6. Performing Futures: Breast Cancer, Pre-emption, and the Biosecurity Individual

> Each woman responds to the crisis that breast cancer brings to her life out of a whole pattern, which is the design of who she is and how her life has been lived.
> *Audre Lorde*

While Wexler's memoir takes its heft from exploring a seemingly mysterious disease that few people know about, breast cancer narratives have a different urgency because the disease is so commonplace. One in eight women in the U.S. "will develop breast cancer over the course of her lifetime;" "in 2020, 276,480 new cases are expected to be diagnosed" and "42,170 women are expected to die" from breast cancer in the U.S. alone (Breastcancer.org, "Statistics" n.p.). The opening lines of Audre Lorde's iconic *Cancer Journals* describe the individuality of the experience and the incision that a cancer diagnosis represents as an injury not only of the body, but of the person. Her narrative stands out as her analysis reaches beyond the individual illness experience toward broader questions of gender, class, and racial injustice. Biomedical and biotechnological progress, as well as cultural representation such as Lorde's breast cancer narratives have changed the meaning of the disease and have created new forms of breast cancer experiences. Especially the focus on breast cancer risk and genetics has shifted the moment of crisis that Lorde described in the lines above. The possibilities of biomedical diagnostics in the field of breast cancer and the focus on diagnosing and treating risks have made preventive and pre-emptive security practices the dominant way of understanding and confronting breast cancer.

In this chapter I will examine the impact of biosecurity practices and the messianic narrative of scientific salvation in the context of breast cancer risk. I will turn to the "regime of surveillance medicine" (Armstrong 403) and the material effects produced by the security narratives of breast cancer prevention and pre-emption. Breast cancer is considered a national as well as global emergency and "a modern epidemic" (Schneider et al. 244). The war on breast cancer, however, is not only a national and global security concern but represents individual struggles. Nonetheless, the biosecurity practices in the context of breast cancer reiterate the omnipresent national security logic. I will therefore highlight how the individualized biosecurity practices follow the same pre-emptive logics and describe the place where national and individual biomedical security intersect. The existential uncertainty produced by the logics of national security narratives are reiterated in individual(ized) biosecurity performances pervading the public sphere and private lives in the U.S.. And these biosecurity performances give rise to a new form of biosecurity individuals: the breast cancer previvor.

Early detection and prevention of breast cancer has been a central element of the biomedical security narrative and its promise to "cure" for a very long time. The gospel of prevention proliferated throughout the 20th century focusing more and more on establishing and defining risk groups, and increasingly on defining risk individuals and practices of pre-emption. In place of a cure, the urge for testing has forwarded the detection of cancer, pushing the diagnosis to *before* a cancer develops and manifests. Improved screening technologies have facilitated the diagnosis of precancerous cells such as lobular carcinoma or ductal carcinoma in situ (DCIS), which are often medically and discursively treated as if they were breast cancer.[1] Driven by the promise to cure the body and eradicate breast cancer, pre-emptive logics of biosecurity are particularly salient in the post-millennial understanding and confrontation of breast cancer. Especially the possibilities of diagnosing genetic markers for breast cancer risk – facilitated by the discovery of BRCA1 in 1994 and BRCA2 in 1995 – have made interventions in the (still) healthy body to foreclose a potentially diseased future an accepted biosecurity practice in the U.S. (Fosket 339).

The diagnosis of a genetic marker such as the faulty BRCA1 or BRCA2 increases the "normal" risk of a woman to develop breast cancer to 65% on average. This is a frightening numerical reality that has garnered considerable public attention. These mutations only represent 0.1 to 0.6 percent of the population, however, they are on the forefront of most recent breast cancer representations.[2] The diagnosis of genetic markers for breast cancer risk is not a result such as the pre-symptomatic diagnosis of Huntington's disease. The genetic markers indicate an increased risk and a potential for a future cancer affliction. Nonetheless, "high risk" individuals are defined and treated as if pre-symptomatically ill in the biomedical security complex, and invasive strategies are used to treat the potential future cancer. Individuals diagnosed with hereditary breast and ovarian cancer have two choices. They can begin an increased and individual medical surveillance regimen with medical tests every three months and one additional annual Magnetic Resonance Imaging (MRI) to detect cancer in its earliest stages, or they have the choice to undergo chemoprevention (pre-emptive chemotherapy) or pre-emptive surgery. In this chapter I

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[1] Lobular cancer as well as ductal carcinoma in situ (DCIS) represent tissues that could develop into cancer, but do not represent a diagnosable cancer. Laura Esserman from the Carol Franc Buck Breast Cancer Center highlights that this name is misleading as it really is a marker for a risk factor rather than for an actual carcinoma (qtd. in Orenstein, "Feel Good" n.p.). Nonetheless, individuals with DCIS often opt for mastectomies (ibid.).

[2] Other more common risk factors are "age, genetic factors (or heredity), poverty, diet and nutrition, and lifestyle" (Frisby 491).

will focus on the security narratives that legitimize such seemingly drastic material effects. I will therefore not focus on the extensive body of breast cancer narratives, narrative accounts of individuals afflicted with breast cancer, but rather narratives of individuals at risk of breast cancer, which “often take place at an uncanny locus of embodiment and disembodiment” (DeShazer and Helle 9).

While Barron H. Lerner, author of *Breast Cancer Wars*, still pondered the question of how such experiences of individuals treated for a breast cancer risk could be understood – in medical terminology they were called “unaffected carrier” – the term “previvor” is today an established label for these risk individuals. The neologism previvor is not a term created for the sake of academic analysis but a terminology that was first adopted by afflicted individuals. It was developed by Sue Friedman, founder of BRCA patient advocacy organization Facing our Risk for Cancer Empowered (FORCE), a previvor herself. The name describes the experience of individuals who live with an increased hereditary breast and ovarian cancer risk “surviving” a not (yet) existent cancer. I will turn to the security narratives produced by previvors, specifically the public representations of previvor “testimony,” such as the celebrity accounts by Jessica Queller and Angelina Jolie published in *The New York Times*, as well as narratives published in forums and self-help groups. With these examples I will emphasize testimonies as public performances of biosecurity individuals which shape the public representation of breast cancer risk and of these new biosecurity identities.

Most analyses of previvor testimony place these texts in the context of health and disease and interpret them accordingly. They most prominently grapple with the simultaneous absence and presence of both of these categories (Herndl, “Virtual”, Nye, DeShazer and Helle). I think this perspective neglects that these texts and experiences are articulated and constructed in terms of security. Though scholars assert that these narratives are expressions of radical uncertainty, I wish to show that the security narrative of medical salvation establishes a pervasive image of security which is at core performative. I will therefore read biosecurity practices as performances that help to shape the experience and understanding, and to a certain extent the reality of the affliction. I will show how the biomedical developments, specifically the growing possibility of genetic testing for breast cancer risk markers produce a new category of illness identity and thereby performatively produces an illness experience, which is premised on the understanding of security. By investigating the role and impact of cultural performances, I wish to demonstrate that current biosecurity is based on performance and theatrical methods to legitimize its pre-emptive logics. The representation of previvors and their security narratives heavily relies on the “history of meaning” (Bouwsma 285) established in the breast cancer movement. I will therefore first focus on the performances that have (in)formed the understanding and reaction to the “crisis” of breast cancer, establishing a narrative of survivability. I will then turn to individual accounts of previvors, to show how these acts of giving testimony represent a necessary acts in establishing biosecurity and the identity of the previvor.

Performativity, Biosecurity Culture, and the Breast Cancer Movement

> Previvor or Survivor?
> If you have been diagnosed with cancer, you are a *survivor*. You're a *previvor* if you have a family history of disease, an inherited mutation, or other factor that predisposes you to developing cancer and you've never been diagnosed.
> *Sue Friedman et al.*

Today's previvor movement and the proliferation of security narratives of previvors are – albeit decisively different in many ways – tightly connected to the narratives constructed in the cancer movement and its relation to the messianic narrative of scientific salvation. The material realities produced by the post-millennial security narratives can only be understood when analyzed in their relation to the "history of meaning" produced by a long line of female performances that have defined security in the context of breast cancer. The aim is here not to repeat medical history but rather to focus on the performances that have shaped both the research and the public image of the disease. The disease as well as its representations have a long history that has been well documented, and extensively researched.[3] Samantha King for instance asserts that the disease "has been transformed in public discourse from a stigmatized disease . . . to an enriching and affirming experience during which women with the disease are rarely 'patients' and mostly 'survivors.'" (S. King, "Pink Ribbons" 473). Accordingly, the security narratives concerning breast cancer represent a radical shift from passive patient to empowered subject, which is embodied by the biosecurity identity of the survivor as well as by the previvor.

Though this change might seem radical the security narrative of controllability and hope, and the underlying messianic promise of scientific salvation have remained fairly constant. While the promise of finding a cure for cancer persistently remained ahead and out of reach, improved treatment options and diagnostics seem to have changed the prospect of a breast cancer affliction. In many ways it appears as if medical progress has simply changed the image of the feared disease from a definitive death-sentence to a manageable disease *if* it is detected early enough. Better treatment options and screening possibilities made "the survivor" a more tenable position, and therefore a more prominent symbol of security. However, besides scientific findings these changes have been closely related to and were facilitated by public performances – performances that have stressed the survivability and controllability of breast cancer when following the medical script.

Most historic accounts of cancer treatment emphasize the long line of mainly men and their heroic battles against the disease, such as the surgeon Professor William S. Halsted. The rise of breast cancer surgery is traced back to him and the turn of the 20th

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[3] Following the theoretic consent that disease is always both culturally and biologically determined (Sarasin, Davis and Morris), breast cancer has variously been argued to be a socially constructed disease (Kasper and Ferguson).

century. Halsted championed radical mastectomy – the removal of both breast and underlying muscle tissue – as the only way of preventing the spread of the cancer. Retrospectively judged as unnecessary and harmful in many cases, the practice "became the undisputed path that generations of surgeons trod with diligence" (Lakhtakia 167). The inability to provide security from breast cancer was not represented as an inaptitude of the dominant security practice but as the failing of individuals and their ability to report possible symptoms. To provide the promised security it was crucial to establish a pervasive security narrative that would motivate individuals to consult a doctor as quickly as possible. The image of cancer as a definite death sentence as well as the ignorance of the warning signs of cancer had to be challenged by the dissemination of information marking "the beginning of an erosion of the public silence" (Carter 655).

This distribution of information and the normalization of biosecurity practices were decisively facilitated by female performances. In 1913 the first pamphlets informing about cancer and the security practices of cancer prevention started to circulate in the U.S.. The public health education, initiated by the American Society for the Control of Cancer (ASCC), was targeted at a female audience and published in women's journals (J. Patterson 74). Pamphlets circulated the narrative that cancer was survivable promoting a "'Message of Hope' – early detection – available to all Americans" (J. Patterson 76). In the 1930s the ASCC officially decided to "fight cancer with publicity" (qtd. in Lerner, *Wars* 43) by propagating the curability of cancer.[4] They relegated the task of cancer education to a newly established female subfield, headed by Marjorie Illig: the "Women's Field Army" (WFA). The information drives of the WFA represented public performances that staged biological security as a decisively female task on the home front against cancer. And the most crucial message circulated in these performances was that "delay kills" (qtd. in Lerner, *Wars* 47) while medical salvation stood ready at hand for those prepared. In 1940 the public representation of cancer was further increased by a public relations campaign that introduced the aspect of charity and fundraising to the struggle of the ASCC (J. Patterson 173). The campaign successfully raised more money than the ASCC's entire funding in its first year (Lerner, *Wars* 50). And it increased the stronghold of the messianic narrative of scientific salvation promising the coming of biosecurity as unquestionably ahead if scientific research was supported and funded.

The increased circulation of the security narratives of cancer prevention also established the proliferation of individual biosecurity practices that translated individual responsibility into individual embodied acts. In the 1950s the urge for breast self-exams started to circulate, teaching women to read their own bodies for signs of the disease (Lerner, *Wars* 55). The breast self-exams converted the biosecurity practice of surveillance into individual biosecurity practices – performances that are omnipresent today. These performances not only mandate individual responsibility for one's biological security –

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[4] Medical professionals also had to circulate the new image of security within their own circles with events such as the conference "Cancer is Curable" in 1932. The general sentiment of security granted by the medical profession led to the foundation of institutions with names such as "Cured Cancer Clinic" in Pondville (Lerner, *Wars* 42–43). Lerner calls this process for the post war years "inventing a curable disease" ("Inventing").

the self-reliant biosecurity individual – but make individual female performances a crucial constituent of biosecurity. As embodied and ritualized experiences, biosecurity thus became a crucial part of female identity in the United States. Since 1963, when mammography was developed, the urge for earlier and more regular testing became louder and more pressing, further emphasizing preventive security practices as the most crucial element of improving mortality rates. At the same time, this growing "technoscientific biomedicalization" (Clarke et al., "Charting" 88) made security increasingly unattainable for the individual and a matter of expert reading.

