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**A DISCURSIVE ANALYSIS OF CANCER
SURVIVORS' IDENTITIES**

MICHAEL PATRICK JOSEPH RUDDY

A thesis submitted to the University of Huddersfield in partial fulfilment of the requirements
for the degree of Master of Science by Research

The University of Huddersfield

September 2017

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Abstract

This thesis explores how people who have experienced cancer construct themselves in talk of their experience of the illness. Semi-structured interviews with six adults who had completed cancer treatment and were considered to be cancer free or in remission were analysed using a discursive psychological approach. Cancer has been characterised as being both an acute and chronic illness. The sequelae of treatment and uncertainty over possible recurrence of the disease mean that there is not a discrete point at which one ceases to be a cancer patient. As such the challenges to identities that may arise following a cancer diagnosis can be considered different to those that may arise following other serious illnesses. Cancer also carries with it cultural associations about the culpability of the patient for their illness, as well as a number of culturally legitimate narratives that are centred around metaphors of heroic battles or journeys of self discovery. Previous research has suggested that disparity between the identity challenges being faced by the individual with cancer and the identities into which others may altercast them into can result in cancer patients and survivors not receiving the support that they need. The analysis revealed that a consistent feature of the accounts was maintaining continuity between pre- and post-cancer identities. Where post-cancer changes were acknowledged these were assimilated into pre-cancer identities. Contrary to some previous research none of the participants oriented to the identity of being a cancer survivor. This finding is discussed in relation to methodological differences between the current and previous research and in relation the identity concerns present the participants' talk. I also discuss the constraints that discourses of austerity politics place on the identities available to cancer survivors who find themselves unable to work following treatment.

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This adventure began with an acceptance letter from the University of Huddersfield telling me that my research would be supervised by Viv Burr. The prospect of being under the supervision of someone whose work was so prevalent in my undergraduate reading was both a privilege and terrifying. That terror was misplaced. Both Viv and Nigel King allowed me the space to discover what exactly I was looking to research. I hope the experience wasn't too painful for you both.

Finally, I wish to dedicate this thesis to my family, whose love and support not only got me through the dark days of cancer but also through those times when I wondered why the hell I was doing this. We did it.

Chapter 1 Introduction

The aim of this research is to explore how cancer survivors construct their identities.

Lifetime occurrence of cancer is predicted to affect nearly 1 in 2 (47%) members of the UK population by 2020 (Maddams, Utley, and Møller, 2012). For certain variants of the disease survival has increased (Siegel, Miller, and Jemal, 2015). Improvements in detection and treatment, along with an ageing population, mean that the number of survivors in the UK is predicted to rise by one million per decade between 2010 and 2040 (Maddams, Utley, and Møller, 2012).

The impetus to carry out this research came from my own experience of cancer. From the moment of diagnosis and throughout treatment and recovery I observed contradictions between our common sense understanding of cancer and my own endogenous concerns. Part of this common sense understanding relates to the 'privileges and obligations' (Willig, 2011) that receiving a cancer diagnosis entails. Unlike most other illnesses a cancer diagnosis carries moral judgements about the culpability of the patient for their illness (Sontag, 1991; Mukherjee, 2011; Mitchell, 2015). Similarly, there are different cultural expectations about how a cancer patient should behave in comparison to other illnesses (Willig, 2011). Within the confines of medical establishments the cancer patient is no different, passively surrendering control of their body to medical professionals. Outside of these environs, however, the cancer patient is expected to play an active role in their recovery, so much so that to be recognised as not doing so is to risk opprobrium (Willig, 2011). This active role involves being seen to fight the disease, displaying a positive attitude towards the illness and its treatments, and under no circumstances talking about the possibility of death (Willig, 2011). While the cardiac patient is expected to rest and recuperate, the cancer patient is conscripted into a battle against cancer's 'ruthless secret invasion' (Sontag, 1991:2). At a time when treatment may leave patients physically near inanimate, our common sense understanding of cancer is filled with vigorous metaphors of

battles and fighting, of victories and losses, and of journeys of self-discovery (cf. Cancer Research UK, 2017). This disparity between cultural expectations and the challenges faced by the individual with cancer has the potential to constrain the identities available to them.

Further cultural expectations are placed upon those patients for whom cancer treatment is successful. While their bodies may have been purged of malignant cells, cancer often continues to be present in their thoughts and emotions, in memories of the extreme experiences of treatment, and in the prospect of the disease returning. There is a cultural association between surviving cancer and being offered a second chance at life (Little et al, 2002). This second chance carries with it a moral obligation to assess the life that has gone before and to consciously choose what kind of life is to be lived going forward (Little et al, 2002). Those resuming their pre-illness lives and identities are expected to do so untroubled by the everyday stresses that previously may have bothered them (Cantrell and Conte, 2009). For those unable to, or who choose not to, resume their pre-illness lives there is an expectation that they will find positive meaning in the experience of cancer, accommodating this meaning into a new version of their pre-cancer identity (Little et al, 2002). Being a cancer survivor can be a complicated business.

The important point here is that the privileges and obligations outlined above are part of our common sense understanding of cancer, culturally available knowledge that we share through talk and texts. They are part of the discourses of what it means to be a cancer patient or a cancer survivor, 'systematically form[ing] the objects of which they speak' (Foucault, 1972, p. 49). Amongst those objects are both the illness¹ itself and the subjectivities available to the individual living with or after that illness. Within a social constructionist theoretical framework these discourses and the subjectivities or identities available within them are constituted in everyday talk (Burr, 2015).

1 I discuss the differences between sickness, illness, and disease in Chapter 2 along with the social construction of illness.

Understanding how people who have experienced cancer construct themselves in talk of that experience offers an insight into the identity challenges that experience of the disease may present. Identity challenges are not limited to the existential threat of the disease but are also presented by embodied changes that may preclude roles or activities that previously contributed to one's identity. Disparity between who the cancer survivor considers themselves to be and who their social and support networks consider them to be has been shown to lead to survivors compromising on the support they receive (Miller, 2015). This compromise arises due to a need to manage the competing communication goals of maintaining consensus with those around us and articulating the challenges being faced by the individual. Understanding the identity challenges that the individual is facing may not only facilitate better communication but also ensure appropriate support. Drawing on a Discourse Analytic approach that focuses on the action orientation of everyday talk, I examine what social actions people accomplish by constructing themselves in a particular way. I also explore how individuals position themselves within the dominant discourses of what it means to be a cancer patient or survivor as they construct their identities.

In Chapter 2 I review the relevant psychological literature relating to the social construction of illness, cancer, and the identity challenges that cancer may present. In Chapter 3 I outline the ontological and epistemological assumptions of a social constructionist approach and differing approaches to discourse analysis before describing the discursive psychological approach and analytical process that I have drawn upon. I present my analytical findings in Chapters 4, 5, and 6. Each chapter assumes a different analytical lens, focusing on one aspect of identity rather than describing discrete processes or features of identity construction. In Chapter 7 I consider my findings in relation to previous research and discuss future areas of research along with some of the challenges and benefits of the methodological process I have used.

Chapter 2 A review of the literature

Introduction

Within this chapter I review the psychological literature relating to cancer, specifically in terms of how our common sense understanding of the disease makes available specific ways of being for the individual diagnosed with the disease (Willig, 2011). I begin by outlining the social construction of illness or the lived experience of a disease, and how such experience is shaped by the historical and cultural context in which it occurs. Much of our common sense talk of cancer draws upon metaphor. As such I offer a review of the literature related to the two dominant metaphors pertaining to cancer, those of the battle metaphor and the metaphor of cancer as a journey. I provide an overview of the literature related to cancer survivorship and the identity challenges faced by individuals for whom treatment is successful. I conclude the chapter by introducing my research question and highlighting how this research aims to extend our understanding of the identity challenges faced by cancer survivors.

2.1 The social construction of illness

In contrast to the medical model of illness, which assumes the universal and invariant nature of disease, a social constructionist theoretical framework conceptualises the experience of illness as being shaped by cultural and social systems. Radley (1994) described three distinct components to how illness is conceptualised in industrialised Western societies: *Disease*, *Sickness*, and *Illness*. *Disease* refers to a biological condition and its associated pathological symptoms. Medical doctors make diagnoses based on interpretations of such symptoms, yet these diagnoses and classifications of what constitutes a disease (or abnormal health) have changed across historical and cultural contexts (Foucault, 1988) and as such are neither universal, invariant, nor free of cultural

influences. Radley conceptualised *Sickness* as the patient being assigned temporary reprieve from their usual social obligations, such as working or caring for others. He argued that people are allowed to adopt '*the sick role*' as long as cultural expectations of illness, such as promptly seeking and accepting treatment from a medical doctor, are met. The cultural expectations placed upon the person in the sick role extend from their immediate social circle to their employers, government policies and even employment law. The third component that Radley described is *Illness*, or the lived experience of a disease. How an illness is experienced is not only influenced by physical symptoms and any limitations that they bring to bear but also by the meaning that the sufferer confers upon their condition, how it impacts upon cultural norms of expected behaviour, and how others conceptualise both the illness and person suffering from it (Conrad and Barker, 2010). Some illnesses, such as Myalgic Encephalomyelitis (M.E.), may be contested and viewed by some as not being an illness at all (Horton-Salway, 2001). Some illnesses are considered disabilities while others are not (Conrad and Barker, 2010), while yet other illnesses such as HIV/AIDS are stigmatised with moral judgements against a particular lifestyle, personality type, or presumed culpable behaviour (Sontag, 1991).

2.2 Cancer metaphors

Much of our common sense understanding of cancer draws upon metaphors. Lakoff and Johnson suggested that 'the essence of metaphor is understanding and experiencing one kind of thing in terms of another' (1980:5). They argued that our use of metaphor extends beyond adding a 'rhetorical flourish' to language and that it influences how we conceptualise the world. For example, the metaphor of argument as war conceptualises arguments as an adversarial practice that results in a winner and a loser. The goal of such an endeavour is to destroy your opponent's argument, targeting the weak points in their argument and shooting them down. In other words, the metaphor guides behavioural norms. Within Lakoff and Johnson's Cognitive Metaphor Theory metaphor shapes our thoughts and these

thoughts are reflected in our language. In contrast, within a discursive psychological approach metaphors are discursive resources that we draw upon to shape arguments that are constructed to achieve specific social actions. For example, the metaphor of immigration as a cancer that threatens our national identity carries 'social, emotional and aesthetic values that influence the interpretation of the utterance' (Musolff, 2012:303). Couching immigration in such a way side steps having to offer justification for being anti-immigration. Instead, the listener is invited to draw upon their knowledge about the undesirability of cancer, the existential threat that it presents, and the necessity of seeking treatment (Musolff, 2012). While cancer is often used as a metaphor for any undesirable state of affairs, in relation to the disease itself two metaphors dominate our common sense understanding of it: the battle metaphor and the journey metaphor.

The Battle Metaphor

Mukherjee (2011) chronicled the introduction of the idea of a war on cancer as an awareness and fundraising initiative in 1950s America. More than half a century later the notion of a war on cancer and the associated battle metaphor have persisted in the face of ongoing criticism from medical doctors (McCartney, 2014), psychologists (Hurley, 2014), cancer patients and those who find themselves spanning multiple categories such as doctor and cancer patient (Granger, 2014) or psychologist and cancer patient (Willig, 2011). Critics of the battle metaphor have argued that it is particularly harmful when treatment fails, painting a negative picture of those who succumb to the disease as not having fought hard enough (Demmen, Semino, Demjén, Koller, Hardie, Rayson, & Payne, 2015) and stigmatising their memories for surviving relatives (Hurley, 2014). Others have criticised the battle metaphor for the negative connotations of toxic or debilitating treatments fighting the patient (Semino, Demjén, Demmen, Koller, Payne, Hardie, & Rayson, 2015) and the constraints that it may place on patients expressing their emotions. By positioning the patient as fighting their disease emotions such as fear or sadness may be suppressed due to

the cultural expectation that one must always display a positive, fighting spirit (McCartney, 2014). This expectation of displaying a positive spirit has been characterised as the 'tyranny of positive thinking' (Penson, Schapira, Daniels, Chabner, and Lynch, 2004:711). Similarly, there is a belief that bad things will happen to those who do not express a positive attitude (see Ehrenreich, 2009, for a critique of positive thinking in breast cancer culture). Contrary to such beliefs, no association between a fighting coping style and survival rates has been identified (Petticrew, Bell, and Hunter, 2002; McCartney, 2014).

The negative impact of the battle metaphor is not limited to the cancer patient. Hauser and Schwartz (2015) have argued that bellicose cancer metaphors, which conceptualise cancer as an enemy, may reduce the uptake of some cancer prevention behaviours. This is because preventative behaviours often involve avoidance or reductions in cancer-related activities such as smoking or prolonged exposure to direct sunlight. Such self-limitation or avoidance is not synonymous with fighting or battling the enemy head on.

Contrary to the criticisms outlined above, other researchers have argued that whether the battle metaphor is empowering or disempowering is context specific. Semino et al (2015) reported that violence metaphors employed in an online cancer forum were used in an empowering manner by patients when treatment was working, when patients had successfully fought (against their doctors) to be given specific drugs, and when patients talked with other patients in mutually supportive terms about their battles against a common enemy. Penson et al (2004) highlighted that medical professionals often prefer to work with the metaphors that come from the patients themselves, whether they be militaristic, sporting, or idiosyncratic. Such metaphors can provide a common language between doctors, who tend to conceptualise cancer as a disease described in technical terminology, and patients who are conceptualising their illness as a threat to their mortality or their sense of who they are (Charmaz, 1994).

