that are privileged by survivorship discourse.

In this study, I have considered how popular breast cancer survivorship is uniquely constructed within the Canadian social and political context. However, given the limited scope of this study and the sample examined, questions remain about how the Canadian context shapes survivorship discourse. In particular, I am left with a number of questions about the CBCF itself, how it functions, and how it constructs itself as a central site for the production of Canadian breast cancer survivorship discourse. Further, questions remain about the cause, meaning and implications of the 2011 discursive shift in the CBCF materials that I identified in Chapter 6, at which point breast cancer survivorship increasingly became framed as a problem of individuals and their intimate others. It is outside the purview of this study to speculate about the mechanisms behind this shift; however, an in-depth examination of the CBCF itself, its annual reports and the Canadian political climate at this time may provide important insights and context for understanding this shift.

Finally, a critical understanding of the CBCF and its role in shaping breast cancer survivorship discourse in Canadian are particularly pressing at this particular historical moment as the CBCF and the Canadian Cancer Society have recently merged. Prior to this February 2017 merger, these were the two largest, most prominent, and profitable Canadian cancer organizations. Financial constrains due to declining rates of public financial support have been reported in the Canadian media as the cause driving this merger. However, despite this reported decline, these two foundations combined account for the majority of Canadian charitable funding for cancer research, prevention, advocacy and community programs. Together they generated over 1.5 billion dollars in the past 30 years (CBCF, 2017). Significantly, this merger has further consolidated the power of Canadian, cancer-related, non-profit agencies and created the conditions in which a single agency now has the ability to set, shape, and direct the research agenda for breast cancer, and cancer more broadly, in the years to come. This concentration of power among a single agency in the absence of transparency, and easily accessible avenues for survivors, and the public more broadly, to shape the direction of research dollars and the agenda for
advocacy is deeply concerning. Now, more than ever, it is critical to ask questions about the social and political dimensions of breast cancer advocacy, activism and philanthropy in Canada.
Bibliography


Appendix A: Springer Journal Sample Information

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**Purposeful Sample**
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### Appendix B: CBCF Sample Information

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Appendix C: Analysis Sheet Template

1. Bibliographical data:
   - Title:
   - Date of publication:
   - Author/Institution:
   - Type of material (e.g. video, article, narrative):
   - Date text was first read:

1.b. Detailed description of the composition (Run for the Cure sample only)

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<td><strong>Action Processes</strong> (i.e., what are the central subjects doing?)</td>
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2. Key themes / absences:
   a. What topics are touched upon in the text?
   b. How frequently do these themes emerge?
   c. What topics are absent?
   d. How do these topics relate to each other and overlap? What themes/discursive strands seem to be entangled together? Are there themes/discursive strands that do not seem to speak to each other?

3. Significant words or images:
   a. Are there particular words or images that stand out as significant? How are they given specific meaning?
b. Are there associations established between these significant words or images?

4. Production of truth
   a. How does the particular discourse work to persuade? How does it produce its effects to truth? (focus on claims to truth and knowledge)
   b. What forms of knowledge does the text refer to? Are there forms of knowledge that are absent from the text, or that are undervalued/consider illegitimate?
   c. Are there moments at which dissent is acknowledged (even implicitly) and dealt with?
   d. What work is being done to reconcile conflicting ideas, to cope with contradiction or uncertainty or to counter alternative discourses (highlighting other processes of persuasion)

5. Interpretive repertoire:
   a. What interpretive repertories or systematically related sets of terms / central metaphors are used?
   b. What are the significance of the use of these interpretive repertories? What cultural ideas or “common sense” ideas do they draw on or speak to?
   c. Are there forms of knowledge that are absent from the text, or that are undervalued/consider illegitimate?

6. Power relations
   a. Who is defining, identifying, or assessing the problem and based on what?
   b. Who is addressed as having power to ‘fix’ the outlined problem and based on what?
   c. What actors are mentioned in the text, and how are they portrayed?
   d. Who is likely to benefit from the discourse as conveyed within this text? Who is included within this text and who is not?
   e. What potential problems are silenced and how?
   f. What solutions or suggestions are being made?

7. Subjectivity
   a. What kinds of subjectivities are made possible and idealized by contemporary discursive constructions of breast cancer survivorship?
   b. How is survivorship conceptualized in the text?
   c. Who engages in survivorship and who does not or cannot?
   d. What is absent with regard to how survivorship is constructed?
   e. What kind of relationship are subjects called to take towards survivorship?
   f. What kind of relationship are survivor subjects called to take towards their bodies and health?
   g. What kinds of conduct are survivor citizens incited/compelled towards?
   h. How are ideas about gender, sexuality, race and other forms of difference constructed through these discursive constructions?
8. Temporality
   a. What kinds of future are survivor citizens compelled/ incited to reach towards?
   b. What kind of relationship are survivor subjects called to take towards the future?
   c. How are ideas about futurity and time expressed in different genres of breast cancer survivorship and how are these temporal dimensions related to particular constructions of subjectivity? What kinds of temporal trajectories are constructed by discourses on breast cancer survivorship?
   d. How does ambiguity come up in discursive representations of survivorship? How is it concealed?

9. Risk
   a. How are discourses of risk are brought into discourses of survivorship? How are discourses of survivorship are bought into risk? How they co-constitute each other? How is risk located within the discourse?
   b. How is risk addressed or referred to within the text? What concept of risk does the text presuppose and convey?
   c. Are and how are processes of riskification drawn upon?
   d. What other rationalities does the text refer to (or bring in)?

10. Other peculiarities of the texts?
   a. Are there unique things about this text? (e.g. what was surprising, unexpected, unique)
   b. Were you reminded of similarities/contradictions to other texts? What did you notice and why?

11. What is the overall message of the text?
Curriculum Vitae

Name: Rachael Pack

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