

“Sick woman” or “half woman”?

Breast and cervical cancer, emotional script and representations of female body in a mediterranean area of Italy

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Abstract

The proposal aims to highlight the semiotic elements of the discourse that refer to the symbolic ones of representations, and that transform the therapy in an exercise of professional dominion aimed to modify the perception of the self of the female patient through the subversion of specific emotional script.

The mapping of the emotional scripts of shame and modesty, in their performative evolution, will be useful to demonstrate how and through what relational strategies the medicalization performs a gender violence which leads to exclude and self-stigmatise the sick woman, considered a “half woman”.

The reflection that has its incipit in the ascertainment that the female body has been and keeps being a means of “male dominion” and object of “symbolic violence” as well as physical, and favors unexpected articulations related to a female body affected by breast or uterus cancer with often devastating effects on the woman’s self-perception.

This proposal provides a reflection on the effects of experience of female cancer in the emotional sphere and in the gender relations of 36 Italian and stranger women. The research aims at discussing the role of medical therapy as a social practice of male domination that imposes a traditional representation in which female beauty is equivalent to the physical integrity and full functioning of specific attributes sexed (uterus that creates, breast that feeds). The focus of research is an analysis particularly focusing on the transformations of perception of body as *Körper* and the emotions which, cross-sectionally, constitutes the self-perception of *Leib*.

Keywords: female cancers; emotions; representations; male domination

Woman’s body and cure contexts

The concept of health has assumed only recently connotations no longer exclusively sanitary. Other aspects with multiple implications involving the subject’s whole socio-relational sphere have been associated to it. The attention to the multifactorial aspects of the phenomenon, especially when female cancers invalidate the ill woman’s self-perception and daily life, has involved the gradual abandonment of the organicist conception, focused on the physiological aspects of the pathology, according to which health coincided with the absence of disease thought as «the bad

functioning of biological mechanisms that are studied from the point of view of cellular and molecular biology» (Ardigò 1997: 42). The awareness of the complex relationship between biological and social factors determining health and disease of the human beings (Vinay 2004), sheds light on the methodological usability of the "correlational paradigm" that considers «the health (...) evaluating all the dimensions (economic, biological, relational, cultural, communicational) that belong to it» (Cipolla 2004: 85). More specifically, the reproductive health is an indicator of the health of the women, connected to the ability to "make babies", and highlights many of the implications between health and gender inequalities (Pizzini 2001; Conrad 2007), which refer to models and cultural representations based on the symbolic violence of male domination (Bartholini 2013).

Suggesting a reflection that has its incipit in the ascertainment that the female body has been and keeps being a means of "male dominion" (Bourdieu 1998) and object of symbolic violence (Jackman 2002; Collins 2008; Corradi 2009) as well as physical, favours unexpected articulations, if related to a female body affected by a breast or cervical cancer. In these cases made more vulnerable in its innermost sexual aspects, it is progressively submitted to an implicit stigmatization of 'a body to cure and reject' with often devastating effects on the woman's self-perception.

The purpose of this dissertation is not limited to consider the disease as the product of some systemic and relational variants (Clarke 1991; Seale 2002), but on shedding light about the identity and emotional dysfunctions that are caused, precisely when sexual-reproductive organs of the women are affected by uterus cancer.

We will try to show, in the following pages, as the body of a woman suffering by breast and cervical cancer, becomes public (Pizzini 2001) because "practiced" (auscultated, felt, smelled, touched) by medical and healthcare who exposes it to the stigma of "mutilated body" in her femininity and her procreative capacity.

During the therapeutic routine, following the diagnosis of breast or uterus cancer, the binary oppositions of "health-disease", "feminine-masculine" and "beauty-power", cross with those of exposure-punishment, cure-manipulation and modesty-shame.

Such conceptual dyads, intertwining by opposition, define the levels of acceptability and refusal of the subject in the patient's act of perceiving them. The body of the woman, that is "practised" (auscultated, perceived, smelt, touched) during the anticancer treatments, is the foundation of a weave associating the representations of female disease to physical undesirability. The analogy beauty-health, declined to female, belongs to a western cultural tradition traditionally controlled by male power (Bordieu 1977) and still traceable in the doctor (more generally sanitary staff)-relationship and in those that influence the primary and secondary socialization webs of the female patient.

