

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

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7 Skowronski is taking a PhD in social anthropology at the National Research Center in Complementary
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15 Risør is mainly interested in researching symptoms and sensations in clinical encounters, linked to
16 illness experiences and health-seeking practices, especially concerning functional disorders, cancer,
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23 Andersen's research is thematically related to contemporary orientations to cancer disease control:
24 exploring the construction and management of diagnostic uncertainties (e.g. introduction of cancer

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

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31 She is mainly interested in social and cultural processes between people who experience illness, their
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36 Abstract

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

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

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

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

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

61 **Introduction**

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

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

66

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

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

71 These two reflections by Bjørg and Siri give a glimpse into how they experience the aftermath
72 of cancer² in their social environment and some characteristics of their village. They were two
73 of the 10 main informants in one-year anthropological fieldwork in 2014 conducted in a
74 coastal village with less than 3000 inhabitants³ in Finnmark, the northernmost county of
75 Norway. Like the other study participants, Bjørg and Siri lived in the village during the
76 fieldwork, had undergone cancer diagnosis and treatment and were in the process of resuming
77 their everyday life. The analysis is developed mainly from the experiences with, and stories
78 given by four of the informants Bjørg, Siri, Kari and Ole. We seek to understand the social
79 embeddedness of thoughts and worries, how they mould social reality and at the same time
80 are constituted *by* social reality (White 1997; Wikan 2000; Kleinman 1988). We explore how
81 Bjørg's relationship to her husband, children and friends is configured through her worrying
82 and the possibility of experiencing relapse. Siri experiences the potential event of becoming
83 seriously ill once again as less disturbing, due to her integration in a non-anonymous, socially
84 closely-knit village. For Kari, it feels inappropriate when her son is worried about her. She

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

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

89

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

91 The number of patients who live with cancer as a chronic illness is increasing, and many need
92 continued care or treatment at home, in primary health care and in specialist services (Olsen
93 2015; La Cour, Johannessen, and Josephsson 2009). This patient group experiences bodily
94 sensations that may endure and influence everyday activities, such as cognitive limitations,
95 sleep problems, fatigue, pain, and physical limitations, which cannot always be easily
96 categorised or compartmentalised as new symptoms, late effects or discomfort connected to
97 other illnesses (Harrington et al. 2010). Balmer, Griffiths, and Dunn (2015) suggest that a full
98 'recovery' after a cancer diagnosis may be impossible, partly due to thoughts around possible
99 relapse dominating everyday life. Living in the aftermath of cancer treatment has therefore
100 been characterised as a 'betwixt and between state', pointing to Turner's (1969)
101 understanding of liminality, indicating a 'not-ill-not-healthy state', marked by uncertainty and
102 strong emotional experiences (Blows et al. 2012; Little et al. 2002).

103 Relevant for the context of this paper are studies that focus on the relational and
104 emotional aspects of this not-ill-not-healthy phase. In Norway, as in other Scandinavian
105 countries, we see an increase in the transfer of care practices from institutions to families,
106 which also means changes in emotional experiences for patients and families after cancer
107 treatment (Olsen 2015). Close interpersonal relationships have been shown to be core
108 mediating features in how cancer is experienced and symptoms are presented. In this context,
109 the use of the idea of 'joint ownership of cancer' has been suggested (Illingworth et al. 2010).

110 A study of breast cancer survivors explains how the multi-dimensional aspects of women's
111 relationships with family, friends, co-workers and care professionals has a significant impact
112 on their coping strategies and how they make sense of their breast cancer experiences (Tighe
113 et al. 2011). Relatives and friends can experience helplessness in terms of how they 'are
114 supposed to react' to the former patient's changed body, marked by treatment. Such dynamics
115 can encourage silence and secrecy about cancer (Rasmussen, Hansen, and Elverdam 2010).
116 Seppola-Edvardsen, Andersen and Risør (2016) show how former cancer patients balance
117 sharing uncertainty in order to find a strategy for '...managing the state of living within
118 existential uncertainty, without letting it dominate social situations. This way former cancer
119 patients [...] care[...] both for themselves and others'. (2016, 382)

