The cancer may come back: Experiencing and managing worries of relapse in a North Norwegian village after treatment

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pathways and the establishment of ‘at risk’ patient groups or ‘delayers’), the entanglements of science and bureaucracy in Western healthcare systems, and the value of sensorially oriented scholarship to symptom research.

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Abstract

Little is known about how people living in the aftermath of cancer treatment experience and manage worries about possible signs of cancer relapse, not as an individual enterprise but as socially embedded management.

One-year ethnographic fieldwork was conducted in a coastal village of under 3000 inhabitants in northern Norway. Ten villagers who had undergone cancer treatment from six months to five years earlier were the main informants. During fieldwork, the first author conducted qualitative, semi-structured monthly interviews with them, and participated in their everyday activities and relationships, including families, friends and co-villagers.

In this article, we contemplate human emotions as arising in contexts of transactions, capable of creating social realities. By including this perspective, we highlight how people who recover from cancer construct and experience worry about possible relapse in relation to close family members, friends and co-villagers in the socially closely-knit and relatively isolated village. These emotional experiences emerge through relationships with others, have communicative characteristics and take place in interaction with the social environment of their village. While informants attempt to protect family members by avoiding sharing worries with them, they express the need to share their worries within friendships. However, they experience both comfort and challenges in managing their worries in relation to acquaintances in the village.

Overall, the study enhances understanding of the social embeddedness of emotions in everyday life, by revealing how worries of relapse of cancer configure and relate to various social contexts.

Keywords: Anthropology of emotions; relapse; aftermath of cancer treatment; Northern Norway; worries
Introduction

So you want to show people around you that… as long as you’re officially healthy and everything, then society or your social circle demand that you don’t… it shouldn’t be talked about. You did get better again, didn’t you?

(Bjørg, 41, diagnosed with ovarian cancer in 2013)

Well, the good thing about living in such a small village is you won’t be forgotten. That’s kind of the good thing about people gossiping about others all the time: people also talk about you and how you are.

(Siri, 42, diagnosed with ovarian cancer in 2010)

These two reflections by Bjørg and Siri give a glimpse into how they experience the aftermath of cancer in their social environment and some characteristics of their village. They were two of the 10 main informants in one-year anthropological fieldwork in 2014 conducted in a coastal village with less than 3000 inhabitants in Finnmark, the northernmost county of Norway. Like the other study participants, Bjørg and Siri lived in the village during the fieldwork, had undergone cancer diagnosis and treatment and were in the process of resuming their everyday life. The analysis is developed mainly from the experiences with, and stories given by four of the informants Bjørg, Siri, Kari and Ole. We seek to understand the social embeddedness of thoughts and worries, how they mould social reality and at the same time are constituted by social reality (White 1997; Wikan 2000; Kleinman 1988). We explore how Bjørg’s relationship to her husband, children and friends is configured through her worrying and the possibility of experiencing relapse. Siri experiences the potential event of becoming seriously ill once again as less disturbing, due to her integration in a non-anonymous, socially closely-knit village. For Kari, it feels inappropriate when her son is worried about her. She

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2 Instead of using the term ‘cancer survivor’, which indicates an explicit state of cancer as belonging to the past, we chose to describe study participants as being ‘in the aftermath of cancer’. In this way, we emphasise the various challenges of the state after treatment.

3 undisclosed due to anonymity
sees herself as being the problem solver and mediator in the family. Ole’s experience of
having had cancer taught him how difficult it was to share intimate health information with
men of his age in the small village. He sometimes feels left alone with his thoughts and
worries.