In the 1970s, female performances of giving testimony further changed the understanding of breast cancer, which had remained a silenced and stigmatized experience despite the public relations campaigns. Scholars assert that the personal stories of women have decisively shaped the "history of the disease" (S. King, "Pink Ribbons" 476).[5] Most famously, Betty Ford's breast cancer diagnosis in 1974 and her public testimony is seen as paradigmatic in breaking the silence surrounding breast cancer. According to Lerner, Ford's act of giving testimony led to an increased demand of the biosecurity practices of early detection and boosted the publicity and desirability of projects such as "The Breast Cancer Detection Demonstration Program" (*Wars* 175). In such public performances women did thus not only share their struggle with breast cancer but embodied the promised security if the assigned "sick role" (Parsons, "Sick Role" 257) was performed properly: survival. Ford's post-surgery photo series (Kennerly), for instance, represents an almost unchanged First Lady. The performative acts of giving testimony thus represent both the imminent threat of cancer, and the promised security when following a medical script, underlining the authority of the medical profession as arbiter of security. But Ford also asserts in her speech to the ASCC in November 1975: "I just cannot stress enough how necessary it is for women to take an active interest in their own health and body" (Ford). Biomedical salvation, though relying on expert readings was clearly also premised on the responsibilization of the individual.

At the same time as breast cancer became a much more publicly discussed and recognized topic, female performances also began to renegotiate the security practices prescribed by medicine and science, especially the Halstedean radical mastectomies. Biopsy and radical mastectomy were at the time performed as a "one-step surgery" if the probe tested positive, which left women disenfranchised. Influenced by the feminist movement women began to challenge the medical authority which defined them as passive patients or cancer victims. As one of the pioneers of "medical feminism" (Mukherjee 199) Rose Kushner criticized the radical interventions into female bodies in *Breast Cancer* published in 1974.[6] However, it wasn't simply the published critique but individual

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[5] In the 1950s Baba Zaharias publicly discussed her experience with the illness, followed by Shirley Temple Black, Betty Ford and Happy Rockefeller in the 1970s. Many scholars attribute the "destigmatization" (S. King, "Pink Ribbons" 476) of breast cancer to the act of giving testimony as well as the women's health movement (Kasper and Ferguson (Eds.), Klawiter, Ehrenreich, "Welcome").

[6] Most crucially, her personal testimony emphasized that the practice of radical mastectomy had no scientific evidence to support it (Lerner, *Wars* 172). This fact was known but did not change the adherence to the practice and the belief in its promise of security of the mainly male practitioners. The medical surgeon George Crile had critiqued the generalized application of radical mastectomy in *What Women Should Know About the Breast Cancer Controversy* showing that radical mastectomy

performances that challenged the security narrative and ultimately changed the security practice. Especially Kushner was famous for her interventions in conferences and expert meetings, staging performative disruptions (Lerner, *Wars* 180). The performative acts of disobedience included not only activism but therapeutic choices. Kushner, as many women following her, refused to undergo the prescribed security practice of radical surgery (Mukherjee 200). Though the inevitability of the invasive practice was ultimately rejected by the biomedical institutional framework, the female performances of refusing radical mastectomies and the one-step surgical procedure, and campaigning against it were instrumental in advancing this change.

In the late 1970s and 1980s the medical authority over the security narratives was further challenged as the security practices garnered an extensive body of feminist critique in the rising genre of breast cancer narratives and art. Most of the works that emerged at that time "both inform and are informed by feminist activism and theory" (Hartman 155). Since the 1990s the long tradition of autobiographical accounts of breast cancer – beginning in the U.S. with Abigail Adams Smith's account in 1811– has received academic attention. Many texts are today canonized examples of the literary negotiations of the "new" identities forged by the experience of breast cancer.[7]

In many breast cancer narratives, the question of identity and the injury to the identity and body are central themes (Herndl, "Virtual" 222). Becoming "wounded storytellers" (Frank) the individual narrators emphasize the need of re-establishing and re-affirming their subject position. These female performative acts of claiming an identity have changed the male and biomedically authored security narrative further redefining the responsibility allotted to breast cancer patients by the "sick role." According to Arthur Frank, these individuals have transformed the responsibility of becoming healthy again into the responsibility to define the meaning of the illness experience (13). As such, the writing of the individual breast cancer testimonials turns into a security practice of self-healing (Herndl "Our Breasts" 228).[8]

Audre Lorde's iconic *Cancer Journals*, for instance, emphasizes this need to recreate her identity after her mastectomy surgery and the loss of her breast. She highlights the emphasis on the use of prosthesis, which reveals the prescribed performative necessity to embody an image of security. The prosthesis in the case of breast cancer facilitates the appearance of an intact, normal and healthy body to the public audience – a performative act that infuriated Lorde in the 1980s and Eve Kosovsky Sedgwick still in the 1990s.[9]

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did not alter mortality rates nor improve the outcome. Voices such as his did not, however, reduce the dominance of the practice.

[7] These texts include Susan Sontag's *Illness and Metaphor*, Audre Lorde's *Cancer Journals*, Bobbie Ann Mason's "Spence & Lila," breast cancer poetry such as Katrina Middleton's "Mastectomy," or Adrienne Rich "A Women Dead in her Forties," Barbara Rosenblum's and Sandra Butler's *Cancer in Two Voices*, Margaret Edson's play *Wit*, Eve Kosofsky Sedgwick's "White Glasses," and Barbara Ehrenreich's "Welcome to Cancerland" to name but a few.

[8] Today, the therapeutic importance of narrative and storytelling in the process of healing is commonly asserted and termed "narrative therapy." Yoe Gu even asserts that "[n]arrative therapy is regarded as one of the most influential trends in contemporary psychotherapy" (479).

[9] In "White Glasses" Sedgwick delivers her breast cancer narrative in which she describes the anger she felt (and recognized in others) attending a support group meeting in which prosthetics were

Though offered as a therapeutic tool to establish a sense of security the unapologetic urge to use prosthetics came under scrutiny of feminist critics. This "prosthetic pretense" (56) as Lorde called it, did not only "perfect" the semblance of bodily security, it effectively made breast cancer survivors invisible, "passing" as normal in the public. It performatively erased them. For Lorde "[t]he emphasis upon wearing a prosthesis is a way of avoiding having women come to terms with their own pain and loss, and thereby with their own strength" (41). In contrast, Lorde renders the breast cancer survivor as warrior who wears her scar with pride. Finding her spiritual and corporeal heritage in the myth of the Amazons, she exclaims: "I am not a casualty, I am also a warrior" (Lorde 13).

Illness narratives are, thus, performative acts that provide alternative security narratives focused on the perspective of the individual, very much in the sense of Wibben. Today, the extensive body of illness narratives is seen as a crucial and ongoing challenge to the heteronormative male dominated knowledge production and the disempowered position of the female patient. In contrast to Ford's public performance, these testimonies were thus not intended to advance biosecurity practices. Nonetheless, they have at the same time further reinforced the symbolic position of the survivor. And while all these public performances have enabled a broad public discourse they have also created new normativities, such as facing cancer and becoming an empowered survivor.[10] Not surprisingly, in the late 1970s also the medical institutions revised their model of the cancer patient, making a conscious attempt to re-define the individual as survivor to further encourage the proselytization of the "gospel of early detection" (Lerner, *Wars* 248).

The symbolic position of the survivor as a stand-in for breast cancer security was further enforced by the institutionalization of the National Breast Cancer Awareness Month in 1985. The associated events procured a national stage for the struggle against cancer staging security as a question of early detection and cure. And also the growing number of non-profit breast cancer institutions such as Susan G. Komen Breast Cancer Foundation and the National Alliance of Breast Cancer Organization further increased the visibility of the survivor as a stand-in for security. Survivors quickly turned into the most important driving force of the breast cancer awareness movement. Though the movement was initially critical of medical authority and its heterosexist discourse, preventive measures have remained a central focus in their activism.[11] This emphasis on the survivor produced according to Susan Ferraro the expectation that "if you do your breast

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promoted reducing the female body to the heterosexual male gaze that must be spared the corporeal reminder of mortality (203).

[10] S. King asserts that these survivors "emerge as a symbol of hope" ("Pink Ribbons" 473) and six years later she even calls the figure of the survivor the "archetypal hero" ("Pink Diplomacy" 286).

[11] A study set up to produce official guidelines on the age when testing should be necessary was inconclusive in its published suggestions. The evaluation had not been able to find statistical evidence for the necessity of early mammography screening. But breast cancer interest group and female legislators, most of them survivors, campaigned for the necessity and benefits of these early screening regimens. Still today, the generalized urge for testing in those under the age of 50 with normal risk is highly controversial. Breastcancer.org, as well as most other breast cancer institutions assert that the decrease in mortality after the 1990s in the United States cannot be correlated to early increased screening regimens.

self-exam and you get your mammogram, your cancer will be found early and you will be cured and life will be groovy" (n.p.).

The breast cancer movement quickly developed into one of the strongest and most widely recognized patient movements, represented and widely recognized by its pink ribbon. Furthermore, corporate and pharmaceutical interest have started to influence the breast cancer movement more heavily. Today, Breast Cancer Awareness Month turns whole cities pink and the emblem of breast cancer awareness, the pink ribbon is "little more than a fashion accessory and a marketing logo" (Hughes and Wyatt 281). The wide array of biosecurity performances that constitute Breast Cancer Awareness Month are sponsored by Astra Zeneca (Ehrenreich, "Welcome" 50), the leading pharmaceutical company in preventive breast cancer treatment. Not surprisingly, most events and performances further amplify the urge for preventive security practices. In 1996 *New York Times Magazine* described breast cancer as "This Year's Hot Charity" (Belkin) and it is often cited as a "favorite charitable cause" (S. King, "Pink Diplomacy" 476) for cause-related marketing.[12] These breast cancer awareness events dominate the public representation of breast cancer and its security narrative, forming an allegiance with corporate and pharmaceutical interests of the "Cancer Industrial Complex" (Ehrenreich, "Welcome" 52).

The magnitude of today's breast cancer performances become apparent when looking at the numbers of participant in such public events. According to the Komen Race for the Cure website the 3.1 km run took first place in 1983 with 800 people. Today it takes place "in 9 countries with nearly 140 Races globally" and 8.5 million participants (Komen.org). In every event, the importance of testing, and the unavoidability of medical intervention is reiterated and enforced. Survivor performances represent the center of these events as for instance the survivor ceremony, which is part of every awareness run. The performances reiterate the individual responsibility of every woman to take the right choice for security. Todd M. Tuttle et al. argue that these representations produce a "breast-cancer over-awareness" which is leading to a higher number of choices for more radical interventions.

This so-called pink movement has drifted far from its initial groundedness in second wave feminist critique. The performances that initially served to give voice to a "different" story of security have become more mainstream norm-conform expressions of able-bodied femininity. Breast Cancer performances are not only focused on inspirational sporting events but on the ultra-feminine healthy looking survivors, who dominate the movement's representations today and are the main vehicle to raise awareness for breast cancer prevention (Hughes and Wyatt 281). Carter asserts that since the late 1990s the movement performed a representational shift that stresses a "back to normal" (Carter 661) appearance. Breast cancer representation returned to the performance of bodily integrity as a visible sign of security. Indeed, even Matuschka, the icon of the breast cancer scar, had her breast reconstructed bowing to socio-cultural pressure, as she confesses

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[12] The variety of fundraising programs expand activism to everyday acts completely unrelated to breast cancer. Though benevolent, from a cultural critical perspective, programs such as the branding of regular products in pink risks to reduce activism and care into an easily consumable good which converts breast cancer into a commodified signifier, as scholars such as Samantha King point out ("Pink Ribbons" 480).

herself (Good Morning America). Emily Waples stresses that the "culturally emplotted cancer narrative" of survival (50) has been extended by the "subjects re-incorporation into a healthy body politics" (ibid.). The calls for representation and voice have been answered – but instead of the initially envisioned form of empowerment it has led to the "homogenization of the breast cancer patient" (Carter 657).

But the 1990s not only brought an unabashed coalition with corporate interests and consumerism and a return to a heteronormative representation of female able-bodied security. The revolution of communication and digitization revolutionized the distribution and authorship of biosecurity narratives. The internet and increasing digitization opened another performative space for the representation of security narratives, their exchange, and negotiation. Forums and digital support groups became a crucial part of breast cancer activism and a crucial resource for many afflicted individuals. Most of these forums were dedicated to cancer survivors. The technological revolution, especially the genetic revolution, however, had facilitated a new group that needed public representation, recognition, and support: the previvor.

