Warriors and Survivors: Constructing the Gendered Cancer Patient as Hero

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Abstract

Patients with genital or reproductive cancers are constructed by medical, academic, and popular discourse to be either female or male patients. A cursory review of the cancer literature suggests that male and female patients are constructed in the form of either hegemonic masculinity or emphasized femininity. However, upon deeper analysis, it is clear that cancer discourse is always a transformative discourse. A person starts out whole and pure, without cancer, and goes through a journey with his or her cancer. In that journey, she or he is constructed through processes of social markedness and material discursiveness as either a warrior or survivor. The warrior patient experiences a transformation from hegemonic masculinity to a subordinated form of masculinity, one whose locus is not the penis or testicles. Instead, these men locate their masculinity elsewhere on their bodies and also learn other ways to express their masculinity. Alternatively, women, while also experiencing transformation, must adhere even more strictly to the norms of emphasized femininity in the adoption of the survivor narrative, and if they do not, will likely be blamed for falling victim to the cancer. The defining attributes of the survivor narrative are the same, or very similar to, features of emphasized femininity. In their opposing cancer hero narratives, then, women must embrace emphasized femininity whereas men are presented the opportunity to embody a new masculinity. In the transformative hero narrative, women transform into a more submissive and docile creature, while men transform into a more flexible and powerful creature, revealing the asymmetry between men and women in this society.

It is generally accepted within both academic and popular circles that there is little biological evidence that supports any connection between stereotypical women's and men's behavior such as nurturing or aggressiveness with biological facts. Gendered behaviors and gender identity itself are culturally and socially constructed (Kessler and McKenna, 1978). In the social sciences, the belief is that the processes and structures of gender relations define people's bodies in gendered terms rather than their biological makeup—i.e., hormones, chromosomes, anatomy and so forth. Simply stated, the vagina and penis are important as markers of gender identity because of social processes and not because of inherent biological facts. In this way, people who produce sperm cells are considered "male," and those who produce egg cells are considered "female" (Kessler and McKenna, 1978). Indeed, the most persuasive, albeit teleological argument typically provided for asserting the "naturalness" of a binary gender classification rooted in biological sex is that "women can bear children and men can produce sperm" (Gurevich et al., 2004). These apparent connections between the biological and the social are not universal nor are they natural, however.

The assumption that people's bodies are socially gendered asserts that this holds for bodies in health and in sickness. Yet as I will show, bodies with cancer are reinterpreted through a set of material and discursive practices that define those bodies in particular feminine and masculine ways. These processes are distinct for women's and men's bodies with cancer and yet each version relies on dominant gender definitions of femininity and masculinity. In this paper, I explore the academic and popular discourse that creates the gendered cancer patient. I first briefly discuss the material-discursive and embodiment approaches to gender construction, which emphasize the role of language and discourse in the creation of gendered categories (Butler, 1993). In the rest of the paper, I rely on Connell's (1987) conceptions of hegemonic

masculinity and emphasized femininity to explore how cancer patients are gendered in ways that are simultaneously both consistent with and in contrast to these dominant masculine and feminine forms by exploring the discursively created male cancer patient, and then the female cancer patient. I also draw upon the model of hero narratives and archetypes (Seale, 2002; Connell, 1995) as the mechanism by which male and female cancer patients are discursively produced.

In modern Western society, genitals are considered the preeminent bodily features that classify a person into one of the dual sex categories of male or female (Kessler and McKenna, 1978). Disease processes that primarily affect the genitals and sexual organs, therefore, such as testicular and prostate cancer; ovarian, uterine, and cervical cancer; and to a somewhat lesser extent, breast cancer, are perceived to inhere to the gender of the ill person. Because only individuals with certain biological characteristics- for example, only persons with testicles, who are typically defined as "male," can get testicular cancer, testicular cancer is seen as a man's cancer, dealt with by men in masculine ways. Similarly, because people with ovaries, uteruses, and cervixes are generally assumed to be "female," cancers of these organs are understood as women's illnesses, experienced by women in feminine ways. Although both women and men contract breast cancer, it too is perceived predominantly as a women's illness. Breast cancer patients are portrayed as female (Susan G. Komen For the Cure, 2008) and are popularly presented as experiencing the disease in a distinctly feminine manner.