In an operation of stripping of flesh of meanings, it is possible to retrace the passages through which that very female body, when victim of a disease that deprives it of that seductive power intrinsic to the same sexed anatomy, and that compromises the seductive capacity (in its original meaning of “*se ducere*”, leading toward herself) of the ill woman, becomes a body to ‘discard’ but, above all, a body exposed to the loss of all those decency screens which used to activate the sense of self and give the contextual elements of its own identity.

To activate this stripping of flesh, we shall avail ourselves of the results of a survey made on a sample of 36 interviewed foreign women living in Sicily and Sicilian women suffering from breast or uterus cancer, in order to highlight the “dystonias” and the “prejudices”, the indirect and unreflecting stigma that the therapeutic course produces, and that interrelate in collective representations still referable to a masculine, cultural dominion.

The following pages aim to highlight, in medicalized and biomedicalized relationships, the semiotic elements of the discourse that remind to the symbolic ones of representations, and that transform the anticancer treatments and/or the convalescence in an exercise of professional dominion aimed to modify the perception of the self of the patient through the subversion of specific emotional script.

The act of locating the emotional script of shame and modesty, in their performative evolution, will be useful to demonstrate how and through what relational strategies the medicalisation affirms a gender violence which leads to exclude and self-stigmatise the sick woman, who considers herself a ‘half woman’, even after having overcome and won her personal battle against cancer. Violence associating the benefit of the subject to the health of sexual organs and of the anatomic parts identifying the female gender (uterus that creates, breast that feeds).

On a more general level we should like to demonstrate how the very context of the cure of the ill body produces further processes of gender stigmatization/discrimination, above all if compared to the conceptual dyad shame/modesty, indecency/décor of the body, traditionally belonging to a western cultural model.

Perception of the female health and emotional script

Around sickness is situated a complex congeries of social and cultural representations not only connected to strictly biomedic factors but, rather, to experiences of relational type, referring to *soma* and legitimized in the sexed sphere of the female body.

According to Scheler’s distinction borrowed here, the body is, at the same time, living (*Leib*) on the subjective level and physical (*Körper*) on the objective one, and the emotions thence springing are organically ‘sexed and of gender’ as well as

relationally 'sexed and of gender'. It is therefore physical body, but also perceived body. It constitutes the bridge of acted and reflected intersubjectivity. It is the material concretization of the discourse, of the narrations and dominant normativity (Butler 1990, 1993) and of the body's commodification processes (Baudrillard 2003, 2005; Anders, 2007) and of the spectacularization of emotions (Debord 2008).

If in daily life the body contributes to its holder's social acknowledgment (Hochschild 2003; Illouz 2004), when that very daily life unfolds in those sanitary environments in which the body is cured, it becomes the stage onto which the judging power of the diagnosis pushes towards a self-lobotomy of the patient according to representations of youth, beauty, health, sexuality. During the various stages of the therapy, the patient redefines the social rapports in which she is involved, and subverts the emotional scripts referred to her.

Along with a reduction of the acceptance of the physical body (*Körper*), any therapeutic intervention ends up in an invasion in the private borders of the patient/in-mate's bodily identity (*Leib*) that, in reversing the previous self-perception, in the unity of physical body and living body, thus transforming the same phenomenology of the emotions linked to the relational practices: modesty is transformed in shame, the fear of sickness in self-disgust, the exposition in punishment, the cure in submission to others' will. As a matter of fact, "the fact that the gender body is performative shows that it possesses no ontological status apart from the various acts that constitute its reality" (Butler 1990, 191). In Butler's performative setting, sickness is one of the most frequent topos in which the society's stigmatizing power is exercised on the subject carrying a physical body, which is also social body, namely "body socially perceived" and the two aspects are "so close as to be perceived fused" (...) *while* the tension between them allows the elaboration of meanings" (Douglas 1970: 122). However, «The body is curiously absent to us during health, and it is only in sickness that it makes itself fully felt, and then as that which unsettles the sense of self» (Shildrick 1997: 10). The body perceives itself only in its burden, when the sickness threatens and impoverishes the foundations upon which the social identity of the subject rests.

