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Gender & Society 2007; 21; 857

DOI: 10.1177/0891243207309898

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THE BALANCING ACT

Care Work for the Self and Coping with Breast Cancer

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Care work is both gendered and relational, defined typically as the care women do for others. When faced with a chronic life-threatening illness such as breast cancer, women must learn to perform care work for the self. Drawing from participant observation and 60 in-depth interviews, the author explores the gendered strategies and justifications women use to cope with breast cancer and engage in care work for the self. Women in the study used a multiprocess, gendered "balancing act" to learn to balance their needs with the needs of others, which involves setting boundaries and establishing criteria for accepting and asking for help. These strategies reflect a negotiation of normative expectations that stress women's selflessness, empathy, and caring for others.

Keywords: breast cancer; chronic illness; gender; care work; care work for the self

I don't always look after myself first. I mean, I make sure I have everything I need, [and do what I] need to do, but I always look after other people too. ... I think if you ask people too much to help you, you become a nuisance when you're sick. ... There's a good way to be sick and a bad way to be sick.

—Amy, age 48

INTRODUCTION

Coping with breast cancer requires *care work* as individuals manage a broad range of needs. Some of these result from treatment and ill health, whereas others involve the maintenance of everyday life and the continuation of particular roles and identities. Care work is a process that involves

AUTHOR'S NOTE: An earlier version of this paper was presented at the annual meeting of the Society for the Study of Symbolic Interaction in New York City, August 11, 2007. I would like to thank Denise Copelton, Stephanie Nawyn, Glenna Spitze, Marybeth Stalp, James Zetka, Dana Britton, and other anonymous Gender & Society reviewers for their helpful comments on earlier versions of this paper.

GENDER & SOCIETY, Vol. 21 No. 6, December 2007 857-877

DOI: 10.1177/0891243207309898

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emotionality and responsiveness, situating it within a two-way relationship that requires paying attention to the needs of others and responding to those needs (Graham 1983). A well-developed literature on care work argues that gender plays a major role in structuring care work processes, with the primary responsibility for care work falling directly on women (Abel and Nelson 1990; Aronson 1992; Devault 1991; Duffy 2005; Gerstel and Gallagher 2001; Herd and Meyer 2002). Some scholars argue that when women take on everyday caring responsibilities, their perceptions and identities begin to approximate gendered cultural expectations such as nurturing, empathy, and service (Hochschild 1989; McMahon 1995). Others assert that because women regularly do care work, caring itself has become feminized, or equated with feminine attributes (Cancian and Oliker 2000; Crittendon 2001; Tronto and Fisher 1990).

Care work also contributes to differences in how women and men perceive and respond to illness. In preparation for caring roles, women learn to monitor their health and the health of others simultaneously, whereas men learn to ignore or endure physical pain and discomfort (Hockenberry 1995; Lorber and Moore 2002). Because women are more likely than men to perceive and acknowledge health problems, some conclude that women are also more likely than men to seek and obtain care. Certainly women use the health care system more than men and regularly experience medical surveillance and intervention (Lorber and Moore 2002; Nussbaum 2001). However, illness rates do not consistently support the notion that women are more likely to be sick than men (Annandale and Hunt 2000; Macintyre, Hunt, and Sweeting 1996). Furthermore, women's care work for others may function as a barrier for women to obtain care for themselves when they are sick (Popay and Groves 2000; Zimmerman and Hall 2001).

Because care work is understood as what women do for *others*, it shapes what women are willing to do for *themselves* when facing illness. Building on the above literature, I conceptualize *care work for the self* as the institutional, relational, and identity-related dimensions of care work within a gendered situational context that recognizes the self in relation to others. In addition to concentrating on their own healing (emotionally and physically), women coping with breast cancer manage gendered expectations that construct women as selfless, empathetic, and caring. *Care work for the self* is a theoretically useful concept for exposing the continued relevance of gender as a moderating factor in shaping women's emotional and behavioral responses to illness and health protection.

THEORETICAL FRAMEWORK: CARE WORK FOR THE SELF

The gendered expectation of selflessness that is embodied in care work shapes the conditions under which women will establish boundaries for care work for the self. The excerpt that opens this paper illuminates the balancing act as a strategy for gendered self care. Particularistic and often self-imposed guidelines that incorporate gendered norms about femininity and care work for others construct a model for a “good way to be sick.” This framework shapes what women are willing to do for themselves as well as what they expect, ask for, and accept from others. Continuing to look after other people is a key component of the balancing act as women learn to redefine the terms of care work for others and incorporate their own care needs.

The notion of reciprocity is particularly relevant for understanding the conditions under which women will engage the balancing act to perform care work for the self. For example, in her study of single mothers and the role of romance in their everyday lives, Nelson (2004) found that women regularly engaged in assessments of *balanced* reciprocity with people who were experiencing similar life circumstances and situations of need. Nelson describes how women held themselves accountable to strict norms of reciprocity that involve promptly returning goods and services, avoiding imposing on people, and observing a hierarchy of recognized needs within a particular social network (2004, 441). Understanding where one’s needs fit in relation to others provides a normative foundation for the give and take of balanced reciprocity. These norms emerge from and help to create a sense of mutual obligation, which is at the heart of care work relationships (Rossi 2001; Stack 1974).