However, there are no inevitable connections between the genitals, cancer, and gender. As research on post-operative transsexual women with prostate cancer demonstrates (Molokwu et al., 2008), people with vaginas—i.e., female persons may in fact succumb to "male" cancers, and female-to-male (FTM) transsexuals may experience cervical, ovarian, vaginal, or uterine

cancers (Dizon et al., 2006). Any presumed natural connection between genitals and gender is spurious (Kessler and McKenna, 1978), as the recent media frenzy about Thomas Beatie's two pregnancies (Conlan, 2008; Goldberg and Thomson, 2009) demonstrates. Though breast cancer, for example, is predominantly portrayed in the mass media as being a "woman's illness" (Susan G. Komen For the Cure, 2008), men's rates of breast cancer are 1.4 per 100,0000 (Susan G. Komen For the Cure, 2008). Indeed more men die of breast cancer every year than testicular cancer (Jain, 2007).

Academic and media portrayals of cancer patients as *feminine* or *masculine,* merely because of the bodily site of the cancer, do not represent already-gendered patients; instead this discourse actually creates the gendered patient. Cancers of the reproductive organs do not adhere themselves to mere unsexed body parts, such as arms, legs, or bones, but to socially constructed *male* or *female* body parts- the testicles, prostate gland, cervix, vagina, and uterus. The academic cancer literature and popular cancer media is not peopled with cancer patients- it is populated with *male* or *female* patients, who experience their cancers in particular feminine and masculine ways.

EMBODYING GENDER THROUGH HERO DISCOURSE

In everyday life, it is presumed that "men" and "women" enter into a set of socially constructed relationships produced and reproduced through people's actions (Connell, 1995) and thus it follows that already-made men and women develop genital cancers and through their gendered experience of the cancer, reproduce that particular gendered experience. However, gendered patients are created by the discourse and experience of cancer. Gender is a temporal process that begins at the moment a human body is born; the gendered and sexed body is created as it comes in contact with society (Butler, 1993). This creation is in large part a result of the

language and discourse of gender; therefore, materiality and the social representation of gender are codetermined (Butler, 1993). Medical and scientific knowledge represents a map of power relations (Fujimura, 2006), and these relations, in the form of scientific discourse and language, reinforces and legitimates existing gender dichotomies, distinctions, and inequalities. Materiality is an effect of power, technology, and ideology (Butler, 1993), and as a result, the physical body is inextricably linked to the social processes that engender it (Fausto-Sterling, 2005).

The material-discursive, or embodiment, approach to gender suggests that physical embodiment is inseparable from beliefs, perceptions and interpretations regarding the physical body (Gurevich et al, 2004). This theoretic framework equally emphasizes the role of socio-historical forces and biological bodies in the creation of gendered experience. Therefore, talk *about* the body is intrinsically linked to talk *through* the body (Gurevich et al., 2004), and the two are co-constituted. In other words, our relationships and responses to bodies both our own and others are mediated through and constructed by medical and related discourses about our bodies and their meanings. In terms of cancer, not only does talk about cancer create the gendered patient but it also forms the expectation of what male and female cancer patients should be (Wilkinson and Kitzinger, 2000). When male or female persons are given a cancer diagnosis, they have a rich oral and discursive legacy from which to draw appropriate gendered cancer patient behaviors.

