

## A Lived Experience of Breast Cancer as a Scholar of Intersectionality

### Kristi Tredway, PhD

Johns Hopkins University, Under Armour Breast Health Innovation Center, The Sidney Kimmel Comprehensive Cancer Center, Baltimore, Maryland.

*Each woman responds to the crisis that breast cancer brings to her life out of a whole pattern, which is the design of who she is and how her life has been lived. The weave of her every day existence is the training ground for how she handles crisis... For some women, in a valiant effort not to be seen as merely victims, this means an insistence that no such feelings exist and that nothing much has occurred. For some women it means the warrior's painstaking examination of yet another weapon, unwanted but useful.*<sup>1(p7)</sup>

**Audre Lorde**

**Audre Lorde (1934-1992)** is a key figure in Black feminism and contributed to the formation of intersectionality as an epistemological project. For a particular group of feminists, Lorde is our beacon, highlighting intersectional inequities as a self-described "Black, lesbian, mother, warrior, poet," as she would say during her many public appearances, and crafting a road map for many feminists, especially those who live with multiple minority subject positions. As a student and social activist, I devoured all of Lorde's writing... except for *The Cancer Journals*.<sup>1</sup> Thinking this book must be "a downer" because it was about cancer, I focused my attention on her other writing. Now, as a survivor of breast cancer, the same disease that Lorde documented in her book and that eventually took her life, I could no longer ignore this particular embodied link to Lorde's work and life. The lived experience of a cancer diagnosis and treatment, coupled with my training in intersectionality and cultural studies, paved the way for me to become a scholar of cancer disparities from screenings to treatment and survivorship, while remaining focused on the social categories of race and sexual orientation. In this article, I navigate my own intersectional lived experiences to illuminate the complexities of using intersectionality. Intersectionality often produces more questions than answers; however, this depth and complexity is what makes it so useful when doing research.

### Discussion

#### Intersectionality

*Somewhere, on the edge of consciousness, there is what I call a mythical norm... In America, the norm is usually defined as white, thin, male, young, heterosexual, Christian, and financially secure. It is with this mythical norm that the trappings of power reside within this society.*<sup>2(p116)</sup>

**Audre Lorde**

*Intersectionality* was named as such in 1989, when Kimberlé Crenshaw penned the term,<sup>3</sup> but it is clear that Lorde is seeing the same framing well before that nam-

ing. Intersectionality has now become popularized, and thus its depth is often misunderstood or simply overlooked, in public discourse. Its popular iteration focuses solely upon the various social categories that we all belong to but ignores any analysis of the differing levels of power that are shaping those social categories. Social categories exist in and through 4 domains of power: *interpersonal* (everyday interactions), *disciplinary* (rules and surveillance), *cultural* ("common sense" expectations in our society), and *structural* (large-scale, interlocking social institutions). These 4 domains of power, known as *the matrix of domination*, show how "intersecting oppressions are actually organized."<sup>4(p18)</sup> Too often, analyses of social categories remain focused on the interpersonal domain, looking at personal identities or microaggressions between 2 individuals. However, it is the cultural domain, through which the disciplinary and structural effects of racism, sexism, and homophobia are shaped, which makes these effects seem "normal" and allows for the perpetuation of these biases. This epistemological backdrop is what I had when faced with my breast cancer diagnosis.

#### Breast Cancer

*Within those weeks of acute fear came the knowledge – within the war we are all waging with the forces of death, subtle and otherwise, conscious or not – I am not only a casualty, I am also a warrior.*<sup>1(p19)</sup>

**Audre Lorde**

Prior to being diagnosed with breast cancer, my marginalized social categories had been based on sex (female), race (mixed American Indian), sexual orientation (lesbian), and gender expression (masculine gender presentation). My cancer diagnosis made me keenly aware of another axis of social categories: health vs disease. Breast cancer is a disease predominantly affecting women. Furthermore, women, especially those who live within multiple intersections of marginalized social categories, are forced to contend with other stigmatized forms of embodiment—such as the lived experiences of race, sexual orientation, and gender expression—causing multiple layers of minority stress.

In the early morning of my biopsy appointment—a biopsy that would confirm my stage 0 grade 3 breast cancer—I took a selfie in the waiting room to document what leaving my house at 5 am for the 2-hour drive to a 7 am appointment looked like. (Reader: It is not a good look!) Moments later, the intake nurse walked through the waiting room, and I was certain she was coming for me, since it was my scheduled time (and it was so early that the backlog of patients had not formed yet). She looked right at me but kept walking by, looking at each

#### Corresponding

**Author:** Kristi Tredway, PhD, Johns Hopkins University, Under Armour Breast Health Innovation Center, The Sidney Kimmel Comprehensive Cancer Center, Baltimore, MD 21287 (ktredway@hmi.edu).

patient as she moved. Reaching the end of the waiting room, she turned around and walked back to a more central spot in the room, which was about 3 feet from me, and shouted, "Kristi Tredway." To my surprise, I was seemingly identified as neither a person who would be named "Kristi Tredway" nor a person who would be there for a breast biopsy.