Modeled on the survivor the experience of genetically inherited breast cancer risk was constructed as a form of "anticipatory survival" (Nye 107). The individuals, however, often sat uncomfortably between two chairs, that of the breast cancer survivor and that of the (still) healthy. In the late 1990s Betty Friedman founded the internet platform FORCE, which is dedicated to the rising number of individuals who live with a "high risk" for hereditary breast and ovarian cancer (HBOC). The platform has created another performative space for the new breast cancer experience and its security narratives to be performed, defined and negotiated. The experience of previvors and the activism giving voice to their experience was recognized in the Breast Cancer Education and Awareness Requires Learning Young Act (EARLY Act) of 2009, which supports the education and awareness raising of "high risk" individuals at an early stage. FORCE has successfully campaigned for national recognition and support which was officially instituted in 2010 with the National Previvor Day as part of the Hereditary Cancer Awareness Week.

Since 1995 the subgenre of "BRCA or 'previvor' narratives" (DeShazer, *Mammographies* 2) has emerged, which has further proliferated both, in number and in form since 2000.[13] Previvor testimonies do not predominantly exist in the literary form of a published book; they represent a mosaic of representations and performances, which is why I will focus

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[13] "Traditionally" published illness narratives of previvors such as Janet Reibstein's *Staying Alive: A Family Memoir* (2002), Elizabeth Bryan's *Singing the Life: A Family in the Shadow of Cancer* (2007), and Jessica Queller's *Pretty is What Changes: Impossible Choices, the Breast Cancer Gene, and How I Defied my Destiny* (2008), Masha Gessen *Blood Matters: From Inherited Illness to Designer Babies* (2008), and Amy Boesky's *What We Have: A Memoir* (2010) discuss the ambiguous position of the biosecurity individual defined as "high risk." And self-help books such as Dina Roth Port's *Previvors: Facing the Breast Cancer Gene and Making Life Changing Decisions: a Groundbreaking Guide with the Stories of Five Courageous Women (2010)* or Sue Friedman's, Rebecca Sutphen's, and Kathy Steligo's *Confronting Hereditary Breast and Ovarian Cancer: Identify Your Risk, Understand Your Options, Change Your Destiny* (2012) indicate more clearly how the exemplary life narratives should be read: as authentic exemplary narratives that help the individual understand their own biosecurity identity and position between health and disease to intervene successfully in the genetic prophecy facilitated by the biosecurity practice of testing.

on different forms of testimony. Platforms such as FORCE, Bright Pink, Young Survival Coalition, or Breastcancer.org all facilitate and actively encourage the exchange of testimony. Under forum pseudonyms previvors offer stories which are often fragmented and focused on specific parts of their biosecurity identity. They not only represent the post-modern life and individual with its diverse surfaces of representing and forming an identity but the increasingly fragmented sense of biological security which is defined by biomedical risk assessment and based on the construction of pervasive security narratives.

The previvor narratives represent paradigmatic examples of pre-emptive action taken in the present to foreclose the possibility of the future threat. Boesky asserts that the previvor testimonies express “a need to testify” (“Witnessing” 90) but I would go one step further. This need to testify is a necessary act to establish individual security narratives that negotiate the ambivalent situation between security and insecurity revealing the performativity of the new biosecurity identity.

Test and Testimony: Becoming a Previvor and a Biosecurity Individual

In 2005 Jessica Queller wrote the *New York Times* Op-Ed piece “Cancer and the Maiden”, followed by an appearance on national TV, and the publication of her memoir *Pretty Is What Changes* in 2008. In 2013, Angelina Jolie’s public testimony of her decision to have a pre-emptive double mastectomy was published in a similar Op-Ed piece titled “My Medical Choice.” The same day Kristi Funk, Jolie’s surgeon, published “A Patient’s Journey: Angelina Jolie” as a complementary narrative on the Pink Lotus Breast Cancer Web site. Two years later, *The New York Times* published the sequel to Jolie’s first previvor testimony “Diary of a Surgery” which describes the decision for the laparoscopic bilateral salpingo-oophorectomy, the surgical removal of fallopian tubes and ovaries. These texts mark two different historic moments in the popularization of the genetic test representing the “beginning” of genetic testing for breast cancer and its later more established phase. Furthermore, they represent different perspectives during the experience of the previvor. Queller’s texts represent different moments in her process of becoming a previvor. Her first narrative was written after her diagnosis with a BRCA1 mutation but before deciding for and undergoing treatment. Her memoir is written after having undergone the double mastectomy and reconstructive surgery. Similarly, Angelina Jolie’s testimonies mark two different moments. The first one was written after the mastectomy while the second was written while undergoing the process of oophorectomy, an even more invasive intervention since it changes the actual constitution of the body instigating premature onset of menopause. Both celebrity accounts represent their choice for radically invasive treatment – the pre-emptive surgical removal of healthy body parts – as an empowered act of overcoming disease.

Previvors are predominantly young and healthy. In the case of Queller and Jolie both were diagnosed in their early to mid 30s, ten to twenty years before the dominant security narrative of breast cancer frames women as at risk and in need of preventive breast cancer screening. The previvor narratives of Angelina Jolie and Jessica Queller are acts of bearing witness to an incision and change in identity triggered by the precarious experiential situation of being at risk exposed by the genetic test. The testimonies are often read as extensions of the genre of breast cancer narratives since they are closely related thematically as well as in form and function. As their early predecessors in the 1970s, previvor testimonies largely aim to expound the benefits of preventive security practices, in their case genetic testing and pre-emptive surgical intervention. They further share many aspects of more "traditional" breast cancer narratives with their emphasis on war metaphors, the fighting of a "disease" and overcoming it. The narrators represent themselves as self-reliant biosecurity subjects empowered by the diagnostic possibility to determine genetic predispositions for certain breast cancer variants and the medical choices they have made. They represent paradigmatic examples of individualized biosecurity practices that highlight the responsibilization of the individual for the possibility of biomedical salvation. However, there is a decisive difference between breast cancer (survivor) narratives and previvor narratives in how security and the body are understood and confronted.

Arthur Frank asserts that illness narratives are not only told by an afflicted individual but "by bodies that are themselves the living testimony" (140). In contrast to the "wounded storyteller," the narrators of previvor narratives cannot be easily subsumed under this category. The injury to the body caused by the "disease" which is being fought is in most cases not materially present as such. Neither Angelina Jolie nor Jessica Queller has been diagnosed with a pre-symptomatic disease, as in the case of Huntington's disease, but with an increased susceptibility to cancer. The positive test result shifts the body in its positionality to security – not its position in terms of health. Though not afflicted with a diagnosable cancer, previvor testimonies represent a renegotiation of identity caused by a biomedical emergency. In doing so, these life writing texts do not just testify and describe a "new" biomedical identity and the experience of this emergency but are performative acts claiming and producing the biosecurity identity of the previvor.

"Five months ago, I took a test for something called BRCA genetic mutation" (Queller, "Cancer" n.p.). Jessica Queller opens her testimony in *The New York Times* with the moment her identity shifts from that of a healthy young woman to a biosecurity individual defined by a genetic predisposition. The biotechnologically facilitated diagnosis plays an integral part in the testimonies of previvor experiences and their individual claims to a risk identity. In Queller's memoir the position and diagnosis is clarified already in the title and repeated in the preface. And Angelina Jolie, too, explains early on in her narrative: "I carry a 'faulty' gene, BRCA1, which sharply increases my risk of developing breast cancer and ovarian cancer" (Jolie, "Medical" n.p). Through these narrative acts of claiming the identity of the previvor the women foreground their biological make-up as a crucial element that defines their embodied selves. The individuals thus re-position themselves to a presupposed normal biological security. They thereby become primarily defined as risk individuals understood as a deviation from a biosecurity "normal." These claims introduce the testimonies as confessional statements, which reveal the "truth" about the self. They represent acts of exposing the self, making visible what would usually remain unseen. Previvors remain invisible, not only because corporeal problems are still considered one of the most private areas of one's life, but because there are no outside signs or symptoms that mark a previvor. The testimonies thus need this ascription to express their experiences and to make known the precarious normality they live with.

The two Op-Ed pieces, as texts published in newspapers and targeted at a broader audience, necessitate such a claim to the biosecurity identity as an introduction of the reader to the basic facts of these genetic risk markers. They provide an initial explanation for the meaning of the biomedical ascription. Especially Queller's first testimony from 2005, when the genetic marker and pre-emptive treatment of cancer were comparatively unknown to the general public, needed a translation of biomedical knowledge to establish bioliteracy of the reader (which follows this introductory confession). But also in "in-group" performances, such as forums or workshops, this act of identifying oneself as a previvor with the exact biomedical diagnosis holds a central position. In a forum hosted by Breastcancer.org, Lilypond identifies herself as "positive for BRCA2" (Lilypond) and Robin31 asserts that she "was negative for BRCA1 but positive for BRCA2" (Robin31). Though most prominent, the BRCA 1 and 2 mutations are only the best known genetic markers as the multiplicity of previvor testimony in forums reveal. Bc31 for instance "turned out to be BRCA1/2 negative, but positive for a CHEK2 mutation" (Bc31).[14] The self identification represents almost a ritualized and formulaic part of previvor testimony. The centrality of these confessional statements, which are comparable to the importance of the diagnosis in traditional illness narratives, indicates how crucial the biomedical description is for establishing the biosecurity identity of a previvor. The biomedical diagnosis represents the only way of describing and knowing the body. Since the body lacks a material or perceivable change, the act of naming the self depends almost exclusively on biomedical terminology and knowledge production. The narratives therefore represent the security practice and produced diagnosis as performative turning points. The genetic test result is represented not only as descriptive but as deeply performative, producing a changed understanding of the body.

This changed understanding is initially defined by the official risk assessment. Jolie explains that her "doctors estimated that I had an 87 percent risk of breast cancer and 50 percent risk of ovarian cancer" ("Medical" n.p.). The shift is not described as an intimate encounter of an individual with her body,[15] but with a numerical and statistical definition. The doctors, the border guards of the porous line between health and sickness inform the individual of her security status. Security is thus represented as lying beyond the realm of individual experience while biomedicine represents an unquestionable authority in deciphering the bodily signs and establishing a sense of security. The genetic test as a professional reading of bodily signs and their assessment in terms of security and risk is therefore of utmost importance to know "my reality," ("Medical" n.p.) as Jolie puts it. The biomedical knowledge repositions the individual in their relation to security – not health. In these representations, however, it appears *as if* the test provided a definite diagnosis that shifts the reality of corporeality.

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[14] Each marker represents a specific risk potential for a different set of cancers, not only occurring in different body parts but different in their biochemical characteristics. These "names" define the diverse experiences subsumed under terms such as previvor or "risk individual."

[15] Though I will be writing about a female experience and the demands of biosecurity made on the female body in this chapter, it is pertinent to stress that the breast cancer previvor can be male as well.

The biomedical diagnosis of an increased hereditary cancer risk thus stands in for a material and perceivable breach. As a cancer diagnosis, the knowledge of one's risk represents a rupture that separates life in before and after. Queller asserts in her first testimony that "[i]t's akin to Eve taking a bite of the apple. Once you have the knowledge, there's no turning back" (Queller, "Cancer" n.p.). The testimony of the previvor and the positioning in the narrative act thus appear as a twice told tale in which the test itself is represented as testimony, a witnessing of the body – the truth inside which defines the identity of the previvor. And also the diagnosis and the chosen medical treatment are put into a seemingly causal relation to the diagnosis as if the statistical potential was expressive of a definable and definite truth, providing certainty. Jolie for instance asserts: "Once I knew this was my reality, I decided to be proactive and minimize my risk as much as I could. I made a decision to have a preventive double mastectomy" (Jolie, "Medical" n.p.).[16] The knowledge of the genetic mutation facilitates the confrontation of the risk offering the hope to control the future and initiating the script of previval. Not surprisingly then, most previvor narratives emphasize testing as the initiating performance, the most crucial act of becoming a previvor.

