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Gender, loss, and the erosion of bodily capital: A study with women diagnosed with late stage breast cancer

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ABSTRACT

To learn about the gendered experience of bodily loss, this paper analyzes interviews with women diagnosed with metastatic breast cancer (N = 32). Across the interviews, we find that specific bodily sites – hair, breast(s), thinness – and the gender norms associated with these sites do not loosen their grip near the end of life, but rather constitute meaningful sites of loss. Interviews demonstrate that when women lose a valued physical characteristic they also feel the loss of gendered statuses associated with that aspect of the body. We theorize the resulting emotional experience as positionality grief, or sorrow over an injured sense of self and that is tied to a sense of lowered place on social hierarchies. For feminist scholars, our study links women's complex desires with their particular forms of embodiment that delimit spaces of possibility in the social world. For Bourdieusian scholars, our study calls attention to the importance of focusing not just on the acquisition, but the loss of embodied capital in social life. The implications of these bodily changes, therefore, structure how women grapple with gender and sexuality over the course of their lives.

Introduction

Over the course of their lives, people make extensive investments in their bodies, investments that link social expectations with intimate desires, a sense of self, and opportunities for the future. For some, these bodily investments dissipate slowly with time and age. For others, these bodily investments are lost more suddenly through catastrophic illness or accident. To learn about the gendered experience of embodied loss, this paper analyzes interviews with thirty-two women diagnosed with metastatic breast cancer. We find that cancer offers an important and useful space to assess the loss of bodily investments for women, who have had to develop specific types of attachments and capital in their physical bodies. In the study, we found that this form of domination does not loosen its grip near the end of life, but rather women's bodies become sites of compounded loss. Previous research on cancer and bodily loss has

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demonstrated that when women lose a valued embodied (and gendered) characteristic – hair, breast(s), thinness – they experience the loss of gendered status associated with that aspect of the body (Rubin and Tanenbaum; Ussher et al., "Renegotiating"). We build on this previous research and add an additional layer: we theorize the resulting emotional experience as *positionality grief*, or sorrow over an injured sense of self, that is tied to a sense of lowered place on social hierarchies.

Grief over bodily losses reveals the manifold and uneven ways that gendered forms of domination are "anchored" in the body. Women diagnosed with cancer undergo physical changes quickly and often experience a wide range of outcomes. Lumpectomy or mastectomy changes breast shape. Hysterectomy results in vaginal dryness. Radiation dulls skin tone. Steroids and other medications cause weight gain. This variation, and the quick onset of such changes, enable us to isolate, define, and compare the experiences of multiple but differentiated losses. We find that discussions of hair loss invoked demands for aesthetic labor associated with femininity; breast change invoked sexualization and the internalized male gaze; weight gain (caused by medical treatments, such as steroid regimens) invoked sizeism and normative discontent about body weight. Our study contributes to the effort to show how desires and expectations for intimacy, attention, or money change over the life course in ways that are gendered and embodied. In addition, this study calls attention to the importance of focusing not just on the acquisition, but the *loss* of bodily capitals, which adds a missing layer to the theorization of how embodiment is both gained and lost over time.

Gender, embodiment, and domination

Above, we defined positionality grief as sorrow over a sense of loss of self and social status that is the result of physical changes. This definition calls attention to how an injury to the body can also be an injury in the deepest sense of self and social position. The concept itself builds on complementary insights from feminist and Bourdieusian theories about how embodiment is linked to identity, desire, emotion, social position, and systems of domination.

We begin from the insight that investments in the body are a regular part of the performance of gender (West and Zimmerman). For women in the US today, "doing" gender frequently means enacting the correct sort of femininity, which involves managing appearance, comportment, and physique, in accordance with imperatives to be pretty, sexually appealing, youthful, thin, light-skinned, and toned (Bordo). To be properly feminine is also to embody and provide for male erotic preferences in accordance with the heterosexual matrix (Butler; Pyke and Johnson; Schippers; Fahs).

To meet those gendered expectations, women may undertake practices like hair styling, make-up wearing, working out, skin bleaching, and cosmetic and bariatric surgery (Gimlin; Hunter, "Persistent Problem"; Pitts-Taylor; Glenn; Kwan and Trautner; Groven et al.). In a Bourdieusian framework, these practices can be thought of as efforts to acquire and use gender-salient bodily capitals, where bodily capital is defined as physical characteristics that act as resources to be exchanged and transferred in a variety of ways (Bourdieu; Wacquant; Bridges; Paradis; Hutson). The performance of femininity, as a form of gender expression, can be an act of creativity, agency, play, and self-expression as people alternately reproduce, pursue, and resist various social expectations (Davis; Reischer and Koo; Frost; Pitts-Taylor). This is true even while gender socialization frequently involves the internalization of systems of oppression, such as patriarchy and racism, that operate below conscious awareness (Young, "Throwing Like a Girl"; Bourdieu). Bodily losses can be deep psychic wounds, especially for women who have made significant investments in beauty and body work throughout their lives (Clarke, *Facing Age*).