The distinction between physical body and sexed body is found in the anatomic distinction between reproductive and productive organs. The latter ones - breast and uterus - define in power and act any woman's "gender-value" produced by the mystification between the aesthetic and physiological dimension. On the anatomic dimension the woman is marked for what on the aesthetic level, through a series of tracts and aspects, more or less fragile and vulnerable of the feminine, refers to the uterus. A sick body is exposed, when precarious, parcelled and unstable, to the sanitary-medical power and the evaluation dominion of the diagnosis, whose implications are sometimes more devastating than the same sickness because of their performing through social implications and representations rather than biological evidence. (Brown *et al.* 2011).

Despite the repertoire of a masculine and feminine that performatively defines the script of the relationships, the body of a sick woman is stigmatized in its gender marks “malfunctioning” and the part that occupies the place of the whole (the whole) is defined through that corporal stigma, applied with the diagnosis, that «underlines and constitutes a particular fracture between virtual social identity and social actualized identity” of the patient who is so “declassified from complete person to marked, discredited person» (Goffman 1963, 17-20), for the same fact that one aspires to restore its bio-psychic balance, while on it is imposed the violence of the projection socially defined of physical body and sick sexed body.

The subject affected by neoplasms, during the therapeutic procedure investing the very subjective emotional and relational sphere, transforms the modesty of her bodily self in shame, and the fear of the physical and disfiguring consequences of the sickness in disgust for herself. In these two passages – “fear versus shame” and “modesty versus disgust” – is situated the whole emotional phenomenology arising from the treatment of those cancer diseases affecting the sexual/sexed organs of a female body.

If «the subjective modesty is a particular form of feelings-of-the self, and therefore a feeling of the individual’s self-defence» (Scheler 1953: 37), the perception of the bodily modesty, of which the sexual one is the most concrete expression, opens up a tension between the self and the other, a dialectical dimension, erotic and seductive, placing the subjects of the relationship, doctor/patient, sanitary staff/inpatient in a dialectic and asymmetric tension. The perception of modesty in relation to one’s own body does not discern its physical dimension (*Körper*) from the sexed one (*Leib*). If fear, as corporeal perception, distinguishes the I from others, the emotional script of modesty describes the corporeal gratification deriving from the awareness of being equipped, supplied with a body, and the gratification deriving from it is all internal to the perception of the Self as compared to the one of the other.

Shame is instead a “social shame.” It makes the subject “victim” of an indirect and symbolic violence, produced by some disgust that is hidden behind the apparent professional detachment from the sick. Shame and disgust, in fact, «emotions are particularly subject to a normative distortion and, therefore, are unreliable and inappropriate to lead to a public practice, precisely because of the specific features of their internal structure» (Nussbaum 2003, 31). However, it is precisely the shame, in its primitive value, and disgust, in its component unreasonable, to colonize the emotional sphere and behavior the patient during the cancer treatment.

Modesty becomes shame (and self-loathing) through the same practices of medicalization and care that are supplied to the sick body by medical staff in the first instance and by family and friends of reflex.

The sick – especially when it's a woman – tries a "primitive shame", that is «a shame closely linked to (...) the reluctance to accept that the state of need represents, like the disgust, a way for hiding to ourselves the our humanity» (Nussbaum 2003: 33).

Emotional scripts of disgust and shame are the effect of a real violence exercised by medical and sanitary staff. A person with a mutilated body *no longer feels* the modesty as its threshold of the difference between the self-body and the other's body, and transforms this perception in the biceps of shame/self-loathing. In fact this is one of the contemporary forms of symbolic violence that in achieving the well-being of sick requires a representation of health in opposition to the disease, determined by the parameters – aesthetic and sexual – of male domination. Women suffer the symbolic violence of male domination and rather than to feel the modesty as self-perception of own body (*Leib*), they feels shame and disgust for their own body (*Körper*) offended by breast or cervical cancer and, therefore, "become indecent". The body must be therefore hidden and covered by clothes – often large and shapeless – that de-sexualize the image of the ill woman of cancer, conferring to her a sufficient propriety.

The decorum, as noted Tamar Pitch, is synonymous with a "false consciousness". It is the basis of a set of representations that influences practices and social behaviors. The function of the decorum is that to obscure and to remove what does not correspond to the aesthetic guidelines of "public decency" and "decency urban". Cancer, in its bodily effects epidermal, in those of its mit-derm and final stages of disease, through the exhibition of a bald head as well as through the temporary removal of a breast, becomes indecorous for the simple fact that it provokes reactions – and then constraints – emotional to the others.