The connection forged between caregiver and care receiver, especially when it is voluntary, offers intimacy, familiarity, commitment, and belonging that potentially lead to positive health outcomes (Robert 1999). This relationship highlights women’s sense of entitlement to care both for themselves and for others. Women tend to honor caring commitments even when they are detrimental to themselves (Stack 1974). Caregivers sacrifice vacations, social activities, and time alone to provide care for others (Cantor 1983; Karp 2001). Although financial considerations compel many caregivers to guard their paid work lives against the intrusions of care work, care work often leads to work–family conflict (Marks 1998). Women’s unequal participation in care work therefore has potentially deleterious effects on mental and physical health, including high levels of stress and depression (Arendell 2000; Bird 1999; Duffy 1991; Thompson and Walker 1989).

Gender socialization and the feminization of care work encourage women to engage in activities directed at maintaining good relations. Rather than focusing on their own needs, gendered norms of balanced reciprocity, giving, and self-sacrifice encourage women to focus on the needs of others. There are, however, situations when women are willing to disregard these norms provisionally. Nelson's (2004) study of single mothers is, once again, instructive. Nelson finds that while single mothers do honor norms of reciprocity within their relationships in general, in certain situations they are willing to accept substantial imbalances within their *romantic* relationships. When it came to the practical affairs of everyday life such as cooking, household maintenance, and interacting with the children, women were willing to accept *imbalanced* reciprocity because they were already dealing with complicated and encumbered lives. They really needed the help. To accept the help without feeling obliged to reciprocate in similar ways, Nelson argues that the women strategically explained their partners' actions in terms of romantic gift-giving. When women interpreted the help in this way, they were able to transgress norms of reciprocity and accept imbalance. For these single mothers, imbalanced reciprocity was justified because the transgression was ultimately geared toward the well-being of the family.

The diagnosis of a chronic, life-threatening illness would necessitate similar norm transgressions when it comes to reciprocity. In addition to the construction of an illness identity, treatment alone often requires major changes to a person's daily routines and responsibilities. To manage illness and its impact on their everyday lives, people need help and they may not be able to return the favor. For women, compliance with gender norms that stress nurturing, empathy, and self-sacrifice situate concern for others above the self even when women are on the receiving end of care relationships (Sulik 2007). Although illness necessitates care work for the self, imbalanced reciprocity is a gender transgression that women must learn to accept and negotiate. By examining the balancing act as a process of negotiation that women use to try to restore balance when engaging in care work for the self, this research expands upon Nelson's analysis of imbalanced reciprocity. In providing strategic explanations for imbalance, women construct an illness narrative that enables them to understand and structure their experiences. In turn, efforts to balance their needs with the needs of others permit women to develop ways to perform care work for the self and manage the disruption of illness. I turn to my discussion and analysis of this issue after I describe my research methods.

METHODS

This paper is part of a larger study on women's experiences as breast cancer survivors in the United States (Sulik 2005). I collected data over a three-year period (2001-2004) in interviews with 60 breast cancer survivors, using a grounded theory approach to qualitative analysis (Glaser and Strauss 1967). To more fully understand the social context of breast cancer, I also used informal interviews and other observational techniques (Gubrium and Holstein 2002; Lofland and Lofland 1995). I worked for six months as an administrative assistant and volunteer with a community-based breast cancer organization before and during data collection. In addition to interacting with volunteers and researching breast cancer topics, this allowed me to participate in business meetings, regional and national conferences, community events, and educational programs. I read books written for breast cancer survivors, examined key Web sites and informational materials typically given to women diagnosed with breast cancer, and read accounts of the breast cancer experience (e.g., newspapers and magazines, promotional materials for breast cancer events).

After gathering data from an initial sample of women from the organization where I engaged in participant observation, I recruited additional participants from five support groups, two treatment centers, two breast cancer-related community events, public bulletin boards, and through snowball sampling. Sample characteristics are illustrated in Table 1. I conducted 60 intensive interviews in total with women in New York and Pennsylvania, aged 31-79 years (mean = 53.6), who were diagnosed with breast cancer. The years of survivorship ranged from one year (22 percent) to 10 or more years (13 percent), with the greatest percentage of women in the two- to four-year range (42 percent). This suggests that the experience of a breast cancer survivor remains vivid for many women even years after diagnosis and treatment. The vast majority of respondents were white, married, and highly educated. The data, therefore, predominantly reflect white, heterosexual, middle-class norms around femininity.

Interview Schedule and Data Analysis

The interview schedule for the intensive interviews had a loose chronological order, open-ended questions, and clustered themes (Reinharz 1992). These related to the diagnosis story, and the impact of breast cancer on a woman's life, relationships, and perspectives. I inquired about reactions from family, friends, coworkers, medical professionals, and even strangers to gain insight into respondents' personal experiences of social

TABLE 1: Sample Characteristics

Marital status		Years of survivorship	
Married	76.7% (<i>n</i> = 46)	1 year	21.7% (<i>n</i> = 13)
Divorced	11.7% (<i>n</i> = 7)	2-4 years	41.7% (<i>n</i> = 25)
Widowed	5.0% (<i>n</i> = 3)	5 years	3.3% (<i>n</i> = 2)
Never married	6.7% (<i>n</i> = 4)	6-9 years	20.0% (<i>n</i> = 12)
		10 or more years	13.3% (<i>n</i> = 8)
Race/ethnicity		Number of children	
White	90.0% (<i>n</i> = 54)	3 or more children	15.0% (<i>n</i> = 9)
African American	5.0% (<i>n</i> = 3)	1 or 2 children	56.7% (<i>n</i> = 34)
Other	5.0% (<i>n</i> = 3)	0 children	35.0% (<i>n</i> = 17)
Educational attainment		Occupation	
High school diploma	16.6% (<i>n</i> = 10)	Service	11.7% (<i>n</i> = 7)
Some college	15.0% (<i>n</i> = 9)	Administrative	35.0% (<i>n</i> = 21)
Bachelor's degree	31.7% (<i>n</i> = 19)	Education	35.0% (<i>n</i> = 17)
Beyond bachelor's	36.7% (<i>n</i> = 22)	Professional	25.0% (<i>n</i> = 15)

support or stigma. When I asked what kept them going day to day during the most difficult times, I learned of strategies used to deal with role strain and feelings of personal responsibility for their health.