**Background: Cancer worries in a social context**

The number of patients who live with cancer as a chronic illness is increasing, and many need
continued care or treatment at home, in primary health care and in specialist services (Olsen
2015; La Cour, Johannessen, and Josephsson 2009). This patient group experiences bodily
sensations that may endure and influence everyday activities, such as cognitive limitations,
sleep problems, fatigue, pain, and physical limitations, which cannot always be easily
categorised or compartmentalised as new symptoms, late effects or discomfort connected to
other illnesses (Harrington et al. 2010). Balmer, Griffiths, and Dunn (2015) suggest that a full
‘recovery’ after a cancer diagnosis may be impossible, partly due to thoughts around possible
relapse dominating everyday life. Living in the aftermath of cancer treatment has therefore
been characterised as a ‘betwixt and between state’, pointing to Turner’s (1969)
understanding of liminality, indicating a ‘not-ill-not-healthy state’, marked by uncertainty and
strong emotional experiences (Blows et al. 2012; Little et al. 2002).

Relevant for the context of this paper are studies that focus on the relational and
emotional aspects of this not-ill-not-healthy phase. In Norway, as in other Scandinavian
countries, we see an increase in the transfer of care practices from institutions to families,
which also means changes in emotional experiences for patients and families after cancer
treatment (Olsen 2015). Close interpersonal relationships have been shown to be core
mediating features in how cancer is experienced and symptoms are presented. In this context,
the use of the idea of ‘joint ownership of cancer’ has been suggested (Illingworth et al. 2010).
A study of breast cancer survivors explains how the multi-dimensional aspects of women’s relationships with family, friends, co-workers and care professionals has a significant impact on their coping strategies and how they make sense of their breast cancer experiences (Tighe et al. 2011). Relatives and friends can experience helplessness in terms of how they ‘are supposed to react’ to the former patient’s changed body, marked by treatment. Such dynamics can encourage silence and secrecy about cancer (Rasmussen, Hansen, and Elverdam 2010).

Seppola-Edvardsen, Andersen and Risør (2016) show how former cancer patients balance sharing uncertainty in order to find a strategy for ‘…managing the state of living within existential uncertainty, without letting it dominate social situations. This way former cancer patients [...] care [...] both for themselves and others’. (2016, 382)

Several studies on illness narratives and illness recovery use the term ‘anxiety’ in focusing on emotional aspects (Likely and Switzer, 2016; Carlson, 2016; Tamagawa et al., 2015; Enache, 2012; Roaldsen et al., 2015). Studies of emotions connected to cancer also relate to the worries involved using the term ‘depression’. Anxiety and depression, however, tend to describe more severe, clinically defined emotional states than ‘worrying’ (Hirai et al. 2008; Lampic et al. 1994; Montazeri et al. 2001). The informants did not articulate anxiety in terms of a possible illness state, but used the Norwegian word ‘bekymra’ connected to a possible relapse; this is usually translated as ‘worried’, but may also imply being nervous, uneasy, disquiet, anxious or unsettled. Hirai et al. (2008), Lampic et al. (1994), Montazeri et al. (2001) and Stark et al. (2002) describe possible cancer-related affective scenarios, for instance: ’[w]orried about what examination may show, [w]orried about not being able to ask questions [or w]orried about identifying signs of cancer…’ (Lampic et al. 1994, 121).

Participants in the study would often describe similar scenarios. They were worried about not managing work or family life, or about their children’s wellbeing, or if the road would be open in the winter when they needed to see the doctor in a different town. In other words,
‘worry’ is linked to ‘disquietude’ or ‘feeling uneasy’, often about possible expected and unexpected events.

While these studies show us aspects of how the aftermath of cancer is experienced in social contexts, we only have sparse information on how worries about possible relapse actually arise and are modified in everyday contexts, and how people in cancer recovery experience and manage their worries in different everyday relations. From a perspective of understanding worries as occurring relationally *between* people and as an intrinsic part of the social (Hadolt forthcoming), we explore worries as a phenomenon, based on experience-near stories, and consider how worry exists not only as a particular emotion in itself, but as relationally embedded and structured, organised and articulated in particular settings (White 1997; Hochschild 2003; Lutz and White 1986). In this paper we aim to unravel and understand how worries about bodily sensations and possible relapse in people living in the aftermath of cancer treatment configure and relate to various social relations and contexts.