Metaphors such as the battle metaphor not only have a representational function of rendering past experiences and constructing a portrayal of one's current circumstances, they also have a determinative function (Gibbs and Franks, 2002). The use of metaphors allows people to 'project their futures' in terms that empower them as they confront what Hurley called 'society's paradox' of marching 'towards uncertainty, towards death rather than deny[ing] it' (2014:313). Hurley suggested that the persistence of the battle metaphor may be influenced by the need of those who survive the death of a loved one to 'honour a fallen hero' and by being 'shaken at seeing up close that life is ultimately not controllable' (2014:314). She also argued that it offers doctors an object towards which they may direct negative feelings about the toxic treatments they deliver to patients and the frequent losses associated with cancer treatment. However, both of these ideas conflict with the findings of a study by Demmen et al (2015) who reported that family carers rarely used fighting metaphors, and no battle metaphors at all, when talking about the illness and treatment of their loved ones, and that medical professionals used 'protect' and 'confront' metaphors in discussions with patients rather than using the battle metaphor. Similarly in a study by Gibbs and Franks (2002) the metaphors used by women suffering from cancer were often no different to the embodied metaphors used by people in good health. Given the pervasiveness of metaphor within our everyday talk perhaps this is not surprising. Tropes such as 'it was a battle to find a parking space' are arguably so commonplace as to have lost their militaristic associations. This same ubiquity applies to the second metaphor that I wish to review, that of 'cancer as a journey'.

The Journey Metaphor

The 2007 National Health Service (NHS) Cancer Reform Strategy abandoned using battle metaphors in favour of talking about cancer as a journey, with different models of care portrayed as different pathways and the implication that cancer is a travelling companion

(Semino et al, 2015). The journey metaphor avoids the negative implications associated with 'losing the fight' against cancer, placing the success or failure of a journey outside of the control of the individual and instead making it contingent upon the terrain and obstacles encountered throughout the journey. A study by Semino et al (2015) found that even when there are setbacks, within the journey metaphor the results are not as catastrophic as with the battle metaphor. This is because setbacks, by their nature, are temporary whereas defeat by an opponent in a metaphorical war is more likely to be perceived as final. The journey metaphor also mitigates disagreements between doctors and patients. Since they are travelling the same path, with the same goal destination, any disagreements about how to reach that destination are simply differences of opinion. Similarly, obstacles on the path are obstacles for the doctors as much as for the patient.

Semino et al found that journey metaphors were empowering for cancer patients when they offered a sense of 'purpose, control, and companionship' (2015:4). Like the empowering use of the battle metaphor amongst groups of patients fighting a common enemy, Semino et al observed that patients often talked of making the journey in the company of other patients. Unlike the battle metaphor, however, patients who had made the journey earlier, or who were further along the same path, sometimes offered support to those patients just starting out or facing 'rocks in the road'. Semino et al also found that journey metaphors could give patients a sense of control or feeling of being in charge of their journey. The metaphorical construction of a visible path with metaphorical milestones is mirrored by the comments of an oncologist who suggested that 'the doctor needs to provide mile markers in the patient's journey, to tell the patient roughly where they are' (Penson et al, 2004:710). I would argue that the journey metaphor benefits doctors in another way in comparison to the battle metaphor. Within Western medicine, and oncology in particular, doctors refer to the techniques available to treat a disease such as cancer as their armamentarium (Mukherjee, 2011). The obvious militaristic etymology of this term can serve to position the doctor as the source of the physical distress that the patient may be experiencing. The

choice of 'weapon' from the armamentarium is made by the doctor. In contrast, within the journey metaphor there is an implicit assumption that the path the patient is to travel is a feature of the world rather than a path constructed by the doctor. Doctors may choose (or recommend) specific treatment pathways but these are as much tools for the journey as they are the path to be travelled. As such the journey metaphor avoids doctors being construed as a foe and becoming the object of the patient's 'fight' as Demmen et al (2015) suggested can happen with the battle metaphor. This is not to say that the journey metaphor removes the power relations that exist between patient and doctor. Rather, I would suggest, such power relations become more akin to the relationship between an expert guide and non-expert traveller as they traverse hostile terrain.

The notion of the path that the patient is to travel being a feature of the world could also be said to offer institutional benefits when treatments are not working. Within the battle metaphor, if a particular treatment is not working, a new way to attack the tumour must be found. However, within the current UK public healthcare system the availability of cancer drug treatments is not solely determined by their clinical efficacy or safety but also by whether they provide 'value for money for taxpayers' (National Institute for Health and Care Excellence, 2017). Consequentially, not all possible treatments are available within the NHS. As such the hospital, NHS, or government could be accused of blocking potentially life saving ways of fighting or defeating an individual's tumour. While a losing battle may be turned around by committing more or different resources to defeating the enemy, when the terrain on a journey becomes challenging the onus is still upon the cancer patient to keep moving forward. Responsibility for completion of the journey relies as much (if not more) with the patient as it does with the institutions who control treatment resources.

Approaches to the use of metaphor

Much of the existing research into metaphor use has focused on categorising or quantifying the use of specific cancer metaphors. A great deal of this research draws upon Conceptual Metaphor Theory (Lakoff and Johnson, 1980) in which metaphors are assumed to be representations of conceptual categories that pre-exist social interaction. As mentioned earlier, Lakoff and Johnson argued that metaphors are central to how we think about the world. They are a means of understanding an abstract or unfamiliar idea in terms of another more familiar idea. This raises the question of why different groups (patients, carers, medical professionals) appear to draw upon different metaphors of cancer and its treatment. If the same conceptual metaphors are available to everyone, how do people choose which metaphors they make use of? Charteris-Black summed up this limitation of a cognitive approach to the study of metaphor as it assuming 'that metaphor use is an unconscious reflex, whereas a pragmatic view argues that speakers use metaphor to persuade by combining the cognitive and linguistic resources at their disposal' (2004, as cited in Hart, 2008:94). Attempting to understand what it is speakers are persuading their listeners of is beyond the scope of quantitative methodologies, both in their focus on quantifying metaphor use and the assumption that the choice of metaphor is 'an unconscious reflex' rather than a discursive resource consciously chosen to achieve a specific action. To attempt to understand this we need to examine what the use of a particular metaphor accomplishes for the speaker. Doing so requires adopting a methodology that is mindful of the indexical nature of language, acknowledging that meaning is co-constructed within activity sequences between speaker and listener(s), and that rather than reflecting a concept within the mind metaphors are discursive resources used to construct a particular account of the world. Similarly, the brief consideration above of how institutions may benefit or suffer from the use of a particular cancer metaphor highlights the situated nature of our common sense understanding of cancer. Our talk occurs within a social, political context that entails shifting power relations between

speakers as well as between the individual and the subjectivities that dominant discourses make available to them. To ignore the sociopolitical context in which metaphors are employed is to ignore these power relations and the power of metaphor. To date, very little research has widened its analytical lens to focus on the wider cultural context as well as the context of the local interaction. A notable exception is Ehrenreich's (2009) scholarly critique of breast cancer culture and its roots in the neoliberal ideology of individual responsibility. However, whilst Ehrenreich is a cancer survivor, this was not an empirical study that aimed to observe how cancer survivors situate themselves within dominant discourses either in their everyday talk or talk of their cancer experience.

2.3 Cancer survivors

The term *cancer survivor* holds different meanings within different groups. Originally the term had a biomedical definition, referring to someone who had been treated for cancer and remained disease free for five years. This definition was challenged by Fitzhugh Mullen (Dirven, van de Poll-Franse, Lonneke, and Aaranson, 2015), a medical doctor and cancer patient himself, who argued that rather than there being separate paths for those who survive cancer and those who do not, everyone diagnosed with cancer follows a single path of survivorship through different key stages. Mullen suggested that there are three stages to survivorship: *acute survivorship*, the period immediately following diagnosis when the focus is on surviving treatment; *extended survival*, when treatment is completed and the patient is focused on dealing with the physical and psychological after effects of treatment; and *permanent survival*, where recurrence of the cancer seems less likely to the patient but they are still dealing with the long term physical and psychological effects of treatment (Bell and Ristovski-Slijepcevic, 2013). Mullen's definition of who is classified as a cancer survivor has subsequently been modified by the National Cancer Institute to include family, friends, and caregivers of those diagnosed with cancer. Conversely, the European Organisation of Research and Treatment of Cancer limits classification as a cancer survivor to individuals

who have completed primary treatment following a diagnosis of cancer and who now show no evidence of active disease (Dirven et al, 2015). The term *survivor* is also considered distinct from the term *survivorship*, which refers to the period of time following primary treatment and cancer recurrence or end of life (Bell and Ristovski-Slijepcevic, 2013).

The label *cancer survivor* has been criticised for ignoring differences between the many forms of cancer, stage of malignancy at the time of diagnosis, and other factors such as age, sex and ethnicity (Bell and Ristovski-Slijepcevic, 2013). It is applied homogeneously to hundreds of diseases, the survival of which is contingent upon effective screening and the availability of successful treatments for that particular disease. Given the heterogeneity of definitions of who qualifies as a cancer survivor and its contested nature Kahn et al (2012b) suggested that researchers who choose to adopt the term should set out operational descriptions that clarify how they are using the term. As such, when I refer to someone as a cancer survivor I am referring to someone who has completed cancer treatment and is living cancer free or in remission.

Resisting the cancer survivor label

Not only is there a lack of consensus over who qualifies as a cancer survivor amongst the institutions and organisations mentioned above, there is also a lack of consensus amongst the people towards whom the term is directed (Kahn et al, 2012). Understanding why people adopt or resist the identity of being a cancer survivor has been the object of considerable research. A study by Hubbard, Kidd, and Kearney (2010) found that while some people resisted being labelled a *cancer survivor* they nevertheless identified themselves as a *survivor* in terms of their general attitude towards adversity. To these individuals cancer was just another obstacle in a series of challenges that life had presented them with and which they had overcome. A study by Miller (2015) found that the survivor label may be resisted by some people due to it tying them to their illness as they attempt to

move beyond it post-treatment, a finding that is in accord with Kahn et al's (2012) earlier study. Studies by Kaiser (2008) and Kahn et al (2012) both found that while some cancer survivors used the survivor label in regards to other people, they rejected it in reference to themselves. This was due to a fear of recurrence, i.e., they could not be sure that they had survived, or due to feeling that they had not been close enough to death to warrant being classed as a survivor. The idea of proximity to death or receiving harsher treatments, such as chemotherapy, being associated with self-identification as a cancer survivor has also been reported by Cho and Park (2015) in a study involving people diagnosed during adolescence and young adulthood. Similarly the same idea was observed by Jagielski, Hawley, Corbin, Weiss, and Griggs (2012) in women who had experienced breast cancer, and by Kahn et al's (2012) explicit questioning of what people who had experienced cancer thought of the term *cancer survivor*. Cho and Park observed that identification with being a survivor varied considerably with the type of cancer. Similarly, Jagielski et al (2012) found that a more positive prognosis, being told that treatment was curative, better mental health (at the time of the study post-cancer treatment), and having received chemotherapy could all be independently associated with identification as a survivor. Cho and Park acknowledged the methodological limitations of asking people to select one cancer-related identity rather than multiple identities, while Jagielski et al's study involved identifying statistical correlations between factors such as age and treatment received with whether participants identified themselves as a cancer survivor when overtly asked. A limitation of such studies is that they cannot tell us whether the participants describe themselves as a cancer survivor in everyday talk. In everyday talk we tend not to select an identity from a list offered to us. Rather we draw upon diverse discursive resources to construct our identities to meet our goals within the immediate interaction. Little et al (2002) have argued that there is no culturally validated survivor identity and as such there is a need to identify what the survivor identity means to the individual who adopts or resists it. Exploring the actions accomplished by adopting or resisting the identity of cancer survivor not only can contribute to our understanding of what the identity means to the individual but can also

shine a light on the subjectivities that dominant discourses of being a cancer survivor make available.

2.4 Cancer and the expectations of others

Our identities are not determined solely by ourselves or in isolation. Any identity we assume requires validation from, and is influenced by, those around us (Hubbard et al, 2010). For example, Miller (2015) found that people who have completed primary cancer treatment may be altercasted into a survivor identity by their social network. Altercasting is a process whereby the way other people talk about us assigns us a particular identity (Weinstein and Deutschberger, 1963). In Miller's (2015) study cancer survivors reported being treated as someone who was over the experience of cancer (they had put the experience behind them) when that did not reflect who they considered themselves to be. Other participants reported social networks treating them as being the same person they were before cancer when this was an identity that they no longer wished for themselves or were unable to resume due to the sequelae of treatment. Miller found that cancer survivors often adopted the identities (whether 'survivor' or 'the same as before') that others were altercasting them into in order to maintain consensus and keep communication with their social networks open. The need to maintain consensus was also sometimes driven by a need for social support yet, conversely, maintaining consensus sometimes came at the expense of the support that the cancer survivor wanted. The expectations of others were not only constraining the identities that the cancer survivor could assume but also constraining the support provided to them.

The influence of the expectation of others is not limited to the identities that individuals with cancer assume but also extends to how cancer survivors are expected to behave. Cantrell and Conte (2009) highlighted that there is often an expectation from others that the person who has survived cancer should display a perennially positive disposition and be untroubled by the everyday frustrations of life once they have completed their treatment. Similarly, as

mentioned in Chapter 1, Willig has characterised the social expectations placed on cancer patients as an obligation to react to the disease with a culturally 'legitimate narrative' (2011:897). She argued that there is a cultural imperative to think positively and to fight the illness rather than to adopt a narrative of passivity and suffering. Ehrenreich (2009) suggests that this ideology of positive thinking is born of economic interests and the discourses of a neoliberal, meritocratic society where the individual takes responsibility for their own financial well being, their health, and their success. Within such an ideology, those who fall short in any of these categories do so because they did not try hard enough or did something to bring about their less than optimal circumstances. In this regard, the expectation of others can be considered to extend beyond the social and support networks described by Miller (2015) and encompass a more general cultural expectation. While some past research (Kahn et al, 2012) has highlighted cultural differences in the adoption of the term cancer survivor, little research has explored how cultural expectations limit the subjectivities available to cancer patients and cancer survivors.

2.5 Identity challenges

A medical diagnosis of any sort 'marks the moment when the individual is inserted into the discursive field associated with the diagnosis they have received' (Willig, 2011:901). As well as the loss of control over one's body that a medical diagnosis entails (Willig, 2009; Kameny and Bearison, 1999) there is also a loss of control over the narrative of one's life (Stacey, 1997; Ehrenreich, 2009; Willig, 2011). The individual receiving the diagnosis is positioned as a patient and constrained by the discourses of their illness. In this respect, many of the challenges to identity that cancer presents are shared with other serious illnesses. For example, Miller (2015) described the construction of three separate identities during the cancer experience: the old (pre-cancer) identity, the patient identity (during treatment), and the new identity that emerges post-cancer. These parallel the stages of identity change

described in rheumatoid arthritis (Bury, 1982) and traumatic brain injury (Cloute, Mitchell, and Yates, 2008).