My goal was to understand participants' holistic worldview by eliciting illness narratives (Oakley 1982) and to generate theory using a constant comparative method (Glaser and Strauss 1967). I simultaneously collected data and developed analyses over the course of the research, including coding data, formulating concepts, and constructing theoretical models. As conceptual categories and properties emerged, I developed a substantive model of the processes that influence breast cancer survivors' experiences and coping strategies. This is accomplished by defining the properties of the categories and understanding the relationships within and among them. To allow for emergent themes, I revised the interview schedule periodically to incorporate and evaluate relevant categories such as entitlement to care, setting boundaries, and accepting/asking for help. The model presented in the next section demonstrates the gendered dimensions of women's strategic explanations and responses to breast cancer.

FINDINGS: THE BALANCING ACT

The *balancing act* is a gendered coping strategy respondents used when managing breast cancer. By employing this strategy, women attempt to maintain their own integrity in doing care work for the self without neglecting others. Although breast cancer necessitates that women

become care receivers, gender expectations conflict with the need to focus on the self (Sulik 2007). Thus, women with breast cancer develop strategic explanations that allow them to balance their needs with the needs of others. The balancing act requires negotiation around *setting boundaries* and establishing criteria for *accepting and asking for help*.

First, throughout the process of boundary setting, women assess their immediate needs and priorities in the context of their obligations and responsibilities. In setting limits on what they are willing to give to others and on what they expect of themselves, women make adjustments to work schedules, household responsibilities, family obligations, volunteer work, socializing, and their overall commitment to themselves. Second, women establish standards about when it is appropriate to accept help from others and the conditions under which it is reasonable to ask for help. Deciding when it is appropriate to accept help and ask for help involves a constant appraisal of whose needs and desires should take priority. For example, women struggle to accept help in accomplishing everyday tasks such as cooking, cleaning, driving, laundry, and child care. They grapple with how to acquire other forms of social support related to researching treatment information and sharing personal feelings with those who may be uncomfortable discussing cancer. While such emotional labor is typical for women doing care work, it can be an added burden when doing care work for the self.

Setting Boundaries

The sense of mutual obligation within gendered norms of reciprocity can be a strong barrier for women attempting to renegotiate their responsibilities and obligations to others. Even so, respondents believed focusing on their own needs, goals, and limitations to cope with breast cancer and its aftermath to be a necessity. Women often interpreted care work for the self to be a constructive and essential form of *selfishness*. In the context of coping with breast cancer, this word choice is especially significant, demonstrating the continued relevance of selflessness and regard for others as a social norm for women (Sulik 2007). For instance, 48-year-old Ruby discussed taking care of herself in a self-conscious and somewhat disparaging way. She said, "I've become *selfish* [my emphasis] in the way that I know I need to take care of myself. I need to know my own limitations even in little ways." While Ruby's statement suggests an emphatic intention to focus on her own needs and engage in care work for the self, the use of the word *selfish* to describe her perspective reveals the disconnection between normative feminine expectations and the self-interestedness required to do so.

With regularity, the women interviewed stressed how focusing on the self was the key to taking care of oneself. Viewed both as a necessity and a result of personal limitations, care work for the self provided the central justification for setting boundaries, both in terms of putting oneself first and curbing obligations to others. Respondents' ideas about how severe they believed their diagnosis to be provided a frame of reference to determine what their needs and priorities were, with the ultimate goal of preventing pain and suffering. However, for the most part, any diagnosis was severe enough to warrant—at least for a while—putting themselves first and placing boundaries on others' needs, desires, or expectations.

Saying “no” was one of the primary boundary setting techniques respondents used. It was, however, a skill that had to be *learned* and continually relearned. Ruby went on to say,

You know sometimes some people will say, “Can you work?” And I say, “Well, you know, I just worked three days in a row. I am sorry I can't help you out this time, but maybe next time I can help you.” It's ... learning to say no. ... Learn[ing] to realize what I want to do in this life.

Clearly, saying no is a developmental process. Typically, women are willing to start learning the process of saying no when and if they feel a boundary is justified or deserved. Having already worked for several days, Ruby felt that she deserved a day off. Even for the deserving woman, however, saying no is not assured. This boundary can be accomplished more readily when it is accompanied by feelings of remorse for setting the boundary and feelings of hope in the possibility of saying yes at some point in the future. Ruby believed she was justified in focusing on her own needs and taking care of herself. Yet, she apologized for setting this boundary and held out the promise of future help. Ruby regularly traded shifts and tried to engage in practices that would help her as well as others. Feelings of remorse grounded in expectations for balanced reciprocity complicated care work for the self.

Although interviewees believed that breast cancer should be reason enough for them to consider their personal needs and priorities and focus on themselves, the reality was that focusing on the self required negotiation and consistent effort. Fifty-seven-year-old Barbara makes this point clear when she recounts her attempts to resign from a volunteer treasurer position:

After I was diagnosed, I spent about a week working on the annual report. I did it in July before my lumpectomy because I didn't want to burden

somebody else with that job. I had been treasurer for the year. I tried to keep up the work after that, but I told them I couldn't do this now, and they'd have to get somebody else.