**Methods and setting**

This analysis builds on the overall project ‘SenCancer - Sensing illness in everyday life: Care-seeking and perception of symptoms among cancer survivors’, at the University of Tromsø, Norway. Skowronski, the first author, conducted one-year anthropological fieldwork in the village. The two-hour flight to the nearest hospital with an oncology department and the isolated geographic location in general suggested that these patients had particular challenges in the aftermath of cancer treatment.

She followed four men and six women who lived in the aftermath of cancer treatment in their everyday life and relationships in the village. All belong to a numerous and gradually growing group of people (Coleman et al. 2011; Sant et al. 2003) who survived cancer and who will probably continue living with this experience for many more years. They were recruited through the local general practitioner, the local cancer nurse, acquaintances, and an
announcement in the local newspaper. They were all Norwegians, had different types of
cancer and were between 41 and 82 years of age. Nine had completed conventional cancer
treatment. One participant still had cancer, which was kept at bay by three different
radiotherapies. The timespan since treatment varied between three months and 10 years at
study start and all 10 main informants had resumed most aspects of their everyday life. They
had varied experiences related to the diagnosis, ranging from an uncomplicated operation four
years ago to the experience of relapse and living with complications.

For them, the personal bodily experience of cancer started either with a surprising
diagnosis, or days, weeks or months of uncertainty about something unusual in their
physiology. Skowronski met the informants at a stage where they had been medically treated,
but almost all of them were experiencing worries about the cancer returning, having a relapse,
becoming ill again or getting cancer again.

The fieldwork included biographical interviews and monthly semi-structured
interviews with the 10 main informants, as well as participant observation and day-to-day
conversations with them and other villagers (Flick 2012; Kuesters 2009; Schuetze 1983). One
biographical interview was conducted with each of the 10 informants recovering from cancer
in the beginning of the fieldwork, with a focus on their illness stories. By telling illness
stories, protagonists do not necessarily reveal clinical and physical facts about being ill, but
rather how they experience illness accompanied by and embedded in complex negotiations in
everyday social life. When people tell stories, they make references to individual logics of
seeing the world and how they are involved in it and to people being part of it (Mattingly and
Garro 2000; Wikan 2000; Hunt 2000). For this reason, starting fieldwork by exploring
participants’ illness stories gave us an impression of their experiences and feelings related to
illness and treatment. These initial interviews formed a basis for the monthly semi-structured
interviews, which included questions about well-being, perceptions of bodily changes, bodily
sensations, and symptoms. Participants were also asked questions about the persons involved
in decisions about seeking care, their encounters with the health system and reasons for
choosing a particular care service and finally, how they evaluated the health care services that
were relevant for them. Combining these methodologies allowed us to gain access to the
‘lived experience’ of the bodily sensations and emotions of Bjørg, Siri, Kari and Ole and other
informants in this phase after cancer treatment.

**Into the village**

Skowronski arrived in the village in February 2014, three days before the end of the polar
night, after having made a few advance contacts with staff of the health care centre, so that
some people expected her visit. The transition from being new in the village to meeting many
acquaintances while walking along the street went quite quickly, as everyone seemed to know
everybody. She engaged in local life, walking around the village, singing in the choir, joining
the knitting club and the local orchestra; in all these settings she regularly met the people
recovering from cancer and other villagers.