While Miller's (2015) study describes three separate identities, these are not necessarily mutually exclusive. A study by Baker et al (2016) found that individuals recently diagnosed with or receiving treatment for cancer often drew upon both old (pre-cancer) and new (post-diagnosis) identities in talk about their emotional experiences following diagnosis. A strength of such research is its focus on the individual's conception of their identity rather than the researcher's identity labels. Similarly, unlike questionnaire based research such as Cho and Park's (2015) study discussed earlier there is not an assumption of a single, enduring identity. Identities are plural and in drawing upon multiple identities contradictions may arise that need to be reconciled. Likewise, these plural identities are interrelated rather than occurring in isolation from each other. Clegg Smith, Klassen, Coa, and Hannum (2016) have argued that much past research can be criticised for focusing on cancer identities in isolation rather than in relation to pre- or post-cancer identities.

Discontinuity of identity

Little et al (2002) conceptualised personal identity as having three components: embodiment, continuity, and memory. They suggested that the identity challenges presented by extreme events can be characterised as discontinuities in any or all of these aspects of identity. Such challenges are not unique to cancer. Physical functioning may be affected by many other diseases, such as a stroke or heart attack, to the extent that one is unable to fulfil the social roles previously used to define oneself (Charmaz, 1994) resulting in a discontinuity of embodiment. Similarly, existential disruption or a challenge to our sense of continuous identity (Little et al, 2002) is not unique to cancer but may also be experienced following other serious illnesses. Where the identity challenges presented by cancer differ from those associated with other serious illnesses is in the ongoing existential

threat that the disease presents even after one is no longer classed as a cancer patient and is considered to have survived the disease. Even though an individual may be cancer free, the disease often continues to be present in their thoughts and emotions, in memories of the extreme experiences of treatment, and in the prospect of the disease returning (Little et al, 2002). Cancer may also present a challenge to 'future memory' (Little et al, 2002). Future memory is different from goals or future plans. It is a means of giving meaning to who we consider ourselves to be, imagining our future self looking back on defining moments in our life. For example, imagining being a parent and the meaning and sense of purpose that this identity would give us (Little et al, 2002). If such future memories become unachievable through the effects of cancer or its treatment our sense of who we are and who we are going to be is challenged. The cancer survivor is subsequently faced with deciding what direction their life is to take and who they are now to become. Surviving cancer also carries with it the association with a second chance at life (Little et al, 2002). There is a moral obligation to assess the life that has gone before and to choose the type of life that is to be lived going forward (ibid).

Chapter summary

This review of the literature has highlighted the dominant ways in which cancer is talked about within our culture and how these dominant discourses potentially make available certain subjectivities for those living with or beyond cancer. Past empirical research has examined the identity implications of illness and cancer to some extent. However, this work has mostly utilised quantitative methodologies and has focussed on assessing the prevalence of a narrow range of pre-determined identities putatively related to cancer survivors rather than the identities cancer survivors assume for themselves. There is a lack of research which acknowledges the shifting, multiple nature of identity and its relationship to both local and cultural context. Additionally, there is an absence of research which

examines the construction of such identities during the course of social interaction.

Therefore, the research question addressed by this project is:

How do people construct themselves in talk about their experience of cancer?

Specifically:

- How do cancer survivors position themselves within dominant cancer discourses?
- What discursive resources do they draw upon within their accounts?
- What social actions are accomplished through a cancer survivor's chosen identity?
- What does a particular identity afford the individual over the other identities available to them?

Chapter 3 Methodology

The aim of this research project is to examine how individuals who have experienced cancer construct themselves in talk about their personal cancer experience. As discussed in Chapter 2, a diagnosis of any disease can change how the individual sees themselves and how they are viewed by others (Willig, 2011). Cancer possesses its own unique cultural associations and stigmata (Sontag, 1991) and carries with it what Willig described as an obligation to react to the disease with a culturally 'legitimate narrative' (2011:897). My focus here is not on the phenomenological lived experience of cancer but rather on how the person who has experienced cancer constructs themselves within such talk, the identities they assume in the spotlight and shadows of our shared cultural narratives of what it means to be a person living with or after cancer. In other words, how they draw upon or resist our common sense understanding of cancer. Such common sense is constituted by the discourses of a given culture. As such the proposed method of analysis is the discursive psychology approach described by Potter and Wetherell (1987) and Edwards and Potter (1992) and later developed by Wetherell (1998) to adopt a more critical stance in terms of acknowledging the sociopolitical context as well as the local context in which interactions take place. Wetherell's critical approach aims to encompass some of the objects of Foucauldian discourse analysis, such as power relations and the constraints that social structures place upon the individual, into the discursive psychology approach of Potter and Wetherell. In light of this I will briefly outline both the Foucauldian approach and the discursive psychology of Potter and Wetherell (1987) before describing Wetherell's (1998) approach and how it aims to combine elements of both methods by considering 'one stance in terms of the other' (Wetherell, 1998:388). The research question of *'how do people construct themselves in talk about their experience of cancer?'* is informed by a social constructionist theoretical framework, and I begin this chapter by outlining the epistemological and ontological assumptions of such a framework.

3.1 Theoretical framework

A social constructionist approach to the study of social psychology is informed by a relativist epistemology or theory of knowledge. It assumes that whether or not a material world exists we can only know it through signs and symbols such as language. Since these signs and symbols are historically and culturally situated, and constantly changing, meanings are not fixed or transparently mapped onto the 'true nature' of objects or people:

"Different constructions of the world can only be judged in relation to each other"

(Burr, 2015:93).

Edwards outlined a distinction between ontological and epistemic social construction, arguing that within discursive psychology the focus is on the 'constructive nature of descriptions rather than entities that (according to descriptions) exist beyond them' (1997:48). The focus is on how the descriptions people produce allow them to both *know* and *construct* the world around them. Within a social constructionist framework a material world does not precede our descriptions of it, instead a version of the material world is constituted by those descriptions (Edley, 2001b) whether they are descriptions of social practices or of rocks or atoms (Edwards, Ashmore, and Potter, 1995). When we talk or think about the world we are doing more than offering a value neutral description of the world. We always 'encounter the world from some perspective or other' (Burr, 2015:172) and those perspectives influence the particular construction that we make use of in any given context (Potter and Wetherell, 1987). Within such a theoretical framework the individual, like material objects, is constituted in everyday talk and through the discourses that are culturally available to them.

3.1.1 Discourse

Discourse has been variously defined as 'practices that systematically form the objects of which they speak' (Foucault, 1972:49), as 'all forms of spoken interaction, formal and informal' (Potter and Wetherell, 1987:7) and as 'a set of meanings, metaphors, representations, images, stories and so on that in some way together produce a particular version of events' (Burr, 2015:74). Common to all of these conceptualisations is the notion of discourse as social action (Wetherell, 2001). However, the social actions in question vary with the level of analysis: whether it is at the micro level of interpersonal interactions or at the macro level of how discourses create social structures that govern 'the way that a topic can be meaningfully talked about' or 'used to regulate the conduct of others' (Hall, 2001:72). Different conceptualisations of discourse have given rise to different methods of analysing discourse. These can broadly be divided into two approaches. The fine grained analysis of discursive psychology is influenced by conversation analysis and ethnomethodology and interested in the action-orientation of everyday language use. Foucauldian discourse analysis is interested in investigations of discourse, power, and the subjectification of the individual (Wetherell, 1998).

3.1.2 Foucauldian discourse analysis

Foucault was interested in how discourse 'produces the objects of our knowledge' (Hall, 2001:72). He argued that social practices entail meaning and that such meanings define acceptable ways that a subject can be talked about or ways that we conduct ourselves in relation to that subject (Hall, 2001). In other words, discourses construct 'certain ways-of-seeing' and 'ways-of-being in the world' (Willig, 2001:107). Foucault also suggested that power, knowledge, and discourse are inextricably related (Carabine, 2001) and one of the aims of the Foucauldian approach is to question whose interests are best served by a particular discourse. Certain discourses may become more common sense than others and

consequently be accepted as 'facts' or more truthful, resulting in alternative discourses being marginalised or viewed as less truthful (Willig, 2001; Budds, Locke, and Burr, 2017). This resulting hegemony has consequences for the subjectivity of the individual since, within the Foucauldian approach, the individual is another object constituted by discourse rather than an active agent employing discursive strategies in social interactions to achieve their social goals. Discourses constrain the ways-of-being available to the individual and the question of whose interests are best served by dominant (or alternative) discourses can be extended to encompass the ways-of-being that a particular discourse makes available.

The Foucauldian approach concerns itself with identifying the characteristics of the social worlds constituted by discourses, and how these social structures influence the subject positions available to the individual (Willig, 2001). It does not concern itself with how individuals draw upon shared discourses to construct versions of reality or identities that suit their social goals. A focus on this performative nature of language use by individuals is the concern of discursive psychology.

3.1.3 Discursive psychology

In contrast to the cognitive psychological approach, which conceptualises language as a transparent proxy of an individual's thoughts or emotions, discursive psychologists concern themselves with the performative, action-oriented nature of language (Potter and Wetherell, 1987). Cognitive processes such as remembering, attribution, and identity are re-conceptualised as discursive actions. For example, remembering is viewed not as a process of information retrieval and the recounting of a past event but instead as a way for an individual to construct a version of reality that helps them meet their social goals through justification, attribution, classification, or blaming (Willig, 2001). Such processes emerge through 'all forms of spoken interaction, formal and informal, and written texts of all kinds' (Potter and Wetherell, 1987:7) and discursive psychology focuses its investigations on how

language is used (in a performative sense) in these situations. Psychological concepts such as identity, prejudice, or attitudes are not something that a person has but instead are things that a person does through their use of the discursive resources available to them within particular cultural and historical contexts (Potter and Wetherell, 1987; Willig, 2001).

The cognitive and discursive approaches differ not only in their ontological assumptions about psychological concepts such as identity, but also in their epistemologies and the assumptions they make about knowledge, the world, and the role of the researcher (Willig, 2001). The identification of 'personality types' relies on self-reports of research participants, an approach that has been criticised for assuming that participants are 'naive subjects, intent primarily upon accurately reporting their cognitions to the researcher' (Wilkinson and Kitzinger, 2000:801). Participants' stated identification with particular phrases is taken as evidence of underlying enduring beliefs or attitudes. These assumed attributes of the individual are taken to be stable and enduring to the extent that future behaviour can be predicted from statistical analysis. The categories and phrases that participants are asked to identify with may not reflect their 'endogenous concerns' (Wetherell, 1998). Consequently there is what Edwards (1997) calls a 'reading-in' of the researcher's categories into the language choices of participants and, as I discuss in section 3.5, below, the process of coding or translating language from one type of data to another, along with the selection of statistical tests, is taken as being free from the influence of the researcher and the theoretical underpinnings of the research. In contrast, a discursive approach focuses on both the language used and the context in which it is employed, cognizant of the influence of the researcher on the participant's choice of language. It is anti-essentialist and does not assume any enduring traits of the individual but instead is premised on the idea that the individual is socially constructed through discourse to achieve social actions within a specific context (Burr, 2015). Language is not considered to be a proxy of inner thoughts or a means of transmitting these thoughts between different minds. Rather language is

considered to constitute both the social world and the individual within that social world. Discursive approaches ask what social actions or goals are being achieved by a particular discursive construction and how are they being achieved (Wetherell, 1998; Budds et al, 2017).

Whilst both the Foucauldian approach and discursive psychology are interested in the action orientation of language, they differ in where they focus their respective investigative lenses. The discursive approach is focused on the action orientation of language within specific interactions and it does not overtly address the wider social or political context in which the interactions take place (Willig, 2001). As such the approach can be criticised as being apolitical and viewing the individual in relative isolation from the wider social context (Burr, 2015). Conversely, the Foucauldian approach can be criticised for ignoring the agency of the individual by focusing on social institutions and practices. However, the two approaches are not mutually exclusive and several critical approaches to discourse analysis have emerged that aim to draw upon features of each approach (Wetherell, 1998; Budds et al, 2017).

3.1.4 Critical discursive psychology

Critical Discursive Psychology adopts a perspective that acknowledges the agency of the individual, making use of culturally available discourses as they construct different ways-of-being and ways-of-seeing, but one that is also aware of the constraints placed on subjectivities by dominant discourses within a given cultural, historical, and political period. Budds et al (2017) describe such an approach to conceptualising discourse as being both constitutive and constructive, 'in the sense that it, to some extent, shapes, enables and constrains, possibilities for identities and social action' yet 'it can be a tool used by participants within social interactions to achieve particular effects' (2017:13-14). Critical discursive psychology aims to do this through analysis of the subject positions (Potter and

Wetherell, 1987) that people adopt and the interpretative repertoires (Potter and Wetherell, 1987; Willig, 2001) that they draw upon. I will now briefly outline these two concepts.

Interpretative repertoires are a 'culturally shared toolkit' (Burr, 2003:60) of linguistic resources that people draw upon to construct accounts, justify behaviour, or construct themselves. Potter and Wetherell suggested that interpretative repertoires are often 'organized around specific metaphors and figures of speech (tropes)' (1987:149). Whilst they may draw upon common sense or cultural synonyms they can be considered indexical, with the same repertoire being used by different people to achieve different goals depending on how, and in what context, they are drawn upon. Potter and Wetherell suggested that it is not enough to simply identify the different repertoires without analysing the context in which they are available, that we also need to consider the 'uses and functions of different repertoires' and the 'problems thrown up by their existence' (1987:149). In setting out his critical discursive approach Edley makes this one of his analytical concepts, arguing that by identifying interpretative repertoires 'we begin to understand the limitations that exist for the construction of self and other' (2001a:201). Within Edley's approach we identify and examine these limitations from the perspective of individuals adopting different subject positions within the interpretative repertoires available to them.