The cancer discourse that contributes to the gendering of patients is public and private, scientific and popular, mediated and highly intimate. Although all cancer discourse plays a role in the creation of gendered patients, scientific discourse, and the actions that spring from it such as cancer testing, prognosis, and treatment regiments, may be particularly potent forces in the creation of gendered patients. Rhetorical language mediates the scientist's access to the objective

world generating scientific, "objective" knowledge grounded in socially and culturally significant belief systems (Happe, 2006). Scientific discourse is privileged, claiming to represent the "real" while always articulating, legitimizing and, naturalizing the social structures and subjectivities they create and enable (Happe, 2006). Scientific discourse's power rests in claims to structural neutrality, but these ideological assertions serve to depoliticize social actors by asserting that actions are apolitical and objective (Apple, 2004).

There can be no one single concept of masculinity or femininity. Instead, ideas of masculinities (Connell, 1995) or femininities denote difference, or similarity, in socially constructed interactions. These multiple masculinities and femininities are created through discourse. Among other attributes, the cancer discourse is a hero narrative, and it is differential hero narratives that create the gendered cancer patient and multiple masculinities and femininities. Constructed as a journey, the hero narrative contributes to others' perceptions of the cancer patient as well as shapes the self-identity of the hero/patient (Giddens, 1991). Through the hero narrative, patients are provided the opportunity to imagine that they can control cancer through the effort of will (Seale, 2002). Breast cancer has become the exemplar of cancer journeys (Moynihan, 2002) and hero narratives; however, society offers different hero narratives to men and women. *Warriors*, the male cancer patient hero, use agency and personal power to actively fight against his illness. Warrior heroes transform their existing masculinity into dominance over the cancer. Female cancer patients draw from the hero-as-*survivor* narrative. In this narrative, the female cancer patient perseveres in the face of grave danger and embodies strength and resolve to become victorious against her cancer. Both sexes, in the discourse of the hero, are offered paths to the common goal of a self-willed victory over cancer and the limitations of the body (Seale, 2002), but the gendered nature of the hero narratives contribute to

the construction of gendered cancer patients.

CONSTRUCTING THE MALE CANCER PATIENT AS WARRIOR

Hegemonic masculinity is not a particular characterlogical type that can be codified in lists; it is instead the masculinity that occupies the hegemonic, or dominating, position in a particular set of gender relations (Connell, 1995). Masculinity, therefore, is always a relational concept and can only be understood and recognized in contrast to other subordinated masculinities and femininities (Connell, 1995). However, some stereotypic characteristics are typically associated with western hegemonic masculinity, such as the restriction of experience and expression of emotions; toughness and violence; self-sufficiency; being a "stud;" no "sissy stuff;" and being powerful and successful (Kiss and Meryn, 2001). Others have noted that some of those traits associated with the current hegemonic masculinity relate to sexuality: sexual competence, the ability to give a partner orgasm, strong sexual desire, prolonged and reliable erection, being a good lover, fertility, and heterosexuality (Clarke and Robinson, 1999). The warrior narrative both draws on, and complicates, hegemonic masculinity when men experience cancers that affect the parts of their bodies most strongly associated with hegemonic masculinity: the genitals and sexual organs. Testicular and prostate cancers affect men at a spot where their bodies "concentrate" masculinity (Clarke and Robinson, 1999).

As the biological center of sperm production, testicles are among the primary signifiers of hegemonic masculinity in western culture. Testicular cancer typically affects men between the ages 15-34, and is the most common form of cancer in men of this age group (Buetow, 1995). Men's own discourse about testicular cancer testifies to the linkage made among men between the testicles, masculinity, and the threat to masculinity that testicular cancer poses. In fact, men's discourse about prostate and testicular cancer tends to focus more on the bodily site of the

disease (Seale et al, 2006) than on other aspects of the cancer experience. The centrality of testicles in the coherence of male identity is exemplified by research in which college-aged men rated losing a testicle to cancer as the second-most humiliating experience, second only to being unable to maintain an erection during sex (Morman, 2000). Testicular cancer patients experience the damage or loss of one or both testicles as the absence of a physical and symbolic marker of masculinity and normality (Gurevich et al. 2004). Markers of a man's ability to achieve an erection, testicles are a central indicator or sign of masculinity (Romeo et al., 1993). Prostate and testicular cancers that threaten this ability also threaten the core of men's masculinity.

