Sociology of Breast Tissue

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Soziologie des Brustgewebes

Zusammenfassung. *Grundlagen:* Die operative Entfernung der weiblichen Brust und onkologische Behandlungen verletzen das Körper- und Selbstbild von Frauen sowie ihre Gefühle. Elf Brustrekonstruktionspatientinnen schildern ihre Erfahrungen. Argumente der Frauen für und gegen Sofort- oder Sekundärrekonstruktion erlauben Rückschlüsse auf Kommunikationsprozesse sowie den Fluss von Informationen in den unterschiedlichen involvierten Fachdisziplinen.

Methodik: Im Rahmen dieser Beobachtungsstudie* werden Instrumente der narrativen Medizin, der Ethnografie, der Medizinsoziologie sowie der Kommunikationswissenschaften miteinander kombiniert. Wir arbeiten mit teilnehmender Beobachtung und offenen Interviews.

Ergebnisse: Die chirurgische Wiederherstellung der körperlichen Integrität und des Körperschemas erfordert die Einbeziehung von psychosozialen und kulturellen Faktoren, die jede einzelne Frau individuell für sich selbst definiert. Indikationen und Therapiekonzepte können aufgrund der Forschungsdaten individuell abgestimmt werden.

Schlussfolgerungen: Ein gegenseitiger Übersetzungs- und Vermittlungsprozess wird angeregt – ChirurgInnen lernen die Sprache(n) ihrer Patientinnen besser zu verstehen und die von ihnen behandelten Frauen tauchen in die Vorstellungswelten der plastischen und wiederherstellenden Chirurgie ein.

Schlüsselwörter: Brust-Sofortrekonstruktion, Sekundärrekonstruktion, Körperbild, psychosoziale Implikationen, Kommunikation, Kultur, Gender.

Summary. *Background:* Breast cancer, mastectomy and treatment in oncology injure body and self. In this field study we investigate concerns, needs, anxieties and decision-making processes of patients after they are diagnosed with breast cancer. Six patients, who

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underwent immediate breast reconstruction and six with secondary plastic surgeries after mastectomy[**], tell their stories. They share their experiences and histories with me[***], a sociologist and communication scientist, who accompanies them during surgical treatment and beyond. With the documentation of subjective breast reconstruction narratives we aim at deepening an understanding of socio-cultural, political and symbolic meanings of female body tissue.

Methods: The crucial aim of this ethnographic long-term project is the exploration of emotional, social, cultural and gender specific aspects, which determine the life quality of breast reconstruction patients – including these categories into therapeutic concepts.

Results: Surgical reshaping of the body's integrity requires the inclusion of psychosocial and cultural factors, which are defined by each single individual woman herself. With the help of this research data indications and therapeutic conceptions can be individually improved.

Conclusions: A mutual translation and mediation process is inspired. Surgeons strengthen their understanding of the patients' voices and languages. Treated women plunge into the imaginary worlds of their plastic and reconstructive surgeons.

Key words: Immediate and secondary breast reconstruction, body image, psychosocial implications, communication, culture, gender issues.

Prologue

Breast tissue as a synonym for the female body unfolds a variety of psychosocial and cultural narratives. For this field study we combine approaches in narrative medicine, ethnography, sociology and communication studies. We use participant observations and qualitative biographical interviews as research tools. In 1950, the Viennese psychiatrist Paul Schilder [1] published his study *The Image and Appearance of the Human Body*, declaring in the third part of the book the importance of the "sociology of the body-image." Until now surgical discourses rarely include societal constructions of the human body. They are woven into a physiological fabric, shaping standardized biomedical pattern. According to the

[**] Eleven women have been interviewed. One patient had both breasts operated. Thus she is counted twice, for immediate as well as for secondary breast reconstruction. There has also a control group of six patients been interviewed, who did not develop breast cancer but had other surgical interventions at the plastic surgery division.