The village faces the open Barents Sea to the north, and in the other directions partly
hilly surroundings. The inhabitants experience strong winds, especially in the wintertime, and
a foggy climate in the summertime. Life in the village is partly regulated by the extreme
differences between summer and winter. When the sun is always up in summer, many
villagers spend a lot of their free time in their cabins, fishing and relaxing outside the village.
‘Outdoor recreation has a special position within the Norwegian leisure-time tradition, and
cabin life is strongly influenced by the philosophy to live a simple life outdoors’ (Vittersø
2007, 278-79). During winter, most of the day is pitch black and people often use snow
scooters in their free time. The permanent cold wind disperses the snow and makes ski
trousers and thick winter coats a type of standard clothing for many months.
In 2011, most people in the village worked in the service industry, the secondary sector of the economy, or the local health and care services. Even though the fishing industry has diminished over the years, it is still considered the main industry in the village (Folkvord and Foss 2013). The village has a primary and secondary school to 10th grade. There is just one of various institutions: one health centre with one GP, one church with one vicar, one police station, one hotel and one museum.

Most villagers live in detached houses, clustered around the one main street, which almost every villager would pass through regularly. While most female pensioners would have their morning coffee in the only local kiosk, men would meet up in the only local coffee shop. Whoever buys medicine before noon has to pass this group of women, since the only tiny pharmacy counter is inside the kiosk. The village is known for a high concentration of sports, handicraft and music clubs. Almost every villager is a member of at least one local club or organization, and such engagement is highly appreciated in the village. In the knitting club, for example, in which women of various ages participate, the state of health of individual villagers was often discussed. Someone had a heart attack and another person had not showed up at work for almost two weeks. Someone had noticed that the light in someone’s house was switched off now in the evenings, which was unusual. Having a boarding card when taking the plane was not always necessary, since the airport workers could connect most faces to the passenger list. The closely-knit concentration of people and activities in the small village means that anonymity is practically non-existent.

The two-hour flight to Tromsø, where the nearest hospital with an oncological department is located, is often delayed or cancelled. The isolated location of the village is a challenge for the inhabitants in accessing specialised health care. Locally there is one GP and one cancer nurse available.
Anthropological perspectives on the social embeddedness of worries

Emotions are structured by our forms of understanding and a culturally and socially ordered past (Levy 1984; Lutz 1988; Shweder 1994, 2004; Rosaldo 1984). In this paper, we are analytically guided by anthropological considerations that emphasise emotions as relational phenomena or affective states: ‘… [E]motions are everywhere prototypically social […] their core meanings and pragmatic consequences pertain to interpersonal relations and interactions’ (White 1997, 236). Anthropologist Geoffrey White (1997) suggests that emotions are not merely biological reactions to certain events but arise in social contexts or transactions and may be seen as shaping the course of events and defining social relations. He finds it crucial to take into account the specific meanings and uses of emotion in people’s everyday lives to interpret the significance of emotion in individual lives and social interactions. Arthur Kleinman reminds us that ‘…we must be able to see the patient suspended […] , in the web of relationships that constitute a life world…’ to be able to understand ‘…the swings of symptoms and disability…’ which are connected to constant emotional and interpersonal changes (1988, 181). We have been inspired by the Norwegian anthropologist Unni Wikan, who illustrates how emotions are embedded in and navigated by social realities in her ethnography in Bali (1989). A person who experiences and tells about an emotion is always embedded in a cultural context and a society in which this emotion can have social tasks or consequences (Wikan 1989). In this paper, we also consider Hochschild’s (2003) concept of ‘emotion work’, which describes the emotional manipulation that people perform on themselves and others to meet ‘feeling rules’ in terms of emotional intensity, direction (e.g. positive or negative) and duration in a particular situation (Hochschild 2003; Thomas, Morris, and Harman 2002).

By interlacing these perspectives with the fieldwork experience in the village, we considered the different social settings and relations in which worries are spoken about,
thought about and generally dealt with by the participants and analysed how the thoughts and worries of Bjørg, Siri, Kari and Ole configure relationships to family, friends and the village community. Three analytical themes were developed by evaluating the empirical data: ‘Protecting the family’, ‘Sharing with friends’ and ‘Lack of anonymity in the village’. These are connected to three important everyday social settings in which worries are experienced, namely within the family, with friends outside the family and in the socially closely-knit village. By differentiating between these three social contexts, we will highlight how worries can be talked about in different relationships and settings, and how the different ways of handling worries influence the processes of creating and strengthening relations.