However, the biomedical ascriptions represent only a seemingly objective anchor of the narratives that are otherwise dominated by ambiguity and speculation. The use of medical terms and the emphasis on the exact statistical risks to identify the self disguises that the diagnostic test result is not descriptive of an empirically present threat but describes a potential future, a possibility which might or might not take place. The test does not diagnose a *certain* future as is the case in Huntington's disease but a *potential* future. Queller most clearly ponders this conundrum in her first testimony. She asserts that "modern science acts like a crystal ball," which promises to divine one's future and provide security.[17] The medical narrative of risk, however, "doesn't provide solace so much as open a Pandora's box" (Queller, "Cancer" n.p.). Describing the test as "Pandora's box" defines the knowledge of possible future cancer as a curse. But using this proverbial symbol of unexpected (and self-inflicted) calamity and misfortune also gestures toward storytelling. Pandora's box is not so much an object but first and foremost a myth, a narrative that has generated a plethora of stories imagining the curses that opening the box would unleash.[18] As the object in Greek mythology, the test does not represent an object that just uncovers the "curse" of the BRCA mutation. Rather, the test produces narratives of potential futures. The genetic test does not merely represent a testimony of

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[16] The temporality produced by genetic testing has been labeled "Genetic Time" (Nye) or "genomic time" (Conrad). In this genetic time people diagnosed with a genetic pre-disposition are regarded and represented as if pre-symptomatically ill, entering into an "anticipatory mode of patienthood" (Nye) determined by following the script of previving. The practices of previving thus effectively make the "high risk individual" a cancer patient without having cancer.

[17] She further indicates the ambiguity of the knowledge provided by the test in the title of her testimony. "Cancer and the Maiden" refers to "Death and the Maiden" by Roman Polanski, a cinematic rendering of having to make a decision without knowing for sure, or ever being able to know for sure if one's decision is the right one. Both titles are derived from the Medieval Dance of the Dead.

[18] Derived from Hesiod's "Works and Days" which originally described the act as a revenge. Interestingly, hope is supposed to be the last "item" left in the box. Throughout the centuries the arts have continuously used, rendered and adapted the myth.

a genetic mutation recognized in the body. It functions as a plot instigator producing future scenarios. These future scenarios, as in biosecurity exercises, are fictional narratives of security and threat. On the one hand, the test result opens the slim chance of remaining cancer free, on the other hand it gives shape to the more likely narrative of early and aggressive cancer affliction. The biomedically facilitated narratives do not describe the ambiguous position of the previvor as a third space between security and threat, however, but provide different narratives of competing futures. These narratives render the body as a speculative future which is formed on the basis of statistical risk assessment, a deeply collective security narrative. But it is not simply the biomedically produced narratives of the two competing futures that define the reality of the previvor.

The testimonies are necessary narrative acts to transform this abstract and collective narrative of biosecurity into individual narratives. The statistical probability of the projected futures defines the experience of the previvor and represents the changed perspective on individual security. The narratives represent "statistical panic" and lives "haunted, if not stalked by statistics of disease" (Woodward, "Statistical" 13). The testimonies foreground the different risk potentials and probabilities for different cancers and reiterate them almost like a mantra. "[S]tatistics show that having the mutation means it's almost certain that I will develop breast cancer at some point in my life" (Queller, "Cancer n.p.). Queller turns the statistical narrative into a description of her individual future. By representing the body as a speculative future the statistical narrative of biosecurity is, thus, individualized.

Scholars such as Coleman Nye assert in this context that the diagnostic practice represents "the enacting of immaterial disease" (108) which "charges these women's symptomless bodies with a pathology that is not diagnostically there in a strict clinical sense" (107). But the test result does not simply charge the body with a disease nor does it produce a definite security narrative defining the body as sick. First and foremost, the biosecurity practice and its diagnostic prediction turn "bodies into places of narratable disease" in the absence of the disease (Belling, "Narrating" 233). Rather than merely providing the narrative that charges the individual body, the diagnosis "invites" the individual to think through the future scenarios emphasizing the high likelihood of a future cancer affliction. The test as a "divinatory technology" (M. Locke 17) thus asks the individual to rethink and retell their life story within a different teleological structure: that of the "not yet" sick. The change indicated by the testimonies is thus primarily a cognitive, or rather narrative one.

Since becoming a previvor is initially first and foremost an experiential shift that is prompted by a change in understanding, the testimony of the test relies on the individual as audience or witness who acknowledges the implications of the security performance of the test. The retrospective narratives of this conversion often represent this transition as an instant event triggered by the performance of the diagnostic result, such as Angelina Jolie's quoted above. Queller, however, emphasizes that this becoming a previvor is a process. She dwells on this "moment" which keeps repeating until the biomedical term is appropriated and made her own. She describes how she receives the letter with her positive test results for the BRCA mutation, then hides it, coming back to it: "I read the report once, tucked it back into the envelope, put it in a drawer. / Then I blocked it out for three months" (Queller, *Pretty* 85). The next chapter starts with the description of her new biosecurity identity: "[w]hen I next opened the drawer, it was almost Christmas" (Queller, *Pretty* 86). "By December, a nagging internal voice pushed through my carefree veneer and urged me to set up an appointment at a reputable clinic for preventing women's cancer" (Queller, *Pretty* 87). Queller's coming to terms with the newly gained information shows that the identity of the previvor is not solely defined by biotechnologically facilitated reading of the body. Rather, it represents an acknowledging and reacting. The self identification thus echoes on a personal level what Burgess describes for security in general where the notion of security and what is understood as a threat is constructed by "permitting it to be shifted from the order of the ordinary politics to one kind or another of exceptional politics" (Burgess 2). Assuming and appropriating medical ascription in the case of the previvor represent therefore necessary speech acts. Rather than merely the test result, the identification of the self with the biomedical ascription represents the plot instigator of the new security narrative which negotiates the meaning of potential cancer affliction and "premature" mortality.

Becoming a risk individual and previvor thus relies on individual acts of giving testimony and rearranging the individual life narratives. In her memoir Queller reflects on the writing process of her earlier *New York Times* testimony, describing it as her personal turning point.[19] She represents her process of becoming a previvor as an act of reading and writing. Her research for the Op-ed piece for the *New York Times* – her first previvor testimony – describes the process of coming to know her own positionality as a biosecurity individual and understanding the meaning of her new identity. "For two months I came home directly after work . . . sat at my desk, and scoured the internet for articles on the BRCA mutation" (Queller, *Pretty* 100). Renegotiating her identity is not based on a different way the body is, or can be experienced but primarily on a process of learning abstract and largely scientific knowledge. Queller chronicles her way of learning starting with Wikipedia and "ninth-grade biology" on genes (Queller, *Pretty* 100) tracing her path of becoming a bioliterate biosecurity individual. She represents herself as an informed and self-reliant subject who forms her own opinions by actively seeking out knowledge and information.

This information, however, comes not only from biomedical institutions such as the genetic counseling in the Cancer Center but is marked by "new forms of knowledge production . . . distribution and consumption" (Clarke et al. "Biomedicalization" 163), which are described by scholars as a decentering of the biomedical authority over security narratives. Most important to Queller's process is the reading of the FORCE website "obsessively for months" (Queller, *Pretty* 170). She asserts that "[t]he FORCE website opened a whole new world to me" (Queller, *Pretty* 105) because it is providing a well curated database for the newest medical research on hereditary breast and ovarian cancer and also because it provides hundreds of the testimonies by other previvors. The process of reading and becoming a bioliterate subject chronicles the progression from abstract knowledge to individual identification, which the testimonies on FORCE also exemplify. Rewriting her life interwoven with the biomedical knowledge she acquires represents the narrative act which allows her to find and express her identity as previvor.

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[19] While Queller represents this process of conversion as following the knowledge of the genetic test, more often this experience precedes the test and is accompanied by genetic counseling.

The practices of reading *and* writing are thus crucial constituents in the process of becoming a previvor. In fact, the act of giving testimony represents a necessary speech act and a performative and narrative turn that does not only describe but facilitates and produces the "new" biosecurity identity.

The act of rewriting one's life with the new perspective of biosecurity appropriates traditional markers of difference, redefining them as crucial elements of the security narrative. Additionally to the biomedical ascription, family history, ethnic belonging, age, maternal status, and relationship status play a crucial role in the experiences of hereditary breast and ovarian cancer risk. And all of these characteristics are described as additional risk markers that sharply distinguish the meaning of biosecurity identities. The genetic test emphasizes the disparate likelihood of different ethnic groups to test positive for a particular genetic predisposition. Ashkenazi Jews and people of Caucasian and Eastern European descent are much more likely to test positive for the recognized risk markers.[20] Similarly, age and maternal status are defined as further risk factors that contribute to an increased risk of breast and ovarian cancer.[21] Most importantly though, the family history is used as a main indicator to predict the individual risk. To fully understand the risk, the individual is literally required to reestablish their family history in terms of a disease genealogy. On Bright Pink for instance, previvors are actively urged to "collect your family history" and guided in the pursuit as a practice of managing risk ("Personal Stories"). The previvor testimony is therefore further a necessary act to define the meaning of the diagnosed genetic risk and the individual disease potential. The testimonies are thus not just descriptive of a biomedical experience but necessary narrative acts that significantly determine the new identity of the previvor and their experience.

The testimonies represent curative practices of life writing as self-healing but are at the same time necessary narrative acts that produce material effects. Rather than just describing a coming to terms with the new risk identity, the testimonies require the individual to make choices. Jessica Queller describes this experience as "[a]lthough I am currently cancer-free, the knowledge of my genetic predisposition requires me to squarely face excruciating life choices" ("Cancer"). In the case of an increased hereditary cancer risk medicine does not establish a defined framework with clear suggestions of which treatment to choose. In medical discourse and genetic counselling an enhanced screening-program or the pre-emptive surgical intervention are represented as different choices of security. "[D]octors don't really know what to tell women with BRCA mutations except to be vigilant about increased surveillance. . . . The surest way to prevent breast cancer and ovarian cancer is to have your breast and ovaries removed. Recent studies show that undergoing these radical surgeries will reduce the risk of inherited breast and ovarian cancers by 90 percent" (Queller, "Cancer" n.p.). Medical literature, however, does

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[20] African Americans are less likely to test positive for mutations of BRCA 1 or 2. This assertion does not imply that African Americans are not prone to a different genetic mutation, and therefore more secure. Though less likely to be afflicted with a known genetic mutation and represented by lower numbers in cancer afflictions in comparison to Caucasian Americans, African Americans have a higher mortality rate than the average breast cancer patient (Frisby 489).

[21] Early childbirth and full breastfeeding are crucial in reducing risk according to Breastcancer.org and represent therefore biosecurity performances.

not indicate a difference in mortality between increased surveillance and pre-emptive double mastectomy and oophorectomy, which means "the test is unaccompanied by any clear recommendations" (Queller, "Cancer" n.p.). Previvors therefore not only rewrite the self but need to establish individual security narratives that legitimize their choices. The testimonies do not represent a coming to terms with a diagnosis but a necessary act of determining the implications of the diagnosis by establishing a convincing security narrative. The construction of the personal security narrative is therefore necessary for the individual to represent the surgical removal of healthy body parts which seemed "crazy" and "outrageous" to Queller initially, as an act of taking "informed decisions" from a biomedically self-empowered subject position.

The testimony of the previvor is thus not just a representational act but a necessary narrative construction of a security narrative that produces the threat of the disease as an experienceable reality as well as the necessity to intervene in the body to foreclose the potential cancer affliction. To represent the previvor as an empowered biosecurity individual the testimonies rely on the two narrative elements of breast cancer doom and hope in biomedical salvation. The messianic promise of medical salvation as well as the threat and doom associated with a breast cancer affliction form dystopian and utopian narrative elements, as Völz puts it, that compete with each other. Both narrative strands are crucial to legitimize the biosecurity practices.

The Affective Fact: The Doom of the Breast Cancer Apocalypse as a Question of Time

Breast cancer strikes down on individuals, creeping up on "normal" life, interrupting it. The danger and threat is immanent and its effects physically and materially present. It is often described as an apocalyptic event that will remain a life-long presence for the afflicted individual: "not 'Apocalypse Now' but 'Apocalypse From Now On'" as Sontag phrases it in a different context (176). The previvor does not share the experience of such an apocalyptic strike but needs to establish the meaning of the threat posed by a possible cancer affliction narratively. They thereby create a radically different temporal relation to security. While the apocalypse of a cancer diagnosis has never really materialized for the previvors analyzed here, it is made present by collapsing past and future into the present narratively and performatively. The narratives convert the uncertain and temporally distant breast cancer prophecy into an apocalyptic event that is merely a question of time affectively producing the urgency to confront the absent disease in the present. They do so by turning to the past.