[***] Manfred Frey and myself developed the research design for this study. Combining approaches of very different scientific cultures – reconstructive surgery and sociology – is challenging for the both of us. Since we are aware that our backgrounds and thus our arguments are to some extent contradictory, though respecting the position of the other, we consciously reflect on our dialogue in this contribution. Our continual negotiations unfold a productive cross-disciplinary controversy in progress, which is in a way mirrored in the relationships between (male) surgeons and (female) patients.

political scientist Zillah Eisenstein [2], who herself developed breast cancer, the "breast speaks sexual desire, maternal feeding and mammies, and the objectification of females, reducing them to their bodies" (57). How do these categories resonate in the voices and stories of breast reconstruction patients? Listening attentively to our patients, learning from their illness experiences, reveals a rich complex of knowledge. Paradoxically surgical methods and treatment modes – as an epistemic culture – conceal the narrative flesh of "bare life" [3]. The scalpel literally paints over these subjective personal histories.

The poet and breast cancer activist Audre Lorde [4] writes in *The Cancer Journals* about her experiences with breast cancer: "The pain of separation from my breast was at least as sharp as the pain of separating from my mother. But I made it once before, so I know that I can make it again" (25-26). Lorde decided against the reconstruction of her breast. She did not even like to wear a prosthesis. "For not even the most skilful prosthesis in the world could undo that reality, or feel the way my breast had felt, and either I would love my body one-breasted now, or remain forever alien to myself" (44). Feeling alien to oneself – being stigmatized among others – is still, although more than thirty years later, one of the unbearable problems breast cancer patients suffer of. Nevertheless one of the leading breast surgeons at the *Medical University in Vienna (MUV)* replied on my request of how many women after mastectomy decide for plastic surgery, "my personal experience is that the predominate part decides against breast reconstruction." His statement included primary as well as secondary reconstructive surgeries. Of course the explanations of women, who had their breasts reconstructed, speak another language.[****] Monika, 44 years old, clerk and mother of two adult children, had her immediate breast reconstruction in October 2005. I first met her the day after her operation. Since then we are regularly in touch. The last interview with her took place in the oncology day clinic in April 2007. Monika got her 15th *Herceptin*®-infusion.

> Monika: I understand this but I don't have the courage. ... I am more of the sort of people, who orient themselves on others. I don't have so much self-consciousness that I go outside and say, »that is how I am!«

Feeling as a desirable woman – particularly in the eyes of her husband – for Monika is intimately connected with having "two equal breasts." Until now she hides her operated breast in public. "After doing sport I always try to find a shower cabin with a curtain. I don't like

[****] The research materials of this case study consist mainly of (audio and video) interviews. The conversations were performed in German. Christina Lammer translated the patients' statements into English. Names of patients are altered, protecting their privacies.

other people to see my breast. I believe that they get anxious." She considers one more operation within this year (2007). According to Paul Schilder [1], a "body is necessarily a body among other bodies. We must have others about us" (281). Thus our bodies do not exist in isolation from one another. "We are interested not only in our own integrity but also in the integrity of others" (ibid.). This mutual connectedness between ourselves and other people or things in the world around us, is particularly interesting in the body related communication and negotiation processes among surgeons and patients.

Cancer as a stigmatizing metaphor: patients experience illnesses like cancer as stigmatizing metaphors. Susan Sontag [5] analyses in her study *Illness as Metaphor,* cancer even as embedded in a language of war. Tumours are »invasive«, cancer cells build »colonies« and the »power of resistance« is not strong enough. Treatment either includes a quite military taste.

> Monika: You will be stigmatized forever. This is like a mark on you. There is an excuse for war injuries. They are inflicted by someone else. For you it is a disease, which always signifies you. Of course everyone strives after making it invisible.