Discourses make available particular ways-of-being or subject positions for the individual (Willig, 2001). Within the Foucauldian approach the focus is on the constraints that discourses place on subjectivities. The critical discursive approaches of Wetherell (1998) and Edley (2001) concerns themselves as much with the inconsistency of the subject positions assumed by an individual as with how the individual is positioned by dominant discourses. Subject positions are used by individuals to meet their own social goals (Wetherell, 1998), the choice of subject position changing as they manage the exigencies of

a given interaction. The fluid nature of subject positions not only highlights the contextual nature of accounts and identities, Potter and Wetherell also suggested that:

"Varying accounts can be thought of as the residue of the social practices through which people organise their lives"

(Potter and Wetherell, 1987:122)

This thesis adopts a critical discursive psychological approach to examining how people construct themselves within talk of their experience of cancer. It aims not only to explore the identities that individuals construct for themselves within a given interaction, but also to identify the constraints that dominant discourses may place upon those subjectivities. In doing so the goal is to identify power relations that exist within our common sense understanding of cancer, and to ask who benefits (and how) from a particular discourse of what it means to be a cancer patient or survivor. By widening the analytical focus beyond the local interaction in which talk occurs, we can achieve a more complete understanding of what that talk accomplishes.

3.2 Sampling and recruitment

Participants were adults (minimum age 18, no upper age limit) who had completed initial cancer treatment at least one year prior to taking part but with no upper limit on how long ago they had completed treatment. Initial cancer treatment refers to treatment following a first diagnosis of a cancer of any kind. The exclusion of those who had received a second or further cancer diagnosis was partly the result of the research question looking at self-identities through and beyond cancer, i.e., the experience of cancer as a single episode in that individual's life, and partly due to the existing literature about the identity challenges that may follow cancer not distinguishing between those diagnosed with a single primary tumour and those with multiple primary tumours or subsequent metastasis. Volunteers were

recruited through Macmillan Cancer Voices (an online resource for cancer survivors to volunteer in fundraising, advocacy, or research), the Macmillan West Yorkshire Facebook page, and through word of mouth through my own extended social network. A web page providing information about the nature and purpose of the research was hosted at www.withthroughandbeyondcancer.com. I considered online recruitment to offer greater potential for recruiting participants who had been treated for different types of cancer and participants of a wider age range than my own extended social network. It also offered the opportunity to recruit participants who were not known to me, either directly or indirectly, and avoid any issues that may arise from familiarity. None of the participants were known to me before the research. The online recruitment campaign ran for four weeks. One participant was recruited through word of mouth, one made direct contact after seeing an online recruitment advert, and four were recruited through the Macmillan Cancer Voices website. Two additional enquiries were received about taking part but not followed up by the respondents. The six participants were the first six people to volunteer and a notice that the project had recruited all the participants it required was placed on the Macmillan Cancer Voices website² and www.withthroughandbeyondcancer.com. Six participants were judged to be an appropriate number given the time frame and scope of the project.

Participants

Below I provide a brief biography of each participant. Pseudonyms have been used throughout this thesis in all cases except for my own name.

Alan was diagnosed with a brain tumour when he was thirty years old. Initially he was told that the tumour was benign, the malignancy only being acknowledged when he travelled

² Closed opportunities to take part in research remain on the Cancer Voices website even after recruitment has closed.

overseas for specialist treatment. Prior to his diagnosis Alan had worked as a builder. Following brain surgery to remove most of his tumour Alan suffered from a seizure disorder and was no longer able to work professionally. However, he still undertook some work as a builder by volunteering for a housing charity. At the time of our interview Alan's tumour had been in remission for around 2 years. He is married with two children.

Bernadette was diagnosed with breast cancer just prior to her fortieth birthday. She underwent a mastectomy and radio and chemo therapies, but chose not to undergo reconstructive surgery. Bernadette had been cancer free for nearly 5 years at the time of our interview. She is a professional artist and mother to three school age children.

Greg was diagnosed with throat cancer ten years prior to our interview when he was 43. He underwent surgery as well as chemo and radio therapies. A sequelae of the radiotherapy was that Greg had been unable to eat for nearly ten years and received his nutrition through percutaneous endoscopic gastrostomy or a tube through his stomach wall. In the months immediately prior to our interview Greg had been undergoing a pioneering surgical treatment that would allow him to eat a soft diet. Greg had been forced to retire on health grounds following his treatment. He had been cancer free for 10 years.

Deborah was diagnosed with breast cancer shortly after her fiftieth birthday. She underwent surgical treatment and had been cancer free for 2 years at the time of our interview. She is the mother of 2 teenage children and one grown up child. Prior to her diagnosis Deborah had begun retraining in order to leave a job that she described as making her ill.

Margaret was diagnosed with bowel cancer when she was 67, two years prior to our interview. She had been widowed 5 years earlier when her husband had died from multiple myeloma (cancer of the bone marrow). During his treatment Margaret's husband had taken part in a drug trial involving Thalidomide. As a result of this he lost the use of his arms for the last 2 years of his life. Margaret has two adult children.

Sarah was diagnosed with breast cancer around her fiftieth birthday. She underwent surgery and chemo and radio therapies, followed by reconstructive surgery. Sarah has 2 adult children and has been cancer free for 10 years at the time of our interview.

3.3 Method of data collection

The method of data collection was semi-structured interviews. This allowed participants the freedom to talk about aspects of their cancer experience that was important to them within loose topic areas that I judged to be related to identity. The use of interviews in the social sciences has been criticised (see Potter, 2012, for a discussion of the major arguments) for leading to an analysis of contrived talk rather than the naturally occurring talk that Potter and Wetherell (1987) referred to in setting out their approach to discourse analysis.

Participants may react to the presence of the researcher, providing talk that orients towards the participant's perceived expectations of the researcher rather than their own everyday concerns. However, Potter (2012) rejected such criticism, arguing that there are no 'systematic differences' between Police interviews in which reactivity to the researcher is not an issue and those interviews undertaken explicitly as research. Similarly, Madill (2011) has argued that the talk in semi-structured interviews shares one of the qualities (indirect complaints) of talk between friends - albeit a more asymmetrical version of it. While naturally occurring talk continues to provide what Madill calls the 'gold standard' of data, the ethical and practical constraints on recording such talk in the context of my area of

interest made doing so prohibitive. However, the use of semi-structured interviews in this project may have offered participants a context not found in their everyday talk. Given that all volunteers were aware of my own experience of cancer any reactivity may have been towards myself as someone who has experienced cancer as much as to myself as a researcher (or indeed both). King and Horrocks (2010) highlighted the co-production of knowledge that takes place when data from interviews are analysed: both the interviewer and interviewee are engaged in the interaction, influencing and being influenced by each other. What is important here is to consider the discursive actions of both interviewer and interviewee within the context of the 'activity sequences' (Edwards and Potter, 1992) of the interview. As such my analysis encompassed not only what was being said by the participant but also how my questions and status within the interaction may have coloured responses to my questions.

Interview guide

An interview guide (Appendix 3) was produced to provide a number of prompts to explore a range of aspects of the cancer experience and produce rich data. The guide was partly informed by reflection on my own experience of being diagnosed with cancer and the challenges that this had presented to my sense of who I am, and partly informed by the existing psychological literature relating to cancer and the identity challenges that it may present. As the questions were deliberately broad to allow participants to talk about what was important to them, a number of probes or more focused questions were created to facilitate more in depth exploration of the participant's initial answer. Draft topic areas and questions were discussed with the research supervisors and the interview guide revised based on these discussions.

3.4 Ethical considerations

Ethical approval was sought from and granted by the School Research Ethics Panel of the School of Human and Health Sciences (SREP/2016/007). Informed consent (Appendix 1) was given by all participants. All volunteers were provided with an information sheet (Appendix 2) about the study. This outlined who was undertaking the research, the aim of the study, and what participation would involve. The information sheet was available online via a web page accessible from the online recruitment advertisements placed on the Macmillan Cancer Voices website and Macmillan West Yorkshire Facebook group.

As part of both the verbal briefing and debriefing processes participants were advised of their right to withdraw. This information was also included in the information sheet (Appendix 2). Participants were advised that they could request a copy of the transcription of their interview within 2 weeks of the interview date. Volunteers were also able to withdraw during a subsequent one month period by emailing the researcher.

Talking about the experience of any illness can be emotionally upsetting and the information sheet included details of telephone support lines to provide participants with emotional support.

3.5 Analysis

The analytical process involved three steps consisting of transcription, analysis using Edwards and Potter's (1992) Discursive Action Model as a guide to what people are doing with their talk, and consideration of Potter and Wetherell's (1987) tests of analytical validity.

Transcription

Transcription can be considered the first stage of analysis since it not only entails becoming familiar with the data (King and Horrocks, 2010), it also reflects and shapes theory (Du Bois, 1991). Oliver, Serovich, and Mason (2005) outlined a continuum of transcription systems, with naturalised and denaturalised transcription as the two poles of the continuum. Naturalised transcription systems attempt to translate the fine details of spoken speech, such as pauses, changes in pace or volume, stutters or hesitations, into a written verbatim transcription; denaturalised approaches omit such details and focus on what is said rather than how it is said. Oliver et al linked these two approaches to different epistemological assumptions about the nature of language, suggesting that naturalised approaches assume that 'language represents the *real* world' (emphasis in original) while denaturalised approaches assume that 'within speech are meanings and perceptions that construct our reality' (2005:1274). In other words the former assumes that transcripts are transparent records of what was said, the latter that transcription is a 'representational and interpretative process' (Davidson, 2009:39) which means transcripts are as much a reflection of the theoretical concerns and choices of the researcher as they are a rendering of the talk in question. Oliver et al (2005) described how elements of naturalised and denaturalised approaches may be combined depending on the particular research objectives. The absence of a canonical pairing of a particular transcription method with a specific theoretical framework means that the relationship between theoretical assumptions and the method adopted needs to be made explicit (Davidson, 2009), which I will now do.

The research question of '*how do people construct themselves in talk about their experience of cancer?*' focuses on how individuals position themselves within the available interpretative repertoires relating to people who have experienced cancer. The focus is not on the intricacies of 'turn taking and conversational repair' (Burr, 2015:181) as in conversation analysis, but rather is on the content of their talk. As such a naturalised

transcription system employing detailed notation, such as the Jefferson (1996) system typically used in conversation analysis, was not required and would have impacted on the readability of the transcripts, possibly obscuring the 'wider discursive meanings in the data' (Budds et al, 2017). Therefore I have used an abridged version of the Jefferson system that includes details of pauses or other paralinguistic features to help establish the context or flavour of the interaction for the reader. King and Horrocks (2010) have suggested the inclusion of paralinguistic features of speech, such as changes in volume or elongation of specific words when they are used ironically, is useful to help establish the context of the transcribed talk for the reader, and that such features can be selectively used where they affect the meaning of what is said. The notation used is given below in Table 1 (below).

(.)	Un-timed pause
(0.5)	Timed pause with time indicated in seconds
((laughs))	Non-verbal information or paralinguistic features of speech
[Yeah]	Overlapping speech. Speech within square brackets overlaps with that directly above it in the transcription

Table 1 (above): Transcription key

Following transcription a period of repeated reading of each interview was undertaken until I arrived at the point Edley (2001) described as 'having a sense of what comes next'. What followed was an iterative process of identifying sections of talk that I felt related to the research question and issues of identity. To do this I made use of Edwards and Potter's (1992) Discursive Action Model.

The Discursive Action Model

One of the challenges that the postulant researcher faces in undertaking discourse analysis is what Edwards called 'the lack of a clear distinction between theory, phenomena, and method' (1994:17). Potter and Wetherell (1987) have similarly suggested that discourse analysis is 'heavily dependent of craft skills and tacit knowledge' (1987:175). In order to explicate some of this tacit knowledge Edwards and Potter (1992) put forward their Discursive Action Model (DAM). This is not a model in the tradition of cognitive psychology, whose models tend towards 'link[ing] together putative mental operations to show how input is transformed to a different output' (Potter, Edwards, and Wetherell, 1993:388) often without instantiating how such transformations take place. Rather the DAM 'is designed to link different features of participants' discourse together in a systematic manner' (ibid:388). In practice the DAM afforded me a number of lenses through which I could interpret the data. The first of these lenses was a focus on action, or what people were doing with their talk, rather than a focus on participants' cognition or behaviour. The second lens was a focus on issues of fact and interest. Any account is open to being challenged as serving the self-interests or prejudices of the individual who offers it. As such accounts are rhetorically constructed to undermine alternative versions (descriptions) of events (Edwards and Potter, 1992). The final part of the DAM, and the final lens through which the data was read and interpreted, is a focus on agency and accountability. Accounts are often constructed as presenting facts, or features of the world beyond the control of the speaker. Such factual reports attend to issues of accountability or who is responsible for certain events within the account. Issues of accountability may also be present in the reporting of an account.

Limitations of the methodological approach

Discursive psychology's focus on localised interaction can be criticised for excluding the wider social context and power relations that exist within, and between, social institutions.

However, the discursive psychological approach described by Wetherell (1998) and Edley (2001a), and adopted by this study, attempts to foreground any constraints placed upon the individual through the identification of interpretative repertoires.

Similar to criticisms of cognitivism for assuming that language transparently represents the speaker's thoughts, discourse analysis can be criticised for the implicit assumption that the meaning of talk is 'assumed to be transparent to the analyst [but] its possible interpretation by other parties is not investigated' (Burr, 2002:123). Schegloff (1997, as cited in Wetherell, 1998) has criticised discourse analysts for importing their own categories and theoretical concerns into the analysis rather than focusing on the concerns of those whose talk they are analysing. Addressing this criticism, Wetherell emphasises that it should always be possible to 'point to the data' (1998:394) to substantiate any claims that are made about how people are using talk.

Validating the analysis

The analytical process described above is concerned with what Potter and Wetherell call the 'function and consequence' (1987:168) of talk. Once these have been identified, Potter and Wetherell described the next stage of the analytical process as the formulation of tentative hypotheses about these functions and consequences. The data is once again revisited looking for evidence to support any hypotheses. Potter and Wetherell (1987) outlined several criteria that may be used as justification for the validity of any discourse analysis, the first of which is that any analysis should provide coherence to the data or demonstrate how it fits together. Any hypotheses about a particular pattern of accounting being used for a specific goal should be applicable to the whole body of data and not just specific passages. In other words, there should be no explanatory or logical gaps in the explanation offered by the analysis. In cases where the hypothesis does not appear to apply, Potter and Wetherell

suggest that identifying features that mark that passage out as a special case can be used to confirm the scope of a theory or how much it can account for, a process they call 'confirmation by exception' (1987:170).