"My mother fought cancer for almost a decade and died at 56" (Jolie, "Medical" n.p.). "My Medical Choice," Jolie's first public statement, opens with the description of her mother's experience of cancer, and her second testimony "Diary of a Surgery," further includes her maternal grandmother's and aunt's cancer affliction. Though the intimate experience of breast and ovarian cancer is mostly physically absent from a previvor's life, the suffering and dying from these conditions hold a central place in the narratives. Much more than survivor narratives, previvors acknowledge the death and the corporeal suffering due to cancer (DeShazer and Helle 9). As Jolie's, Queller's testimonies both emphasize her mother's struggle with breast cancer and dying from ovarian cancer. In fact, in her memoir Queller dedicates ten chapters to her mother's breast cancer narrative. As a form of disease genealogy the early deaths of family members frame many previvor narratives. Mary K. DeShazer therefore asserts in this context that previvor narratives have a particular memorializing element that pays tribute to these relatives who have died from cancer (1). But as much as these family histories of cancer are memorializing their struggle and death, they also serve a crucial role within the security narratives provided by previvor testimonies.

Most obviously the accounts help to define personal risk, as shown previously. The disease genealogies are a mandatory part of rewriting one's life narrative when becoming a previvor. In shorter testimonies in online forums these narrative elements represent quick death counts such as the reports on the Voices of FORCE page, a database of previvor testimony: "BRCA 1 positive Father was a carrier of the gene. Lost 3 paternal Aunts to Breast, Uterine and Ovarian cancer" (Lisa J). Here the list of deceased clearly functions as a form of tagline defining the narrative, reflecting on the self and the inherited risk rather than being represented in their own right. The genealogy of family cancer gives the uncertain future of cancer affliction a material history. "My mother passed away from breast cancer 20+ years ago, at the age of 53. Her only sister (my aunt) also passed away at the same age from breast cancer, a few years before my mother. . . It was not until my cousin was diagnosed at the age of 48 that we got in touch with the genetics department" (Calgary 002). Rather than just functioning as a memorializing narrative reflecting on the past, these accounts serve as a narrative of fate that projects the future. It represents a legitimization for the biosecurity choices of the individual in which fear is the main motivation to "be proactive" (Jolie, "Medical" n.p.).

The testimonies of past family cancer afflictions make clear that for the previvor the crisis of breast cancer risk comes rarely unannounced. Rather, in most testimonies breast cancer is represented as a long determined prophecy that is looming ahead. "My mom died when I was almost 15. She battled cancer for about 6 years. Ever since, I've known in my heart I was at high risk of developing bc" (Ana). Many previvors such as Ana on FORCE articulate that they knew about their high risk. The threat of a breast cancer apocalypse has thus been part of the previvor's life all along and is not initiated only by the security practice of testing. Breast cancer apocalypse for the previvor is "a long-running serial" (Sontag 176), which is not an individual but a "transgenerational" cancer experience (DeShazer and Helle 9). The beginning of cancer is in these narratives thus not located in the body of the individual but in the bodies of their mothers, fathers, uncles or aunts, and grandparents.

The struggles of family members turn into the first narratable beginning of the disease though absent in the narrator's body. The family history – the perspective on the past – establishes the risk making it narratively present. The representation of this past turns the narrative of inherited genetic risk into a narrative of cancer, and therefore a narrative of illness. It depicts the genetic mutation not as an abstract numerical reality but as a "tangible" material experience. The testimonies, thus, render the inherited risk as an apocalyptic genetic legacy in which cancer affliction, not risk is understood as inherited fate. Queller's and Jolie's renderings of their mother's cancer afflictions represent the looming threat and foreboding of the apocalypse to strike. Rather than simply honoring the memory of their mother's, their testimonies represent the prophecy of cancer doom fixed as a genetic legacy. They thus do not merely reflect on the past but on the individuals prophesied future, conflating the two temporalities.

Nye foregrounds in this context the transition from an eventuality (*if* the disease will strike) to a certainty (*when* the disease will strike). The testimonies show how central the narrative act of rewriting one's life is for this temporal fusion. The probability of such a coming apocalyptic event is narratively turned into a question of temporality. While in the beginning Queller as well as Jolie emphasize the likelihood of their future cancer affliction, the following narrative portrays it as "almost certain" (Queller, "Cancer" n.p.) by representing a possible future as a narration of the past. Representing the "speculative future" framed by familial cancer past creates the sensation "that in all likelihood, cancer is coming for me" (Queller, "Cancer" n.p.). Future uncertainty is narratively domesticated and converted into an event that is merely a question of time. The narratives not only depict the future fate as a way "to look forward as though looking back" (Wald, "Future Perfect" 699) but by literally turning back. The past thus stands in for a possible future producing the threat of cancer as a concrete experience. In the security narratives provided by previvor testimony, future and past become a haunting present performatively establishing the potential future as an experienceable present threat.

But the previvor narratives do not simply describe a certain future of cancer affliction as the reason for pre-emptive and invasive treatment. An early cancer diagnosis could be confronted in time when detected since in "sixty-two percent of cases" the 5-year survival rate is 99 percent (American Cancer Society 10). Rather, the emphasis of past suffering emphasizes and defines cancer as a deadly foe that has been witnessed first hand, contrary to this statistical evidence. The portrayal of genetically increased risk is not only a biomedically facilitated narrative but is informed by the memories of what a cancer diagnosis might imply. In these narratives the threat of cancer is represented as a death sentence, confronting and reversing a century of contrary narrative efforts. The narrative elements of past suffering, thus, represents a chorus of doom that decisively contrasts the biosecurity narrative of survivability cultivated in breast cancer culture. "My mother had fought off breast cancer and she waged a ferocious battle against a second cancer, ovarian, when it ambushed her body seven years later. The cancer won" (Queller, "Cancer" n.p.). The previvor narratives dismantle the "fiction of security" embodied by the celebration of the figure of the survivor. Though Queller's mother had lived as a breast cancer survivor for seven years, her ovarian cancer left her with less than two years to live after the diagnosis (*Pretty* 20). The narratives stress that cancer cannot be understood as one specific cancer that can be fought and beaten but as a cluster of cancers that have to be understood in their relation both synchronically and diachronically. The testimonies pay tribute to the fact that in many cases the potential that a cancer reoccurrence signified for survivors has to be retrospectively judged as a fatal fact in most cases.[22] Affliction with cancer and the struggle with it are here therefore not characterized with pink

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[22] Today, the iconic breast cancer narratives are all published with postmortem prefaces, for many of the authors such as Kushner, Sontag, and Lorde, have died since the first publication, the majority of cancer.

teddy bears and uplifting quotes. Rather, it epitomizes Ehrenreich's controversial assertion in "Welcome to Cancerland" that being affected with cancer "IS NOT OKAY" (53). The thanatographic narrative elements serve as examples of what happens if cancer is not detected early enough and not confronted quickly and aggressively. They exemplify that reacting once cancer can be diagnosed is possibly too late and suggest that surviving is not enough anymore.

Opening with a thanatography, however short, makes the testimony of the previvor not (only) a witness account of the body of the previvor but a witness account of the cancer-ridden body of an other. The knowledge and understanding of the threat of cancer are defined as the watching and witnessing of a cancer apocalypse. The previvor do not render the suffering of the body in terms of a "restitution narrative" (Frank),[23] but as a long and painful process of dying. Over ten chapters Queller narrates the rather rapid demise of her mother once the ovarian cancer was diagnosed, as well as the fears and hopes that dominated the process. She describes her mother's fear of death which kept her literally moving, afraid of the bed as symbolic space of dying. Queller chronicles the progressive debilitation of her mother's body, describing how the cancer and related infections were dissolving it from the inside (Queller, *Pretty* 65). The mother is at that point on morphine and not aware of her own decomposing body. The scene appears rather as a gruesome spectacle for Queller and her sister, who are attending their mother's bedside around the clock.

The mother's body in dying is central to Queller's description and understanding of cancer. "As August wore on, her physical appearance grew startling. Each week she seemed to age a decade. It was impossible to reconcile my young, beautiful mother with the sick old woman she had become" (Queller, *Pretty* 71). The process of dying is narrated from the perspective of a spectator deciphering the bodily performance of dying. Watching the body slipping from a "paragon of health" ("Cancer" n.p.) to a body aged and debilitated beyond its age describes the body as a readable sign represented solely in the voice of the spectator. "Every breath she took was like drowning. The thick, heavy, gurgling sound of her gasping breath will forever haunt me. My mother's eyes were filled with terror, her mouth frozen in a permanent o" (Queller, *Pretty* 78). The description of the corporeality of her mother's deathbed leaves the most lasting imprint in Queller's memoir. And the suffering condensed in this dying scene indeed "haunts" Queller as well as her previvor testimony. The descriptions of dying as a witnessing and reading of the pain of an other remain caught in the unrepresentability and impossibility to understand it as scholars such as Sontag and Elaine Scarry have both pointed out. The Levinasean "face" of the other that will remain "refractory to all light" (Levinas, *Time* 75) does not decenter the individual, as he suggests, but is represented as a contemplation on the self.[24] In this

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[23] In 1995 Arthur Frank asserted in *The Wounded Storyteller* that most illness narratives follow the formulaic structure of a "restitution narrative" (77) of "[y]esterday I was healthy, today I am sick, tomorrow I will be healthy again" (ibid.).

[24] Levinas asserts that the other's mortality takes ethical priority over the mortality of the self as the self recognizes the other as other in the moment of dying: "In that relation with the face, in a direct relation with the death of the other, you probably discover that the death of the other has priority over yours, and over your life" (Levinas, *Alterity* 164).

description the body of the dying mother is not just refractory but reflecting. It serves as a mirror into the individual potential future of the spectator-narrator. It is therefore not the cancer affliction but the cancer death which is depicted as inherited fate.

What is represented as at stake in these narratives is thus not a possible cancer affliction but a "bad death." "[H]aving watched my mother die a brutal, horrific death – to me, cancer is the worst thing in the world, I don't want to gamble with it. I don't want to gamble that maybe we'll catch it early enough. After going through a long, long process I came to the decision that I would do anything I needed to do to prevent it in the first place" (Queller, *Pretty* 165). The thanatographies forming the family history give shape to exactly this "worst thing in the world." These narratives give fear a tangible object. The mother's fate epitomizes that the possible future can only be foreclosed if eradicated before it materializes.

The narrative of death and dying represents the apocalyptic narrative strand that produces the urgency to confront and manage the future. The urge to act in the present to avert this apocalyptic future thus describes an "affective fact" (Massumi, "Future Birth") rather than a rational decision based on scientific facts. The narratives reproduce cancer death as inherited fate and as the event that has to be foreclosed by the biosecurity practices, which is a significant difference to a potential future cancer affliction indicated by the diagnosis of the genetic mutation.[25] The reasoning for pre-emptive surgery is based on the fear of the coming apocalyptic event made tangible and present by the narrative of the past. This fear replaces the fact that the disease is not there, and is not certainly coming.

The apocalyptic narrative element provided by the previvor testimonies depicts a hopeless situation at the same time as it offers hope. Though the previvor narratives exemplify stories of apocalyptic breast cancer doom, they also describe a katechontic turn and the possibility of self-empowerment and control. The narratives express the hope for a new beginning if the status quo is changed and challenged by radical intervention now. Framed by the impending apocalypse, pre-emptive logics and the practices of previving are illustrated as the only possibility to avert the coming apocalypse.

Hope and Fear: The Choice for Security and the Script of Previval

The genealogy marked by suffering and early death represents fate, which the security narrative of the previvor and the act of previving contrast and compete against. The perspective on the mother's cancer affliction is represented as an inability to do anything, or as Queller's psychologist phrased it: "Your mother is going to die from cancer, Jessica. There is nothing you can do but bear witness" (*Pretty* 49). In contrast, Queller as well as Jolie and many others, decide not to bear witness to their own bodies but intervene in them. "I now have something my mother did not: the warning that in all likelihood, cancer will be coming for me" (Queller, "Cancer" n.p.). Queller emphasizes as their distinguishing element the missing knowledge of the cancer affliction which she foregrounds

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[25] Nye asserts that to make this leap, or to bridge that gap between absence and presence of the disease it requires "affective labor" (Nye 114).

as fatal rather than the cancer itself. The feminist trope of "not becoming one's mother" with which Queller describes her mother-daughter relation pre-cancer becomes a life-sustaining narrative and performative act for Queller which pervades her entire previvor testimony. She asserts that "I see my life as a negative image of my mother's" (Queller n.p.).

While the narrative of cancer apocalypse is dominated by the testimony of the body of the other in dying, the previvor testimonies explain radical biomedical interventions within a narrative framework of messianic salvation. Previvors articulate a narrative of hope and give shape to the promise of future security, controllable and manageable with biomedical interventions. Instead of a "writing back" at the biomedical security apparatus, the previvor testimonies represent the radical biomedical interventions as empowerment. Framed by the breast cancer apocalypse described in the last section, the "burdensome knowledge" of the test is converted into the perspective of empowerment – "knowledge is power" (Jolie, "Diary" n.p.). The test thus becomes a salvational practice – a choice for security.