120 Several studies on illness narratives and illness recovery use the term 'anxiety' in
121 focusing on emotional aspects (Likely and Switzer, 2016; Carlson, 2016; Tamagawa et al.,
122 2015; Enache, 2012; Roaldsen et al., 2015). Studies of emotions connected to cancer also
123 relate to the worries involved using the term 'depression'. Anxiety and depression, however,
124 tend to describe more severe, clinically defined emotional states than 'worrying' (Hirai et al.
125 2008; Lampic et al. 1994; Montazeri et al. 2001). The informants did not articulate anxiety in
126 terms of a possible illness state, but used the Norwegian word 'bekymra' connected to a
127 possible relapse; this is usually translated as 'worried', but may also imply being nervous,
128 uneasy, disquiet, anxious or unsettled. Hirai et al. (2008), Lampic et al. (1994), Montazeri et
129 al. (2001) and Stark et al. (2002) describe possible cancer-related affective scenarios, for
130 instance: '[w]orried about what examination may show, [w]orried about not being able to ask
131 questions [or w]orried about identifying signs of cancer...' (Lampic et al. 1994, 121).
132 Participants in the study would often describe similar scenarios. They were worried about not
133 managing work or family life, or about their children's wellbeing, or if the road would be
134 open in the winter when they needed to see the doctor in a different town. In other words,

135 'worry' is linked to 'disquietude' or 'feeling uneasy', often about possible expected and
136 unexpected events.

137 While these studies show us aspects of how the aftermath of cancer is experienced in
138 social contexts, we only have sparse information on how worries about possible relapse
139 actually arise and are modified in everyday contexts, and how people in cancer recovery
140 experience and manage their worries in different everyday relations. From a perspective of
141 understanding worries as occurring relationally *between* people and as an intrinsic part of the
142 social (Hadolt forthcoming), we explore worries as a phenomenon, based on experience-near
143 stories, and consider how worry exists not only as a particular emotion in itself, but as
144 relationally embedded and structured, organised and articulated in particular settings (White
145 1997; Hochschild 2003; Lutz and White 1986). In this paper we aim to unravel and
146 understand how worries about bodily sensations and possible relapse in people living in the
147 aftermath of cancer treatment configure and relate to various social relations and contexts.

148 **Methods and setting**

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

155 She followed four men and six women who lived in the aftermath of cancer treatment
156 in their everyday life and relationships in the village. All belong to a numerous and gradually
157 growing group of people (Coleman et al. 2011; Sant et al. 2003) who survived cancer and
158 who will probably continue living with this experience for many more years. They were
159 recruited through the local general practitioner, the local cancer nurse, acquaintances, and an

160 announcement in the local newspaper. They were all Norwegians, had different types of
161 cancer and were between 41 and 82 years of age. Nine had completed conventional cancer
162 treatment. One participant still had cancer, which was kept at bay by three different
163 radiotherapies. The timespan since treatment varied between three months and 10 years at
164 study start and all 10 main informants had resumed most aspects of their everyday life. They
165 had varied experiences related to the diagnosis, ranging from an uncomplicated operation four
166 years ago to the experience of relapse and living with complications.

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

172 The fieldwork included biographical interviews and monthly semi-structured
173 interviews with the 10 main informants, as well as participant observation and day-to-day
174 conversations with them and other villagers (Flick 2012; Kuesters 2009; Schuetze 1983). One
175 biographical interview was conducted with each of the 10 informants recovering from cancer
176 in the beginning of the fieldwork, with a focus on their illness stories. By telling illness
177 stories, protagonists do not necessarily reveal clinical and physical facts about being ill, but
178 rather how they experience illness accompanied by and embedded in complex negotiations in
179 everyday social life. When people tell stories, they make references to individual logics of
180 seeing the world and how they are involved in it and to people being part of it (Mattingly and
181 Garro 2000; Wikan 2000; Hunt 2000). For this reason, starting fieldwork by exploring
182 participants' illness stories gave us an impression of their experiences and feelings related to
183 illness and treatment. These initial interviews formed a basis for the monthly semi-structured
184 interviews, which included questions about well-being, perceptions of bodily changes, bodily

185 sensations, and symptoms. Participants were also asked questions about the persons involved
186 in decisions about seeking care, their encounters with the health system and reasons for
187 choosing a particular care service and finally, how they evaluated the health care services that
188 were relevant for them. Combining these methodologies allowed us to gain access to the
189 ‘lived experience’ of the bodily sensations and emotions of Bjørg, Siri, Kari and Ole and other
190 informants in this phase after cancer treatment.