In media representations of men dealing with cancers of any type, but especially those of the genitals or prostate, male patients are commonly portrayed as having been offered a test of pre-existing character (Seale, 2002). In other words, cancer is merely the mechanism by which the man's repressed hero is released. In a study of media representations of men with prostate cancer, Clarke found that a portrayal of the patient with "machismo" prevails (1999b). Cancer is often portrayed in the news media as being frustrating for men, but not for women (Seale, 2002). This suggests that because men are understood to "naturally" possess more agency, their aims will be more easily frustrated than women who are perceived to be less goal-directed. In the same study, Seale found that men were portrayed as considerably less "thrown" by news of cancer than women (2002). Men with testicular and prostate cancer are depicted as well defended against feelings of anxiety and fear, and instead are portrayed as experiencing cancer as a troublesome, frustrating, or even surprising experience (Seale, 2002). Men are more often represented as hard-working, stoic, strong, unruffled, and realistic than women (Seale, 2002). Being depressed and having anxiety related to a prostate or testicular cancer diagnosis is portrayed as being in direct conflict with core areas of male identity (Kiss and Meryn, 2001).

Other studies contradict these results, however, and find that men diagnosed with testicular and prostate cancer are more prone to anxiety, depression, and hostility than are women cancer patients (Peleg-Oren et al, 2003). Overall, however, media representations of men with genital and reproductive cancers represent men as strong and not easily unbalanced; the ideal-typical image is that of a warrior, actively fighting against an oncoming enemy.

Men are socially expected to deal with cancer on their own, or with their doctors (Seale, 2006). Male behavioral norms emphasize decisiveness, autonomy, and emotional control, a position of power reached through the acquisition of medical information (Seale, 2006). For example, in one study, men reported that it was not "macho" to seek advice about their cancer and that it was not "masculine" to demonstrate weakness in the form of seeking help (Chapple and Ziebland, 2002). In one study of face-to-face prostate and breast cancer support groups, men were found to emphasize the importance of information seeking and sharing behavior above any emotional or psychological support (Gray et al, 1996). In her study of online support groups for men with prostate cancer, Sullivan noted that the patients were more likely to speak with an "instrumental" orientation than do women in breast cancer support groups (2003). Men gave encouragement to each other in the form of promoting strength and encouraging each other to keep "their chin's up." However, it is important to consider a potential selection bias in all studies that feature online discussion groups, as men who are drawn to online support groups may already have masculinities consistent with a hegemonic ideal. As these groups allow men to be anonymous, the hegemonic masculinity that dominates these sites could be a result of selection bias.

Highlighting the hero-as-warrior narrative, battle-like terminology is a unique feature of the rhetoric within prostate and testicular cancer support groups, a theme that does not appear in

breast or ovarian cancer support groups (Gooden and Winefield, 2007). In online discussion boards, men speak about "fighting" their cancer, "beating the bastard," and refer to members of the discussion group as "battle scarred vets" (Gooden and Winefield, 2007). Cancer itself is described as punching or striking the patient (Gooden and Winefield, 2007). In their research about media portrayals of testicular cancer, Clarke and Robinson cite the *FDA Consumer* in 1988 as writing, "modern science has *fought* numerous *battles* in the *war* against cancer…the margin of *victory* has rarely matched the *fight* against testicular cancer…a patient can *fight* the disease at various stages and one of the best *weapons in self-defense* is self-examination" (1999, emphasis added). In one of the most popular recent examples of the hero-as-warrior battling cancer, Lance Armstrong and his admirers have become the experts of blending the image of hegemonic masculinity, the hero narrative, and battlefield terminology. When honored as "Sportsman of the Year" in 2002, *Sports Illustrated* magazine quotes him criticizing himself when he feels self-pity about his cancer or cycling as saying, "You pussy, Lance" (Reilly, 2002). He exemplifies the hero archetype and is reported to "…suffer so he won't forget. He suffers to remind himself that he is still alive. He suffers a little so that maybe the big suffering won't come back, the suffering that came with 14 tumors in his testicle, lungs and brain and with moments when he knew he was going to die" (Reilly, 2002).