Körper and *Leib*: German language makes a clear distinction between *Körper* and *Leib*, which is useful for the approach we like to suggest. Hence, *Körper* is to understand as the objectified body of somebody else. Whereas *Leib* refers to *my* living and experiencing body with feelings, perceptions, emotions and sensations. The stories of patients are embedded in their individual *Leiblichkeit*, subjective flesh and sensitive breast tissue. Thomas Ots [6] shows the different nuances of meaning included in these words: "In this original sense, these terms referred to »life«, »person«, and »self«, namely, a person-self as constituted by the quality of being a-life (being a-*Leib*). In contrast, the term *Körper* views the person as a vessel/container to be filled with the spirit of the soul" (116-117). Within the relations and communication processes between patients and physicians the variable meanings of *Körper* and *Leib* play a crucial role. An epistemic problematic is at work, which exemplary unfolds in the interactions between breast reconstruction patients and plastic surgeons. The *Leib* of patients articulates itself through individual voices. This expressive body resonates in the interview materials we have gathered as well as in the conversations of women with their doctors. It signifies *my being* in the world. Plastic surgeons refer to an objectified or medically standardized *Körper*, which they shall reconstruct, bringing destroyed parts back into good shape, avoiding scars, marks and traces of former disease. In surgery the person's individual utterances are silenced. However, in this case study the female *Leib*

expresses a variety of personal stories. We aim at reconnecting these narratives with the biomedical discourse and body of knowledge.

Decision Making – Immediate or Secondary Breast Reconstruction

Epistemic turn in surgical oncology of breast cancer: None of the interviewed women, who had secondary breast reconstruction, knew about the possibility of immediate plastic surgery. In case they had known before the cancer operation, secondary breast reconstructed patients emphasize that a primary surgical option would have been their choice. There are a variety of reasons for this lack of knowledge. The rapid development of surgical oncology and its sub-disciplines, the invention of new devices, medications and materials, leads to a continual transformation of the clinical work together with patients. Transferring scientific advances in biomedicine and new approaches into practice and every day routine is time consuming. Embodied – self-evident – modes of knowledge deeply influence relationships and communication processes between patients and their physicians. Different epistemic cultures are in the play. Dependent on the particular culture a health practitioner grew up with and on his or her idiosyncratic view, s/he communicates knowledge to patients. For years surgical oncologists had in their minds that immediate reconstruction does not fit into a proper therapeutic conception for women, who need a complete removal of the breast. After radiation healing and cosmetic results often were not good enough. Actual studies show similar results after immediate and secondary breast reconstruction (see Manfred Frey in this issue). Thus younger surgeons actively offer these methods. However, this epistemic turn in surgical oncology of breast cancer is still ongoing and not fully incorporated into daily routine work with patients.

Matter of life and death: On the other hand, women are primarily concerned with the matter of life and death shortly after they get the cancer diagnosis. In the first shock phase, they rarely consider plastic surgery because they simply do not dare to ask their breast surgeons. They not even associate burdening psychosocial stigmas with cancer. That reconstructive operations could be possible methods of treatment for body and self-image related problems does not come into their minds. In this situation, patients often are not aware of health threatening as well as stigmatizing effects the disease causes on their bodies and selves. The development of an awareness concerning these issues needs time. Simultaneously plastic and reconstructive surgery is socio-culturally still connected with a particular cliché of »beauty«, which is continually being distributed through media. This peculiar image lives forth in the communication processes between breast cancer patients and their confidential

physicians. Thus beauty is understood as a consumer good and not necessarily associated with claims of getting a »normal appearance« back after breast cancer.

Marguerita, 49 years old, employed, married and mother of three children, decided for immediate breast reconstruction. The day after her operation – she had two operations within a week because the histological results showed that the first one was not effective enough – she explains her decision in an interview (January 2006) the following:

> Marguerita: The tumour is encapsulated. This is positive for me. I told him that I decided for a reconstruction. In the first shock phase I thought, nothing, I need nothing, except of away and yes, need nothing. But these are shocking moments because of operation, breast away and cancer. As I felt quite centred again, we considered and I thought, yes, oh yes. In summer you like to wear low necked shirts or a bikini.