Bodily capitals matter for social position and mobility, especially for women, who have long faced barriers to alternate means of achievement and status. Investments in idealized forms of femininity allow women to reap the social rewards of a highly valued feminine body and to avoid social devaluation and exclusion as best they can (Clarke, "Aging" citing Calasanti and Slevin; Schippers). Thinness, whiteness, and attractiveness are rewarded with enhanced opportunities for dating and marriage (Green; Hakim) and access to higher-wage jobs (Hamermesh and Biddle; Goldsmith et al.; Hunter, "Persistent Problem"; Wada and Tekin; Mears, "Aesthetic Labor"). For white women, the successful embodiment of hegemonic femininity can help lock in a position of advantage across systems of domination (Hamilton et al.). Embodied forms of capital allow social resources to be "cashed in" while remaining hidden, such that the outcomes of social systems – processes that require continual and extensive institutional reinforcement – are systematically misrecognized as natural outcomes of individual capacities (Bourdieu). As a form of capital, however, bodily or physical capitals are unstable, prone to dissipation with age and injury (Wainwright and Turner, "Reflections").

To be ill is not to be excused from the desire for, or demands of, femininity or sexiness; increasingly, it is to be tasked with performing them in new ways, and often with a "positive" attitude. Like women who are aging, women diagnosed with cancer face pressure to be "spunky," which is to say, hopeful, positive, and resilient in the face of great pain

and loss (Sinding and Gray; Ehrenreich; Jain, *Malignant*).[1] This expectation to be persistently happy while ill overlaps with, and extends, an expectation to be persistently sexy while ill. The association of breasts with sexuality and motherhood means that breast cancer, the shared diagnosis of everyone in our sample, is not just a health event but also a disruption of sexuality (Young, "Breasted Experience"; Lorde; Jain, "Cancer Butch"; Sulik; Ussher et al., "Changes"; Sledge). Breast cancer patients are expected to manage their attractiveness and sexiness as they fight for their health (Segal; Waples), which requires continued beauty work (Rubin et al.), for example by wearing lipstick to a mastectomy (Lucas) or being a "crazy, sexy cancer patient" (Carr).[2]

Gendered experiences are also racialized and classed, which means that gender operates differently for people located in different social locations (Crenshaw). Because hegemonic ideals of beauty were forged in a colonial context, beauty is also a form of social power defined in terms of whiteness (Collins; Hunter, "If You're Light"; Cottom). Here, body weight operates as an especially meaningful signifier. Sabrina Strings' history of fat phobia finds that anti-fatness has long been about anti-Blackness, and "one way the body has been used to craft and legitimate race, sex, and class hierarchies" (6). A thin body can signal higher class membership (Gerber), providing entry to rarefied social spaces as well as a means to secure one's status and income. Thus, it can maximize the returns to racial and class-based forms of domination (Wacquant; Mears "Girls"; Hamilton et al.).

Emotional responses to embodied loss reflect a mix of conscious and preconscious commitments. As Pierre Bourdieu writes, the internalization of the system of gender happens "through the schemes of perception, appreciation and action" that accrue over the course of a lifetime and therefore remain below consciousness. Bourdieu concludes that the "practical acts of knowledge and recognition" of gender "often take the form of bodily emotions" (*Masculine Domination* 37). Accordingly, we do not expect the white women who make up almost the entire sample to be consciously aware of – and therefore able to articulate – how whiteness shapes their experience of embodied loss. Instead, we remain mindful of how racism, as a social system that intersects with capitalism and patriarchy, structures the context in which personal losses are felt. Beauty

[1]Cancer treatment mimics aging in that both draw people away from characteristics associated with youth, like a slender and toned figure, smooth skin, and colorful hair (Sinding and Gray; Clarke and Griffin). Cancer and its treatments drain energy, cause cognitive difficulties (e.g. "chemo-brain" resembles "senior moments"), can induce frailty, and raise the specter of the end of life.

[2]Proper recovery means recovery of the breast; some women report that they cannot return to normalcy after a mastectomy without reconstructive surgery (Crompvoets). Others report feeling pressured to have unwanted reconstructive surgery (Rubin and Tannenbaum; Coll-Planas and Visa; Brown and McElroy). Some who chose not to have reconstructive surgery may see that choice as an empowering act of resistance against heteronormativity and patriarchy (La et al.).

work, in the context of illness, is both a way to mitigate threats to gendered identity and a safeguard against the erosion of other kinds of losses of economic and social capital over time that are far more likely to be intuited than consciously understood.