Protecting the family

Kari and Bjørg, but also other participants, experienced emotional obligations in terms of needing and wanting to protect family members from emerging worries about a possible relapse, and hinted at feeling guilty about the effect of their cancer on family and friends (Balmer, Griffiths, and Dunn 2015). Besides meeting Kari regularly for the interviews, the first author was seeing her every week during one of her free time activities. Kari liked sharing or being told funny anecdotes during breaks and often burst into laughter. This was not the case during the interviews, usually conducted at her house. She cried when she recalled the times when she was acutely ill and said that she was still sometimes worried. When Kari, mother of three, was told that she had cancer, and subsequently told her husband and children, her initial reaction was to console them. Like other female study participants, Kari described finding it unusual to be looked after when she became ill. She stated that she avoided expressing her worry in front of her son, since that usually makes him worried too: ‘But the thing I find so awful is perhaps that he’s going around worrying. Because he’s only twelve years old, he shouldn’t go around
worrying. He should be happy.’ White (1997) writes that emotions involve other people and do socio-moral work in everyday life, as they are always embedded in a field of interpersonal relations and actions. They are moral because they possess evaluative and behavioural elements. Kari’s worries were accompanied by a moral guilty conscience towards her son as she felt that his role was not to be worried about her.

Ramey (1988) finds that being part of a nuclear family means that one’s own life circumstances become conditioned by those of other family members. Previous research shows how women often feel responsible for the emotional wellbeing of the family, not only in the case of illness (Devault 1999). However, the descriptions of the participants, including men, reveal that the female role as carer is not the only factor: worries of relapse seem to have the potential to trigger a lasting crisis in families. In a similar way to Kari, Bjørg experiences how being worried about possible relapse is not always appropriate in family situations:

Sometimes you’re an actor at home. When I’m worried about cancer stuff from time to time, I keep saying that my work was stressful or I’m tired, you know? I try to protect them [her family].’ [...] So I don’t talk to my husband at least about it all the time. It’s about shielding him. I know him and I also know how he’ll respond. He trivialises it right away: “[...] Now you’ve just been checked.” He’s trying to get things down to earth. So I do actually know what he’s going to say, if I start getting worried: “And anyway, if you’re worried, then you can go to the doctor, I can’t help you with that, can I?” [...] So the result is that I actually mostly talk to my colleagues about it.

A number of scholars (Olsen 2015; Fitzpatrick and Olson 2015; Devault 1999; Seppola-Edvardsen; Andersen and Risør 2016) have connected this avoidance of sharing certain thoughts about cancer in families to Hochschild’s concept of ‘emotion work’ (2003). Hochschild discusses how private and public expectations are connected to the manipulation of feelings. These expectations are informed by a complex interplay between social structures, cultural norms, organizational climates and individual roles. In other words, worries are shaped and signified by the social emplacement, e.g. the family context. When Bjørg became
ill, she discussed with teachers and other parents possible ways of talking about cancer with her own and other people’s children. This was part of her efforts to adjust to organizational climates and expectations in the school. She was also aware of expectations and climates in her family and did emotion work to comply with what she experienced as feeling rules in this phase of her illness and healing process.

Bjørg: [My colleague and I] actually work very closely together […] I’m actually not eager to find out if there’s something there [she means a new tumour for instance]. It’s more that someone should hear that I’m still concerned […] Yes well, I know what he [husband] is going to answer, and then I see the fear in his eyes. And then he gets anxious. And sometimes he can get a bit irritated. And sometimes I can see that he is scared and… sometimes he tries to listen to me. But she [friend] is like: “Oh my God, I would be exactly the same.” […] She [friend] understands me. And she doesn’t say: “You’ll be checked then and then. And you’ve just been told everything was ok and the cell sample was so and so.”