The diagnosis of cancer is shocking. It puts people into a stunning existential crisis. They are confronted with the finiteness of life. Being alive – a-*Leib* – is not self-evident anymore. Regina, 42 years old, married and mother of two children, under tears told me of her experience with the cancer diagnosis: "I could not stop thinking about my children. Will they grow up without their mother?" She had her mastectomy one year before. The interview took place two days after her secondary breast reconstruction (in March 2006). The interviewed women are, according to the sociologist Arthur Frank [7], "wounded storytellers. People telling illness stories do not simply describe their sick bodies; their bodies give their stories their particular shape and direction" (27). The patients we accompany act as body-selves and we analyse the symptoms of their psychosocial and cultural suffering.

Reconstructing breast tissue: Between 2004 and now, Brigitta had six breast surgeries. The 57 years old woman has an adult daughter. She works as an employee in a leading position. Both of her breasts have already been operated. In an interview in May 2007 she answered my question, whether her surgeon offered immediate reconstruction before she had her breast completely removed:

> Brigitta: No, on the contrary. … They told me that this isn't done anymore. They came away from performing immediate reconstructions because of negative effects, when chemo and radiation are necessary. … Before the second operation [Brigitta had a partial resection short before the mamma amputation], already downstairs in the operating room, I met a young physician and started crying immediately. He gave me comfort. … Told me that I could get reconstructed. I said, »I don't want to invest all my money in beauty operations«.

Comparing her secondary, with own tissue reconstructed breast, with the immediate definitive expander implantation on the other side, Brigitta has a clear opinion: “This is my own tissue and this [the other breast] is an implant. An implant is an implant.” In her regard the implant is an object existing of dead material, whereas the flap graft embodies a living part of her self. This impression has a lot in common with the aforementioned distinction between *Körper* and *Leib*. Accepting the flap of her belly as belonging to her *being* in the world, the refillable silicon and saltwater cushion beneath the skin of her other breast feels alien to her.

The body as a »spare parts store«: Surprisingly different are Christa’s statements. She is 36 years old, diet assistant, married last summer and got pregnant some months ago. Her immediate breast reconstruction took place in February 2006. She as well received a definitive expander implant. The day after her operation I asked her what she thinks about the implantation.

> Christa: This was less of my worries than having wounds and scars everywhere. I had the feeling one is such a spare parts store. I also heard that the nipple is removed. This was really a problem for me.

Christa’s position brings the symbolic and societal implications of breast tissue even further. In her notion of being a »spare parts store«, she regards herself as *Körper* and not as *Leib*. Within her inner dialogue she interprets breast tissue as a material component. Thus she mimetically and ironically overtakes in a particular way the role of her plastic surgeon, looking at herself through an objectifying, standardizing lens. At the beginning of her statement she is speaking with her experiencing, anxious and vulnerable body. In this sense breast tissue is perceived as warm and tender female flesh.

> Christa: I’m not sure, whether it wasn’t the easy way. One was prepared to put the implant inside. It was weird. It [the tumour] was away, and I wasn’t relieved. … I don’t have the basic trust that it was the best solution. Maybe it’s really because I expected it to be different.

For Marguerita breast reconstruction has to do with “exchange”. That is why she wanted to get her own tissue transplanted. Unfortunately she is too thin. She decided for a definitive expander implant because she could not imagine having further operations, more pain and a second wound. She is happy with her decision. In her view illness includes symbolic meaning and she understands “exchange” in a broader sense, connecting cancer with maladjusted behavioural pattern in her life. Hence, Marguerita takes the disease as a chance for change – of her body and of her way of living.

Trust as magic formula: Breast surgeons are confidential and influential persons for the women they treat. This is mirrored in the decision-making processes of breast reconstruction patients. Karin, 51 years old, nurse and since March retired, and Monika, had their breasts immediately reconstructed. Both women did not like to get too many operations.

> Karin: I saw him [the plastic surgeon] and since he already knows me, I thought, we do what he thinks is right. Since I don't know anything about implants, it was his decision anyway. … I asked him what he would suggest to his wife. He said, »the first variant« [immediate reconstruction].

Patients are overwhelmed by different surgical methods and most of the interviewed women find it very difficult to decide shortly after the cancer diagnosis. Christa struggled with her decision and she wished that the physicians would choose for her: "How shall I know the best method for me? … I was down that there are so many possibilities and that he [the plastic surgeon] did not say, »this is the best solution for you«. My first thought was implant anyway." For Monika sensation was immensely important for her choice.