Current study

Feminist scholarship on gender has long recognized the importance of a life span perspective. Laura Carpenter and John DeLamater note that despite the considerable work that exists on the mutual constitution of sex and gender, we still lack adequate empirical work on how the two change together over the life course. Our study is drawn from a purposive sample designed to provide variation within three age groups, as the following section will detail. As such, it is well positioned to contribute to our understanding of how sex and gender change together over the life course. We develop the concepts of *relative loss* and *relevant context* for theorizing women's responses to bodily changes that are gendered and sexualized in different ways over time. Despite these differences, we find a striking continuity: the fact that both younger and older women express positionality grief at the end of life speaks to the expansive and relentless nature of gendered forms of domination.

Bourdieusian scholarship has long argued for closer attention to embodiment and its relationship to capital, but most of this focus has been on its acquisition and use, not its dissipation and loss. There are exceptions. Studies of models, dancers, and athletes report a race "against the clock" to cash in on bodily capital before practitioners age out of highly competitive fields (Mears, *Pricing Beauty*; see also Wainwright and Turner "Just Crumbling"). Corey Abramson explains that old age is in many ways defined by the absence of embodied capacities that can be partially offset by social and economic resources. Unlike those studies, our focus is on the salience of gender, not in elite athletic and performance fields, but more generally in social space. To advance the conversation about bodily capital loss in non-elite spaces, we turn to theorizing positionality grief, which we argue is crucial to the understanding of how bodily capital is accumulated and lost, below the surface of any individual's recognition.

A theory of positional grief foregrounds how a physical injury can also be an injury to a person's sense of self and social position. Our aim is to draw attention to how emotions reflect linkages between intimate bodily losses and the macro-level social systems that punish through the very routes where capital had once accrued. When women lose hair, breasts, or thinness, at stake are a set of internalized, valued commitments that are part of the everyday performance of gender, some of which may have been cultivated

through a lifetime of investments of time and money, all of which have very real consequences for future life chances. A focus on positionality grief underscores just how pernicious, destabilizing, and fraught investments in bodily capital can be for people, even as they fight for their lives.

Data and methods

The data are drawn from a study of well-being and sexual health of women diagnosed with metastatic breast cancer at a Midwestern breast cancer clinic. Metastatic breast cancer is a late-stage cancer that has spread from the breast to other parts of the body. The median survival rate is approximately twenty-six months (for people diagnosed since 2007, see Thomas et al.). While incurable, many women with this cancer continue treatments to extend their life span, treat symptoms, and generate scientific knowledge.

Sample

Following a protocol approved by an Institutional Review Board at the University of Michigan (HUM00040128), researchers worked with medical providers to prescreen patients during their routine clinic appointments. To qualify for the study, patients had to be female, with a life expectancy of greater than three weeks, over the age of twenty-one, with no major psychiatric illness diagnosis, and able to read or speak English. Researchers approached patients who met these criteria and asked whether the patient would be interested in participating in a study concerning quality of life, which involved a take-home survey and the possibility of a face-to-face interview.

192 patients agreed to take the survey study, of whom 108 (56%) consented to be contacted separately for an interview, and thirty-two of whom were subsequently interviewed (see Tables 1 and 2 for additional details).[3] This was a purposive sample designed to provide variation within three age groups: eight respondents were aged thirty to forty-nine; eighteen women were aged fifty to sixty-five; and six women were aged sixty-six to eighty-five. One of the authors (McClelland), a white woman in her forties at the time of the interviews, with extensive experience in qualitative research, conducted the face-to-face semi-structured interviews in a private room in the breast cancer clinic.

[3]Researchers contacted seventy-three patients by phone to schedule an interview that coincided with a future oncology appointment. Of these, sixteen were not scheduled to be in the clinic in the four months when interviews were scheduled, fourteen declined, seven could not be reached after three attempts and were considered a passive decline, and four were in hospice or deceased.

Table 1. Participants' age, relationship status, and age at breast cancer diagnoses.

Name	Age at interview	Relationship status	Age at initial BC diagnosis	Age at metastatic diagnosis
Cheryl	35	Partnered	32	34
Patricia	40	Partnered	37	40
Betty	43	Single	33	40
Mary	46	Divorced	45	45
Bonnie	46	Partnered	40	44
Sandra	48	Partnered	46	46
Karen	48	Divorced	40	44
Joyce	49	Partnered	43	48
Elizabeth	50	Partnered	38	48
Carol	53	Divorced	45	52
Lisa	54	Partnered	54	54
Janet	55	Single	50	53
Teresa	55	Partnered	46	54
Barbara	56	Partnered	52	55
Diane	56	Partnered	53	53
Janice	56	Divorced	55	55
Pamela	57	Single	52	52
Margaret	58	Partnered	58	58
Judy	58	Partnered	55	55
Brenda	59	Partnered	49	52
Sharon	60	Partnered	53	56
Denise	60	Partnered	49	59
Connie	61	Partnered	20	44
Shirley	62	Partnered	56	61
Linda	63	Single	44	53
Nancy	65	Partnered	56	64
Cynthia	66	Divorced	36	65
Donna	67	Divorced	57	62
Beverly	68	Partnered	52	65
Debra	69	Single	49	59
Susan	76	Partnered	63	68
Laura	77	Partnered	69	75

Notes: All names are pseudonyms; BC = breast cancer.