Bjørg helps us to understand the social embeddedness of her ‘emotion work’, which consists of hiding thoughts around a possible recurrence of cancer from her husband. Sharing her thoughts might make him again relate to the possibility of her pain, suffering, bodily deterioration or death, and can be seen as attempt to help the family to heal and recover from the entire experience. The love and connection between Bjørg and her husband makes her try to protect him from those emerging worries, while he himself tries to normalise and/or avoid this worried atmosphere at home. The protection of the family from worrying is connected to the family reconciling to everyday life after going through a phase of a life-threatening disease and demanding treatment for one of its members. Cancer is not merely the domain of the ill person, but can be experienced ‘…at the dyadic level, where cancer [is] jointly and interactionally owned and processed’ (Illingworth et al. 2010, 26). This also applies to the relationships in Bjørg’s family which have changed and are constituted by her worries. The constituting and changing consist of the experience of a difficult crisis in the family and of the
need to protect individual family members. Her emotions take a specific form within the family setting, and mould e.g. family mealtimes, discussions with her husband and dialogues with her children (White, 1997).

Bjørg finds that her friend responds quite differently from her husband when she talks about her worries of relapse. Like other participants, she points out differences in constructing and sharing worries among friends and family members at this stage of recovery, which leads us to the focus of the next section.

**Sharing with friends**

Unni Wikan (1989) reflects on expressions of and responses to worries and sorrow. She shows how her informants in Bali believe that emotions can be chosen and that sadness and laughter can spread. They believe that laughter makes one forever young and creates health, happiness and good social relations. People would try to cheer up a sad person and make an effort to make the person laugh. Just as the ‘hot’ emotions of anger, jealousy and envy respond to shock treatment by cold water, so do sadness and unhappiness respond to treatment by their opposites, laughter and cheerfulness. ‘It seemed an awful thing to do, from my point of view, as I was raised to think that people should cry to get their feelings out when they are sad and had difficulty in understanding how laughter could serve this function and be a driving force in health care.’ (Wikan 1989, 300)

Wikan’s reaction to how her informants deal with sadness is an example of a ‘Western’ manner of relating to people with worries, which is to support them to express emotions bodily and verbally, to prevent them from being suppressed. Most participants in the study also expressed a need to verbalise worries in relation to others, and for many of them, relationships with friends met this need. Kari stated why it was important to her to have friends and family in the phase after cancer treatment:
‘We talk about everything, maybe not with my boyfriend, but [...] with Marte [her friend] and Mona [her sister-in-law, whom she calls her friend]. [...] I can chat with them about everything from my feelings towards my boyfriend to my feelings about the illness, about my fear of getting cancer again.

Kari illustrated how one important attribute of the relationship with her friend and sister-in-law was the possibility of sharing problems and worries. With her new boyfriend, she did not necessarily like to talk about difficult topics. Her worries are not only due to the appearance of bodily sensations or pain, but are enacted in various relationships, involving a wish to manage the worries and change the situation (White 1997).

Bjørg often struggled to avoid bringing up worries about possible relapse with her husband and children, but explained how this was easier with her friend. Her own and her husband’s lives are intertwined and interdependent to a much greater degree than those of Bjørg and her friends. In Western contexts, we hope for emotional support and advice from friends in difficult times, even for material help when facing an existential crisis (Bell 1999).

As Bjørg and Kari mention, they receive emotional support from their friends who recognise and understand particular feelings and take time to listen. Bjørg appreciates her friend’s understanding that it is morally right to discuss worry in this ‘betwixt and between’ phase of healing and possible illness.

Inspired by White’s (1997) understanding of how emotions can be understood as arising in contexts of transactions, capable of creating social realities, we can consider how Bjørg’s and Kari’s relationships with their friends are constituted by sharing those worries and strengthened by talking about intimate thoughts while spending time together. They feel understood, partly relieved and less worried about any possible relapse.