Initially, Barbara felt responsible for the annual report because she knew it was a difficult job, a "burden" in fact. She completed the report before her surgery, but after her treatment began she felt she could no longer continue in the position. The organization found a temporary replacement, but "they assumed that [she] would take it back as soon as [she] was better." Barbara reiterated her stance: "I told them to tell whoever took it over that I was not going to take it back, because my priorities have changed and I'm going to want to spend my time differently." Despite her insistence, members of the organization continued to pressure her, saying that they "have so few people to work on things in the chapter that they need me to be the treasurer." Barbara felt strongly that while she had agreed to the job in the past, she was not going to do it again. Refusing to take no for an answer, the president of the organization called Barbara at home. Up to this point, Barbara declined the position in a calm but assertive way, explaining that her priorities needed to change following her breast cancer diagnosis. Then, her tone changed, as she indicates here:

The president called me and said, "Is there any chance that you will take the treasurer for next year?" I said, "*I hate to say so* [my italics], but no, I'm not going to take it. It's a hideous job that nobody wants. ... Why should I take a job that everybody hates when my time is most likely limited?"

Even though she was still ambivalent, Barbara stayed firm in her decision, and told me that the conversation with the organization's president agitated her.

Although Barbara said that it was "hard for her to say no" because she knew how "desperately they needed someone" to do the job, she also felt that the organization was taking advantage of her when she had an illness that would potentially shorten her life. Barbara was diagnosed with inflammatory breast cancer, which accounts for about 1 percent of all breast cancers and is a rare type of invasive cancer that usually spreads rapidly to other parts of the body (Love 2005). Knowing her prognosis, Barbara was concerned "with the fact that [her] life is going to end a lot sooner than [she] thought it would." Barbara's use of the present tense reveals this sense of urgency, and it is the urgency that reinforces her feelings of exploitation. Continuing her discussion of the president's phone call, she said:

They can pay somebody to do it if they have to. Why should I be the sucker? Let somebody else be the sucker. I tried to do a good thing. I did my share. I told them to give me a small job, and I'll do it.

Barbara clearly believed that her refusal to continue the volunteer work was warranted, that the organization was acting inappropriately, and that she had already given sufficiently. Like Ruby, Barbara believed she had the right to set a boundary that would enable her to do care work for the self and had constructed a viable explanation for imbalance. Barbara modified her position in the end because expectations for balanced reciprocity required her to negotiate the boundary and ultimately make adjustments to accommodate others.

The difficulty these women had setting boundaries rests upon deeply embedded norms involving nurturance, empathy, and selflessness. These difficulties were sometimes attenuated with reinforcement from others—family, friends, neighbors, coworkers, support group members. Participants were better able to set boundaries and make them stick if they had some kind of a sounding board to validate their demands. For instance, 70-year-old Sharon recounted a conversation with her adult son in which she discussed her concern about being photographed during her treatment. Sharon did not want to remember this period of her life, but she felt uneasy about stopping others from taking pictures of her during social occasions. Sharon's son reassured her by saying, "don't let anybody take your picture if you don't want them to." Although Sharon was unsure about whether she had a right to deny others from taking her picture, her son's assurance strengthened her resolve.

While others can be a sounding board and source of validation in setting boundaries, sharing personal concerns can actually increase one's sense of obligation to others. This is especially the case for women who have commitments to broader communities. Fifty-one-year-old Melinda told me about a Healthy Women's Program she attended that was targeted to African American women and breast cancer awareness. She said, "There wasn't a large attendance because one of the problems, especially within the African American community, is they don't talk about it. ... It's hard to get them to deal with any type of health-related programs." Melinda was committed to sharing her story as an African American woman surviving breast cancer. Sharing with others validated her experience as an African American woman, and she wanted to encourage other women to do the same. Melinda's sense of responsibility to this community became a strong impediment to engaging in care work for the self. Melinda made this point clear when she began to recount all of the speaking

engagements, interviews, and volunteer work she had been doing during the two years prior to our interview.

[First, I was] a speaker at the “Making Strides” breakfast and there must have been about 500 people. ... That September, [a local newspaper] (through American Cancer Society) wanted to do an article on it. Then Channel Six did a story because I ... volunteered for the Look Good Feel Better Program. Then [another local newspaper] was doing a story on when a coworker gets cancer. ... It was good to be able to share with people ... but ... after a while I said, “This is not okay. All of a sudden I’m just so busy again.”

Melinda believed she “got good press” because she is an African American woman, and organizations (and media outlets) are trying to reach out specifically to this group because of high mortality rates. But for Melinda, this was added pressure. She felt personally responsible for sharing her story because she believed that “in the African American community ... a lot of people are in denial.” Yet, Melinda did “not want to be the poster woman for breast cancer.” She said, “*I allowed myself* [my emphases] ... I took the focus off of me and I began to focus on what I could do with other people and helping other people ... it’s been a struggle.” In addition to feeling responsible for her community, this statement reveals that Melinda also felt responsible for setting a new boundary. When Melinda says that *she allowed herself* to focus too much on the needs of others, her statement reveals that she feels personally responsible for the intrusions of care work for others in addition to care work for the self. She does not place the burden of responsibility on others to respect the boundaries she has already set. Such negotiations are a regular part of participants’ efforts to focus on their own needs.