> Monika: Imagining that there is tissue detached and sewed on somewhere else. I perceive something like a tip. Makes me totally happy. Many people ask, whether I am in pain. For me this is no pain at all. … I would not have felt this with an implant.

In Monika's statement pain is a positive sensation. The mentioned "tip" gives her the feeling of being alive – as there is something left of the removed body part and thus of her woman- and selfhood. However, this sensitive peak does not correspond with her lost nipple, it is in a way comforting her. The sensory experience she describes is a creative one. She makes sense of her vulnerable freshly reconstructed breast tissue in an optimistic gesture. Her absent breast becomes narrative. According to Arthur Frank [7], "People certainly talk about their bodies in illness stories; what is harder to hear in the story is the body creating the person" (27). In Monika's narration her own *Leib* intimately folds in and out.

Seeing Oneself with the Surgeon's Eyes

The surgeon as confidential person: In the conversations between breast reconstruction patients and surgeons an exchange of knowledge takes place. Physicians explain particular modes of treatment as well as surgical methods to their patients and women express their understandings of the female breast. Both partners within these communication processes speak of breast tissue as a *metonym*, as part of the whole, although out of rather different socio-cultural backgrounds and contexts. Rita Charon [8] provides the following distinctions

of knowledge types: “Irreducible to one another and both essential for effective medical practice, narrative knowledge and logico-scientific knowledge together allow humans to gather and to comprehend information about the world. Logico-scientific knowledge is used to collect and evaluate replicable, universal, generalizable, and empirically verifiable information. … Narrative knowledge, on the other hand, concerns the motivations and the consequences of human actions” (148-149). For in oncology treated women, for instance, skin – referring to the integrity of the self, embedded in a broader history – means something else than for surgeons. In contrast, they use tegument as a material component for healing and reconstructing the body.

> Monika: I can imagine that the plastic surgeon does not see my breasts. He sees, no idea, lines or something else. Possibilities of dealing with skin, approximating this in a way that the right one does not differ from the left one. One feels the ambition of the surgeon. He said, »and tell Professor G. that I need this skin under any circumstances«. This is weird.

Breast reconstruction patients not only engage themselves in dialogues with their plastic surgeons. They furthermore enter into constant inner struggle with themselves. The interviewed women literally learn to view themselves with the eyes of their physicians. A mutual reciprocal relationship is developed, including empathy on both sides, finding the best solution together. This is not always an easy task.

> Christa: I had another picture in my mind. Was not prepared for an implant. I know that this is not finished yet and will become larger. It was still very crushing.

Professor F. said to Christa the day after the operation that it maybe was a “misinterpretation”. That she gets an implant was already clear before the intervention. She was sure “that he understands the way I go” but was simultaneously disillusioned afterwards.

Understanding male surgeons: The interviewed breast reconstruction patients have without exception been operated and treated by male surgeons. This was fine with them. Most of them reflected on the fact that their plastic surgeon is a man as an advantage.

> Brigitta: He [male plastic surgeon] as a man had a fully different view. With her [female plastic surgeon] I had the impression that she would preserve the volume. … He argued that the size is not so important. Optically the nipples shall be on equal height. The bosom shall not be lop-sided. This would attract attention.

Although patients notice that a male plastic surgeon has another view than a female one, gender issues are not necessarily a conscious part of their stories. In a *Leib* centred approach constructions of sex and gender unfold meaning differently. The human body itself is deeply gendered. We exemplary explore these categories in notions of *skin*, putting into question how gender categories are articulated in the clinical practice. Viewing breast tissue not as socio-politically and culturally neutral fabric but rather – within and through the patient-physician relationship – as creatively formed substance.

> Brigitta: It was emaciated. It was not even a plain surface but a real trough. … Yes, indeed, [immediate reconstruction] does not feel as real amputation.