Procedure

Before the interview, each subject sorted sixty-three cards about aspects of sexual health into piles according to how much they agreed or disagreed with the statement on the card. The interviewer then asked participants questions about changes to their sexual health prompted by cancer, periodically referring back to the information communicated during the card sorts as a way to probe further into the respondent's understanding. Interviews lasted approximately one hour, and respondents were compensated with a $20 gift card. Interviews were audiotaped, transcribed, and analyzed thematically (Terry et al.) using open coding through multiple readings of the data. This resulted in master codes pertaining to how women talked about specific aspects of their bodies (hair, breasts, vaginal dryness, weight/body size) and experiences (physical pain, age, "feeling fat").

Table 2. Sample Characteristics.

	N = 32	(%)
Race		
White/Caucasian	29	(91%)
African American/Black	1	(3%)
Missing	2	(6%)
Partner status		
Partnered/married	21	(66%)
Divorced	6	(19%)
Single	4	(12%)
Missing	1	(3%)
Education		
High school	7	(22%)
Some college, AA degree	9	(28%)
College degree	7	(22%)
Advanced/prof degree	8	(25%)
Missing	1	(3%)
Sexual orientation		
Heterosexual/ Straight	32	(100%)
Income		
<$20,000	4	(12%)
$21,000–40,000	5	(16%)
$41,000–60,000	9	(28%)
>$60,000	13	(41%)
Missing	1	(3%)

All respondents identified as cis-gendered and heterosexual. Nearly all of the women identified as white and two-thirds of the women were partnered with men at the time of the interview, making the findings most relevant to the experiences of this population. The sample size of thirty-two, while limited, had the advantage of minimizing participation burdens on a population of subjects near the end of their lives. Chi-square and *t*-tests revealed no differences between the interview subjects and larger study's participants' demographics, diagnosis, or treatment characteristics (including mastectomy, radiation, chemotherapy, and other therapies).

As an in-depth study of thirty-two mostly white, mostly partnered, straight-identifying cis-gendered women, these findings are useful for theory-building about how embodied loss is experienced, but they are not representative findings about women and bodily loss. A more diverse sample would be needed to understand the experiences of trans women, women of color, and non-straight women. Despite these limitations, we believe these interviews tell us something about how scholars interested in embodied capital can think about the experience of decline, especially in terms of how it is gendered in different ways over the life course.

Findings and discussion

When asked about intimate and sexual health, the majority of respondents described their experience of having been and being treated for cancer in

terms of a litany of damaged body parts (hair, breasts) and physical capacities (bending, vaginal wetness). Within those discussions of bodily loss, clear patterns developed about the nature of the harm. Hair loss was tied to the loss of a general feminine appeal to the public and invoked the demands of aesthetic labor. Breast loss called up concerns around sexualization, as women anticipated losing the desires of current or potential male partners. Weight gain invoked both public and private concerns, and for many women represented an exacerbation of an existing point of dissatisfaction. These associations of body parts with specific modes of domination should be thought of as overlapping tendencies, rather than mutually exclusive domains. This is especially true for weight, discussions of which were especially likely to merge concerns about aestheticism and sexualization. In all cases, subjects grieved the various social affordances associated with different aspects of their body. The experience of loss varied not just by the physical experience and type of social status inscribed in that part of the body, but also by each woman's unique configurations of body capital earlier in her life and current life stage.

"It truly is a defining thing:" Hair loss and aesthetic labor

Nearly all of the women in the study had been diagnosed and treated for earlier stage cancer over many years, which gave them experience with hair loss and regrowth. Unlike other losses discussed in this article, hair loss is uniquely recoverable. When the cancer treatment ends, hair regrowth begins, and the idea that hair "grows back" was frequently mentioned in interviews. Subjects explained that the loss of hair could be relatively less concerning over the long term, but shocking and painful at the time of onset. Diane, fifty-six years old and partnered, explained that losing her hair was "the hardest thing I went through."