The beauty obtained through the manipulation of the body using the aesthetic engineering, creates the wellness of the sick woman only from a perspective of "false consciousness" (Fusaschi 2011a). The reconstruction and the "empowerment" of femininity would seem to pass by the cultural imposition of a plastic and cosmetic surgery in «a renewed form of civilization of the body, connected with the sexuality and subjected to a permanent male domination» (Fusaschi 2011b: 82).

The body is then primarily a social construct, a "political" body. The diseases are not only found in the physical body, but – as illnesses – in the self-perception of the sick women who blend together their emotions to the common perception of the disease imposed by the dominant culture (Illouz 2004). It follows that women with breast cancer or uterine cancer «apply patterns that are the product of male power or, in other words, their thoughts and their perceptions are structured in accordance with the structures of the relationship of domination who suffer and their acts of knowledge are, inevitably, acts of gratitude and submission» (Bourdieu 1998: 22).

The qualitative research

The research took place between December 2013 and August 2014 and covered the Hospitals of “Sant’Antonio Abate” of Trapani and “San Giovanni di Dio” of Agrigento and the “Civic Hospital” of Palermo. It was made up of three phases: a literature review, a participant observation, a qualitative investigation.

For qualitative research were conducted 36 in-depth interviews with a sample of 31 of the Sicilian women and 5 foreign women, all residents in Sicily and the Catholic religion, who have lived through the experience of cancer and aged between 35 and 55 years.

The in-depth interviews, consisting of about 60 questions each, identify some elements that describe – between desire to heal and fear of a cancer treatment with the removal of the breast or uterus, free choice of health care and the symbolic violence incorporated into health treatments – the steps of the redefinition path of female identity. In redefining the identity of patients, aspects of their *Körper* – such as hair loss, dry skin, swelling of the limbs, urogenital atrophy etc. – subvert the emotional scripts referable to their *Leib* and their own self-perception

We tried focusing on the ambiguous or problematic aspects of cancer experience made by interviewees, and due to the discursive practices both doctor-patient and private ones (partner, friends and work colleagues). It was, from our point of view, to highlight the different way of perceiving the own body before and after the diagnosis, before, during and after the anticancer treatment, and to make it stand out, as well as practical in everyday hardships, the conflicting feelings, the dominant, cultural representations of the female beauty and the negative emotional script (shame and disgust of self) that gradually arose.

The subjective perspective and autobiographical interviews conducted has shifted the emphasis from the medical knowledge to “know the experience” dropped in everyday life, because «the meaning of life that experience opens to the subject is purely personal, but [...] the world of experience is structured by the effects of the action of countless other men and women» (Jedlowski 1994, 209-212).

It was then possible to highlight three dimensions along which to read the story of the interviewees through in-depth interviews carried out:

- the biographical, in other words the concrete dimension of the lived experience of events and situations;
- the subjective dimension, understood as psychic and semantic reality consists of what is considered to be significant in her biography and her bodily identity in relation to the culturally dominant representations;

- the discursivity of the story, produced in the dialogic relationship of the interview, which corresponds to what the woman intended to say in relation to her biography or experience of the disease, and which stands in our research through the lens of gender and symbolic, gender violence.

The material of the interviews was then treated in "key heuristics and hermeneutics" (Kaneclin Scarpati and 1998), in order to characterize the events experienced by the interviewees.

The phenomenology of the emotions that accompanied the changes to the identity of the interviewees in the various stages of their biographical experience of uterine cancer or breast cancer – from the "discovery" of the disease and its developments – in most cases identified by the sample of the interviewees – to its eradication (when this took place) – has intended to offer a peculiar view of the gender relationships.

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The interview explored seven thematic areas:

1. self-perception before and after cancer diagnosis and anticancer treatments,
2. emotional scripts that have accompanied the sick,
3. the changes occurring in family relationships and friendships of the interviewees,
4. the degree of acceptance, rejection or collaboration with the medical and paramedical staff, with particular regard to the symbolic references of male domination,
5. changes in the daily lives of the interviewees,
6. priorities and complementary aspects of everyday life of women with breast or uterus,
7. the relationship with your partner.

Here we will describe some of the aspects that emerged in relation to areas 1, 2 and 3.

The Discovery of the disease and self-perception

The diagnosis of cancer is always a traumatic experience that it is hard to transfer from the objective fact – heard and understood conceptually – to an effective awareness of women with cervical cancer or breast cancer. From interviewees have understood the gravity of the illness, they had the perception of not being more autonomous and to depend on the help of others. Their existence has been placed in the hands of others.