What is clear is that, as a patient, I was misidentified. What is not clear is exactly how. For this nurse, something about my appearance did not add up. I did not want to blame the nurse because I knew this was not an interpersonal issue; however, being trained in intersectionality, my curiosity was piqued about what had just happened. I was being policed through the disciplinary domain; however, that did not easily fit. The waiting room seemed like an extremely ineffective place for health care professionals to police people based on race, sexual orientation, or gender expression, especially when they are busy enough providing care for patients. If this was an issue based in the structural domain, that is a slow and arduous change to be made, though a necessary one when needed. I look masculine, but my medical record says that I am female, so maybe I simply looked like a man and, thus, would not have breasts to biopsy via the mammography-guided stereotactic biopsy that I was scheduled for. Also, the combination of a masculine appearance with a female body can be socially read as being a lesbian.<sup>5</sup> I am a lesbian, but viewers do not know who others are sexually attracted to when they see people, so that information usually gets conveyed through gender expression, sometimes mistakenly so. My medical record also states that I am half American Indian, but I do not "look" American Indian. Any of these could be plausible explanations for my experience that morning in the waiting room. A quick judgment of which bias, if any, occurred would not do intersectionality justice, and would not be where I choose to spend my energy; however, this experience lets us see a complicated interaction that on the surface looks simple.

What I became intensely focused on, even before my lumpectomy, was understanding what happens to women who look like me and how I can work toward ensuring that the experience I had never happens to anyone else. When I was diagnosed, I made a conscious effort to speak the previously unspeakable, to make vis-

ible the previously invisible, countering the culturally entrenched expectations that women remain silent about their diagnoses. This refusal to be silenced emanates from decades of social activism, of making those who look like me and love like me visible. It was not easy though; it also involved the strong support in that present moment by 2 people, my best friend and my surgeon, until I could speak again. Through finding my voice, I found a renewed sense of my own power.

### Conclusion

*What is there possibly left for us to be afraid of, after we have dealt face to face with death and not embraced it? Once I accept the existence of dying, as a life process, who can ever have power over me again?*<sup>1(p24)</sup>

**Audre Lorde**

There are a few scholars explicitly using intersectionality within public health arenas. My own experience of having some of my intersectional social categories as the basis of a negative experience during my biopsy changed my career trajectory, launching my research career in breast cancer disparities. The experience that I describe here did not harm me physically, and I was able to process it mentally through a theoretical exploration; however, these types of experiences can contribute to mistrust by others with similar experiences and have the potential to deter individuals away from timely care. We must develop approaches to care that are inclusive.

Within the area of oncology, the use of intersectionality, including analyses of power and power relations, is vital to creating a more nuanced understanding of health disparities among patients undergoing cancer care. By exploring the disciplinary, cultural, and structural domains, we can apply intersectionality to medicine to better serve historically marginalized patients who are not heard and are made to feel invisible. Intersectionality allows us to see and understand invisibilities. It also shows us the power maintaining and disciplining those invisibilities of particular social categories, and those people who span multiple social categories. Choosing to center the experiences of patients with cancer living at the intersections of multiple social categories, we are creating space for our shared humanity, across patients, health care clinicians, caregivers, and friends and family. Lorde's work helped show me that.

**Published Online:** August 4, 2022.  
doi:10.1001/jamaoncol.2022.2838

**Conflict of Interest Disclosures:** None reported.

1. Lorde A. *The Cancer Journals*. Special Edition. Aunt Lute Books; 1980.
2. Lorde A. *Sister Outsider: Essays and Speeches*. Crossing Press; 1984. [Note: throughout her writing, Audre Lorde capitalizes Black, but not other words

one might expect to be capitalized, such as white, america, christian. Her quotes have been retained in their original format.]

3. Crenshaw K. Demarginalizing the intersection of race and sex: a Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *Univ Chic Leg Forum*. 1989;1:139-167.

4. Collins PH. *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*. 2nd ed. Routledge; 2000.

5. Tredway K. Judith Butler redux—the heterosexual matrix and the out lesbian athlete: Amélie Mauresmo, gender performance, and women's professional tennis. *J Philos Sport*. 2014;41(2):163-176. doi:10.1080/00948705.2013.785420