Thematically, what distinguished hair loss from breast loss and weight gain was its public signification of womanhood. Linda, a sixty-three-year-old widow, illustrates this when explaining why she disliked her wig:

> I think because I saw it so much as a part of what we notice when we go out in public. That a woman and her hair are something that you always look at. You know, it's a defining thing; it truly is a *defining thing* [authors' emphasis]. Men now can be bald and it's perfectly okay, but a woman who is bald, we will look twice at, whether it's in a positive manner to say, "My God." … And when I lost my hair for the first time I just was a basket case because I felt that it so defined who I was. And no matter what my husband—my husband was alive at that time—and no matter what I said it made no difference. It just made me feel like I was pretending … to be, you know, a female. To fit in … with society's answer to, you know, womanhood, which is to have some sort of hair.

For Linda, a sense of how she would be evaluated as a woman by people outside of her marriage meant that her husband's support did not alleviate her sense of loss.

Other women similarly invoked the idea of a public gaze when discussing hair loss. Carol, a fifty-three-year-old divorced woman, noted the special importance of hair as "the thing that people see first." She discussed her grief over lost beauty while getting a haircut: "The last time – even sitting in the hairdresser chair was hard, because … to be forced to sit and stare into the mirror, and [pause] not being able to look away, and it's like, okay, this is how much I've lost." Note the context here. Hair salons are organizations that specialize in instilling the norms of gendered aesthetics (Barber). They are, in Debra Gimlin's words, "an arena for the dissemination of both age- and class-appropriate standards of appearance and an understanding of the identity implications of appearance" (143). The context of the salon may well have intensified Carol's sense of loss.

Our study is consistent with other research that finds women doing extensive beauty work to manage the public appearance of hair loss through wigs, scarves, and hats (Sulik). When breast cancer patients in our sample discussed efforts to manage hair loss, they sometimes slid into discussions of other kinds of aesthetic labor, like putting on makeup or removing hair. At forty-six, Mary was divorced and not dating at the time of the interview. When asked what advice she would give to others, Mary's advice on how to cope with hair loss wound around to beauty work more generally:

> … don't be so sad about losing your hair because it does grow back … I didn't actually mind losing it on my legs and my vagina and every—it could have stayed gone. [laughter] But it comes back. It does come back. You know, so you don't have to look like an alien for long. But don't—try not to be depressed about that. You know, put on lipstick, you know, throw on a little eyeliner on your bottom lid or, you know, put on your earrings, and, you know, just try to, you know, beautify yourself where you, you feel comfortable.

Note how hair elicited a discussion of beauty norms and practices, and through that, further discussions of other kinds of aesthetic labor. Note as well the depersonalization implied when Mary says she looks like an "alien." Losing her hair was a serious blow to her self-esteem and identity, one that challenged her place in the social world, but in a way that was recoverable and therefore temporary.

"I almost feel that he's [been] cheated:" Breast loss and sexualization

What distinguished discussions of breast change from discussions of hair loss and weight gain was the extent to which respondents invoked male desire and the intimate male gaze. To be sure, breast loss could make women feel

less feminine in ways similar to hair loss. For Carol, who had so acutely felt the loss of her hair while at the beauty salon, breast loss was another blow to her femininity. "Well, you got no boobs, of course you're going to feel less feminine." Cheryl, who at thirty-five was the youngest person in the sample, reported that "I didn't feel feminine at all anymore" when she lost her breasts. Yet as some women talked about breast loss at length, they revealed more precisely how their femininity had been injured. This came up in two main ways: in the discussion of the cost to their partners' sex lives and in decisions around reconstructive breast surgery.

When discussing breasts and sex, women frequently discussed male desires alongside their own. For partnered women, this meant discussions of partners' erotic preferences. Lisa was fifty-four and married at the time of the interview, and had only been diagnosed with breast cancer that year. Her discussion of how her surgery changed her sex life included a discussion of her husband's enthusiasm for her breasts: "Oh he loves 'em. He just loves 'em. He would face plant if ever he had a chance, and, you know, that's the first thing he's – you know, when he was on top was, you know, there was a lot of action going on with my breasts." Patricia was one of the younger participants in the study. Forty years old and married at the time of the interview, she described the loss of her breasts as a loss shared by her husband: "I–I don't feel like I'm cheated, but in a way, I almost feel that he's cheated, because, you know, that's not there [laughter] anymore for him." Carol, who was married when she lost her breasts but later divorced, similarly reported that she felt her body betrayed her *and her husband*, leading to his extra-marital affair.

For partnered subjects, the importance of the intimate male gaze is further reflected in how much work women put into managing it during moments of sexual intimacy. Barbara, a fifty-six-year-old woman, wore a special bathrobe with a zipper that could cover her chest while having sex. Patricia (forty, married), like many women in the study, discussed wearing a tee-shirt during sex, for her and her husband's sake. These efforts were not just about covering the lack of breasts, but also the addition of scars. Such "covering up" during sex is a particular kind of gender labor that combines beauty work with efforts to manage a partner's erotic desires (McClelland "Gender").