When the doctor told me I had cancer of the uterus, at first I thought he was not talking about me. A few minutes later, I said me that the doctor had formulated a sheer hypothesis – the worst – compared to my state of health. And he had no certainty (Anna, 55 years).

It was not true, I was in a movie, was not about me. My breasts, I was there as if it were attached – do not know – a kitten. It was a part of me that I was fair, even turgid, full (...) No, I could not be patient with breast cancer (Francesca, 37 years).

Subsequently, very soon, the incredulity leaves the place to the anger and the desperation, as in Erminia, for example:

I reviewed, as the photo finish, all my life: the hardships, the unpleasant events, the death of loved ones, and I asked myself: Why even uterine cancer now, just fifty years? Why? Why die? (Erminia, 53 years).

Immediately, when I have understood that it dealt with me, I hated everybody. All, my mother, my husband, my friends, my work colleagues. Everybody will be lived for a long time. My husband would be married another time after my death; my mother would have found a further motive to feel unlucky, to cry and to make herself console by neighbors or by nuns in church; my friends would have forgotten me soon. I have thought that I was alone. Alone of forehead God (...) if God there was somewhere (Marzia, 54 years).

The women interviewed understand that their lives will be destabilized, during the anticancer treatments: they will become as fighters, and that this will lead to the waiver of the roles and the habitus that they played until the day before. It is a real “*reductio ad unum*”: the breast or cervical cancer trapped inside themselves, their awareness (*Leib*) trapped inside their body (*Körper*).

I would have liked to do the things of everyday life, running, boating, cycling, sunbathing on the beaches of Trapani. And instead I had to stay in hospital, spending time in medical facilities where other women, like me, were cured. I felt as an endangered animal species or a dying breed (Alina, 38 years).

Even doctors and the entire medical équipe exert a dominant and almost violently function in the subjective perception of the sick woman. The professional duty – to cure when is no longer possible to prevent – turns often, at stages following the cancer diagnosis, in a rigid prescription of prohibitions and concessions concerning the working time and loisir time, what you can and what you cannot do. This leads to a substantial transformation of woman affected by breast or uterus cancer, who becomes one thing and one thing only with her disease to have to combat, destabilizing her own identity. The will to tackle the cancer – that a good oncologist knows stimulate to

woman affected by breast or uterus cancer – turns a “woman of the female gender” into a “sick gender neutral”.

My practitioner was a man, another man like my father, my brothers and my husband, who decided in my place: when to go to the hospital for treatment or controls, when to be hospitalized, when to be operated on, what to do or not to do between a hospitalisation and a round of chemo (Fatima, 45 years).

I had always felt pretty. Now in front of the doctor who was studying my mammogram, I was just a poor patient (...) “in his hands” (Greis, 48 years).

In the hospital, during one of the checkup that the doctors seek to patients every morning, the head of the department arrived with four medical doctor under training. A thighs open looks I was invaded by strangers eyes, and I was ashamed and disgusted with myself (Manuela, 55 years).

Emotional script that accompanied the experience of the cancer

The emotions you feel from the discovery of cancer and during all the therapeutic iter have been mixed.

Silvana remembers how the disease has not only put a strain on her mental balance, depleted his social image. At first, he says, he had the comfort of her husband and most of her son. With the worsening of the disease, had more difficulty in performing the duties and tasks of the past, and also his self-esteem decreased.

I moved to Rome, to my son’s house, for about six months with my husband. This allowed me to be near to my son for the time that I could still live and enjoy the best of care in a center specializing in breast cancers. My husband was on leave because he had given up going to the bank, to stand by me. My son, in that same time period, he studied to support the final university exams.

I could see, day after day, I had become a burden: my body, this useless body with its organs irreparably sick, with a uterus like a broken record and a “vagina that did not sing anymore.” I sucked me alone, sucks, and said nothing more and more. Only my eyes spoke truly (Silvana, 56 years).

The emotions you feel from the discovery of cancer and during the whole therapy have been mixed.

The most intimate aspects of relations with the partners seem to be negatively impacted. The perception of one’s body, shame (which took the place of shame) of having to show feeling “disabled” – also in view of the fact that among the interviewees, while some of them had suffered a partial removal and therefore had scars rather small, others had undergone total excision – denigrates the image and identity of the

women interviewed. And it is just in case of having sexual intercourse, that most of the women surveyed thought that nothing would be as in the past, because the same interviewees were deeply and intimately changed.