Potter and Wetherell's second check of analytical validity is *participant orientation*.

Discourse analysis is an interpretative endeavour (Fairclough, 1989) and what the analyst sees as consistent or different are not necessarily what participants see as consistent or different. The analysis should demonstrate participants' orientation by 'pointing to the data' (Wetherell, 1998) to clearly illustrate how a participant interprets and reacts to what is being said

Potter and Wetherell's third test of validity is the ability of an analysis to identify new problems and solutions. An analysis may identify regular patterns of accounting which support a hypothesis that participants are drawing upon different interpretative repertoires, such as Mulkay and Gilbert's (1983) analysis of biochemists' explanations of scientific theories. Mulkay and Gilbert identified instances where these repertoires appeared incompatible to themselves, as analysts, but not to the individuals drawing upon the repertoires. The biochemists oriented to the incompatibility of the two repertoires within their talk. This prompted the identification of a third (reconciliatory) repertoire that Mulkay and Gilbert labelled the *truth will out device*.

The final test of validity that Potter and Wetherell outlined was fruitfulness, or the extent to which an analysis 'make[s] sense of new kinds of discourse and to generate novel explanations' (1987:171). This may be a new way of answering old problems or linking issues that were previously considered to be unrelated (Wood and Kroger, 2000). Antaki neatly summed up the fruitfulness of a piece of research as 'the aha! experience' (2004).

The selection of extracts and reflexivity

The process outlined above describes various checks used in the selection of extracts for analysis. At the end of this stage of the analytical process, not all of the chosen extracts will necessarily be chosen for in-depth analysis. This may be as a result of initial analysis helping to refine the research question or a narrowing of analytical focus to one particular area that is identified as worthy of more in-depth analysis. Explicit justification of the choice of extracts for inclusion in the final report is surprisingly rare within discursive psychology journal articles. This could leave an analysis open to the criticism of not being representative of the body of discourse as a whole, or the researcher selecting extracts that support their own agenda. Louw, Todd and Jimarkon (2014) demonstrated how such 'cherry picking' of extracts could be used to support competing hypotheses about the same data. They put forward a mixed-methods approach to the selection of extracts based on the frequency of occurrence of keywords within the data. However, this was within the domain of corpus linguistics. Within discursive psychology such a method could be criticised for what Edwards (1997) called 'labelling and counting' rather than focusing on the performative nature of the talk being analysed. So how does one justify the inclusion of one extract over another? In describing their criteria for selection of passages for analysis, Madill and Barkham (1997) highlighted the interpretative nature of discourse analysis arguing that the goal is 'to reach an understanding of the text and present it in such a way that the reader can assess this interpretation' (1997:234). Similarly, Fairclough's caution against treating texts as objects 'whose formal properties can be mechanically described without interpretation' (1989:27) is a reminder that the goal is not to describe the world as it really is, or to present a 'true' account of what is going on in participants' talk, ignoring the role of the researcher in the process. The goal is to offer an interpretation of a text, one that reflexively takes into account the analyst's own orientation towards what is being said as much as it takes into account the participants' orientation. So how exactly did I do this in practice?

The research question of 'how do people construct themselves in talk of their experience of cancer?' relates not only to the construction of a particular account but also to what individuals are constructing themselves in relation to. As such, following the initial analysis I began to group passages of talk into categories of what that talk was oriented towards. In other words, what the individual was constructing themselves in relation to. In contrast to a thematic analysis, in which the same theme is present within different extracts of talk, I was as much interested in differences between how individual participants accomplished similar actions. For example, the extracts included in Chapter 4 can all be considered challenges to the individual's identity yet each is oriented towards a different type of challenge, and each makes use of very different discursive techniques to negotiate that challenge. Similarly, while all the extracts within Chapter 5 can be considered to relate to negotiating continuity of identity they do so in ways that are different from each other. I considered the variety of discursive resources being drawn upon to offer rich insights into the research question. The extracts in Chapter 6 stood out for two reasons. These extracts all come from Alan who, while living cancer free at the time of our interview, was living with a prognosis of his brain tumour beginning to grow again within the next 7 years. Alan also described himself exclusively in terms of his working life. Following brain surgery he was no longer able to engage in paid work. As such I considered his identity talk to be of particular interest, given this change in circumstances would, on the face of it, require Alan to construct a new post-cancer, post-work life identity.

Co-construction of knowledge in research

Given the ubiquity of cancer in our society it is reasonable to assume that a fair number of researchers are themselves cancer survivors. However, little research has focused on the role of the researcher who has survived cancer in the co-creation of knowledge. The notable

exception is Willig's (2009) scholarly reflection on the role of writing in the search for meaning following her cancer diagnosis. In terms of empirical work, Little et al (2002) acknowledged one member of the research team as being a cancer survivor, though the methodology they adopted (grounded theory) was one that involves achieving consensus about the themes identified within participants' talk. As such, while still an interpretative process, the knowledge produced cannot be considered to have been produced solely by cancer survivors. In contrast my own status as a cancer survivor means that the findings of this research can be considered to be knowledge co-created solely³ by those who have experienced cancer.

³ This is not to ignore the role of the research supervisors who did not identify themselves as cancer survivors.

Chapter 4 Findings: challenges to identities

Introduction

This chapter focuses on talk related to challenges to people's identities presented by their cancer diagnoses. The extracts chosen here illustrate some of the variability in the concerns of the participants in question, as well as highlighting some of the discursive techniques that they use to negotiate the different identity challenges that their diagnosis presents to them. The notion of illness as biographical disruption (Bury, 1982; Charmaz, 1994) entails an interruption to both who we know ourselves to be and who others know us to be. In discursive terms, receiving any medical diagnosis 'marks the moment when the individual is inserted into the discursive field associated with the diagnosis they have received' (Willig, 2011:901). However, people may resist as well as adopt the dominant subject positions available within this discursive field. Any biographical disruption may not necessarily be construed in negative terms, even if it is a consequence of a negative event such as being diagnosed with cancer. The concept of biographical disruption also contains an implicit assumption that the interruption caused by the illness is temporary, that normal service will be resumed after an indeterminate period. This notion of resuming pre-cancer identities is one of the areas that I focus on in this chapter, and also in chapter 6 where I consider how people negotiate new identities after their cancer treatment is complete.

Claiming and resisting the patient identity

The first extracts that I present for analysis come from Sarah, who was diagnosed with breast cancer at age 50 around ten years before our interview. After explaining my motivation to carry out the research I asked Sarah "*Can you tell me what happened to you?*". Sarah began her answer by telling me how she had worked "*all my life*" (line 2) as a clinical psychologist. Sarah retired from her role as a clinical psychologist three and a half

years after completing her cancer treatment (*"I was fifty one and a half when I went back (1.5) and I decided I was going to go at fifty five"*, Interview 6:477-478). She described how *"retiring for me was such a big thing (.) I've (.) being the end of (0.4) something that I found really hard towards the end of my professional life (0.9) I gave away (0.4) all my books (.) all my lecture notes going back from undergraduate years that I'd still got (0.5) I got rid of all of those (.) Absolutely everything I got rid of (0.6) Erm (1.4) And it was just like (2.1) shutting a door on a bit of my brain (1.1) that is just locked"*, Interview 6:855-862). Despite this definite end to her professional career, Sarah still drew upon aspects of her identity as a psychologist within her account. For example, Sarah described how when talking to members of a breast cancer support group that she was still a part of that she hoped *"my professional background enables me (0.7) to be able to say something that's helpful to them (0.3) without burdening them with (0.8) what is was like for me"* (Interview 6:576-8). It is against this background that I introduce Extract 4.1.

I have chosen the following longer extract not only for Sarah's explicit identity talk, which forms only a small part of quite a lengthy monologue, but also for how it illustrates the situated and occasioned nature of identities. Sarah, like all those who took part in the study, was talking about an experience several years in the past and talking about it within the context of a research interview. I have touched on the debate over whether interviews can be considered natural talk in the previous chapter (Section 3.4). The issue that I consider of interest here is that of reactivity towards the researcher, or how the presence of a researcher (even as an observer who does not directly engage with the participant) can influence the talk of participants in interviews. As such I will consider Extract 4.1 in two parts: first in relation the context in which the account is being given (that of retired psychologist being interviewed by a post-graduate psychology student) and then in terms of the account itself. In the sequence below I ask Sarah whether her professional knowledge and experience as a clinical psychologist had been helpful to her during the period of her diagnosis and treatment:

Extract 4.1, Interview 6

612. Michael: You were talking about how your professional experience can
613. help people (.) Do you think it helped you going through it? I
614. mean you talked about (.) at the start you were (.) not really
615. sure what was going on
616. Sarah: I think looking back (.) you know I often hear people talk about
617. people being in denial (.) and I've often thought I'm not quite
618. sure what that looks like and I think well maybe that was in
619. denial (0.4) My brain was not allowing me (0.5) to hear (1.1)
620. or to take in to process (1.2) what was happening to me (0.9)
621. So I can look back and think "Oh yeah maybe that was a good
622. example of denial" (0.9) Erm (0.9) But in terms of coping with
623. the experience (1.2) Erm (3.9) I'm not sure really (0.3) I think
624. I just became (0.6) I stopped being me (0.6) and became (1.2)
625. a patient (1.7) I mean all the (.) there's so much emphasis
626. nowadays on (0.7) patient involvement and patient choice (0.5)
627. and I didn't want to make choices I just wanted to be told (0.3)
628. "This is what you've got to do (0.4) And here's your next
629. appointment (.) Just turn up" (1.2) Erm (1.0) So when I was
630. offered the chance of being on the clinical trial (0.7) I didn't

631. know what to do (.) I didn't want to make choices I just want
632. to be told (0.3) "This is what you've got to take (0.5) Just come
633. along at this time and we'll do it to you and then and go home
634. and take the tablets so you're not sick"

As mentioned above, Sarah began the interview by telling me that she had worked "*all my life as a clinical psychologist*" (Interview 6:2). It is worth repeating this self-description here because of the identity that it 'makes relevant' (Antaki and Widdicombe, 1998) in comparison to the other identities that Sarah could have oriented to. This self-description also has what Schegloff (1992) called procedural consequentiality. It influences proceedings in terms of 'constructing the terms of the debate' (Horton-Salway, 2004:358) within Sarah's account as being "*from a psychologist's point of view*" (Interview 6:5), and also influences the local interaction of the interview. There is an expectation that members of a particular category will possess certain knowledge or behave in a certain manner associated with that category, what Sacks (1972) called category entitlement. Members of the category of medical professionals are expected to be knowledgeable about health and disease, psychologists about thoughts, behaviour and motivations. They are also entitled to make use of specialist knowledge associated with their respective domains. These expectations implicitly inform my question to Sarah (lines 612-615). While the explicit question was '*Do you think it helped you going through it?*' the implicit enquiry was as to *how* her expertise did or did not help her. My own category membership (that of student, researcher, or however Sarah chose to categorise me) is also particularly relevant to this interaction. Not offering an explanation would undermine Sarah's construction of herself as an expert and she provides a possible explanation ("*I can look back and think 'Oh yeah maybe that was a good example of denial'*") for the lack of awareness that she reported at the time of her diagnosis. When Sarah's talk turns towards coping with the experience of cancer she is "*not sure really*" (line 623) whether her knowledge and experience helped her. This is dilemmatic

for Sarah: highlighting that her knowledge and experience were not useful to her in coping with cancer could undermine her membership of the category of expert. She manages this ideological dilemma (Billig et al, 1988) by recasting herself into the category of patient, saying *"I think I just became (0.6) I stopped being me (0.6) and became (1.2) a patient"* (lines 623-625). Sarah alludes to what being a patient means to her when she talks of *"so much emphasis nowadays on (0.7) patient involvement and patient choice"*. This is an emphasis on patient agency and accountability, but *"nowadays"* implies that such emphasis was not always the case. Sarah constructs different categories of patients, those that are empowered and the ones that preceded *"nowadays"*, who implicitly were passive in regards to being involved with making choices about their own treatments. She explicitly resists the idea of the empowered patient, describing not wanting to make choices and the dilemma that this presented her with when offered a place on a clinical trial (*"I didn't want to make choices I just wanted to be told (0.3) 'This is what you've got to do (0.4)'"*, Extract 4.1:627-628). Receiving a medical diagnosis and being cast into the role of a patient has been described as entailing a loss of control over one's body as it becomes the object of medical examination and treatment (cf. Willig, 2009; Kameny and Bearison, 1999). The loss of control over one's body and, similarly, a loss of control over the narrative of one's life (Stacey, 1997; Ehrenreich, 2009; Willig, 2011) could ostensibly be considered negative consequences of a cancer diagnosis. However, within Sarah's account they are not constructed in negative terms. For Sarah becoming a patient offers her a temporary reprieve from the accountability of having to make choices and being in control of her treatment (*"I just want to be told (0.3) 'This is what you've got to take (0.5) Just come along at this time and we'll do it to you and then and go home and take the tablets so you're not sick'"*, lines 631-634). Her diagnosis and treatment facilitated a moratorium from a work situation that she had described as impacting upon her health (*"I'd been feeling (0.7) poorly and burnt out at work (1.2) and thinking 'If only I could break my leg and be off work' ((both laugh)) but not be poorly with it"*, Interview 6:12-14). Since Sarah defined herself in terms of her professional identity, a break from this identity required her to

construct herself in different terms, that of a patient. As such the patient identity could be considered to have been welcomed by Sarah, albeit not in circumstances that she would have chosen (*"I was thinking (0.9) you know "Be careful what you wish for" because (0.7) I wanted a break and here I was getting a break but not in the way that I expected"*, Interview 6:96-99). Rather than challenging Sarah's identity, it could be said that her diagnosis afforded her the opportunity to reposition herself within the same medical discourses, on the other side of the practitioner-patient dualism. However, this presents a new challenge in the form of *"patient involvement and patient choice"*, especially when Sarah is offered a place on a clinical trial (*"when I was offered the chance of being on the clinical trial (0.7) I didn't know what to do (.) I didn't want to make choices"*, Interview 6:628-630). Participation in the clinical trial entails making a choice, something Sarah explicitly says she does not want to do. She negotiates this dilemma by saying *"I just became quite passive and (0.6) and just sat back and let everything happen to me (.) and I didn't really think too much about what was going on I just went from day to day"* (Interview 6:639-642).