In sum, the diagnosis of breast cancer disrupts taken-for-granted assumptions and behaviors related to balanced reciprocity and mutual obligation that are deeply tied to gendered norms of nurturing and selflessness. During this habitual disruption, respondents learned to renegotiate their responsibilities and obligations, to focus on their own needs, and engage in care work for the self. Then they relearned it, over and over again. The guilt associated with doing care work for the self would manifest itself in different ways, such as holding out the promise of future reciprocity or seeking others’ approval for the transgression. This suggests that the women I interviewed had internalized gendered rules of conduct and belief to some degree. If women felt responsible to a broader community, the sense of obligation was even greater, making it more difficult to establish boundaries and engage in care work for the self.

Accepting Help

Participants were highly selective in the help they were willing to accept from others and even more discriminating in the conditions under which they would ask for it. There are two social explanations for this that are closely connected to care work. First, when women regularly exhibit selflessness and empathy, they comply with a *natural* theory of caregiving that defines caring as an innate women's activity. This devalues and obscures women's caring labor, and camouflages the gendered social construction of care work. Second, care itself has become equated with the normative feminine attributes of empathy, emotional sensitivity, and genuine concern for others. These factors shape caring interactions, support networks, the responsibility of families in care provision, and gender differences in caring behaviors and expectations. The feminization of care places care work within women's realm of responsibility and expertise while it simultaneously denies care work for the self.

Sixty-year-old Belinda became a widow just a few weeks prior to her breast cancer diagnosis. She had two grown children, and before her husband died they owned two small equestrian-related businesses in rural Pennsylvania. Having worked dawn to dusk for most of her life, Belinda was independent, resilient, and experienced in selflessness. In many ways, she believed that these qualities enabled her to survive breast cancer. She said, "Women, I think, are far stronger emotionally than people give us credit for." She gave an example:

If you're a mother and you're at home and one of the children is sick ... no matter how bad you feel, you're taking care of that child. You're up in the middle of the night, giving them juice and what have you ... [that] doesn't change just because you got breast cancer.

For Belinda, her business was now her child, and her deceased husband could no longer play a role. She said, "I knew that I had a business to run. I knew that I had one day a week that I couldn't work at it [because I had to go for treatment], but the rest of the time I worked." Belinda's selflessness and work ethic had merged such that she did not allow herself too much time to focus on her sadness or her fears:

There were times, *I won't deny it* [my italics], there were times eight, nine, ten o'clock at night I'd sit here and cry. But sometimes it's better to get that out of your system than to keep it bottled up. And, I had a friend who once said, "Yup, have a pity party for yourself and put a time limit on it. At two o'clock the pity party is over. Get back to work."

Belinda acknowledges her emotions and sees the benefit of letting them out. However, her narrative suggests ambivalence about whether a woman with cancer should admit to feeling sad or sorry for herself. She quickly shifts the discussion to the problem-solving mode she uses to snap herself out of it—"get back to work." This was Belinda's favorite phrase, and she referred to it several times throughout the interview. Like all of the respondents, she did not want to represent herself as a helpless or fragile woman.

Belinda was practiced in actively suppressing her own needs for the needs of her children, her business, her housework, her husband, and her family. After being diagnosed with breast cancer, she had to learn to think about what she needed and wanted for herself:

I do things now that I never would have done (1) if my husband were living and (2) if I hadn't had breast cancer. I was never one to go out and socialize, yet I became the Reach to Recovery lady to go out and talk to other women. Then, I became the Reach to Recovery *trainer* [her emphasis] where I trained other women. I found that to be very fulfilling. ... Never would I have done that before. It would have been work, work, work.

It is this self-determination that led Belinda to think about her own needs and wants for the first time in her life. Still, self-reliance was one thing whereas accepting help was another. Having just become a widow, Belinda was not used to living alone. But if anyone asked her what they could do for her, most of the time she would say, "I'm fine. Don't worry about it." After developing some close relationships through a support group, Belinda began to think about what it meant to accept help from others:

One of the things we talked about was the fact that women should accept help from family and friends. Somebody wants to bring you a casserole for supper, say yes. Even if you're not hungry for it that night, put it in your refrigerator and heat it up the next day.

Just as setting boundaries could be fortified by others, participants were better able to accept help if they had reinforcement from others. In Belinda's case, the support group provided it. Still, her history of selflessness made this an ongoing process. She said, "It's difficult to accept help ... you do learn to accept the help ... isn't that what our life is all about? Do unto others as you would have others do unto you? Still, it's hard to accept."

The strong cultural connection between femininity and nurturance works in conjunction with norms of female sacrifice to construct an ethic of caring that impedes women's care work for the self. Like Belinda, Elaine admitted that, "the whole receiving thing is hard," and went on to

tell a funny story about how a friend tricked an acquaintance of theirs into giving her a gift.

One day we were talking [about my husband] and she said, "What do you mean your husband's not giving you a massage?" I said, "He's never given me a massage, ever." She said, "Well, that's just horrible." We were walking up the street ... we ran into this guy we know ... she says, "Rick. ... Do you give [your wife] massages?" And he goes, "Well yeah. ..." She says, "Oh that's great. How about you give Elaine a massage? She never gets a massage and she needs one. ..." He said, "Thank you. I've been wanting to do something for Elaine and I just didn't have a clue. Thank you. I will be glad to give you a massage. I'm coming over to your house. Tell me what day. ..." He came over. ... And, he gave me the most incredible massage, even worked on my bald head.