Losing one's breast thus goes hand in hand with a "real amputation" of feeling as a desirable female being. Women perceive themselves handicapped and stigmatized in their feminine utterance. None of the interviewed patients get breast reconstructions because their partners are the motivating forces. They need plastic surgeries for their own comfort and wellbeing.

> Brigitta: Oddly enough I also missed my nipple. I thought even a baby has nipples. I have less than I had at my birth. This was a peculiar feeling.

The function of skin as a protecting envelope changes radically with the diagnosis of breast cancer. Women often experience the tumour as physical self-deception. They are shaken in their emotional integrity, which is hardly to separate from the body's affective boundary. Treatment in oncology causes additional distress. Temporarily women feel uncannily alienated. Simultaneously – existentially – they never before were closer to themselves. Perceiving the nakedness of life.

> Marguerita: The preservation of skin made me feel a bit more confident. … It was important to me that this is away and that I, with God's help, may become healthy again. … The appearance is secondary to me.

In the evening before her second immediate breast reconstruction, an assistant physician entered Marguerita's room. I just was with the patient. The doctor said: "You are only skin and bones. Preserving your skin will be difficult tomorrow morning." I was fully aware of the patient's skin worries. Interestingly she did not react on the surgeon's statement. Instead of this, she mentioned in the interview, "doctor N. has so sympathetic eyes. I did not

think about her words." Marguerita seamlessly switched to the logico-scientific surgical conception, conceiving skin as material component.

> Marguerita: The skin was offended. Maybe it [the reconstructed breast] will not be that big than the healthy breast. During the climacteric period the breast shrinks back anyway. Keeping my skin up there is important to me.

The reconstructive breast tissue is narrated as "it" in Marguerita's story. She continually passes over from her experienced narrative knowledge to the objectified logico-scientific one, which she has learned with surgeons. In her narration the manifold transformations she is going through – bodily and emotionally – are lively mirrored. Some parts of the history are still hard to integrate into life. "It" is not yet *my* breast but a thing, an implanted prosthesis, which has to be adapted on a daily basis. The reconstructed breast needs to become included in the embodied self-image. In contrast, the cancer cells – the tumour – are to be excluded of the *Leib* imaginatively. This is a long-term process.

> Karin: Healthy, the [cancer] cells shall be away. I don't care about how the bosom looks like afterwards. Shall not have depressions or something. … One has scars after any surgery.

Reflecting on the female breast as our first psychological object includes far reaching consequences for a patient orientated treatment in surgical oncology and plastic surgery. Consequently the – maternal as well as the libidinous – body and self are to be analysed with much care.

Breas(t)Issue(s) – Psychosocial and Cultural Implications

In 1985, the clinical psychologist Didier Anzieu [9] defines in his brilliant book *Le Moi-peau* skin as psychological tegument of the ego. In psychoanalysis the breast, according to Anzieu [9], incorporates four characteristics: the nutritive breast, the substantial breast, contact to a warm and tender membrane and the breast as active and stimulating container. The motherly breast is our first psychological object. It is thought to be a creative organ. Breast tissue substitutes the female *Leib* as phantasm. The contours of femininity and womanhood shine forth as sensitive integument of the self.

The maternal body: Particularly breast reconstruction patients provide a rich body of narrative knowledge. In this existentially threatening situation, women completely rethink their lives. Jackie Stacey [10] declares the cultural definition of female corporeality the

following: “The maternal figure is … turned into a terrifying spectre who may protect the child from the burdens of responsibility” (86). Breast tissue – as lived and experienced female *Leiblichkeit* – shimmers through in the illness stories.

> Marguerita: I forgot about myself. Thought, yes, that’s also good for me. I put back my own interests. These are hints. The organs tell where you need corrections. In this case, it was a rather strong correction.

Connecting breast tissue and the occurrence of cancer with pattern of behaviour is quite usual in the collected illness stories. Marguerita literally gives voice to the socio-symbolic constructions of her maternal body in her narratives. In her understanding cancer is a natural punishment of her misbehaviour [5]. Thus plastic surgery helps her to find freedom – for herself and among others.