Extract 4.1 has illustrated how Sarah re-negotiated her identity as a healthcare professional and recast herself into the identity of a patient. For Sarah this was not a straightforward crossing of the floor from one party to the other, but rather necessitated describing different categories of patient and how the notion of an empowered patient involved in making treatment decisions was problematic for her. The extract has also illustrated how identities are not only negotiated within an account but also in the telling of the account. Orienting her account as being from a psychologist's point of view has procedural consequentiality for the interview. Sarah's identity is that of an expert in contrast to my own non-expert identity. Sarah's expert status influences my questions to her, and she must defend this status in her answers.

Resisting the cancer patient identity

In contrast to Sarah, the next extract comes from a participant who resisted any challenges that her diagnosis presented to her pre-cancer identity. Extract 4.2 is from my interview with Bernadette, who was diagnosed with breast cancer shortly before her fortieth birthday and had been cancer free for nearly five years at the time of the interview. Much of Bernadette's report of her cancer experience was oriented to the effect that her diagnosis had on her children and how they had reacted to it (*"I think the thing that really really upset me the most was (0.6) not so much having the cancer was the kids and having a Mum with cancer"* Interview 2:93-95; *"my main concern was protecting them from it and not letting them worry about it"*, Interview 2:98-99). In other words, her account was from the perspective of her as a mother rather from the perspective of her as an individual. In the extract below I asked Bernadette about her feelings when her children had not been present - when she may have assumed an identity other than being a mother.

Extract 4.2, Interview 2

- 698) Michael: (0.8) Going back to (.) when you first got your diagnosis you
699) said you had this kind of fight or flight (0.7) and your focus was
700) very much on staying positive for the children (.) protecting
701) your children (0.6) What about when the children weren't there
702) and you take your Mum hat off and it was just you (.) or just
703) you and ((husband)) How did you feel then about (0.9) what
704) you were facing and (0.6) what had happened?
- 705) Bernadette: I'd be lying if I said we didn't have blips and there were
706) emotional times (.) I think (0.4) Erm (.) I'd say half way
707) through the chemotherapy (0.6) Erm I would have like you
708) know (.) I'd look at myself I think the thing with chemotherapy

709) is you get away with being a cancer patient before then (.) You
710) can walk around and you don't look like a cancer patient (.) But
711) as soon as you start going through chemotherapy your looks
712) really do change and (.) you know my hair fell out and my face
713) became quite rounded because of the steroids that they give
714) you before every chemo session to boost your immune and to
715) keep you going (0.8) Erm and you have all kinds of injections
716) and stuff you have an injection in your stomach to boost (.)
717) erm your white blood cells that are produced by your bone
718) marrow so they give you an injection in your stomach so it'll
719) boost your biggest bone in your body which is your pelvis to
720) produce more white blood cells to help combat (1.0) any bugs
721) or anything (0.5) I'm also really prone to cold spots and for
722) some reason the cold spots had started coming along on a band
723) on my back (0.8) and they said that that was quite serious so I
724) had to have another drug on top of the drugs that I was having
725) because of erm (.) if that manifested itself into full blown
726) herpes 'cause I (.) 'cause the chemo had destroyed my (.) it
727) was destroying my immune system and it could kill me so it (.)
728) I know getting flu can kill you while you're (.) So the (1.1) as
729) much as try to shove all that to the back of your head it's still
730) there it's like a shadow there (.) and erm (.) ((Husband)) was
731) brilliant I'd say (.) again up until half way and then (.) there
732) were tears and (0.8) you know as in anything that you go
733) through that's traumatic you (.) you do get to a point where
734) you go "Gosh this is awful" you know? (.) You wouldn't be
735) human I think if you didn't you know and (.) I remember once
736) sort of (0.6) looking in the mirror and it wasn't me you know

737) this (0.7) bald person with bits of her eyebrows missing (.) no
 738) eye lashes and big round face and (.) just looking at her
 739) thinking "God you look like a cancer patient you look like (0.8)
 740) you've had (1.0) you know (1.0) you look like you've been
 741) blasted with a load of (.) radiation (.) You know you look (0.5)
 742) terrible" (1.0) So erm (0.9) And so yeah (.) there were tears
 743) and (1.6) I wouldn't say (0.8) I (0.7) became despondent with
 744) it (.) Or I wouldn't say you know (.) you'd have a good cry (.)
 745) And then you'd pull your (.) pick yourself back up and then
 746) when the kids did come back you'd be positive again you know?

Of interest within this passage is how Bernadette resists the identity of cancer patient. She describes how *"the thing with chemotherapy is you get away with being a cancer patient before then"* (lines 708-709). There is an implicit judgement that being a cancer patient is an identity that should be hidden, it is something you *"get away with"* rather than something other people do not notice or know about you. This negative judgement is not made explicitly in reference to having the disease, or its consequences, but rather in being able to *"walk around and you don't look like a cancer patient"* (line 709-710). Prior to chemotherapy, Bernadette's embodied identity is unchanged as far as how other people see her is concerned. Once her appearance changes, marking her out as someone with cancer, the identity that other people ascribe to her is changed. As mentioned earlier, a loss of control over the narrative of one's life has been described as one of the challenges to identity that follow a cancer diagnosis (Stacey, 1997; Ehrenreich, 2009; Willig, 2011). Central to our life narrative is who we construct ourselves to be, and who others construct us to be. As such resisting having others identify oneself as a cancer patient could be considered a way of defending pre-cancer identities.

When Bernadette's change in appearance does allow others to identify her as a cancer patient she makes use of what Edwards and Potter (1992) call a factual report, drawing on descriptions of biological and medical processes (facts) in a causal attribution for her changed appearance (lines 711-726). Edwards and Potter suggested that making attributions through a factual version of an event is a way of managing dilemmas of stake or interest. In any account the speaker can be judged as having 'desires and motives' (Potter, Edwards, Wetherell, 1993) that can be used by others to discount the speaker's version of events, e.g., it could be said that they are motivated by self-interest. Presenting an account as factual means that any negative evaluation of it becomes a negative evaluation of 'a feature of the world' (Potter, Edwards, Wetherell, 1993:403). My interpretation of what is at stake here is Bernadette's identity as a cancer patient. The changes in appearance that prevent her from getting away with being a cancer patient are 'a feature of the world' and ineluctable. Bernadette does not choose the identity of cancer patient, but she can no longer resist it once her appearance changes.

Extract 4.3, below, is a continuation of the sequence of talk in Extract 4.2. In it Bernadette describes her reasons for choosing to undergo chemotherapy. Once again she makes use of a factual report, this time in justifying her decision to undergo chemo and radio therapies. Two things interest me about this passage. First, that Bernadette's account is once again constructed to justify her decision to undergo chemotherapy. Second, that this factual report is immediately followed by an explicit attribution of Bernadette's motivation for undergoing chemotherapy that is centred on her identity as a mother:

Extract 4.3, Interview 2

747) Bernadette: they said "You've got a sixty percent chance of it coming
748) back" (1.3) If you do all this treatment (.) if you just (.)

749) if you do the chemotherapy and the radiotherapy and
750) everything (0.9) it makes it up to a twenty percent
751) chance of it coming back which is only ten percent more
752) than the average (.) person on the street (1.0) So it
753) were kind of a no brainer
754) Michael: Yeah
755) Bernadette: It were kind of (0.6) OK it's not going to be the best thing
756) going through this chemotherapy but (0.9) man alive I've got
757) three children you know fat lady's not singing for me yet I want
758) to (.) I'm going to do everything I can to (1.4) get (.) get you
759) know (.) clear up this and give myself the best possible chance
760) I can

The first part of this extract offers a factual report in the form of various statistics. The statistics present a marked contrast between Bernadette's prognosis without undergoing adjunct treatment ("*You've got a sixty percent chance of it coming back*") and the likelihood of recurrence after undergoing "*the chemotherapy and the radiotherapy and everything*". This latter figure is presented in relation to "*the average (.) person on the street*". Rhetorically "*only ten percent more than the average (.) person on the street*" provides a greater contrast with "*a sixty percent chance of it coming back*" than saying "*a twenty percent chance of it coming back*" (Potter, Wetherell, Chitty, 1991). To use Bernadette's words, this justifies the decision to undergo chemo and radio therapies as being "*a no brainer*". It also, as mentioned earlier, means that any negative evaluation of Bernadette's reasoning becomes a negative evaluation of 'a feature of the world' (Potter, Edwards, Wetherell, 1993:403) in this case breast cancer recurrence rates and the efficacy of different treatments. In contrast to this factual report, Bernadette subsequently attributes her motivation for undergoing chemotherapy to "*I've got three children*". The dissimilitude

between the two passages, which both offer justification for choosing to undergo adjunct treatment, highlights the need to balance competing communication goals (Miller, 2015). On the one hand Bernadette may be managing the expectations of others in terms of taking responsibility for the cancer, electing to undergo treatments that will leave her chances of recurrence only 10 percent more than the average person. On the other hand she is doing what is best for her and her family.

Identity challenges presented by bereavement

I now wish to turn to my interview with Margaret and the very different identity challenges that she was facing in comparison to Sarah and Bernadette. Margaret lost her husband to cancer five years prior to herself being diagnosed with bowel cancer. She received her own diagnosis two years before our interview. Margaret's husband had taken part in a drug trial involving Thalidomide, and as a result had lost the use of his arms (*"Anyway what happened ultimately was that it destroyed all the nerves in his hands and arms up to here ((indicates elbows)) (1.0) So the last four years of his life he had to be spoon fed (.) He couldn't even wipe his own bottom (1.2) So it ruined both our lives"*, Interview 4:26-30). Margaret underwent surgical treatment for her own cancer but refused adjunct chemotherapy due to what had happened to her husband (*"so everything then I am totally suspicious (.) of (.) the pharmaceutical industry"*, Interview 4:32-33; *"So he said 'And we'll start on the chemo next Tuesday' and I said 'Excuse me, Doctor (0.7) Do I get any say in this?' (0.9) And he was absolutely stunned I said 'I will not have chemotherapy'"*, Interview 4:356-358).

The dominant theme within Margaret's account was not related to any challenges presented by her own cancer diagnosis or treatment, but rather the effect that losing her husband had upon her. Arguably she was renegotiating her identity after the loss of her husband. Indeed

we are all constantly renegotiating identities within social interactions as we attempt to reach or maintain consensus with our interlocutors. The reason I have included extracts from Margaret's interview within a chapter focusing on challenges to identity is that she appears to falter at the start of this renegotiating process. She is unclear (or undecided) about whom to construct herself as in light of the changes to her life.

Margaret began our interview by offering a précis of what had happened to her husband (*"Anyway what happened ultimately was that it destroyed all the nerves in his hands and arms up to here"*, Interview 4:26-28). Extract 4.4 is from the same sequence of talk:

Extract 4.4, Interview 4

583. Margaret: But (0.3) I lost ((Husband)) (1.9) It would have been our
584. fiftieth wedding anniversary last year (2.0) We were married in
585. nineteen sixty five (0.9) and erm (0.7) I can't see the point
586. there's no point in me carrying on

Of interest in this passage is how Margaret's reflection on how she and her husband would have celebrated their fiftieth wedding anniversary is brought to a close by describing how *"I can't see the point there's no point in me carrying on"* (lines 585-586). This was something Margaret repeated throughout her account (*"You see I've seen there's no point (1.3) of my life in my life at all now"*, Interview 4:191-192; *"Anyway so that's really the story of my life and I honestly cannot see (.) There's no point in me being here (.) I'm totally non-*

productive", Interview 4:205-206). Margaret's talk of "*there's no point in me being here*" caused me considerable concern with regards to her wellbeing and subsequently I oriented my questions towards different times in her life. My intention was to see if Margaret's description of her life having "*no point*" extended to other periods of her life, and also to allow her to remind herself (through her own account) of times when she may have judged her life to be meaningful. In Extract 4.5 I asked Margaret how she would describe herself at the present time:

Extract 4.5, Interview 4

429. Michael: (5.2) Picking three different points in your life (2.1) If I'd
430. asked you who you are to describe yourself (0.7) Well I'll ask
431. you now (.) If I ask you to describe yourself now who you are
432. (.) how would you describe yourself?
433. Margaret: (4.8) I'm ((full maiden name)) (0.9) Irish catholic (1.3) Atheist
434. Irish catholic atheist (1.0) Erm (1.0) Mother of two fucking
435. useless sons (2.4) and looking for some point in life and I can't
436. find a point in life (1.3) at all (.) There's no point for me being
437. here now

What interests me about Margaret's answer is how she begins her self-description using her maiden name. After nearly fifty years of marriage it would be reasonable, or even expected, to continue to use her married name. Interestingly, Margaret used her married name in all of our communications prior to actually meeting. However, here she does not draw upon that identity to describe who she is now. She reverts to how she was known before her marriage. In other words, Margaret resists identifying herself in terms of the identity she

has (presumably) used throughout nearly 50 years of marriage. Margaret then describes herself as *"Irish catholic (1.3) Atheist Irish catholic atheist"* (lines 433-434). This is dilemmatic for Margaret given that she is no longer a catholic, but rather an atheist. She negotiates this dilemma by repeating the description and bookending it with the term *"atheist"* for emphasis (*"Atheist Irish catholic atheist"*, lines 433-434). In identity terms such a description constructs a social identity for Margaret. It is an identity that she draws upon throughout her account (*"we're Irish Catholics you see so we all went to either of three schools"*, Interview 4:315-316). Growing up as part of the Irish catholic community was attributed with Margaret becoming a teacher (*"there was enough of us in the end to be able to take control of the City Council and it was (1.0) known locally as the catholic mafia (1.2) Well it was dictated to my Dad that I had to be a teacher (.) catholic school teacher"*, Interview 4:611-615). Margaret described how during her teacher training she had decided it was not the career for her (*"Anyway so after my first teaching practice I had to go and confess (1.0) to the priest that I didn't like it (.) I thought I might seriously harm a child (0.6) and it would be best if they moved me from it"*, Interview 4:622-625) and how her being part of the Irish catholic community lead to her eventually changing career to work in housing management (*"it's really just to explain how I ended up in housing because it was the only decent vacancy where they wanted a catholic in again"*, Interview 4:627-628). Given that these key moments in Margaret's life are all related to her identity as an *"Irish catholic"* drawing upon this identity now offers some coherence to who Margaret constructs herself to be at a time when arguably her individual identity is not so clear. In contrast, when asked to describe herself before either herself or her husband had been diagnosed with cancer Margaret offered a very clear description of how she and others would have defined her:

Extract 4.6, Interview 4

475. Michael: (2.3) And what about (1.1) before (1.3) ((Husband's))
476. diagnosis? If I asked you then how would you describe yourself
477. then?
478. Margaret: (1.1) Erm I would have been a matriarch (1.4) *The matriarch*
479. (1.8) Do you watch Mrs Brown's Boys ((TV show))?
480. Michael: ((laughs))
481. Margaret: A hundred times worse than that
482. Michael: [Mrs Brown?]
483. Margaret: Yeah (.) Erm (4.5) Yes (.) I was (2.2) Feared of nobody (.) In
484. fear of nothing (.) Nothing at all could phase me I could handle
485. everything (1.7) Erm (2.6) ((long sigh)) (0.9) I'm trying to
486. think back before ((Husband's)) diagnosis (4.8) No I think the
487. head of the family really (2.0) Yeah

Within this passage Margaret's self-description is explicit. She is not just "*a matriarch*" but is "*The matriarch*". She qualifies what this means by describing how "*I was (2.2) Feared of nobody (.) In fear of nothing (.) Nothing at all could phase me I could handle everything*" (lines 482-483). She sums herself up as "*the head of the family really*" (lines 485-486). There is a clear contrast between Margaret's description of herself here and her description in Extract 4.5. In years past she was "*The matriarch*" and "*the head of the family*". Today she is the "*Mother of two fucking useless sons (2.4) and looking for some point in life*" (lines 434-435). In the three brief extracts that I have included here Margaret's account is not oriented to her cancer diagnosis but rather to the loss of her husband and how she "*can't find a point in life*" (line 435). The challenge to where she stands in the world is not presented by her being diagnosed with cancer, but by being widowed and unable to move

forward (*"People are saying 'Why don't you go on holiday?' so ((Husband)) and I used to go on holiday a lot (0.8) And I can't bear the thought of going to a place that I've been with him (0.7) and you're walking down the street and think 'God yeah we went in that bar and I remember' you know ((low voice)) I can't do it ((normal voice)) I just can't do it (1.5) So I'm stuck really"*, Interview 4:468-474). Unlike Sarah and Bernadette, whose accounts involved negotiating the challenges that a cancer diagnosis and treatment presented to who they constructed themselves to be pre-cancer, Margaret's account is oriented to the challenges of bereavement and finding an identity in later life.

Chapter summary

In this chapter I have illustrated three very different challenges to identity within the accounts of three of the participants. Whilst these challenges are present in participants' talk about cancer, some of these identity challenges could have followed other illnesses or events. For example, for Sarah the transition from healthcare professional to patient following her diagnosis was welcome in as much as it offered her a reprieve from a professional identity that she had been finding increasingly stressful and impacting upon her health. Sarah negotiated this change in identity by describing how she 'stopped being me' and became a patient. However, this same description would not be out of place in an account of other illnesses. What was of importance to Sarah's identity was the moratorium of her professional identity and finding herself on the other side of the healthcare professional-patient dualism. In contrast, the challenge presented to Bernadette's identity was unique to cancer. Bernadette described how she had been able to hide being a cancer patient before changes in her appearance caused by chemotherapy. Following these changes in appearance Bernadette drew upon the discursive technique of a factual account to manage a potential issue of stake that could arise from her no longer resisting the cancer patient identity. The identity challenge being faced by Margaret was not the result of her own cancer diagnosis but rather of her being widowed and, in her own words, there being

no point in her carrying on. This same identity challenge may have arisen regardless of the cause of her husband's death. In negotiating this challenge Margaret drew upon her social identity as an Irish catholic, even though she had long ago rejected the religion.

Chapter 5 Findings: I'm still the same person

Introduction

The focus of this chapter is talk of being the same person after cancer as before it. In each of the interviews I asked the participant 'Who are you?' both in terms of who they saw themselves as being now, after the disease, and also in terms of how, postdictively, they would have described themselves before their cancer diagnosis. As with the challenges to identity discussed in Chapter 4 the identity work discussed here often involves managing ideological dilemmas, as people construct themselves as being the same person as they were before their illness. The first aspect that I wish to focus on is a distinction between being the same person and being unchanged by the experience of cancer. To talk about being the same person yet at the same time be a changed person may involve contradictions. Indeed our everyday talk is replete with contradictions. We talk of 'being true to yourself' or of 'the real me', yet conversely we are often exhorted to 'be who you want to be' or 'be the best version of yourself'. Similarly, we may talk about being the same person yet at the same time how we have changed over time. There is an assumption that some part of who we are (such as our world view) changes and some part of who we are (such as our values) stays the same. What I am interested in is how people organise talk of being changed or staying the same. For example, which aspects of their identity do they construct as being changed or unchanged? What do they present as evidence of change or continuity within their accounts? In the first extract, I introduce an example of such dilemmatic talk and examine how contradictions are managed when the participant constructs herself as being the same person while also talking of how her experience has changed how she views the world.

In Chapter 4 I illustrated some of the ways in which Bernadette resisted the identity of being a cancer patient. Building on that, I begin this chapter by introducing an example of Bernadette describing how the experience of cancer has changed how she sees the world, rather than changing who she is. Just as she resisted the identity of being a cancer patient she resists defining herself in terms of cancer. For example, in Extract 5.1 Bernadette attributes having a positive attitude towards her daughters travelling and gaining a broad experience of life as being the result of her cancer experience. Extract 5.1 comes from a sequence of talk in which Bernadette had described the experience of fundraising for a cancer charity, that supports one of the hospitals she was treated in, in order to undertake a trip to climb volcanoes with other cancer patients and people affected by cancer.

Extract 5.1, Interview 2

625. Bernadette: But yeah like I say more positives have come out of it (0.6)
626. Erm (0.5) erm yeah and (0.5) you know you do look at life with
627. (1.3) different eyes (0.4) but then you've got to get on with the
628. day-to-day you can't be climbing volcanoes and ((laughter))
629. and living that kind of (0.9) let's live life for today and 'cause
630. you don't know what's round the corner there's still the day-to-
631. day to get on with
632. Michael: [Yeah] Lunches have to be made (.) Clothes washed
633. Bernadette: Absolutely (.) Absolutely (.) It never stops and when there's
634. five of us it never stops so erm (0.5) But again because (.)
635. because I went through that I were (.) Am I taking up too

636. much time?
637. Michael: No not at all
638. Bernadette: Are you sure? So I was (.) I'd be really positive with the girls
639. saying "You need to go travelling you need to do this that and
640. other" and erm so last year ((Daughter)) got the opportunity to
641. go to ((Country)) (.) to see her pen pal (0.8) and we scrimped
642. and saved and got on with (0.4) flew her over she were only
643. ((age)) and that were really hard to do but I wanted her to
644. experience (.) I want her to have a broad (0.5) view of life and
645. experience things that (.) 'Cause you don't know what's round
646. the corner and you know you can't be frightened of everything
647. and and you know there's a risk in everything (.) Erm and (0.4)
648. I think you know (0.7) you must (.) You must em...(1.0) grab
649. life by the balls

This extract begins with Bernadette acknowledging that *"you do look at life with (1.3) different eyes"* after cancer. Bernadette constructs herself as the one who takes care of the rest of the family and places the needs of her family before her own needs or desires (*"you can't be climbing volcanoes and ((laughter)) and living that kind of (0.9) let's live life for today"*, lines 627-629; *"It never stops and when there's five of us it never stops"*, lines 632-633). This positioning was echoed elsewhere in Bernadette's account, describing how *"you know the amount of washing and ironing my ironing and washing breeds in the night you know? ((Laughter)) I've got tonnes of it and you know thirty five pairs of socks a week just*

to you know erm" (Interview 2:1090-1093), and also in Bernadette's description of her initial reaction to her Dad's suggestion that she take part in the volcano climbing fundraiser: "I just laughed at him and went 'Oh yeah as if I've time to climb volcanoes with three kids (0.5) Come on'" (Interview 2:560-561). Within Bernadette's account the needs of her family consistently come before her own needs.

In lines 643-645 of Extract 5.1 Bernadette describes wanting her daughter "to experience (.) I want her to have a broad (0.5) view of life and experience things that (.)". This can be interpreted as a traditional parenting stance, the idea of a parent wanting their children to experience things that they themselves may not have done when they were young. What interests me about this passage is how Bernadette explicitly attributes wanting her daughters to travel and have a broad experience of life to her own cancer experience ("But again because (.) because I went through that I were", lines 634-635; "I'd have never done that (0.4) if I hadn't gone through that experience you know", Interview 2:597-598).

However, the object of this talk of positive change, of looking at life "with different eyes", is Bernadette's daughters not Bernadette herself. Bernadette does not say that this new world view has directly changed who *she* is. While Bernadette may be looking at life "with different eyes" they are still, first and foremost, the eyes of a mother rather than the eyes of someone who has been through cancer.

Extract 5.1 above is one of the few occasions when Bernadette constructs her identity with explicit reference to the experience of cancer. Throughout our interview Bernadette oriented her account towards the effect her diagnosis and treatment had on her family rather than the effect it had on her. Her account was very much that of a mother rather than of her as an individual. The importance of this identity for Bernadette is further illustrated in the next extract. As mentioned above, one of the questions I asked participants was "Who are you?". Extract 5.2 is Bernadette's answer to this question:

Extract 5.2, Interview 2

1048. Michael: (1.6) If I asked you (0.8) 'Who are you?' as in describe who
1049. you are to me (.) now (.) How would you describe yourself?
1050. Bernadette: (0.8) What since having the cancer?
1051. Michael: Well now today
1052. Bernadette: (1.8) Just a normal mum of erm (0.9) three (.) I'm a mum first
1053. my kids come first always I'm a wife and then (.) I'm an artist
1054. I'm passionate about art and erm (0.9) I love screen printing
1055. and passionate about that erm and (1.1) yeah and a good
1056. friend erm (.) Yeah just the cancer doesn't define me I wouldn't
1057. say (.) I wouldn't even call myself a survivor or erm (0.7) a
1058. cancer patient or an ex- I think erm it doesn't the cancer
1059. doesn't define me at all I think I only draw positives from my
1060. experience and that it's erm (1.3) maybe like I say it helps fuel
1061. a lot of decisions that I make and in a more positive way (0.6)
1062. Erm I think (0.7) I would be lying if I said there isn't that
1063. shadow (0.5) That you're (.) there's always there in the back of
1064. your mind (0.7) that (1.1) you know (.) it could come back you
1065. don't know

In lines 1052-1053 Bernadette constructs herself as *"Just a normal mum"* in emphatic terms before setting out other labels (*"wife"*, *"artist"*, *"good friend"*) that she would apply to herself. Just as emphatic as her construction of herself as *"a mum first"* is her assertion that *"the cancer doesn't define me"*. The identities that Bernadette does construct for herself are all identities unrelated to cancer, identities that she may have constructed for herself before cancer or if she had never had the disease. She even explicitly rejects the labels of *"survivor"*, *"cancer patient"*, or *"ex-cancer patient"*. Whilst rejecting constructing herself in terms of cancer Bernadette does acknowledge a positive consequence of her experience of the disease. She describes how *"I only draw positives from my experience"* and that *"it helps fuel a lot of decisions that I make and in a more positive way"*. While Bernadette may *"only draw positives from my experience"* she is, nevertheless, drawing on parts of that experience rather than leaving it behind. Her stance in the world is *"more positive"* as a result of her cancer experience. Arguably this could be interpreted as an implicit construction of a different post-cancer identity, of being a more positive person post-cancer. This change was acknowledged when I asked Bernadette how she would have described herself before her cancer. Her answer was once again prefaced by categorising herself as *"a mum (0.4) first and foremost"* (Interview 2:1083). Bernadette subsequently described her pre-cancer self as *"I probably wouldn't have been as (1.5) enthusiastic about life as much as I am now"* (Interview 2:1084-1085). She expands on this description in Extract 5.3, below, in which she gives examples of ways in which she considers herself to be more positive post-cancer:

Extract 5.3, Interview 2

1093. Bernadette: sometimes I think I'd let the little things get on top of me

1094. which I don't now (1.4) erm so (0.7) I might have sort of not

1095. been as positive (2.0) as I am now about things like that or I
1096. might have let (0.8) little things (0.5) you know but you have a
1097. mind shift when you go through something like that (.) you
1098. look there's a bigger picture and you step back and little things
1099. that did (.) you know "Oh you've left your glass in the front
1100. room again" little daft things (0.8) you know I mean I still say
1101. "Come on clear your glasses and stuff" don't get me wrong but
1102. (.) It doesn't (1.2) grind me down like it used to (.) I don't
1103. know as well if that's (.) that's a little bit of going through that
1104. experience but also experience now 'cause I'm an older person
1105. erm (.) you know you get that bit wiser as you get older don't
1106. you? And also you go through other experiences of friends
1107. having cancer or (.) or other things you know (.) My friends
1108. (0.8) Some of my friends have lost their parents now and
1109. things like that and er you know some of my friends' parents
1110. have got dementia so people you knew [inaudible] now aren't
1111. the same people and I think little experiences like that (.) of
1112. other people not just what I've been (.) make that bit more
1113. positive and wiser as well don't they? So I think erm (1.5) I
1114. think there's a lot of that as well just feeling a little bit older
1115. and wiser

What interests me about this extract is how Bernadette initially attributes her changed life perspective ("*I'd let the little things get on top of me which I don't now*") to her experience of cancer ("*you have a mind shift when you go through something like that*") but subsequently offers an alternative attribution that any change may be the result of her being "*older and wiser*". She warrants this description of herself by describing the experiences of friends having cancer, losing their parents, or their parents suffering with dementia. Attributing changes in her life perspective this way, and by extension changes in herself, normalises the experience of cancer. It is constructed as an unexceptional or to-be-expected part of life. Miller (2015) has suggested that one of the reasons people may resist defining themselves in terms of their cancer (such as identifying as a 'cancer survivor') is that it ties them to their experience of the disease and makes it difficult to move past it. Arguably, normalising the experience of cancer could be a similar strategy for moving past the experience. It becomes a normal part of life in the same way that one's parents dying or being afflicted with a disease associated with old age is considered normal. Culturally we do not have a label for an adult who has lost their parents, in the way that we have labels for children who have lost their parents, perhaps for the very reason that it is a normal, expected part of life. Normalising the occurrence of cancer, by highlighting its ubiquity, may warrant Bernadette's description of herself as "*older and wiser*". She is the sum of her experiences rather than the product of just one experience, her experience of cancer.