191 **Into the village**

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

199 The village faces the open Barents Sea to the north, and in the other directions partly
200 hilly surroundings. The inhabitants experience strong winds, especially in the wintertime, and
201 a foggy climate in the summertime. Life in the village is partly regulated by the extreme
202 differences between summer and winter. When the sun is always up in summer, many
203 villagers spend a lot of their free time in their cabins, fishing and relaxing outside the village.
204 ‘Outdoor recreation has a special position within the Norwegian leisure-time tradition, and
205 cabin life is strongly influenced by the philosophy to live a simple life outdoors’ (Vittersø
206 2007, 278-79). During winter, most of the day is pitch black and people often use snow
207 scooters in their free time. The permanent cold wind disperses the snow and makes ski
208 trousers and thick winter coats a type of standard clothing for many months.

209 In 2011, most people in the village worked in the service industry, the secondary
210 sector of the economy, or the local health and care services. Even though the fishing industry
211 has diminished over the years, it is still considered the main industry in the village (Folkvord
212 and Foss 2013). The village has a primary and secondary school to 10th grade. There is just
213 one of various institutions: one health centre with one GP, one church with one vicar, one
214 police station, one hotel and one museum.

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

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

233 **Anthropological perspectives on the social embeddedness of worries**

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

256 By interlacing these perspectives with the fieldwork experience in the village, we
257 considered the different social settings and relations in which worries are spoken about,

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

267

268 *Protecting the family*

269 Kari and Bjørg, but also other participants, experienced emotional obligations in terms of
270 needing and wanting to protect family members from emerging worries about a possible
271 relapse, and hinted at feeling guilty about the effect of their cancer on family and friends
272 (Balmer, Griffiths, and Dunn 2015).

273 Besides meeting Kari regularly for the interviews, the first author was seeing her every
274 week during one of her free time activities. Kari liked sharing or being told funny anecdotes
275 during breaks and often burst into laughter. This was not the case during the interviews,
276 usually conducted at her house. She cried when she recalled the times when she was acutely
277 ill and said that she was still sometimes worried. When Kari, mother of three, was told that
278 she had cancer, and subsequently told her husband and children, her initial reaction was to
279 console them. Like other female study participants, Kari described finding it unusual to be
280 looked after when she became ill. She stated that she avoided expressing her worry in front of
281 her son, since that usually makes him worried too: ‘But the thing I find so awful is perhaps
282 that he’s going around worrying. Because he’s only twelve years old, he shouldn’t go around

283 worrying. He should be happy.’ White (1997) writes that emotions involve other people and
284 do socio-moral work in everyday life, as they are always embedded in a field of interpersonal
285 relations and actions. They are moral because they possess evaluative and behavioural
286 elements. Kari’s worries were accompanied by a moral guilty conscience towards her son as
287 she felt that his role was not to be worried about her.

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

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

303 A number of scholars (Olsen 2015; Fitzpatrick and Olson 2015; Devault 1999; Seppola-
304 Edvardsen; Andersen and Risør 2016) have connected this avoidance of sharing certain
305 thoughts about cancer in families to Hochschild’s concept of ‘emotion work’ (2003).
306 Hochschild discusses how private and public expectations are connected to the manipulation
307 of feelings. These expectations are informed by a complex interplay between social structures,
308 cultural norms, organizational climates and individual roles. In other words, worries are
309 shaped and signified by the social emplacement, e.g. the family context. When Bjørg became

310 ill, she discussed with teachers and other parents possible ways of talking about cancer with
 311 her own and other people's children. This was part of her efforts to adjust to organizational
 312 climates and expectations in the school. She was also aware of expectations and climates in
 313 her family and did emotion work to comply with what she experienced as feeling rules in this
 314 phase of her illness and healing process.