In these last two sections, we gave a glimpse into the ‘betwixt and between’ phases of Bjørg’s and Kari’s everyday lives, which revealed an attempt to take on new roles in relationships with family and friends because of worry and unease in the aftermath of cancer.
We showed how not sharing worries about possible relapse in the family is a way to strengthen, secure and protect the family and help it to regain its normal everyday life. By contrast, sharing worries with friends means relief and a strengthening of the relationship, while not sharing might even challenge it.

Lack of anonymity in the village

In small places ‘…inhabitants know each other personally; they participate in, and reproduce, a social system characterised by face-to-face contact.’ (Eriksen 2010). A village is ‘a small place’ according to Eriksen; people know each other and about each other and a lack of anonymity is common. In this section, we will look at how worries are dealt with in situations and settings outside the private sphere and home, involving encounters with and/or perceptions of people outside the circle of family or friends. Siri, who is in her 40s, has lived in the village since she was a little child. She stated that the lack of anonymity was intertwined with her experience of worry. Siri prefers living in a small place to a big city; her impression is that people in bigger places are more socially isolated:

Well, the good thing about living in such a small village is you won’t be forgotten. That’s kind of the good thing about people gossiping about others all the time: people also talk about you and how you are. […] So I’m saying that people are taking care of each other, care about each other and […] compared to, well, when you live in a big city, you can actually lie dead for 14 days in your flat before the neighbour starts to notice the bad smell.

These words, which do not necessarily reflect reality, show Siri’s experience of life in the village. She experiences the gossip mostly as an expression of caring for each other. Anthropologists have shown how gossiping influences the experience of emotions for both those who gossip and those gossiped about (Besnier 1995). Based on research in Norway, Norwegian anthropologists have contributed to the understanding of gossip, and shown how it
can be seen as an activity in which the participating persons exchange information, weigh and evaluate together what is acceptable and where the boundaries should go for others and for oneself. Talking about others and being talked about is connected to belonging to the group in question (Gullestad 2002; Foss 2008; Haugen 1983).

Looking at these interwoven social networks and their significance can help us to understand how participants experience illness or signs of an illness returning (Kleinman 1988). Siri, who is involved in certain everyday interactions and routines in the village and sees familiar faces quite often, mentions that gossip, besides its negative connotations, includes reassurance for her; people know about you and how you are, keep an eye on you and would react if things were not as usual. This seems to influence her management of her worries about a possible relapse. She can tolerate it better because she knows that people would start talking and be concerned if she was suddenly no longer seen. Dealing with thoughts and worries around death or illness can be seen as constituted by social dynamics in the village, and contributes to her perception that people would care and be present if something serious occurred.

Every weekday morning at 11 am, one of the main informants, Ole, goes to the only café in the village to meet and chat with other men of his age, and the ethnographer joined him on three different mornings. The café was recently taken over by an Argentinian/Spanish couple. It is decorated in a simple style, and the smell of fried food is constantly hanging in the air. The mostly male group discussed a broad range of topics, including cancer and health, death and illness in general. One person spoke about a friend who died last year, another about a villager who had to take the plane to the hospital to see a specialist. Another one was explaining that he is struggling with ventricular fibrillation. If any of the regulars in the group did not attend, questions would be raised about his absence. News and opinions on a broad range of topics, including cancer and health, death and illness among the villagers were part
of the communicative exchange. Discussions were held around high crime statistics in Oslo, the unpredictable immigration in cities in general and the cooperative feeling in the village. Bigger cities have a rather negative image, in opposition to the comfort of living in a small place. The routine of an informal, daily morning meeting for coffee provided a framework for the feeling of security, stability and belonging in the village for the participants.