A focus on the intimate male gaze also arose as women discussed their decisions around reconstructive breast surgery. Some partnered women who chose not to have reconstructive surgery explained why this accorded with their partner's sexual tastes. Susan (seventy-six at the time of her interview) reported that "I don't think it's bothered my husband that I have no breasts, because he's a hip man, a fanny man." Women who had lumpectomies or mastectomies while single also discussed male desire when reflecting on the decision making around reconstructive surgeries, but in their cases, this took

the form of imagining the preferences of possible future partners. Debra, who was sixty-nine and single at the time of her interview, reported that she was "perfectly fine" with her mastectomies, and her interview stressed how she privileged intimacy with family and friends over romantic attachment. Even for Debra, however, the male gaze remained salient. She talked about what men's responses could be to her scars, and a friend whose partner had a negative response to surgical scarring. When deciding about surgery, Pamela (fifty-seven and single at the time of her interview) asked her spiritual director about what men think of mastectomies. She ultimately decided to forego a mastectomy – not because she thought men would not care, but because she believed she would remain single: "nobody's gonna see it but me. You know. If I got to a place where somebody actually was – if I was really, really interested and, you know, then maybe I'd do it." Karen, who was forty-eight and divorced at the time of her interview, made a similar point when discussing changes to her breast shape following a lumpectomy. "I wonder sometimes if a guy would be able to handle it or not," she says, before explaining that she decided not to have reconstructive surgery but that she would be willing to reconsider if she was dating again. Women who were coupled understood their sexualized bodies as things they shared with their partners, and so they understood injuries to those sexualized parts as shared losses. In other words, sexualized embodied capital of women, in the context of the monogamous relations we see here, was considered a shared resource that accrued and depleted in collective ways. Not just her loss, but *their* loss.

In studies of relationships and sex, scholars have found that the internalization of male desires results in women prioritizing the sexual desires of male partners over their own (Hamilton and Armstrong; McClelland, "Who Is the 'Self'"; Bell). Others have found that the internalized hegemonic male gaze remained relevant for lesbian women (Gagné and McGaughey; Slevin and Mowery). Our data are consistent with this and show that single women when making major decisions about surgery engaged in imaginaries of male desire, as they anticipated and evaluated what men might want sexually from their bodies. The male gaze was not the ultimate basis of the decision to have reconstruction surgery for Debra, Pamela, or Karen, but all still grappled with it.

None of this is meant to imply that discussions of breast loss were exclusively focused on male desire. Women also discussed their own wants, needs, and priorities. They talked about changes to sensitivity, missing their breasts, wishing they appreciated them when they had them, or unwanted changes to breast shape interfering with sex or making them feel, in the words of one respondent, that they looked like a "freak." Nor was breast talk limited to matters of sexualization. To a lesser but meaningful extent, some of the loss of femininity associated with breasts had to do with public

appearance and interactions. This came up in discussions of giving hugs (Carol), wearing low-cut clothes or a bathing suit (Patricia, Elizabeth), motherhood (more on this below), and wearing prosthetics (many women), the latter being a form of beauty work akin to using wigs and scarves to manage hair loss. That said, the extent that male sexual desire was centered in women's discussions of breast changes and loss was striking when juxtaposed with discussions of hair and weight.

"I'm having a closed casket because I am too fat:" Weight gain and sizeism

Weight gain constitutes a loss of thinness, which is itself a highly valued form of bodily capital (Bordo; Gerber and Quinn; Strings), and as such, operates as a form of privilege that can be lost for anyone, regardless of illness. Three things distinguished talk of weight gain from talk of hair or breast loss. First is the extent to which women reported deep shame over it as something that preceded their cancer. Second is the extent to which weight gain merged aesthetics and sexualization. Third is the extent to which thinness is hard to recover.

Unlike with hair loss or breast change, dissatisfaction with body size was something many respondents had experienced before diagnosis. Women specified the cause of their weight gain. For some, changes in body size were a direct result of cancer, either from steroids, inflammation, or symptoms. Carol (fifty-three, divorced), for example, stated, "I have physically changed, especially now that it's in my neck, I look fatter, you know, that kind of thing, the lymphedema and all that." For others, cancer treatments added to existing weight gain. Janet, fifty-five and single at the time of her interview, stressed that "I've always been heavy" but noted that she "gained a lot of weight" as a side effect of her cancer treatments. Bonnie, forty-six and partnered at the time of her interview, said that she had "the normal woman issues, oh, I'm not skinny enough, and, you know, I've got a fat butt like my mom." Karen (forty-eight, divorced) similarly said, "maybe if I gain weight, I don't like the extra, to look at the extra weight. But no, as far as the cancer stuff, that doesn't bother me at all."