Queller's life narratives represent the test as a desirable and responsible decision, albeit a painful one. She highlights the different approaches she and her sister took – the latter decided against the test at the time of the narrative. Queller clearly hierarchizes the different decisions framing them in a teleological structure: "knowing that cancer is often a genetic legacy, I sought out knowledge that would allow me to make informed choices. Knowing that there is a 50 percent chance she did not inherit the gene, my sister is not yet willing to give up the luxury . . . to live her life freely, unaffected by the shadow of illness" ("Cancer" n.p.). Becoming a previvor is represented as a loss of innocence, a choice and decision to give up freedom in exchange for security. According to Queller's representation the sister is "not yet" ready to assume her position as a biosecurity individual. A position, she argues, that her sibling should and in time will (have to) assume. Because the biotechnologically facilitated testimony of the body is represented as necessary knowledge of one's fate and the possibility of being able to "defy destiny" as Queller puts it in the title of her book, and to manage one's own bodily security.

Queller describes the choice for genetic testing as an ethical necessity that seems unquestionable against the horizon of breast cancer death: "I can say without question that my mother would have traded those 51 years of innocence for the dark knowledge that could have potentially saved her life. My mother would have done anything to live" (Queller, "Cancer" n.p.). Diagnostic testing symbolizes the first act in the battle against cancer. And her choice of testing epitomizes here the choice for life, while choosing "not to know" means passively awaiting the fate of a breast cancer affliction. The test, thus, represents an "object of desire" which promises to provide the possibility of controlling the fate of cancer death with the knowledge necessary to take informed decisions. It describes the choice of an empowered individual who will face her trial and tribulations willingly and prepared. Previvor narratives thus represent paradigmatic examples of individualized biosecurity practices that emphasize the responsibilization of the individual for the possibility of the biomedical salvation.

Not surprisingly then, the positive choice for testing as an empowering act is highlighted in most previvor narratives. In fact, in many forum testimonies on Breastcancer.org the choice for testing is the main objective of the narrative. Especially in

Jolie's testimony the choice for the test exemplifies a foregone conclusion on the road to security. Her description reads almost like a line from an advertisement: "Cancer is still a word that strikes fear into people's heart, producing a deep sense of powerlessness. But today it is possible to find out through a blood test whether you are highly susceptible to breast and ovarian cancer, and then take action" (Jolie, "Medical" n.p.).[26] The test provides a form of relief that promises the possibility to control and change fate. Jolie asserts in her first testimony that "[l]ife comes with many challenges. The ones that should not scare us are the ones we can take control of" (Jolie, "Medical" n.p.). And also in her sequel she writes that, "it is possible to take control and tackle head-on any health issue." (Jolie, "Diary" n.p.).

Becoming a previvor is, thus, not just a shift of understanding and a narrative act, as described before, but a shift of doing and following a pre-established script of previval. The genetic test is only the first step in the ensuing security regimen. The security narratives thus demand "to make choices that are right for you" (Jolie, "Diary" n.p.). More central than the ambiguous experiential situation of "radical uncertainty" (DeShazer and Helle 15) is the negotiation of choices implied in the act of genetic testing and assuming the identity of a previvor. Rather than the representation of despair in the face of these dawning numerical realities, choices of the different security practices to manage this precarious state of health are highlighted. The security narrative demands the individual to act and to confront the diagnosed risk by following a rigorous regimen of biosecurity practices that facilitate the act of previving. The testimonies are thus not just narrative acts but a deeply performative act which facilitates material effects.

As the test and the knowledge of risk produced by it, any further biomedical practice is thus represented as a form of controlling fate and preventing this apocalyptic threat. In the ascribed role of biosecurity individuals, previvors become "card carrying members" (Queller, *Pretty* 88) literally equipped with a cancer center ID, as Queller explains.

> I entered through the automatic doors and asked an official looking person where the clinic was. "Do you have a cancer center ID card?" she asked. "No – I'm just here for the clinic. . . ." She pointed to a desk to my left. "You need to get an ID card first. They'll tell you what to do next." I got in line behind the bald woman in the scarf. (Queller, *Pretty* 88)

Previvors are cancer free, nonetheless they enter the ranks of cancer patients because they are being treated in the same institutions and undergoing similar treatments. Previvor narratives show that the narrators literally move into the *same space* and *role* of cancer patients initiating the possibility of "fighting and overcoming" the threat of potential future cancer apocalypse. As the competing narrative, the representation of practices of previving offer an alternative narrative strand which emulates the form of a "restitution narrative," which Frank defined.

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[26] In fact, critics have accused Jolie of having produced a promotional piece for the *Pink Lotus Breast Cancer Center* as well as for the test. This critique was deemed as preposterous by many members of the previvor community (FORCE "Angelina").

Entering the "anticipatory mode of patienthood" (Nye 105) is the initiating prerequisite for "restitution", clearly aimed at controlling and changing the genetic fate by following the script of previval. This script is most clearly chronicled in "A Patient's Journey" on the Pink Lotus Breast Cancer site. Dr. Kristi Funk reports on five stages a previvor will undergo when deciding for a pre-emptive mastectomy: "before diagnosis, after diagnosis, deciding for surgery, preparing for surgery, recovery from operation" (n.p.). Each stage represents different biosecurity practices as steps toward achieving future security. Starting with the family history of breast cancer and a BRCA1 or 2 diagnosis, stage one is described as accumulating information and becoming an informed and bioliterate individual.[27] After identifying as a person at risk and becoming a previvor that enables one to take the right choices, stage two describes the performative practices that define the new relation of the individual to her body. Funk calls "Stage 2: After diagnosis: Travelling the Road of Surveillance." As Funk's metaphor of a journey indicates, this "stage" is not a single act but a reiterative practice. This online supplementary material to Jolie's *New York Times* testimony asserts that in the individualized surveillance regimen the biomedically produced testimony of the body becomes a routine performance; one that defines and confines the life of the previvor. As for "normal" female risk individuals – so every menstruating woman – monthly breast self-exams are strongly advised security performances. Represented by a video link to a "how to"-video clip, breast self-exams are defined as necessary acts which allow the individual to read their own bodies for irregularities and risk signs: a lump, dimpling around the nipple, discharge, or pain. Though representing performances of security, these embodied practices also make the threat of cancer affectively present.

Additionally to the regular self-exams, previvors should undergo an increased screening regimen. Since the knowledge of corporeal security is ultimately unattainable for the hboc individual the body is turned into an unreadable cypher for the self, who needs ritualized biomedical readings to attain a sense of security. The surveillance regimen described on the *Pink Lotus* website, as well as on other self-help sites, consists of four annual medical screens (ultrasound, mammogram, and two clinical breast exams) and an additional yearly MRI screen. Each test represents a performance of security, a necessary ritual to know the present and protect the future security. This regimen begins – if the necessary biosecurity knowledge is given – "at the age of 18, or 10 years younger than the youngest relative with breast cancer" (Funk n.p.).[28] These security performances in medical settings, repeated every three months, offer a sense of security, which is temporarily fixed by the diagnostic result. They represent a certainty obtained *in* the present and *for* the present moment. A certainty which is complicated, however, by the temporality of a looming future threat foregrounded by the genetic security narrative.

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[27] Remarkably in the context of genetic testing, counseling is not mentioned in this guide to the hboc galaxy.

[28] Mammograms are suggested only after the age of 25 because of the risks and side effects – both biologically and mentally – associated with increased screening regimens. In contrast to breast cancer surveillance, ovarian surveillance begins after the age of 35, according to Funk.

Despite the hope and promise attached to these biosecurity performances, they are at the same time characterized by fear which is only relieved temporarily after the embodied act. The threat of cancer in its perpetual mode of becoming is reiterated in the practices, made present affectively as a form of fear and relief. The screening appointments are anticipated anxiously and the anxiety is further increased if the readings show any indication of cancer. Especially Jolie's second testimony reveals how overwhelming her fears become after her yearly blood-test results showed inflammatory markers. "I passed those five days in a haze, attending my children's soccer game and working to stay calm" (Jolie, "Diary" n.p.). The threat of a(n early stage) cancer diagnosis clouds all other experiences, gripping the individual with anxiety. When the tests come back negative Jolie is relieved. However, this respite does not lead to a sense of security so much as to a sense of the precariousness of her corporeality. A sense of security cannot be found in the absence of cancer markers but only by the possibility of pre-emptively foreclosing the possibility of cancer with radical surgical intervention. "To my relief, I still had the option of removing my ovaries and fallopian tubes and I chose to do it" (Jolie, "Diary" n.p.). While the security practice of surveillance and prevention is represented by the interplay of hope and anxiety, only the pre-emptive practice seems to promise the desired security.

The step and decision for a surgery which removes a healthy body part does not solely hinge on performatively making present a non-existent, or "virtual cancer" as Diana Price Herndl describes the genetic cancer risk. Rather than establishing the "virtual cancer" as a co-presence of health and disease, the embodied acts reiterate the fear of the apocalyptic past which the biosecurity individual constructs as a proleptic narrative and identifies her fate with. "My mother's ovarian cancer was diagnosed when she was 49. I'm 39" (Jolie, "Diary" n.p.). Nye attempts to describe and analyze this "temporal dissonance" (108) with the comparison to "theatrical time" (108). She stresses the simultaneousness of health and disease that is paramount to the previvor experience. However, the focus on the individual security narratives and the biosecurity performances they are legitimizing rather suggests that the "healthy body" is overwritten temporally by the immanence of the threat that is afforded by the narrative construction of past as a proleptic narrative. Rather than health and disease existing alongside each other as in Nye's "theatrical time," the narratives of cancer apocalypse represent future cancer death which can only be averted by catching it before it materializes. The narratives thereby render the body a site of the pre-emptive strike.

In the temporality of the precarious normality and the perpetual becoming of threat the biomedically facilitated reading of bodily security is depicted as *not safe enough*, as with the breast self-exams. The fear of cancer death, epitomized in the apocalyptic past, showed that the beginning of cancer cannot be recognized in the detection of an MRI, ultrasound, or mammogram necessarily. "Having witnessed the death-grip of cancer, I am not inclined to wait around for it to strike, especially since exact surveillance machines do not always catch it at an early stage" (Queller, "Cancer" n.p.). The narratives emphasize the perceived unreliability of the surveillance regimen since cancer begins developing long before it is diagnosed. With the emphasis on the possibilities of missing the material beginnings or even the warning signs of precancerous cells, the narratives reveal that the surveillance regimen does not prevent the occurrence of cancer, nor does it control it. Previvor narratives therefore emphasize the "therapeutic lag" (Sunder Rajan, *Biocapital*

152) which ultimately betrays the promise of control attached to diagnostics as practices of security. Queller, for instance, questions if "there [was] a point in doing surveillance, waiting for cancer to strike, and then getting a mastectomy anyway?" (*Pretty* 148) when her doctor tells her that in the case of a breast cancer diagnosis mastectomy would be the recommended intervention. Similarly to not knowing, Queller represents surveillance as "waiting for cancer". The mastectomy, however, offers the means of control that diagnostics promise but cannot provide.

Similarly, Jolie's testimonies as well as Funk's complementary explanations to the narrative from a medical perspective represent pre-emptive surgery as the only possible way to effectively confront the risk of hboc. In "A Patient's Journey" for instance, surveillance is clearly described as a preliminary step toward more radical bodily interventions and security. Framed as a journey, the road of surveillance has a clear destiny: pre-emptive surgical intervention. Stage two is thus represented as an interim to "Stage 3. Committing to an operation" (Funk). Funk asserts that "in the course of these discussions, it becomes clear whether the patient will proceed to a mastectomy." She describes the mastectomy as an individual decision, however, to "proceed" expresses the teleological logic underlying these representations. The individual is in that regard progressing through predetermined steps approaching or approximating an imagined security. Such an image is similarly reflected in many previvor testimonies on FORCE. Though all previvor narratives indicate the individual choice that determines what the right decision to achieve security is, surgery is dominating the public presentation of the act of previving.[29]

This final act of security as a katechontic turn can only be represented in anticipation or retrospection. "A nurse led me into the OR and I climbed up onto the operating table. The room was too bright. I felt like I was in a play. The anesthesiologist asked me questions about writing for television while putting the IV in my arm. . .. I asked if they watched the show, but before I heard the answer, I blacked out" (Queller, *Pretty* 202). The act of security remains arrested in the in-betweeness of losing and gaining consciousness, which renders the individual passive in the hands of experts. "The operation can take eight hours. You wake up with drain tubes and expanders in your breasts. It does feel like a scene out of a science-fiction film. But days after surgery you can be back to a normal life" (Jolie, "Medical" n.p.) Both the surgery as well as recovery are represented as neglectably short. The acute phase and experience of physical impairment takes on a subordinate role in comparison to the decisions of exact procedures and their performative outcome. The surgery, as the concrete act of security seems to disappear behind the triumphant return to normality, the new beginning.