Even though Ole attends most of the morning coffee meetings, he does not necessarily talk about his own illness. In the group, people update each other on the health situation of villagers who are not present; people know about each other’s health and illness, without needing to ask the person directly. A person’s illness is part of the knowing in the community. However, Bjørg and other participants pointed out the other, ‘problematic’ side of the lack of anonymity, especially related to people wanting to conceal their worries from others. Here, the difference between village and private situations becomes apparent: while one is more able to choose and influence situations with family and especially with friends, the reactions in the village seem to be less controllable. Bjørg explained how she finds that the villagers expect her to behave like a healthy person, since she has been officially declared healthy. Earlier, when she came home from hospital after treatment, most of Bjørg’s family members, friends and acquaintances and villagers knew about her diagnosis. She was overwhelmed by the number of bouquets of flowers she got. Even though she experienced what she calls ‘a period of grace’ after her diagnosis, where she had time to rest, and did not have to work, she found the get-well-soon reactions in the form of cards and flowers to be tiresome, since it showed that everyone in the village would know what was going on in her life. Bjørg’s experience of being worried is influenced by being in the village or by the perceptions of its presence, since it can be seen as a social context. White (1997) investigates how ‘…research in a wide range of languages and cultures indicates that when people talk about emotion, they are not talking primarily about states inside the individual, nor are they
talking about responses or events outside the person. Rather, they are talking about processes that mediate or link persons, actions, and events. [...] Emotions are everywhere prototypically social; that at their core meanings and pragmatic consequences pertain to interpersonal relations and interactions.’ We find that ‘being worried’ is experienced by people in recovery in relation to the lack of anonymity, meeting familiar faces frequently in the village, the established meeting places and the comfort and support of the village. Knowing that everybody knows is found to be both comforting and demanding by Bjørg and other participants in experiencing and managing worries of relapse.

Concluding discussion

In showing how people recovering from cancer treatment continue to worry about possible relapse, we drew on anthropological writings on emotions, which are, especially in the context of cancer, quite sparse (Beatty 2013). By contemplating emotions as relationally constituted and as capable of creating social realities (White 1997), we showed how worries have communicative and moral characteristics and are socially produced and modified by interaction with the family, friends and other villagers.

Bjørg and Kari experienced situations in which they attempted to protect family members by avoiding sharing worries with them and carried out emotion work (Hochschild 2003) to help the family recover from the illness experience. At the same time, they sometimes found it easier to share those worries with friends, since these had a different kind of moral involvement in their lives. Friendships were strengthened by sharing worries.

Experiencing worries in the context of the village and in relation to acquaintances in the village meant both comfort and challenge for the participants. On the one hand, the size of the village represents reassurance with its non-anonymous social infrastructure, while on the
other hand this lack of anonymity is experienced as confining; it is difficult to keep
information to oneself and one is confronted with others’ opinions about one’s health.

People who survive cancer are a gradually growing group. This group faces challenges
that differ from those of acute cancer patients or other illness groups (Miller 2015a). We
revealed how worrying about possible relapse is a socially embedded challenge. Such a
challenge can be better addressed, and practical clinical interventions developed, when we
understand how people perceive, understand and deal with such worries in everyday
relationships. Previous research has shown how discussing illness-related topics in a ‘therapy
management group’ has significant relevance for how people seek health care, and how they
make choices within the healthcare system (Janzen 1987). We suggest that there is a need for
further research that explores the social embeddedness of emotions during times of illness.

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No potential conflict of interest was reported by the author.

Ethical Considerations

The project addressed the sensory, emotional and relational aspects of patients’ illness
experiences. This implied that patients and their significant others were vulnerable both
during fieldwork and by being included in the analysis. Particular care and sensitivity were
needed to protect and respect the patients’ integrity throughout the study. The research group
worked specifically on these issues during the study. The 10 main informants provided
informed consent and had the option to withdraw from the project at any point. They were
assured that any information they provided would be treated with confidentiality and de-
identified. All participant names have been changed.

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