These responses illustrate how weight is a "normative discontent" for women in our society (Rodin; see also Farrell). When asked about body dissatisfaction during sex, most respondents contentiously engaged in "fat talk," or ritualized expressions of dissatisfaction about body size, primarily but not exclusively undertaken by women, that bond women around ideals of thinness and fat stigma (Nichter; Gruys). In the interviews, fat talk sometimes merged concerns about aestheticism and sexualization. Donna's (sixty-seven and divorced) discussion of her body size echoed the discussions of male desire that came up with breast changes:

> [L]osing weight would definitely make me feel better about my body … more attractive sexually and feminine, as a feminine person—a female … It might be because I'm not as attractive to—I mean people will say all and all it doesn't matter but it does matter if you're heavy. It does matter to men—they are visual beings and that's one of their ways they get attracted to somebody or turned on. I think it's, it's a primitive response that they have and so I haven't [pause] attracted men in the last however many years because I'm heavy and even when I, you know, have dates from the internet or whatever it rarely amounts to more than one because they're just, I think it's because they're not attracted to me physically. Yeah.

Here Donna is invoking the notion, studied by Francis Ray White, that fat people are sexual "failures." This is an extension of what we saw in the discussion of breast change: women are responsible for enacting male desire, which is seen as natural, instinctual, and inevitable. Donna attributes her pain to personal shortcomings, not normative expectations.

Cynthia was sixty-six years old and divorced at the time of the interview. She reported that she had gained one hundred pounds before she got cancer due to medication she took to manage bipolar disorder. Discussing her ex-husband and unhappy about her mastectomy and weight gain, she explained, "He had made it very clear to me that he was looking for another woman, and he tried, that would be skinny, had to be skinny … she had to be very attractive. I mean, he said that all the time." Cynthia also explained that weight did some of the same aesthetic work of hair, providing a signal about oneself that would be read at a distance:

> Oh, I hate [my body], but it's not because of my mastectomies. It's because I'm fat … I would like to be thinner. It'd be very important … . I would—I guess I'm going to die fat. [laughs] This is how much I detest being fat. I'm having a closed casket. I've already determined that. No way am I having all those double chins. I saw this once on a lady, and I had told my sister, [laughs] "Don't ever do that to me!" So I had made it emphatically, I'm having a closed casket, because I am too fat.

Cynthia's insistence that she wants a closed casket to hide her fat body shows that this is an issue that goes far beyond male desire. Her larger body size is so stigmatizing that she does not want it observed even, or especially, in her death.

Cynthia's discussion also speaks to the way that weight gain is experienced, particularly highlighting a kind of "fat talk" that permeates women's narratives about their bodies, fear of fatness, and disdain for fat bodies which has become a normative part of women's lives (Fahs and Swank). The dominant cultural script in the US today about weight is that it is a matter of willpower. Fat people are expected to not eat or exercise more to lose weight, making fatness the fault of the fat person, regardless of circumstance. Yet while weight loss is frequently discussed as an

achievable goal, on a population level, significant and sustained weight loss through dieting is relatively rare over the long term (Rothblum). The most optimistic projections for weight loss through dieting suggest a one-in-five chance of maintaining a ten percent weight loss for an entire year (Wing and Phelan).

Hair loss raised questions of wigs and scarves until hair grew back; breast loss raised questions of prosthetics, clothes, and reconstructive surgery. There was no ready market or medical solution that allowed women to recover or hide the loss of thinness. With body size, recuperation of the lost capital meant extensive work on the self – as indicated by the repeated mentions of exercise above – that was unlikely to succeed.

The decline of bodily capitals over the life course

The loss of bodily capital can be seen most clearly when women discussed how they evaluated the impact of the losses they felt. When asked about bodily loss, women repeatedly explained, sometimes without prompting, whether they had lost something they had highly valued. Take Susan, who was seventy-six and partnered at the time of the interview. Susan said that she missed her breasts but added that the loss was not especially painful for her: "I have no breasts, you know [laughs], and sometimes I kind of miss that, but not very much, because I had very small breasts [laughter]." In contrast, Patricia (forty, partnered) underscored how central her breasts had been to her identity: "I was the blond with the big boobs … I mean, it was – they defined me." Carol (fifty-three, divorced) similarly made sure to clarify that her breasts were a significant loss: "I had a gorgeous set of hooters. Absolutely gorgeous." Carol also mentioned grief over weight gain: "So … I used to be hot, I'm not hot anymore. And that's hard to come to terms with as well." Donna (sixty-seven, divorced) similarly noted that her weight gain while taking antidepressants meant the loss of a former, sexier self: "I used to be really cute and thin and, you know, so I don't feel as sexy." Of special note here is how male erotic desire shaped this sense of value. Laura, seventy-seven and married at the time of the interview, shrugged off a question about the ramifications of her mastectomy and her feelings of sexiness by explaining that her husband was never "a boob man."