Most previvors emphasize the quick recovery as well as the new statistical reality gained by the surgical intervention ("Stage 5. Recovery from the operation"). "My chances of developing breast cancer have dropped from 87 percent to under 5 percent. I can tell my children that they don't need to fear they will lose me to breast cancer" (Jolie, "Medical" n.p.). Despite the fact that Jolie's statement is factually wrong, she expresses the promise and fiction of security attached to the katechontic turn of the pre-emptive strike. The

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[29] "A positive BRCA test does not mean a leap to surgery. . .. The most important thing is to learn about options and choose what is right for you personally" (Jolie, "Diary" n.p.).

pre-emptive logic of the narrative dissolves the ambiguity of security and threat in its future tense, presenting it as if it was stable, by temporarily fixing it. In the pre-emptive logic of the individual security narratives risk is domesticated. The testimonies represent empowerment and victory over the vulnerability and uncertainties contained in the body.

However, the mastectomy narratives are not closed narratives but in most cases part of a series, as I have indicated previously. Read as serials the narratives expose that the project of bodily security is always unfinished. The mastectomy is followed by increased screening for ovarian and uterine cancer, as Jolie describes in her sequel "Diary of a Surgery." These narratives challenge the initial celebration of having overcome one's genetic fate by the surgical biosecurity act. The sequels offer a relativism to the messianic narrative of medical salvation and the promised security: "I chose to keep my uterus because cancer in that location is not part of my family history. It is not possible to remove all risk, and the fact is I remain prone to cancer. I will look for natural ways to strengthen my immune system. . . . I know my children will never have to say, 'Mom died of ovarian cancer'" (Jolie, "Diary" n.p.). Despite this admission of "radical uncertainty" (DeShazer and Helle 15), the pre-emptive surgery is nonetheless represented as a katechontic turn and a necessary security practice the individual has to take. The swift return to "normality" emphasizes not only the performativity of security but its inherent relationality.

Performing Security: Able-Bodied Femininity and the Other

Though the understanding and representation of biosecurity in previvor testimonies is one of medical salvation, the narratives reveal at the same time that the imaginary of security encompasses a lot more than merely the pre-emptive reduction of risk. The decision for surgery represented in the testimonies is not only a consideration and negotiation of biological risk and the promise of biological security in terms of health, but a consideration of corporeality. It is decisively influenced by contemplations of whether one is able to maintain a "healthy" body image. Jessica Queller makes her deliberations explicit: "Aside from drastically interrupting my life, how might a double mastectomy adversely affect issues of sexuality? My romantic future?" (Queller, "Cancer" n.p.) The questions do not primarily revolve around the question of survival but her corporeality and its impact on her life and identity. Instead of just striving for absolute security her worries indicate that corporeal security is much more than just health and the foreclosure of a cancer death. In her anticipation the treatment and its possible repercussions take the representative place of illness, and project a fearful vision of the material effects of biosecurity. The risks of the surgeries themselves as risky procedures with negative side-effects such as wound infection, bleeding, phantom breast pain to name but a few, remain absent and disappear behind the questions of the speculative future life. Queller reflects on the security practice which promises control of future security as a threat to future life within the parameters of heterosexual normativity. The treatment is described as potentially impairing the normative life course based on the ability to perform able-bodied femininity. The security practice is thus not represented as only minimizing risk but as a threat to the ability to perform an intact bodily femininity. What is at stake when considering individual biosecurity is thus represented as the promise of happiness contained in the access to a normative life hinging on bodily performance.

The security narratives therefore emphasize the quick return to a "healthy body politic" (50), as Waples terms the urge for reconstruction, along side the quick recovery and reduction of risk. Jolie foregrounds this performative aspect of security as a central and reassuring aspect of "recovery:" "Nine weeks later, the final surgery is completed with the reconstruction of the breast with an implant. There have been many advances in this procedure in the last few years, and the results can be beautiful" (Jolie, "Medical" n.p.). Equally important as the return and salvation from breast cancer is the cosmetic result.[30] The greatest success of salvation and the return to the community of the healthy seems to be the seamless return to a normative body image which is necessary to merge back into normalcy. The "back to normal" thus implies the outward performance of security as bodily integrity, representing the norm and the normal. Therefore the testimonies stress the performativity of the body as a sign of security, which reveals starkly "ableist and heteronormative constructs of adult womanhood" (Slater et al. 409).[31]

Not surprisingly then, all three mastectomy texts, as well as the majority of the online testimonies on FORCE, or the BrightPink websites represent reconstructive surgery as the normal choice of security. In fact, neither Funk's nor Jolie's text even considers that a woman might not choose reconstructive surgery. Queller mentions one friend who decided against reconstruction. In contrast to the seemingly natural decision for reconstruction, her decision is explained: "She decided she didn't want any surgeries other than what was medically necessary" (*Pretty* 242). Queller further clarifies that this decision was also an act of memorializing a mutual friend who died from cancer (242). And on the FORCE website only one out of seven menu items under the headline "Breast Reconstruction or Going Flat" is dedicated to advice about not undergoing reconstructive surgery (FORCE Website). This information is furthermore situated at the bottom of the scroll down menu. The performance of security in the previvor movement thus seems to reiterate the representational dominance of the pink movement.

The preparations for the surgery therefore represent a balance of risk reduction and cosmetic result (Funk). More so than the question whether to undergo pre-emptive surgery, the exact details of the surgery and their security implications in regard to body image are foregrounded. Both Jolie and Queller meticulously chronicle their medical treatment, which can serve as an exemplary step-by-step guide to maintain heteronormative standards of female able-bodied security despite the necessary intervention. Especially Jolie's mastectomy testimony explains in detail the treatment she chose. Matter-of-factly she describes the surgery. She explains the preparatory procedures for the surgery: first "nipple delay" "which rules out disease in the breast ducts behind

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[30] In fact, many mastectomy narratives such as Queller's and Jolie's expound that the recovery period, in which the breast tissue is expanded by slowly increasing the size of the expanders, offers the possibility of choosing one's perfect breast size and "improving" one's body look.

[31] The concept of able-bodied normativity is not new nor a contemporary societal category. Martha H. Verbrugge wrote in 1988 about the normativity of "able-bodied womanhood" in the context of 19th century Boston.

the nipple and draws extra blood flow to the area. This causes some pain and a lot of bruising, but it increases the chance of saving the nipple" (Jolie, "Medical" n.p.). Her elaborations make clear that the beautiful result she praised before not only consists in surgically reconstructed breasts but in a breast with all of its "natural" features. Jolie does not elaborate on the increased risk the procedure of "saving the nipple" carries according to the logics of preempting breast cancer. The more breast tissue remains, the accomplished risk reduction is lower. This correlation between biological insecurity and reconstruction is omitted in Jolie's narrative accounts.

In contrast, Queller's memoir reflects on this connection emphasizing it as a decisive part of her process of finding the right treatment. Taking the proper choices in confronting her risk becomes the "shopping for a doctor and treatment" that Clarke et al. have described. It outlines a process of choosing a version of security. One doctor tells her that with his method "'your risk will be reduced by eighty or eighty-five percent instead of ninety. But your new breasts will look fantastic'" (*Pretty* 155). As this quote demonstrates the choice for security is not one for or against reconstruction but for a particular form of surgery based on the desired post-surgery result. In the end Queller decides to leave L.A. where she lived to return to New York and have surgery there as she feels the doctors are more serious about her risk reduction than perfecting her body image. Nonetheless, in Queller's narrative all these considerations are also clearly connected to corporeal security understood as the ability to perform able-bodied femininity as a cornerstone of her future security and ability to achieve happiness.[32]

As with the pink movement, the previvor representations thus stress an "individualizing and heteronormative logic" (S. King, "Pink Ribbons" 477), which also pervades official representations of breast cancer previvors and survivors produced by the American Cancer Society, for instance.[33] This insistence on a healthy and normal way of recovery highlights the relationality and performativity of security. The emphasis on the appearance of the intact body surface emphasizes the importance of staging bodily security and the gaze of the other, who become a witness to the performance. Though the male gaze and the insertion in a sexual economy are clearly central elements in the performance of security, the testimonies also highlight a further form of relationality determining the women's lives and identities, which is motherhood.

Also in this context, security becomes a bodily performance for others: "It is reassuring that they see nothing that makes them uncomfortable. They can see my small scars and that's it. Everything else is just Mommy, the same as she always was. And they know that I love them and will do anything to be with them as long as I can" (Jolie, "Medical" n.p.). The performance of able-bodied security is narrated as a reading of the body by

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[32] The urge and representational dominance of breast reconstruction after mastectomy is criticized and opposed by initiatives such as the National LGBT Cancer Network who argue against the unnecessary practice which especially for sexual minority women seems threatening rather than providing relief.

[33] The program Reach for Recovery in particular has been the focus of a considerable amount of critique as S. King points out ("Pink Ribbons" 477). Nonetheless, newer official representations are also incredibly heteronormative as Carter shows with a more recent video produced by the American Cancer Society called *A Significant Journey: Breast Cancer Survivors and the Men Who Love Them (664)*.

others. In this description, security is never just for the self but inherently connected to the other and performed for an other. While in Queller's texts and many other narratives the heterosexual gaze and its desirability is foregrounded, Jolie emphasizes the gaze of her children. Their scrutiny similarly arrests her in an objectified role defining her as mother instead of a sexual object. More importantly though, her description shows that her surgery not only provides material security protecting Jolie's life. Rather, it has to be understood as offering protection for her children, who will be spared the sight of the non-normative "injured" body. While initially the risk of breast cancer affliction has to be produced performatively to become tangible, it is then reduced to small traces that should not be visible to others. The mastectomy and surgical reconstruction, thus, represent the possibility of making invisible again the suffering that the diagnosis and treatment have caused.

But the ability to perform able-bodied femininity extends from the body surface and cosmetic surgery to the ability to procreate, as expressed by Jolie's emphasis on her role and responsibility as a mother. Equally important as the injury to the body inflicted by the mastectomy is the more invisible injury inflicted on reproductive organs by the pre-emptive oophorectomy. For women who have achieved the normative milestone of motherhood in normative heterosexual female life course the decision for this procedure is depicted as rather straightforward. Jolie asserts that "in my case, the Eastern and Western doctors I met agreed that surgery to remove my tubes and ovaries was the best option" (Jolie, "Diary" n.p.). For her surgery symbolizes empowerment and femininity despite the pre-emptive onset of menopause which this intervention causes. "I feel feminine, and grounded in the choices I am making for myself and my family" (Jolie, "Diary" n.p.). By connecting her choice to the well-being of her children and her role as a mother the pre-emptive intervention becomes a selfless act of a mother. The individualist drive to survive and fear of death is veiled by the emphasis of performing (acts of) security for her children.

For women lacking this normative milestone, however, the considerations seem more troublesome. Queller clearly relates her decision for, or rather against the security practice with her vision of a successful and happy life which is connected to her being able to achieve the role of motherhood. In her first testimony she asserts that "I am single, dating, and want to have a family. I won't consider having my ovaries removed until after I've had children" (Queller, "Cancer" n.p.). Stronger than the urge for security, which is foregrounded in the mastectomy narratives, seems the imperative of procreation and thus the ability to perform able-bodied femininity in form of bearing children. The narratives thus express the "privilege of futurity" (Nye 112) in terms of being able to take advantage of pre-emptive measures as well as a form of fulfilling one's vision of a perfect and happy life: the modern American Dream not only includes both the self-reliant individual economically able to purchase a house as well as bearing the nuclear family that "belongs to it." The first testimony and her initial interviews stress the search for a husband and father while running against her own biological clock. Her later interview in 2008 more clearly indicates the option of biomedically procuring pregnancy by IVF and sperm donation, which she also discusses in her memoir of that year (CBS 5:06; *Pretty* 240).