The hero-as-warrior narrative of the male cancer patient contains many of the elements of a hegemonic masculinity that demands a mute and unemotional patient who bears his illness with stoicism, independence, and resolve (Wall and Kristianson, 2005). Several studies find that men's experience of prostate and testicular cancer is indeed mediated through a hegemonic masculinity, although many scholars argue for a more nuanced understanding of the male experience (Wall and Kristianson, 2005; Gurevich et al, 2004) with testicular and prostate cancer

that involves a transforming masculinity, which can be conceptualized as the hero-warrior narrative (Seale, 2002). The hero-as-warrior narrative, unlike the static narrative of hegemonic masculinity, is one of change and transformation, in which men relocate the source of their masculinity from their testicles and sexual organs to other markers of masculinity (Gurevich et al, 2004). These new markers of masculinity might include his "battle scars" and other memories of his win in a war against cancer, as well as a renewed interest in one's "humanity" (Gurevich et al, 2004), as opposed to a pure genital masculinity. Without this transformation of masculinity, the hegemonic male would be devastated by cancer, because the loss of testicles or the prostate gland equals the loss of the external signifiers of hegemonic masculinity. With the hero-as-warrior narrative, men can replace these signifiers, and hegemonic masculinity, with a form of masculinity that surpasses bodily signs.

The hero-as-warrior cancer discourse creates a male cancer patient who undergoes stages of transformation, shifting the site of his masculine identity from his genitals to his performance in an epic battle against cancer. In this battle, he may rely on some of the features of hegemonic masculinity such as inner strength, but other characteristics of the warrior hero are in contradiction to hegemonic masculinity. The key argument that suggests that the hero-as-warrior cancer patient is constructed as different from hegemonic masculinity is the fact that hegemonic masculinities are always created in opposition to other masculinities and femininities (Connell, 1995; Wall and Kristianson, 2005). However, a man's experience with prostate or testicular cancer is a very personal, but heroic (Seale, 2002) narrative in a battle against the cancer, not against other masculinities or femininities. The warrior's masculinity is positioned in opposition to cancer, not to anyone else. This warrior narrative is slightly different from the survivor narrative seen in portrayals of women's experiences with cancers of the ovaries, cervix, uterus,

and most especially, breast. The rest of this paper will focus on women's experiences and how they are portrayed through the narrative of the female cancer patient as hero-as-survivor.

CONSTRUCTING THE FEMALE CANCER PATIENT AS SURVIVOR

Emphasized femininity refers to the form of femininity, defined at "the level of mass social relations," that is based on women's compliance with their subordination to men and "oriented to accommodating the interests and desires of men" (Connell, 1987). Emphasized femininity is a relational concept, contrasted with hegemonic masculinity (Connell, 1987). Emphasized femininity is the most culturally valued form of femininity, although not necessarily the most prevalent (Kelly et al, 2005). Emphasized femininity, and all other masculinities, including the hero-as-warrior transformative masculinity, is subordinated under the dominating hegemonic masculinity (Connell, 1995). The discourse of cancers of the "female" organs serves to reinforce this emphasized femininity. Female cancer patients experience genital and breast cancers through the hero-as-survivor narrative in such a way that legitimates and enhances emphasized femininity.