Respondents also commented on the contexts in which their losses occurred. Cynthia (sixty-six, divorced), who had so keenly felt the shame of fatness that she spoke of wanting a closed casket, took some comfort in how this loss of attractiveness came later in life:

> I just decided, "Who cares?" [laughs] I mean I—it's not like I was—if I was younger, you know, I remember when I was thirty-six and I found I had cancer.

> First thing I thought of was, "How am I going to look in a tube top?" You know? Because I was skinny, and I was young and all that but, you know, now—[pause] God was with me. He let me wait until I was old and didn't care, but if I was at that age where I felt I needed to hunt for a husband or whatever, it might be a big issue, but I'm not, I'm not interested, so.

Sandra, forty-eight and engaged, decided to opt out of reconstructive surgery, in part because she was no longer a young mother:

> I have a wonderful fiancé, who is very supportive and—which is one of the reasons I probably won't do reconstruction, because I had a double mastectomy, and I'm done having kids, and I'm at a different time in my life, so I think [pause for three to five seconds] it's, um—I'm okay. I'm comfortable, you know, just being who I am.

In these examples, and across the women in the sample, age was an essential element for making sense of their losses. Sandra made sense of her cancer as part of the aging process itself, as part of a larger set of "scars from all your trials and tribulations," as she put at another point in her interview. For Teresa (fifty-five, partnered), "cancer was another layer" of the experience of bodily changes to be navigated: "I'm also post-menopause, and also getting older – everything's all at the same time. I think it's transitioning, in part, even if I didn't have cancer, transitioning from being young and everything went so easily and smoothly . . . ."

From a life course perspective, these discussions indicate that women understand cancer as a form of accelerated aging that causes additional suffering for younger patients. Across age groups, respondents recognized that for younger women, breast cancer was a "turning point" that created a timing mismatch in the life course, so that they had experiences of loss that were out of sync with general social expectations for their life stage (on transitions and turning points, see Carpenter and DeLamater). From a Bourdieusian perspective, these discussions reflect the importance of the match between capital and the dating field. Women made explicit references to whether they were dating at the time of treatment, signaling their level of investment in age-stratified marriage markets (Green).

Conclusion

Among the women in this study, declines in gender-relevant bodily capitals – hair, breasts, thinness – became distinct sites of loss during cancer treatment. Considered together, these losses reveal a set of routes, goods, and practices in which women accumulate and then mourn the dissolution of embodied capitals. We found that the losses of embodied resources are also "lost selves" that people mourn: a lost healthy self, a lost thin self, a lost pretty self, a lost sexual self. This is beauty work as loss mitigation, intended to recuperate or

work around that which is under threat or in decline. The women in this sample mourned their lost embodied experience of the world, particularly around former sites of privilege. We theorize this emotional experience as *positionality grief*.

For feminist scholarship, this study illustrates how it is not simply desire for attention or money, in the context of patriarchy and capitalism, that links gender and sexuality in women's lives. Women's complex desires are also linked through particular forms of embodiment that delimit spaces of possibility in the social world, which means that bodily changes therefore structure how women grapple with gender and sexuality together over the course of their lives. This helps us understand, and take seriously, why a woman's grief over the loss of her breasts may be moderated by her husband's erotic preference for behinds. For Bourdieusian scholars, this work contributes to the emergent study of the decline and loss of embodied capitals by focusing on gender-relevant capitals in non-elite spaces, and by developing a theoretical language – positionality grief, relative loss, relevant content – to aid in that analysis.

Desires for social status are worked out in specific contexts, by people who have unique histories and configurations of capitals. Throughout the study we found examples of women talking about the value of bodily capitals in specific spaces: the value of breasts when in bed with a man who especially desires them, the value of hair in the context of a salon, the value of a fat body when framed in a casket for public display. A focus on bodily capitals provides a guide wire for researchers trying to trace these intersecting demands in lived experience, whether it be through the places that we travel through, or the more intimate and vulnerable landscapes of particular women's bodies.

Not all changes were abrupt or profound losses for a given woman, and so not all changes induced intense positionality grief. For the women in this study, the presence and extent of positionality grief was patterned on women adjusting to the relative extent of a loss, or whether a woman lost a form of capital that she highly valued at the time of treatment, and the relevant context of the loss, or the extent to which a woman felt that the losses violated expectations for her life stage. These interviews, therefore, provide insight into the various goods, practices, and pathways through which women accumulate and then mourn the dissolution of specific instantiations of bodily capitals – capitals that shape the changing linkages of sexuality and gender over the course of their lives.

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