While it took an assertive friend and an odd twist of fate for Rick to give Elaine his gift, Elaine told me later that she practiced daily mantras to learn to accept help from others. She recounted one of her chants: "People are giving you a gift. Do you realize how wonderful it feels when you give a gift to someone? That's how wonderfully they are feeling right now." Elaine's mantra illustrates her own strategic explanation for imbalanced reciprocity. Accepting care from others is appropriate when it is a form of care work for others.

Most women felt they needed to justify *when* and *if* another's acts of kindness were warranted. The notion of reciprocity is central here. Belinda justified accepting help because it reinforced her Christian belief in the Golden Rule. Elaine believed accepting help was warranted if the giver enjoyed the giving. Whether from spouses, children, siblings, neighbors, coworkers, or friends, most of the women interviewed did not have a high tolerance for accepting help. Despite the fact that women do learn to say no and to accept help, there are limitations to their success based on the gendered construction of care work. Being sick required a particular code of conduct that included making others feel good and comfortable. Instead of engaging fully in care work for the self, women's activities were often directed outward, toward maintaining good relations.

Asking for Help

Because accepting care from others negates the selflessness that is associated with feminine gender identity, asking for help is even more complicated. When engaging in care work for others, it is socially acceptable for women to act assertively on others' behalf. Being an agent for the

self, however, runs counter to women's status as caregiver to others. Ruby stressed this point when she said, "When it's your time to get help *for yourself* [my emphasis], it's very difficult to ask for it." This difficulty is visible in the many negotiations, frustrations, tensions, and even resentments discussed throughout the interviews.

Fifty-seven-year-old Cheryl had been diagnosed with breast cancer 10 years prior to our interview. The difficulties she had coping with her treatment and its after effects remained vivid. This became particularly apparent when she discussed the lack of support she received from her family. She remarked, "Nobody ... my aunts, my cousins ... nobody would call and say, 'Can we do anything for you?' ... you do what you have to do and it's kind of hard to ask for help and when you ask for help and you don't get it ... it makes you kind of bitter." If women are socialized to focus on the needs of others, it is not surprising that they would have little experience defining and articulating their own needs. Yet, being one's own advocate also presents difficulties. She went on to describe her husband's role during her chemotherapy treatment.

My husband just wants to ignore it. ... He will go to the doctors with me, not every doctor, but he does go to the oncologist with me. He'll go. He's there, but he doesn't really like to ask questions or anything ... he's just there. Sometimes I get annoyed because it gets tiring to advocate for yourself all the time. You just want somebody else to do it for a while, and I don't get that from him. But, he's not a computer person, so I can't expect him to go on the computer and try to research things. But sometimes I'm just wondering, can't you do something?

Even though Cheryl's husband does go with her to the oncologist, a type of support that many women do not have, Cheryl is clearly upset with her husband's level of attentiveness when he is there, because he is "just there." Cheryl would like her husband to advocate on her behalf and to ask questions. Yet, she does not ask him to do this. Instead, she attempts to justify this perceived lack and change her own expectations. Despite Cheryl's desire to accept the justification she puts forward on her husband's behalf, she remains disappointed with his lack of effort to provide the kind of support she needs. This excerpt illustrates first, how selflessness potentially undermines a woman's capacity to fully define and convey her needs to others, and second, how well-meaning people within a woman's primary sphere of relationships may not know what is needed or how to provide it. Such cross-communication between women and their loved ones can lead to the bitterness and frustration Cheryl describes.

Regardless of the actual severity of their illness or prognosis, women who *perceived* their illness to be severe were more likely to feel justified in accepting and/or asking for help. Those who did not perceive their illness as severe typically viewed their needs as a burden to others. Alice, for example, saw her breast cancer diagnosis to be a major life-threatening situation. This allowed her to maintain a commitment to herself and change her expectations of others, including her husband. She said,

I have a husband who looks at me in a very different light now. I never used to think of myself. Growing up with the nuns, get married, sacrificing all these things ... now I say, "No, I'm not cooking dinner tonight, you're going to take me out." And, he says, "okay."

In contrast, Donna perceived her illness to be less severe. She had been widowed for several years prior to her breast cancer diagnosis and was accustomed to taking care of her grown son who still lived at home. After her diagnosis, Donna was very grateful that her sister-in-law gave her *no choice* but to live with her family during her treatment. She said:

I stayed with [my brother and his wife] through my first chemo. ... Then ... came home ... until I started getting sicker. ... They didn't ... want me to come home at all, but my son [was] by himself. You know how [men] take care of a house. ... For [my sister-in-law] to take me into her home ... was unbelievable. They didn't give me a choice. ... I was very lucky. ... I didn't want to have [a stranger] coming into my home and taking care of me.

Donna believed that women in families are the appropriate caregivers, and that care itself requires empathy. First, she did not want her son who was still living at home to take care of her or the household. Second, she was able to have her needs met without having to ask for it, because her sister-in-law (not her brother) insisted on caring for her. Finally, reinforcing women's general lack of entitlement to care, she demonstrates her remorse by emphasizing how "lucky" she was, not only because of her sister-in-law's generosity and the care she received, but because her sister-in-law anticipated her needs.

Even though participants were still quite particular about from whom they were willing to accept help, many women were like Donna. They simply had an easier time accepting help when others noticed a need and took action to help without requiring respondents to ask for it. When Amy's husband was proactive in providing help, she was extremely thankful:

My husband ... if something needs [to be] done, he'll go do it. ... [The house] is a lot of work and I can't keep up to it right now because I've been sick too much. I just got operated on last week and I've been operated on like three times in the last two months ... so my husband has been helping me. ... You don't have to worry about, "Oh, [the dishes] are sitting over there, and they need to be done." He still does that for me ... if I have a bad day on dialysis he'll get up and get dinner. He's ... a very, a wonderful husband. ... But ... most of the time, I try to be as independent as I can.