My body and self-image among others: According to Paul Schilder [1], it is a “proof of the lability of the body-image that whatever comes into connection with the surface of our body is more or less incorporated in the body” (202). Thus, we even change the body image by clothing, painting lips or face, dyeing hair, cutting nails, washing, “all changes in the appearance” (ibid.), by medical treatment and by (plastic) surgery. In Schilder’s understanding the image of the body “is one of the basic experiences in everybody’s life” (201). What does this mean for women, who develop breast cancer? The interviewed patients articulate that health and getting rid of cancerous cells is most important to them. Appearance is secondary, though they do not like to attract attention in public.

> Brigitta: First I only had a partial resection, two weeks later a complete operation. Until then I took it easy. I even had the opinion that I will get a tattoo some time. I got the impression, for instance at the office with male colleagues, that one is not really accepted or perceived as woman anymore. … One is been looked at differently. I had the feeling they see me as incomplete. … Meanwhile it has become normal again.

The self is constituted among others. Breast operated women often do not feel “accepted or perceived as women anymore” and experience these reactions within their social relationships as rather painful and alienating. Diane Price Herndl [11], literature scientist, who herself developed breast cancer, decided for immediate breast reconstruction. “My choice to have reconstruction was to leap with both feet into the posthuman, the partial, and the contradictory. My new »breast« reflects that: it is me to the extent that it is my own tissue, but it is alien because it has been moved, reshaped, and changed by technology. I am now partial,

because a part of me is missing – I keep using scare quotes around »breast« as an indicator that this flesh is not an actual breast, doesn't feel like one now and never will – and because my choice reveals a partiality for a normal appearance" (151). Price Herndl [11] differentiates between a "normal appearance" and "beauty". Similar statements are to find in the interviews.

> Christina: Do you still like to have a marguerite tattooed?
> Monika: I don't do this anymore. No, if I would go to the sauna, I should have nipples on both breasts. … I want to get my upper part of the body so far that it does not attract attention. … One has a claim on this symmetry. Whether I would use any remedy, I don't know. No idea. I am usually not the type of person, who does beauty operations only to maybe appear more attractive than other women. I'm so far that I live with it. You should not cut into healthy tissue.

The body is reshaped through illness, chemotherapy, radiation and several surgeries. Life itself changes completely. Even the relationships and family situations women live in are reconfigured. *Beauty* has a particular socio-cultural touch in the widespread understanding of plastic and reconstructive surgery. Our interview partners reflect critically on this. They do not identify with women, who undertake cosmetic, aesthetic or beauty surgery. A healthy body is not necessarily connected with *aesthetics* or *beauty*. Nevertheless the meaning of *aesthetics* as a phenomenon is tightly interwoven with aspects of experiencing the world.

> Brigitta: I missed certain spontaneity. It was even unpleasant together with women in community showers. One gets the feeling to be looked at. … At a sudden moment I thought, actually this is unpleasant. When I went by bike to the Donauinsel earlier and it was warm, I undressed and went swimming. Afterwards I would continue my bike ride. I missed this. [Undressing] would really have cost an effort to me.

Breast cancer patients perceive the illness and apparent effects it causes on their bodies in their social environment as alienating and threatening. With the words of Diane Price Herndl [11], although we need to consider cultural differences of plastic and reconstructive surgery in Europe and the US, "mastectomy scar or reconstructed breast, neither would leave me untouched" (153). Any surgery, paradoxically, injures the body's integrity, producing wounds and scars.

The breast as libidinous organ: Libido changes fundamentally with the development of cancer and its manifold modes of treatment. Living one breasted or surgically reconstructed is only one effect, which hinders women in acting out their individual sexuality. Hormonal treatment reduces libidinous sensations to the cero point. Not to forget what it means for a

woman to live bold headed during chemotherapy. All these are massive mutilations of body and self.

> Monika: Women who live totally self-determined in other forms of partnership, I can imagine that they say, »no, I don't need this. I don't care about having one or two breasts.« Maybe they live their sexuality in other ways. However, I know that this is important for my husband. And I like to keep him.