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

324 Bjørg helps us to understand the social embeddedness of her 'emotion work', which consists
 325 of hiding thoughts around a possible recurrence of cancer from her husband. Sharing her
 326 thoughts might make him again relate to the possibility of her pain, suffering, bodily
 327 deterioration or death, and can be seen as attempt to help the family to heal and recover from
 328 the entire experience. The love and connection between Bjørg and her husband makes her try
 329 to protect him from those emerging worries, while he himself tries to normalise and/or avoid
 330 this worried atmosphere at home. The protection of the family from worrying is connected to
 331 the family reconciling to everyday life after going through a phase of a life-threatening
 332 disease and demanding treatment for one of its members. Cancer is not merely the domain of
 333 the ill person, but can be experienced '...at the dyadic level, where cancer [is] jointly and
 334 interactionally owned and processed' (Illingworth et al. 2010, 26). This also applies to the
 335 relationships in Bjørg's family which have changed and are constituted by her worries. The
 336 constituting and changing consist of the experience of a difficult crisis in the family and of the

337 need to protect individual family members. Her emotions take a specific form within the
338 family setting, and mould e.g. family mealtimes, discussions with her husband and dialogues
339 with her children (White, 1997).

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

344 *Sharing with friends*

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

355 Wikan's reaction to how her informants deal with sadness is an example of a
356 'Western' manner of relating to people with worries, which is to support them to express
357 emotions bodily and verbally, to prevent them from being suppressed. Most participants in the
358 study also expressed a need to verbalise worries in relation to others, and for many of them,
359 relationships with friends met this need. Kari stated why it was important to her to have
360 friends and family in the phase after cancer treatment:

361 ‘We talk about everything, maybe not with my boyfriend, but [...] with Marte [her friend]
362 and Mona [her sister-in-law, whom she calls her friend]. [...] I can chat with them about
363 everything from my feelings towards my boyfriend to my feelings about the illness, about
364 my fear of getting cancer again.

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

370 Bjørg often struggled to avoid bringing up worries about possible relapse with her
371 husband and children, but explained how this was easier with her friend. Her own and her
372 husband’s lives are intertwined and interdependent to a much greater degree than those of
373 Bjørg and her friends. In Western contexts, we hope for emotional support and advice from
374 friends in difficult times, even for material help when facing an existential crisis (Bell 1999).
375 As Bjørg and Kari mention, they receive emotional support from their friends who recognise
376 and understand particular feelings and take time to listen. Bjørg appreciates her friend’s
377 understanding that it is morally right to discuss worry in this ‘betwixt and between’ phase of
378 healing and possible illness.

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

384 In these last two sections, we gave a glimpse into the ‘betwixt and between’ phases of
385 Bjørg’s and Kari’s everyday lives, which revealed an attempt to take on new roles in
386 relationships with family and friends because of worry and unease in the aftermath of cancer.

387 We showed how not sharing worries about possible relapse in the family is a way to
388 strengthen, secure and protect the family and help it to regain its normal everyday life. By
389 contrast, sharing worries with friends means relief and a strengthening of the relationship,
390 while not sharing might even challenge it.

391 *Lack of anonymity in the village*

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

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

407 These words, which do not necessarily reflect reality, show Siri’s experience of life in the
408 village. She experiences the gossip mostly as an expression of caring for each other.
409 Anthropologists have shown how gossiping influences the experience of emotions for both
410 those who gossip and those gossiped about (Besnier 1995). Based on research in Norway,
411 Norwegian anthropologists have contributed to the understanding of gossip, and shown how it

412 can be seen as an activity in which the participating persons exchange information, weigh and
413 evaluate together what is acceptable and where the boundaries should go for others and for
414 oneself. Talking about others and being talked about is connected to belonging to the group in
415 question (Gullestad 2002; Foss 2008; Haugen 1983).

416 Looking at these interwoven social networks and their significance can help us to
417 understand how participants experience illness or signs of an illness returning (Kleinman
418 1988). Siri, who is involved in certain everyday interactions and routines in the village and
419 sees familiar faces quite often, mentions that gossip, besides its negative connotations,
420 includes reassurance for her; people know about you and how you are, keep an eye on you
421 and would react if things were not as usual. This seems to influence her management of her
422 worries about a possible relapse. She can tolerate it better because she knows that people
423 would start talking and be concerned if she was suddenly no longer seen. Dealing with
424 thoughts and worries around death or illness can be seen as constituted by social dynamics in
425 the village, and contributes to her perception that people would care and be present if
426 something serious occurred.