In Amy's case, it was her husband who provided the help, but the gendered processes remain: Women in families are the appropriate caregivers; caring requires empathy; women ought to be selfless. Amy explains that she can't keep up the house *right now* because she's been *sick too much*. Clearly, the house is Amy's domain, and there is some level of sickness through which she can continue to maintain it. Doing so is part of Amy's self-concept, and she derives fulfillment from this. For Amy, allowing her husband to do care work undermines her own sense of self while enhancing her husband's status. It is only when she has a *bad* day on dialysis that her husband has to get up and get dinner. When he does this, he gains the credit of being a *very wonderful husband* in part because doing care work is not something men are supposed to do.

Similarly, Alice said, "I'd never really been sick in my life. I went to the hospital to have babies and that was it. All of a sudden, I'm sick and my husband is the one taking care of me! I didn't like the idea of a husband being a caretaker." Alice also believed that care work is women's work. It would have been an assault to her husband's masculinity if he were to take on a caregiving role. Similarly, it would have been an assault to her own femininity if she had allowed him to do so. For many women, putting the needs of others second in order to engage in care work for the self involves a shift in perspective, one that can potentially change the essence of their relationships. To protect important relationships from the burden of care work, many women prefer to rely on themselves and their own resources instead.

Determining an appropriate level of reliance on others and the conditions under which reliance is warranted or requested involves constant consideration and evaluation. Whether from women or men, participants did not feel deserving *enough* of assistance to make demands without attenuating them or seeking to restore balance in other ways. Even though women constructed strategic explanations for imbalance, they still felt guilty about it and frequently tried to reciprocate. For all participants (regardless of marital status, presence of children, career, age, or education),

it was easier to accept help than to ask for it. Many women felt relief when family members or friends simply anticipated their needs and then acted to meet them. By relying on others to initiate care work on their behalf, women were better able to perform care work for the self while maintaining an essence of feminine selflessness.

CONCLUSION

This research examines how women cope in gendered ways with breast cancer. Social factors such as gender, care work, and the feminization of care influence a woman's motivations and capacity to engage effectively in care work for the self in response to chronic illness. Two key factors distinguish care work for the self from care work for others: (1) whose needs take priority, self or others? and (2) the cultural and institutional norms that define care work for others as a natural expression of women's selflessness, and care work for the self as antithetical to this. Such a construction forces women with breast cancer to engage in a balancing act that involves balancing one's needs with the needs of others. As the primary mechanism for engaging in care work for the self, the balancing act analyzes the meaning-making involved in setting boundaries and making distinctions between accepting help and asking for it. Such explanations and justifications can be understood only within a gendered situational context that takes into account the importance of balanced reciprocity for women.

The disruptions that breast cancer diagnosis and treatment cause initiate opportunities for women to make changes in their lives and identities. To manage, many women establish and guard a new sense of self. Gendered cultural expectations, which construct women as nurturing, empathetic, and self-sacrificing, place limitations on women's capacity to maintain a focus on themselves for very long. However, the women in the study did believe to some extent that breast cancer justified doing care work for the self. To accomplish this, they established criteria about when and how to set boundaries, accept help, and even ask for help. When engaging in care work for the self, however, women often felt remorse and tried to assuage their guilt by constructing what Nelson (2004) refers to as strategic explanations for imbalance. Taken together, these explanations provided a set of guidelines for how to be sick *in a good way*. By incorporating gendered norms related to femininity and care work for others, this framework influences women's care expectations for themselves and others.

While these findings highlight the role of gender and the difficulties women in the study faced when dealing with breast cancer, the relatively homogeneous sample (mostly white, educated, middle class, and heterosexual) limits the extent to which these may be generalized to more diverse populations of women. Most of the women negotiated care work for the self in the context of heterosexual families, while taking into account the gendered demands and expectations of husbands and children. Outside the family, women's social networks often reinforced these social expectations. While there were differences in women's satisfaction with doctors, medical care, and health insurance coverage, all of the women had access to some level of medical care, diagnostic procedures, and health insurance. Many women also developed a degree of health literacy through local organizations and resources. Sharing a similar class position in these respects, women in the study experienced similar kinds of constraints and opportunities in daily life. Differences in family networks, class position, and personal and community characteristics would likely modify the strategies most beneficial for particular groups of women. Future research can determine how factors such as age, race, ethnicity, and class influence the complicated balancing act of care work for the self.

Conceptually, care work for the self exposes the power of internalized gender expectations that even breast cancer cannot easily transform. Women's social status as caregivers prepares them for selfless behavior, not the self-interestedness that care work for the self requires. The balancing act is an attempt to negotiate this tension as women try to establish equilibrium between their needs and the needs of others. It focuses on the meanings and explanations women use to establish criteria for engaging in balanced or imbalanced reciprocity. The balancing act is both a process of resocialization and a problem-focused strategy that, if successful, is capable of increasing women's sense of control in coping with the uncertainty of illness and engaging in care work for the self. However, it requires women to relinquish (to some extent) the dominant cultural scripts that construct women's identities in terms of care work for others. Selflessness remains a barrier to women's care work for the self and is one of the driving forces behind the gendered dimensions of women's strategic explanations and responses to breast cancer.