My husband tried to caress me like before, before the operation, to wake me, to make me feel like a woman and wake my erotic zones. I though sucked me. I felt like to have a hole, long and deep instead of the uterus, and I hated myself (Marzia, 56 years).

The doctor had rebuilt one of my breasts (...) but I did not have the nipple into one breast and I ashamed to show me not only when I had sexual intercourses, but even when I undressed to do the routine checks of breast and the ealth check-ups. There was a nipple, the other not. A "din" without a "don" of a "false bell" (Giuseppina, 35 years).

My husband is Muslim. In our religion the children represent the abundance and the "eye of Allah" on our family. I could not have any more children and I was only 35 years old. I despised, and he despised me, even though I said that "I was anyway his wife" (Fatima, 35 years).

When I was young I was very demure. With difficulty I undressed to take a shower in the gym, or when I shared the room with my classmates during the school trips, or when I slept in a tent on campsite with my girlfriends. The sense of shame accompanied me even in my adult life, and I continued to undress with difficulty even before my partners. Now I am my uterus, I'm just a uterus to inspect and I am ashamed as a child who has shit on him (Patrizia, 48 years).

I always felt "pretty" Not beautiful, but nice, yes. Then, after the breast surgery and before the reconstructive surgery of breast, I touched me: one breast and one was not. The doctor that visited did not see me either, I was for him a wound, a table, a surgical cut, cut-back. Luisa, the pretty Luisa with her turgid breast was gone (Luisa, 36 years).

From the evidence gathered shows a cross-section of the tragic biography of the women interviewed with the consequent transformation scripts emotional, concerning both *Körper* that *Leib*. From the interviews it is evident that none of them feels and perceives her bodily self as before the surgery to remove the uterus or breast, nor recognizes herself in her own updated image of a woman's body sick, mutilated in her femininity and imperfect sexually

To deny themselves, for hiding to themselves to have been mutilated in the body

In analyzing the relationships and limitations that become evident in the narrative of the interviewees, it is appropriate to point out how often the same interviewees do not feel comfortable talking about experience of cancer, other times they are their caregivers to be embarrassed. Having no previous experience of this type of cancer pathology, the family members of the sick woman often, while offering the necessary

support to her relative, live in a state of constant emotional oppression as well as their strong, sympathetic emotion. So, in this kind of family relationships that often involve children, siblings and parents, it doesn't talk about the oncological disease, trying not to focus the state of health that threatens the entire universe of reference of the patient and his balance in everyday life.

What, between emotional scripts, we have referred to as "disgust" of her own body, it turns on the relational level, in a diligent practice of distancing from the "world of the Other." The woman who underwent uterine or breast cancer, tries to avoid any contact that is not shielded by the formalities, and takes away from his neighbor.

The testimony of Joan is effective in this regard:

Paola was a university colleague. With her, when we were young, we also made a trip hitchhiking from London to Copenhagen. Even later, when the demands of work and their families have absorbed much of the time that we spent together before we got married, we never stopped seeing each other, at least once a week, to laugh together. We have done so in the twenty years after her degree. However, since I do the chemotherapy (this is the third round of chemo), I heard Paola on the phone but she don't like to meet me and go out together. I do not ask her to come. She doesn't ask me to get coffee (Giovanna, 47 years).

And yet Francesca (37 years):

At first they were so many to be close to me, to make me feel cared (...) but basically I felt like I was a crippled. At least I felt like "marked" (...) sooner or later I would have died. And then I began to be bitchy, to fail, to always be controversy. Was anyone anyway to keep me company, to look out for... someone of my old friends began to avoid seeing me in private. Basically I was for them a useless woman, a "leper" that no one – especially males – wanted to touch.

"To touch the body" becomes, reflected in the perception of the dominant cultural representations of some of the interviewees, almost a "lewd act", as if a surgically operated body – that is not an aesthetically operated body in a common representation) were no longer touched by shame or disgust.