To a certain extent, women with breast cancer keep forever alien to themselves, either with reconstructive surgery or without. According to Elizabeth Grosz [12], referring to Paul Schilder [1], on "Schilder's model, social and interpersonal attachments and investments, as well as libidinal energy, form a major part of one's self-image and conception of the body" (67). Thus, together with their partners – so they live in love relationships – women need to create new ways of feeling desirable. Accepting themselves and being accepted as loved and desired persons is crucial to them.

> Karin: He [partner] said, »this is your body« and I shall decide appropriately. That's right. We've been talking about this but I believe that we don't have problems concerning this. Afterwards it's different. On the whole, it is important that I am healthy.

Breast tissue – as synonym for womanhood, the female body and self – unfolds unexpected psychosocial and cultural implications in the exemplary chosen illness narratives. They are hardly to put into words. Expressing their needs, expectations, desires, anxieties and all sort of experiences in the interviews is to some extent of therapeutic value for the concerned women. Receiving attention from the interviewer brings *normal life* back into being. Repressed or unconscious feelings of loss as well as other kinds of emotions get a voice. This is at least empowering.

> Monika: You don't have any lust sensation. This is repressed. … We are in the middle of a work process within our relationship. *Arimitex*® did not cause so much side effects as maybe is said. Dryness of the vagina and all these things did not occur.

Elizabeth Grosz [12] continues her considerations about Paul Schilder's [1] theory on the body schema the following: "The body image, for him, is formed out of the various modes of contact the subject has with its environment through its actions in the world. In this sense, the body schema is an anticipatory plan of (future) action in which a knowledge of the body's current position and capacities for action must be registered" (67).

> Monika: I feel a little but I feel. This is sheer madness. I believe that this is part of perceiving the body and of being a woman. I feel sorry for women, who don't feel anything. I'm really happy that I did this step. … Simply perceiving a pressure or something on the skin is fascinating. Then I admire the creativity of the surgeon, making this possible.

For Grosz [12] the body image is "synesthetic, just as every sensation, visual or tactile, is in fact synesthetically organized and represented" (ibid.). In Monika's understanding tactile sensations are intimately connected with her perception of the body and "of being a woman" and thus the creativity of the surgeon, which she admires, is only made possible through herself. We perceive our body-selves with all senses.

Epilogue

Breast cancer is a threatening disease and a socio-culturally formed stigma. Women who develop tumours in their breast tissue feel marked and emotionally alien to themselves. Immediate and secondary breast reconstruction helps patients to reconfigure the integrity of the body-self. We suggest a *Leib*-centred approach, including narrative modes of knowledge in the logico-scientific biomedical discourses of surgical oncology as well as plastic and reconstructive surgery. Perceiving the breast as our first psychological object evokes new ways of understanding female cancer patients. Preliminary results of our long-term study with eleven breast reconstruction patients illuminate an epistemic turn in surgical oncology of breast cancer, which deeply influences the decisions of patients for immediate or secondary plastic operations. Thus the cooperation with neighbour disciplines, building multidisciplinary working groups and competence centres, is immensely important for a patient oriented treatment. Breast tissue is an organ of "exchange" and the narrative knowledge of our interview partners strengthens empathy. Experiencing the loss of the breast as "real amputation" and stigmatization of womanhood requires surgical as well as socio-psychological methods that reconfigure the body's »normal appearance«. The integrity of the human body – its injuries through illnesses like cancer and its recovery through surgical interventions – unfolds within this case study in the stories of interviewed and accompanied women.

MEMO

- **Breast tissue is a synonym for the female body-self: Cancer goes hand in hand with socio-cultural stigmatizations and thus causes emotional suffering.**
- **All of the interviewed secondary reconstruction patients would have preferred immediate breast reconstructive surgeries. They did not receive the information about methods in plastic surgery from their confidential physicians.**
- **Breast cancer patients require a combination of surgical treatment in oncology and reconfigurations of the »normal appearance« of body image and self through methods of immediate as well as secondary reconstruction.**

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