REFERENCES

- Abel, E. K., and M. K. Nelson. 1990. *Circles of care: Work and identity in women's lives*. Albany, NY: SUNY Press.

- Annandale, E., and K. Hunt. 2000. Gender inequalities in health: Research at the crossroads. In *Gender inequalities in health*, edited by E. Annandale and K. Hunt. Buckingham: Open University Press.
- Arendell, T. 2000. Conceiving and investigating motherhood: The decade's scholarship. *Journal of Marriage and Family* 62:1192-207.
- Aronson, J. 1992. Women's sense of responsibility for the care of old people: "But who else is going to do it?" *Gender & Society* 6 (1): 8-29.
- Bird, C. E. 1999. Gender, household labor, and psychological distress: The impact of the amount and division of housework. *Journal of Health and Social Behavior* 40 (1): 32-35.
- Cancian, F., and S. Oliker. 2000. *Caring and gender*. Thousand Oaks, CA: Pine Forge Press.
- Cantor, M. H. 1983. Strain among caregivers: A study of experience in the United States. *The Gerontologist* 23 (6): 597-603.
- Crittenden, A. 2001. *The price of motherhood: Why the most important job in the world is still the least valued*. New York: Henry Holt and Company.
- Devault, M. L. 1991. *Feeding the family: The social organization of caring as gendered work*. Chicago: University of Chicago Press.
- Duffy, V. J. 1991. The conflict of nurturance for women: Implications for self-esteem and depression. PhD diss., University of Rochester, Rochester, NY.
- Duffy, M. 2005. Reproducing labor inequalities: Challenges for feminists conceptualizing care at the intersections of gender, race, and class. *Gender & Society* 19 (1): 66-82.
- Gerstel, N., and S. Gallagher. 2001. Men's caregiving: Gender and the contingent character of care. *Gender & Society* 15 (2): 197-217.
- Glaser, B. G., and Strauss, A. L. 1967. *The discovery of grounded theory: Strategies for qualitative research*. Hawthorne, NY: Aldine de Gruyter.
- Graham, H. 1983. Caring: A labour of love. In *A labour of love: Women, work and caring*, edited by J. Finch and D. Groves. London: Routledge and Keegan Paul International.
- Gubrium, J. F., and J. A. Holstein. 2002. *Handbook of interview research*. Thousand Oaks, CA: Sage.
- Herd, P. and M. H. Meyer. 2002. Care work: Invisible civic engagement. *Gender & Society* 16:665-88.
- Hochschild, A. 1989, 2003. *The second shift*. New York: Penguin.
- Hockenberry, J. 1995. *Moving violations: War zones, wheelchairs, and declarations of independence*. New York: Hyperion.
- Karp, D. 2001. *The burden of sympathy: How families cope with mental illness*. New York: Oxford University Press.
- Lofland, J., and L. Lofland. 1995. *Analyzing social settings: A guide to qualitative observation and analysis*. Belmont, CA: Wadsworth Publishing Company.
- Lorber, J., and L. J. Moore. 2002. *Gender and the social construction of illness*. New York: Altamira Press.
- Love, S. M. 2005. *Dr. Susan Love's breast book*. New York: Addison-Wesley.

- Marks, N. 1998. Does it hurt to care? Caregiving, work–family conflict, and midlife well-being. *Journal of Marriage and the Family* 60:951-66.
- Macintyre, S., K. Hunt, and H. Sweeting. 1996. Gender difference in health: Are things as simple as they seem? *Social Science and Medicine* 42:617-24.
- McMahon, M. 1995. *Engendering motherhood: Identity and self-transformation in women's lives*. New York: The Guildford Press.
- Nelson, M. 2004. Reciprocity and romance. *Qualitative Sociology* 27:433-59.
- Nussbaum, R. 2001. Studies of women's health care. *The Permanente Journal* 4:62-67.
- Oakley, A. 1982. Interviewing women: A contradiction in terms. In *Doing feminist research*, edited by Helen Roberts. London: Routledge and Kegan Paul.
- Popay, J., and K. Groves. 2000. Narrative in research on gender inequalities in health. In *Gender inequalities in health*, edited by E. Annandale and K. Hunt. Buckingham: Open University Press.
- Reinharz, S. 1992. *Feminist methods in social research*. New York: Oxford University Press.
- Robert, S. 1999. Socioeconomic position and health: The independent contribution of community context. *Annual Review of Sociology* 25:489-516.
- Rossi, A. S. 2001. *Caring and doing for others: Social responsibility in the domains of family, work, and community*. Chicago: University of Chicago Press.
- Stack, C. 1974. *All our kin: Strategies for survival in a Black community*. New York: Harper and Row.
- Sulik, G. A. 2005. When women need care: How breast cancer 'survivors' cope with being care-receivers. PhD diss., University at Albany, State University of New York.
- . 2007. On the receiving end: Women, caring, and breast cancer. *Qualitative Sociology* 30 (3): 297-314.
- Thompson, L., and A. J. Walker. 1989. Women and men in marriage, work, and parenthood. *Journal of Marriage and the Family* 51:845-72.
- Tronto, J., and B. Fisher. 1990. Towards a feminist theory of caring. In *Circles of care: Work and identity in women's lives*, edited by E. Abel and M. Nelson. Englewood Cliffs, NJ: Prentice Hall.
- Zimmerman, M. K., and L. C. Hall. 2001. Men and women; health and illness. In *Gender mosaics: Social perspectives*, edited by Dana Vannoy. Los Angeles, CA: Roxbury Publishing.

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