In the testimonies of our sample of women it is not clear how the disgust is associated to the shame of their own body surgically tampered and/or mutilated, or to the projection that comes from collective representations but, among the so many interviews, that of Eleanor, who is no longer able to speak, is the most poignant:

After the operation and the removal of the uterus, I had had a dream: I dreamed to have a roof over with many cracks while a storm rages. Under that roof there besides me seven or eight people, now cannot remember, but it was raining, it was raining and the water passed through the holes in the roof and we all bathed. For days, for weeks I lost fluid and blood from the vagina (...). I felt like the roof where the rain passed and at the same time as the people who bathed. I could not protect anyone, for months and for years I have had the awareness of being ruthless become useless and unfit.

Conclusive reflections

From the analysis of the surveys the body suffers from cancer of the uterus or breast showed as the cornerstone of a plot that combines the representations of the feminine disease with the undesirability physics. It shows how the experience of the disease induces the woman to self-mortification of one's self and to the production of devastating emotions, such as shame and disgust. Emotional script that mark the identity on a personal level of self-perception and the relational level especially as regards the aspects affective-sexual life of the interviewees.

The analogy between beauty and health of female representation belongs to a Western cultural tradition based on male power (Bourdieu 1977) and still traceable in the relationship between doctor (medical staff in general) and the patient, and in those that are reflected in the networks of socialization primary and secondary of the woman affected by a breast or cervical cancer (Marzano, 2004; Biancheri et al. 2012). In this sense, the body, made it vulnerable in its most intimate aspects sexed, is progressively subjected to an implicit stigma of "the body to cure and lobotomize" from its gender characteristics and its links erotic, with often devastating effects on self-perception of woman

The diagnosis and the phases of anticancer treatments reduce the ill woman to her disease, performatively affecting her identity, due to the projection that the medical sanitary system refers to the patient, being in continuity with the collective representations associating "what is healthy to what is beautiful" and what is beautiful to the potential of seduction and eroticization of the sexed parts. It is a peculiar aspect of the *social embodiment* (Connel 2006) that in the juxtaposition of genders, refers to the same dialectic between representations and social interactions. It shows a lag found in the collective representation of the female beauty, that is transmitted by a healthy body, and that of an ill body that, being medicalized, ends up lacking seductive power and of that 'right' contribution of social niceness.

The stories about cancer, through the narrative register of the interviewees, give the disease a meaning "unseemly", and the emotional and emotional implications are

reflected in the entire system of reference of the woman and in different spheres of her existence. Collective representations, the logic of symbolic domination and production of emotional scripts such as shame and disgust are interwoven, influencing – as we have highlighted in the research – both personal perception that social relationships of many patients who have been or are still suffering breast or uterine cancer.

The woman suffering from cancer, having limited possibilities of controlling the medical information along with the lead of cultural representations conveyed by it, and which are, even indirectly, discrediting, reduces her ability to have relationships “normal” within the her context. To endure the anticancer therapy corresponds, in fact, to the adaptation-in or to the forced acceptance of a symbolic male domination that makes woman suffering from breast or uterus cancer a person vulnerable and whose balance – personal and family – is more exposed to the destabilization and discomfort. Even the use of plastic surgery, whose border with that of cosmetic surgery is quite labile, can, in this view, be considered «a renewed form of civilization of the body, connected with sexuality in the wake of a perennial male domination» (Fusaschi 2011b: 20).

As showed the women interviewed, the domain of the male symbolic representations is strengthened through the entire course of treatment. It follows as the repeated exposure of her imperfect body becomes a kind of social punishment, while the therapies become physical handling practices, and the decency to turn into shame and self-loathing.

The sick body as “social place” becomes repulsive body and produces a process of self-stigma and shame that involves the whole person reduced to mere physicality medicalized (Conrad 1992 and 2007) and bio-medicalized (Clark and Shim 2009). In the treatment of cancer is realized an alliance between the discursive practices of welfare and those hetero-hegemonic irrepresentability of the disease associated with the female body (Butler 1993). Among them chemotherapy, like other hormonal therapies, has a strong effect on the sex life of the same patients.

In addition to the aforementioned physical ailments, it produces complex in the and peculiar forms of emotional vulnerability that perform irreversibly social life of the woman suffering from breast or uterus cancer, her significant relationships, as well as her own perception of identity.

Inside and outside places of care, the woman is subjected to a de facto progressive “impoverishment of the feeling of shame” and a sort of “injunction to contempt”, tracking their humus in the legacy of a culture based on a male domain and that still influence the practices of prevention and treatment of cancer and tumors of the uterus.

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