427 Every weekday morning at 11 am, one of the main informants, Ole, goes to the only
428 café in the village to meet and chat with other men of his age, and the ethnographer joined
429 him on three different mornings. The café was recently taken over by an Argentinian/Spanish
430 couple. It is decorated in a simple style, and the smell of fried food is constantly hanging in
431 the air. The mostly male group discussed a broad range of topics, including cancer and health,
432 death and illness in general. One person spoke about a friend who died last year, another
433 about a villager who had to take the plane to the hospital to see a specialist. Another one was
434 explaining that he is struggling with ventricular fibrillation. If any of the regulars in the group
435 did not attend, questions would be raised about his absence. News and opinions on a broad
436 range of topics, including cancer and health, death and illness among the villagers were part

437 of the communicative exchange. Discussions were held around high crime statistics in Oslo,
438 the unpredictable immigration in cities in general and the cooperative feeling in the village.
439 Bigger cities have a rather negative image, in opposition to the comfort of living in a small
440 place. The routine of an informal, daily morning meeting for coffee provided a framework for
441 the feeling of security, stability and belonging in the village for the participants.

442 Even though Ole attends most of the morning coffee meetings, he does not necessarily
443 talk about his own illness. In the group, people update each other on the health situation of
444 villagers who are not present; people know about each other's health and illness, without
445 needing to ask the person directly. A person's illness is part of the knowing in the community.

446 However, Bjørg and other participants pointed out the other, 'problematic' side of the
447 lack of anonymity, especially related to people wanting to conceal their worries from others.
448 Here, the difference between village and private situations becomes apparent: while one is
449 more able to choose and influence situations with family and especially with friends, the
450 reactions in the village seem to be less controllable. Bjørg explained how she finds that the
451 villagers expect her to behave like a healthy person, since she has been officially declared
452 healthy. Earlier, when she came home from hospital after treatment, most of Bjørg's family
453 members, friends and acquaintances and villagers knew about her diagnosis. She was
454 overwhelmed by the number of bouquets of flowers she got. Even though she experienced
455 what she calls 'a period of grace' after her diagnosis, where she had time to rest, and did not
456 have to work, she found the get-well-soon reactions in the form of cards and flowers to be
457 tiresome, since it showed that everyone in the village would know what was going on in her
458 life. Bjørg's experience of being worried is influenced by being in the village or by the
459 perceptions of its presence, since it can be seen as a social context. White (1997) investigates
460 how '...research in a wide range of languages and cultures indicates that when people talk
461 about emotion, they are not talking primarily about states inside the individual, nor are they

462 talking about responses or events outside the person. Rather, they are talking about processes
463 that mediate or link persons, actions, and events. [...] [E]motions are everywhere
464 prototypically social; that at their core meanings and pragmatic consequences pertain to
465 interpersonal relations and interactions.’ We find that ‘being worried’ is experienced by
466 people in recovery in relation to the lack of anonymity, meeting familiar faces frequently in
467 the village, the established meeting places and the comfort and support of the village.
468 Knowing that everybody knows is found to be both comforting and demanding by Bjørg and
469 other participants in experiencing and managing worries of relapse.

470 **Concluding discussion**

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

477 Bjørg and Kari experienced situations in which they attempted to protect family
478 members by avoiding sharing worries with them and carried out emotion work (Hochschild
479 2003) to help the family recover from the illness experience. At the same time, they
480 sometimes found it easier to share those worries with friends, since these had a different kind
481 of moral involvement in their lives. Friendships were strengthened by sharing worries.
482 Experiencing worries in the context of the village and in relation to acquaintances in the
483 village meant both comfort and challenge for the participants. On the one hand, the size of the
484 village represents reassurance with its non-anonymous social infrastructure, while on the

485 other hand this lack of anonymity is experienced as confining; it is difficult to keep
486 information to oneself and one is confronted with others' opinions about one's health.

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

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499

500 **Disclosure statement**

501

502 No potential conflict of interest was reported by the author.

503

504 **Ethical Considerations**

505 The project addressed the sensory, emotional and relational aspects of patients' illness
506 experiences. This implied that patients and their significant others were vulnerable both
507 during fieldwork and by being included in the analysis. Particular care and sensitivity were
508 needed to protect and respect the patients' integrity throughout the study. The research group
509 worked specifically on these issues during the study. The 10 main informants provided
510 informed consent and had the option to withdraw from the project at any point. They were

511 assured that any information they provided would be treated with confidentiality and de-
 512 identified. All participant names have been changed.

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