The emphasis on motherhood and reproduction further emphasizes another level of relationality, which is specific to genetic security. Though the pre-emptive security practices seem to have stopped genetically inherited breast and ovarian cancer risk passing down from generation to generation, the threat of cancer does not end with the individual. For the ability to perform able-bodied female security this implies the necessity and need for further biosecurity practices, such as prenatal testing and Preimplantation Genetic Diagnosis (Queller, *Pretty* 240). But also if the knowledge of one's high risk identity comes too late to biomedically protect one's offspring, the responsibility for the self is also represented as an act of making security for the other as one testimony among many on FORCE expresses: "The hardest part of my journey was dealing with the fact that I may have passed this mutation down to my 2 little girls. I struggle with this every day. . .. However, I know that knowledge is power, and they will have the knowledge to make choices in their own journey if necessary" (Lisa J.). Though representing highly individual practices and individual security narratives the previvor testimonies show that the individual and the collective are inherently connected in the context of hereditary breast and ovarian cancer risk.

Making Security – Making Community [34]

Besides representing a necessary narrative act that establishes the apocalyptic doom and the salvational hope which legitimize the individual security choices, these previvor testimonies hold another, more collective function. While choice and the empowered self-reliant biosecurity individual represent the center of previvor narratives, the testimonies are at the same time never just individual security narratives but collective ones. Though biosecurity practices of surveillance and pre-emptive surgical intervention are crucial individual performances of security, and individualized biosecurity practices, they are at the same time performances that produce community and a sense of collectivity.[35] The testimonies therefore do not just emphasize new ways of understanding the individual but represent a relationality between self and other, which lends the narratives their biopolitical force and establishes them as acts of making security.

As previously demonstrated, the narrative construction of security rethinks familial bonds and their meaning by establishing a disease heritage marked by (mainly) matrilineal breast cancer doom as fate. In this context the choice for the test is a deeply ethical one that implies individual security as well as genealogical security and the responsibility for an other. The responsibility of engaging in biosecurity practices is reinforced by the implications for generations to come. Similarly, the act of giving testimony represents a choice and responsibility that are deeply ethical and relational. The sharing of one's biosecurity identity is rendered as an ethical choice which is represented as a crucial security

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[34] This subtitle is a rephrased quote from Maxine Hong Kingston *Tripmaster Monkey*, "We make theatre, we make community."

[35] Similarly, as in captivity narratives, the individual fate is not just establishing the conversion experience and deliverance of the individual but reflects on the fate of the entire community.

practice. The performative shift of identity staged and performed in the narratives implicates the self as much as one's biological family, establishing close connections between relatives that would not necessarily be part of the immediate family. The previvor narratives can therefore never be just about an individual but always implicate the other. As a responsible subject one should inform siblings and parents about their potential risk, but also uncles and aunts, cousins, nieces and nephews. The act of giving testimony of one's own risk identity is, thus, a crucial act of making future security possible for others. Within the family, the act of giving testimony and identifying oneself as at risk is therefore understood as handing down of the information that will convert its audience to become self-reliant biosecurity subjects empowered to take the right choices. The responsibility of giving testimony is thus similarly entrenched as an ethical imperative and the process of responsibilization that is also produced by the test. The act of giving testimony and making one's identity as a previvor public is, thus, a choice which is tied up in the responsibility for others.

Furthermore, the testimonies as acts of making security create a collectivity and a broader community. Originating in the writing of breast cancer activism, previvor narratives have a strong and explicit ethical aim and claim. Jolie's texts for instance reiterate in different forms that, "I hope that other women can benefit from my experience" (Jolie, "Medical" n.p.). As most narratives, Jolie legitimizes her testimony with an explicit didactic and activist gesture. Representing herself and her experience as an example for others she repeats this message as a direct address to the implied reader: "For any woman reading this, I hope it helps you to know you have options. I want to encourage every woman, especially if you have a family history of breast or ovarian cancer, to seek out the information and medical experts who can help you through this aspect of your life, and to make your own informed choices" (Jolie, "Medical" n.p.). The change from the first person narrative to a direct address places the reader in the position of a potential previvor prompted to take responsibility for their own biological security.

The public performance of the risk identity is not only depicted as an individual conversion, a coming to terms, a self-actualization by taking control bravely, and an act of self-healing. Rather, the narratives are directed at the community of the not yet diagnosed as well. The narrative aim is thus awareness raising to expand the community of previvors, which is reiterated in most texts. The testimonies are thus performative acts that claim an identity as well as circulate a particular logic of security, which by and large promotes their chosen path of pre-emptive surgical intervention. The claim to such a biosocial identity articulated in the testimonies is therefore both personal and political, as Peggy Orenstein asserts for breast cancer culture. While survivor narratives are examples of "the benefits of early detection" ("Feel Good War" n.p.), the previvor narratives stage and circulate the benefits of pre-emptive intervention. Biosecurity performances are thus not just restricted to the biomedical and individual performances. Instead, they have to be understood as public performances manifesting biosecurity and spreading the security narrative, its logics and its practices.

While a generalized assertion of "reader response" is difficult to ascertain, the material effect celebrity performances such as Queller's Op-Ed piece and her performances on national TV, or Angelina Jolie's is potentially measurable. For instance, Sabel et al. have analyzed the influence of the growing numbers of celebrity testimony of double mastectomies as a possible factor in patients' decisions, which is often made prior to the consultation with a surgeon (Sabel et al. 1). Angelina Jolie's public performance of her risk status was compared to the public awareness raised by Betty Ford's testimony. It was predicted to produce an "Angelina effect," as *Time* described it. While many anticipated a widespread effect on women's choice for pre-emptive mastectomies (Grady et al.) her testimony rather publicized the possibility of genetic testing and increased the number of genetic tests, as a study from 2016 shows (Igoe n.p.).

But the previvor testimonies go beyond promotional biosecurity performances. They are crucial expressions of "disease communities" (Wald, "Future Perfect" 685)[36] and as public performances represent visible "signs" of "fellow feeling" (Ahmed, *Politics* 130). Broadening the meaning of life writing in its more traditional sense to encompass these proliferate forms of testimonies highlights the performativity of these narratives which reaches beyond the mainstream media. Jolie's and Queller's testimonies were not only followed by an uproar of publicity on national TV and in newspapers, but were discussed at length on the FORCE Message board (FORCE, "Angelina Jolie"). They became part of a network of testimonies and previvor performances, which are crucial in the context of the hboc community. The interconnections and effect of these testimonies might be less influential in measurable numbers, but represent an important constituent of the support network serving as a source of identification. On platforms such as FORCE large numbers of women are free to narratively expose themselves, making the body center stage for the description of the self discussing extensively the most intimate details of deconstructing and reconstructing breasts. The engagement in the forums and the positioning of the self as a biosecurity subject symbolizes the entrance into a "new" family as Suscet, a member on FORCE, posted on its Forum. Queller experiences it as a sisterhood with its own language (*Pretty* 105). She describes her first public post on FORCE as the final rite of passage in assuming her identity as a previvor. In fact, this public identification with the group in front of the hboc (online) community constitutes the second most important narrative and performative act (*Pretty* 169).

While scholars such as Orenstein or S. King criticize these disease communities for their over-emphasis on spiritual uplift, the previvor testimonies on forums serve not only as help for others spiritually but as a form of soliciting advice on how to medically confront the diagnosed risk. The narratives that establish the security narrative legitimizing the chosen course of biosecurity practices do so both for the individual and the community forged by the genetic defect. These previvor narratives are crucial for other previvors in balancing their choices. The assurance on decisions and the necessary information is often sought within these networks of previvor testimonies and information sharing as Queller asserts in her memoir (*Pretty* 105). The Bright Pink website, as many other platforms, offers different threads which follow distinct categories for specific "high risk identities" based on both diagnosis and on the choices made by the different individuals. They provide a special search function called "Connect to Support" which offers "One

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[36] Wald defines such communities as "clusters of afflicted people and those closest to them who come together for support, information, and sometimes activism" (Wald, "Future Perfect" 685) similar to what Rose and Novas have termed "biomedical activism" (Rose and Novas 18) as well as "biosociality" (Rabinow, *Essays* inter alia 99).

on One" mentoring. In these contexts, the narratives appear as a series of testimonies that form a body of possible futures and different "what if" scenarios. They enter into a conversation with each other, often introduced by a "me too" perspective. These other previvor performances are foregrounded as formative in assuming and forming one's own previvor identity and making the choices appropriate for each individual (Queller, *Pretty* 106). While it might seem that official medical security narratives govern these spaces and decisions, female performances of giving testimony, thus, take an important position in the authorship of the security narratives and practices. And such performances take place in chatrooms and in workshops and private meetings as a mixture of narrative and embodied acts of exposing the self in front of others as Queller and many other report (*Pretty* 133).

The texts of individual resilience and the self-reliant biosecurity individual thus do always appear as relational. The disease community that comes together in activism and as a support network furthermore consistently refers back to the nation. Jolie for instance asserts:

> [B]reast cancer alone kills some 458,000 people each year, according to the World Health Organization, mainly in low- and middle-income countries. It has got to be a priority to ensure that more women can access gene testing and lifesaving preventive treatment, whatever their means and background, wherever they live. The cost of testing BRCA1 and BRCA2, at more than $3,000 in the United States, remains an obstacle for many women. I choose not to keep my story private because there are many women who do not know that they might be living under the shadow of cancer. It is my hope that they, too, will be able to get gene tested, and that if they have a high risk they, too, will know that they have strong options. (Jolie, "Medical" n.p.)

Breast cancer, and in particular genetic breast cancer risk as "the shadow of cancer," is acknowledged as an individual challenge as well as a global crisis that needs to be confronted. While affecting a global community Jolie expounds the national emergency of this security threat, which is exacerbated by the capitalist structure in which risk is distributed unevenly. When Queller and Jolie were diagnosed with genetic breast cancer risk, Myriad Genetics, Inc. still held the patent for the expensive test. The decision on this patent was overturned by the Supreme Court just weeks after Angelina Jolie's testimony and the costs for the test have decreased and are paid for by health insurance if available.[37] Nonetheless, genetic testing for breast cancer risk is still deeply entangled in class differences, not only revealing them but producing them as differences of security.

Furthermore, the testimonies represent performances of citizenship and national identity, exposing the fault lines and divisions that mark the nation. The success stories of individuals, such as Angelina Jolie, stand in the lime light of the movement. The dominance of such representations excludes all those who cannot or do not want to partake in the scripted reality of the movement. Though previvor narratives do not omit suffering and dying, it serves as a horizon against which the previvor stands as a symbol of

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[37] The patent was overturned in the Supreme Court case, *Association for Molecular Pathology v. Myriad Genetics, Inc.* in June 2013. Today the costs for different tests and genetic predispositions range between $300 and $ 5000 (Breast Cancer Organization, "Genetic Testing")

security. Instead of representing the "radical uncertainty" of cancer, previvor identity is a story of success: "[t]he only illness story Americans really want to hear" (O'Brien 772). The performances communicating and enforcing the biosecurity practices thus exclude other experiences. The exclusion of individuals dying of cancer or refusing to follow the prescribed script of biosecurity practices represents the downside of the "new" normativities established by the movement.

The nation performed in the series of previvor testimonies is predominantly a white, heterosexist, affluent, and self-reliant individual that appears physically intact, as shown above.[38] While Queller or Jolie chose their affiliation and identification as previvors, both the choice of the test and testifying have to be understood as a form of privilege. As most biomedical developments in what Clarke et al. have termed the "Biomedical TechnoService Complex Inc." ("Biomedicalization" 162), the biosecurity practices as objects of desire promising a good life mark the difference that security makes. Especially in the U.S. preemptive biosecurity practices and therefore the position of the previvor mark an elite, privileged position.

> The particular configuration of time that is operative within economies of the "pre" –prevention, preparedness, preemption – relies not only on a relation to potential threats, but on forms of current security and on a particular form of "responsible" subjecthood. Often, subjects oriented toward an ethics of the "pre" are not vulnerable to the historical conditions of economic exploitation, social marginalization, and political disenfranchisement; they are not generally subject to the wearing out of their bodies and their possibilities through subtle, insidious forms of everyday violence that rob them of a secure or articulable future (Nye 113).

As Nye points out, the privileges expressed and reiterated in the pre-emptive logic of security are subtler than medical expenses that cannot be paid. Those robbed of the ultimate security are those who live in perpetual insecurity in their day-to-day lives and do not have the ability to invest in their futures. This form of biomedical separation or the "peculiar privilege of futurity" (Nye 112) can be read as a new form of classism and also extends to a "new" form of segregation.

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[38] The clearly heterosexist discourse is often coupled with a representational racism that pervades the previvor and the breast cancer movement at large and can also be identified in medical practice and research. The focus on white middle class heterosexual previvors and survivors has created a considerable gap in representations that is believed to affect the differences in mortality rates regarding breast cancer in African American and Caucasian women (Frisby 502). "Although research shows that African American women have a slightly lower incidence of breast cancer as compared to White women, mortality rates are greater" (Frisby 489).