Because emphasized femininity, while it does have its loci in the genitals, tends to be a complete presentation of women, femininity does not reside only in the genitals. Therefore, women's own discourse about reproductive cancers tends to be of a holistic nature, discussing how cancer affects them as a whole person (Seale et al, 2006). This is in marked contrast to men who focus more direct discussion on the site of the genital cancers than holistic concerns (Seale et al, 2006). Hegemonic masculinity is rooted in the genitals; therefore, the hero-as-warrior narrative allows men to shift their masculinity to other bodily and characterlogical sites in order to transform their masculinity. However, because emphasized femininity is located in the entire

body, including the genitals, the survivor narrative, while somewhat empowering, does not allow for the same transformation that the warrior narrative does.

In the same way that external genitals, or the presumption of a penis and testicles (Kessler and McKenna, 1978) signify a male person, the presumption of a vagina, clitoris, and internal reproductive organs signifies a female person. Cancers or other diseases of these organs are perceived as cancers of the feminine body- not as cancers of particular body parts that could belong to anybody. In the same way that testicular cancer is seen to strike at the heart of masculinity, a cervical or other reproductive cancer diagnosis is seen to inhere to the very core of a woman's identity as a female (Kritcharoen et al, 2005). To demonstrate the discursive construction of the female cancer patient using a survivor narrative, I will use examples from the breast cancer, cervical, ovarian, and other reproductive organ cancer literature.

In conversation among themselves, women with cancer emphasize the importance of intimacy and peer knowledge in small group discussions about their shared cancer experiences, focusing on emotional support and friendship (Gray et al, 1996). In a similar study of breast cancer support-group discourse, Gray et al. (1997) found that women described appreciating shared experiences, being understood, and providing hope and sharing laughter as the most important aspects of the support-group experience. In her research of online support-groups for women with ovarian cancer, Sullivan (2003) found that women were more emotionally sensitive, expressive, and shared feelings and talked about their pain and frustrations than men in similar groups. All of these findings of women's discourse in cancer support-groups demonstrate the importance of invoking emphasized femininity as a mode of coping with cancer.

Media portrayals of women with cancer also highlight aspects of emphasized femininity. Media reports of women with cancer focus on women's emotionality in the face of life-

threatening disease (Seale, 2002). Media representations of the emotions of cancer highlight women's presumed innate skills in the emotional labor of self-transformation, which is particularly relevant for cancers, such as that of the breast or testicle, in which the actual physical body is greatly transformed (Seale, 2002). Women are portrayed as feeling overwhelmed with shock, fear and anxiety when given a cancer diagnosis, although these feelings are reported to later turn to depression with an accompanying sense of isolation (Seale, 2002). Women have reported experiencing stronger feelings of loneliness and fear upon receiving a cancer diagnosis than men (Hallberg and Thome, 2004). Women are more likely to be portrayed as skilful emotional laborers than are men, drawing on other women for support in their endeavors to transform the potentially overwhelming fears and distress generated by a cancer diagnosis (Seale, 2002). Women's emotional devastation is key in the media portrayals of cancer survivors found in Clarke's (1999a) study. Others, however, (Seale, 2002) have found that while emotional devastation is indeed present in the popular literature, women are also portrayed transformatively through the invocation of the survivor narrative.

Concurrent with the focus on emphasized femininity is the hero-as-survivor narrative. For men, the hero-as-warrior narrative allows a transformation of hegemonic masculinity into a more nuanced form of masculinity located outside of the genitals and that draws on emotional and other skills that are not frequently presented as part of hegemonic masculinity. For women with cancer, however, the survivor narrative, while also transformative and heroic, is not based on a departure from emphasized femininity. Instead, the survivor narrative is a story of refocusing on emphasized femininity. In other words, the hero-as-survivor narrative is the narrative of the hyper-emphasized femininity. In her often-cited article about the breast cancer culture-as-cult, Ehrenreich noted that "the pink kitsch of breast cancer culture is downright infantilizing" (2007),

a trait that is also often associated with emphasized femininity. Women's survivor hero narrative leads them even closer to mainstream emphasized femininity.

The survivor narrative can be profoundly positive for female survivors of cancer, especially of breast cancer (Helgeson et al, 2004), and women are frequently portrayed as being stronger after experiencing cancer. However, most of the literature about female cancer survivors focuses on aspects of emphasized femininity that enabled them to survive cancer. For example, Foley et al. noted that the most "successful" patients reported that cancer "fostered a greater appreciation of life and a determination to enjoy life without letting the little things bother them (2005). Female survivors of cancer are frequently vocal about the positive impact it has had on their lives and report being more appreciative of life than before the cancer diagnosis, and many make a commitment to the greater good through volunteerism (Foley et al, 2005). In the same study, a cancer diagnosis of the breast or cervix and ovaries had a generally positive effect on woman's quality of life 15 years after diagnosis (2005), primarily because of the enhanced feelings of compassion and community they experience as arising from the cancer experience. The hero-as-survivor narrative describes women developing altruism and compassion for others (Seale, 2002). A focus on community, emotional intelligence, communication, and patience are all features of emphasized femininity and of the hero-as-survivor narrative.

Women are held responsible for their embodiment of emphasized femininity and its role in cancer survival. Not only is the victim blamed, albeit implicitly, when "positive" thinking or a fighting spirit cannot be achieved, but the gendered expectations of people to respond in certain ways to cancer, and the political explanations that foster such an approach, are overlooked (Wilkinson and Kitzinger, 2000). This onus to fight and to prolong life takes the responsibility of

care away from institutional structures, and instead, it is women *as women* who are bestowed with responsibility to behave in ways conducive to survival (Moynihan, 2002). Although both male and female patients are regarded as instrumental to their own recovery from cancer, when men lose the battle, it is because the cancer was "tougher" than him, not because he did not live up to his masculine identity. Women, however, are seen as failing in their roles as women if they succumb to cancer.

CONCLUSION

Patients with cancer are created by medical, academic, and popular discourse to be either female or male patients. A cursory review of the cancer literature suggests that male and female patients are constructed in the form of either hegemonic masculinity or emphasized femininity (Connell, 1987). Upon deeper analysis, it is clear that the creation of masculine and feminine cancer identities is more nuanced and transformative, especially in the male case. The discourse of cancer is always a transformative discourse. The warrior patient experiences a transformation from hegemonic masculinity to a subordinated form of masculinity (Connell, 1995), one whose locus is not the penis or testicles (Gurevich et al, 2004). Instead, these men locate their masculinity elsewhere on their bodies and also learn other ways to express their masculinity (Gurevich et al, 2004). Alternatively, women, while also experiencing transformation, must adhere even more strictly to the norms of emphasized femininity in the adoption of the survivor narrative, and if they do not, will likely be blamed for falling victim to the cancer (Wilkinson and Kitzinger, 2000). The defining attributes of the hero-as-survivor narrative are the same, or very similar to, features of emphasized femininity. In their opposing cancer hero narratives, then, women must embrace emphasized femininity whereas men are presented the opportunity to embody a new masculinity.

Gender is a negotiation (Gerson and Peiss, 1985), not a standard proscriptive force that all people blindly receive. Men with genital cancers negotiate with hegemonic masculinity by transposing their masculinity to other parts of their bodies. Women negotiate with gender to ultimately even further embody the subordinated emphasized femininity in the adoption of the hero-as-survivor narrative. In the transformative hero narrative, women metamorphose into a more submissive and docile creature, while men transform into a more flexible and powerful creature. These gendered roles are problematic for cancer patients, especially female cancer patients of the reproductive and sexual organs. Female patients only option to navigate gendered cancer roles is to take on a *more* docile femininity than emphasized femininity, whereas men get the option to relocate their masculinity away from hegemonic masculinity and onto a form less dominating and hegemonic. Future research should examine both the ways in which men make this switch from hegemonic to non-hegemonic masculinities, as well as any attempts that women make to resist the pull towards hyper-emphasized femininity.

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