In the extracts discussed above I have highlighted the dilemmatic nature of constructing oneself as being the same person pre- and post-cancer while simultaneously acknowledging changes that are being attributed to the experience of cancer. In Extract 5.1 Bernadette negotiated the dilemma of constructing herself as the same person post-illness by accommodating her changed world view into her pre-cancer identity of a mother. The object of Bernadette's talk regarding this new (changed) world view was her daughters rather than Bernadette herself, allowing her to maintain a coherent pre- and post-cancer identity of

"just a normal mum". In Extract 5.2 Bernadette explicitly rejected defining herself in terms of cancer, yet also described drawing on positive aspects of her cancer experience when making some decisions. She expanded on this in Extract 5.3 and offered being *"older and wiser"* as an alternative attribution for her changed perspective.

In the next extracts I wish to discuss a different type of dilemma that arises within talk of still being the same person yet also describing changes that have followed the experience of cancer. This dilemma concerns issues of coherence of identity within an account. Describing oneself as being the same person pre- and post-cancer necessitates constructing a coherent identity within one's account. Inconsistencies in descriptions of the type of person one is now and the type of person one was before cancer potentially undermines the assertion that 'I am the same person' or 'I was the same person'. This is the focus of Extracts 5.4 and 5.5 from Interview 3 with Greg, who was diagnosed with throat cancer aged 43, around ten years before our interview. Three years after his treatment the sequelae of radiotherapy had resulted in Greg having to give up his career with the company he had worked for since leaving school. During the interview Greg described how work had been central to his pre-cancer life (*"it was [important] because we didn't have kids (. . .) My wife's got a career has got a good career I had a relatively good career (0.3) So yeah that involved a lot of our lives and your lifestyle according to it so"* (Interview 3:234-236); *"That's where most of my social life was with with people at work"*, Interview 3:768-769). Since his enforced retirement Greg had undertaken a number of cancer related volunteering roles, working with the National Health Service and cancer charities. In comparison to Bernadette, whose identity was constructed around her role as a mother, Greg's descriptions of himself were centred around his attitudes and motivations rather than his past professional or current voluntary roles. The issue that I consider as being dilemmatic within Greg's account is his description of being the same person yet also, within the same sequence of talk, describing quite marked changes in his attitude and motivations. Extract 5.4 illustrates this dilemma

and how Greg manages it within his account. The sequence of talk in Extract 5.4 follows on from my asking Greg how he would define himself now, ten years after his cancer diagnosis:

Extract 5.4, Interview 3

679. Michael: Well how would you describe yourself to me? Someone like
680. you've just met
681. Greg: (3.1) I dunno I'd just say a fun loving person (.) who loves life
682. Michael: Yeah (2.9) And how would you have described yourself (.) ten
683. years ago (.) before all this?
684. Greg: (0.9) I would have said I'm still the same person (1.7) but I
685. was much (1.4) and it's easy to say (.) I was (1.7) more (0.6)
686. focused (0.7) on my percept (.) other people's perception
687. maybe of you and of also possessions
688. Michael: (1.0) Right
689. Greg: (1.0) Whereas now I'm much more (1.8) it's much more about
690. relationships and (.) Erm (1.8) I mean how I'm perceived by
691. others (.) doesn't (.) I think I'm just as thick skinned and it
692. doesn't particularly bother me (.) But it it's much more about
693. relationships and feelings and things like that (.) Whereas
694. before I think it was much more (0.6) erm (0.6) as I think most
695. people are unfortunately in the world it's much more about me

696. and the world and you know (.) and what (.) As long as I'm
697. alright sort of thing and now (0.6) yeah there's an element of
698. that but it's much more how other people feel and how you can
699. help and things like that
700. Michael: OK
701. Greg: So I think I'm more caring (.) hopefully I'm a more caring and
702. giving person than I was before

In line 681 Greg describes himself as *"a fun loving person (.) who loves life"*. When asked how he would have described himself ten years ago (pre-cancer) he suggests that he *"would have said I'm still the same person"* then immediately modifies this (*"but"*) before describing how in the past he was *"more (0.6) focused (0.7) on my percept (.) other people's perception maybe of you and of also possessions"* (lines 685-687). As mentioned earlier, Greg's account defines him in terms of his attitudes or motivations rather than in terms of any social role such as his past profession or current volunteer roles. There are a number of features of how Greg constructs these attitudes within his account that I wish to highlight.

Greg's account can be considered a before-after account. Before: *"it's easy to say (.) I was (1.7) more (0.6) focused (0.7) on my percept (.) other people's perception maybe of you and of also possessions"* (lines 685-687). After: *"it's much more about relationships"* (lines 689-690). A potential dilemma of stake or interest arises in relation to why Greg's priorities pre-cancer were focused on people's perception of him and his materialism. Describing his priorities as such could lead to a negative evaluation by myself as the listener, the counter argument to Greg's position being that *it is* easy not to be focused on *"other people's*

perceptions maybe of you and of also possessions". In other words accountability for prioritising one's own needs over those of others lies with the individual. Greg is accountable. Such a challenge would construct Greg as being selfish or lacking in social responsibility. There is also the issue of the context of Greg's account. A significant change between Greg's life pre- and post-cancer is that he is no longer able to work. As such any changes in Greg's attitude could again be attributed by myself (again as the listener) to his being in a different social environment. In other words, Greg's past working environment could be interpreted as playing a causal role in his former attitude (*"it was very tough the ((Business)) ten years ago (0.9) was before everything exploded ((financial crisis)) and there was a lot of pressure with (1.5) targets and it was very driven and it was waiting to explode and I'm glad what's happened has happened"*, Interview 3:780-783). The culture of this environment could be criticised as being individualist and lacking in social responsibility. This would be an implicit criticism of Greg himself, given that he had worked in the same industry, for the same company, all of his working life, and that elsewhere in the interview he described one of the benefits of his illness as being *"it's got me out of a work that maybe I should have been bold enough to say "I've had enough and I don't like the way the ((Company's)) going"* (Interview 3:1061-1063).

Greg manages these issues of stake or interest when he describes how *"whereas before I think it was much more (0.6) erm (0.6) as I think most people are unfortunately in the world it's much more about me"* (lines 693-695). He makes use of a number of discursive techniques to defend his position (of having been focused more on himself) against possible challenge. First he objectifies the attitude that is at stake, using *"it"* rather than 'I' (*"it's much more about me and the world and you know (.) and what (.) As long as I'm alright sort of thing"*, lines 695-697; *"it's much more how other people feel and how you can help and things like that"*, lines 698-699). As I have discussed elsewhere, this constructs the attitude in question as a feature of the world rather than as some psychological attribute of Greg himself. He also uses what Pomerantz (1986) calls an Extreme Case Formulation ("as

I think most people are unfortunately in the world", lines 694-695). This is an account that draws upon extreme descriptors such as *all*, *none*, *most* to defend the legitimacy of a speaker's stance, to locate a phenomenon 'in the object' rather than in the words of the speaker, or to construct a behaviour or event as ubiquitous so as to defend it against judgement that it is right or wrong (Edwards, 2000). If everyone or most people do it then it cannot be that bad. If everyone or most people do it then it should not need justifying. And if everyone or most people do it then it cannot be limited to (or a failing of) the industry that Greg used to work in. By describing his pre-cancer attitude as being shared by "*most people*" Greg normalises his past behaviour and also once again locates that behaviour (in Greg's words) "*in the world*". It is a legitimate stance, a stance taken by "*most people*", that does not need justification. Any challenge towards Greg's past behaviour would be a challenge directed at "*most people*" and "*the world*" rather than towards just Greg himself. He further defends his stance by adding a judgement of "*unfortunately*" within his description. In identity terms this may be a negative judgement of Greg's past attitude or behaviour, but it is not a negative judgement of Greg himself. His attitude was how "*most people are unfortunately in the world*", or a feature of the world. Greg's account also makes use of what Billig calls 'two-handed reasonableness' (1998:22), by acknowledging that "*now (0.6) yeah there's an element of that*", a nod of the head before turning away from, but not completely turning his back on, the ideology of individualism or self-interest. Again this guards his account (and his identity) against possible criticism that he may still hold the attitude of "*as long as I'm alright*". He acknowledges that this is indeed the case, only with the proviso "*but it's much more how other people feel and how you can help and things like that*". Acknowledging that there is still "*an element of that*" also creates coherence in Greg's identity. He has the same attitude as he had in the past, he is the same person, only now his priorities have changed. This sequence of talk ends with Greg's description that "*I think I'm more caring (.) hopefully I'm a more caring and giving person than I was before*". He does not say that he is *now* a caring or giving person but rather that he is a *more* caring and giving person than he was before.

Implicitly, these qualities were a part of who he has always been. Again, this adds coherence to Greg's construction of his identity. The qualities with which he defines himself today were always present, even if they were not his priorities.

The dominant theme within Extract 5.4 is of positive changes that have followed Greg's cancer diagnosis and treatment. He highlights a shift in his priorities from material and self interests to being focused on other people's feeling and relationships. What does Greg achieve by constructing his account in this particular way? Davis, Nolen-Hoeksema, and Larson (1998) have suggested that attributing a positive benefit to a traumatic event helps to mitigate negative consequences such as threats to one's self-concept. For example, an individual may attribute a new found appreciation for life or improved relationships to the traumatic event making them re-assess what is important to them. Greg's account could certainly be interpreted in this way. He describes himself as *"a fun loving person (.) who loves life"* (line 681), how *"it's much more about relationships and feelings and things like that"* (lines 692-693), and how *"hopefully I'm a more caring and giving person than I was before"* (lines 701-702). In other words, Greg describes himself as having an appreciation for life and a new found focus on relationships.

In Extract 5.5 I further explore Greg's description of his changed attitudes and motivations. Following on from the sequence of talk in Extract 5.4, I asked Greg how his close friends and family would describe him today:

Extract 5.5, Interview 3

726. Greg: Well hopefully they'd say I'm the same person I don't know it's
727. it's difficult that

728. Michael: But who is that person? I mean the same person as in you
729. haven't changed but if I asked them to describe (.) What's
730. Greg like?
731. Greg: (1.9) Well I hope they'd say a loving person (.) A caring person
732. (.) That's what I would like to think and (.) I always used to
733. think one of the attributes of my job (.) when I used to work
734. (0.6) was having empathy for customers (0.6) and whatever
735. (0.6) Certainly towards the end when you know (0.5) they
736. were in really difficult situations (0.5) Erm but regardless even
737. when (.) when you're lending people money if you're saying
738. "No" (.) so empathy was always a word that was drawn into it
739. and I always thought that was something I had when I worked
740. as ((Job Title)) and you're working with teams and sales
741. teams and things like that (0.6) I would always want them to
742. feel that they could come to me and (0.6) It it was me as a
743. person I would always try and sell (.) So I suppose it was
744. always the person and that's why I say (.) I think I was like
745. that even before (0.7) I think it's just more accentuated now

As in Extract 5.4, Greg first describes himself in terms of the type of person he is ("*a loving person (.) A caring person*") rather than roles. However, he then warrants this description of what he hopes others would say about him by drawing on an attribute of his past

professional role and identity. Greg describes how *"one of the attributes of my job"* was *"empathy"* and explains how he displayed empathy both towards his customers and towards his team. He draws on his former professional identity to warrant his construction of his current self. The dilemma of describing himself as being the same person yet also describing changes in attitude and motivation is negotiated by highlighting how *"I think I was like that even before"* and how *"I think it's just more accentuated now"*. These assertions further add coherence to Greg's identity. The changes described earlier in Extract 5.4 are here negotiated as attributes of Greg's identity that have been present all along, only which are now more noticeable. Constructing his account in this way achieves coherence in Greg's identity.

Extracts 5.4 and 5.5 have illustrated how Greg negotiates the dilemma that arises when talking of himself as being the same person pre- and post-cancer while simultaneously describing changes in his attitudes and motivations between these two periods of his life. This dilemma relates to constructing a coherent identity within his account. Contradictions in the type of person he constructs himself to be pre- and post-cancer potentially undermine his assertion that he was the same person before his illness as he is today. Greg draws on a number of discursive techniques to manage this dilemma, such as making use of an extreme case formulation to construct his previous attitude as being how most people are and a feature of the world. His account is also rhetorically organised to undermine any challenges to the notion that he is still the same person, acknowledging that self-interest still constitutes a part of who he is today though it is now subjugate to his primary concern of *"how other people feel and how you can help and things like that"*.

Moving past the experience of cancer

I wish to make one final comment about the idea of being the same person after cancer. While for both Bernadette and Greg talk of being the same person involved negotiating ideological dilemmas, Deborah's account featured a very different discursive strategy for warranting her description as being the same person. This strategy involves constructing cancer as an episode that was now over. Within Deborah's account the experience of cancer ended when her sister was also diagnosed with cancer:

89. Deborah: in June my sister was diagnosed with ovarian (1.1) So I sort of
90. like (1.3) I only had cancer for two months really ((laughs))
91. because she (.) she (.) I mean it was very serious (.) She
92. survived it (.) She's OK (.) Erm but that sort of like took over
93. really

(Interview 5:89-93)

At the end of the interview I asked Deborah if there was anything further that she wished to say about her cancer experience to which she replied:

"Not really (2.8) It was just an episode (.) Just a (.) that I'd rather not repeat (.) but it wasn't that bad while I was going through it really"

(Interview 5:937-938)

Within Deborah's account cancer was a closed chapter in her life. While such a construction does not preclude describing herself as being a changed person there is, arguably, an implicit assumption that normal service has been resumed.

Chapter summary

In this chapter I have illustrated different types of ideological dilemmas that arise when talking about being the same person after cancer. For Bernadette the dilemma was in describing herself as being the same person yet talking about how her experience of cancer had changed how she viewed the world and the subsequent influence of this new world view on her identity as a mother. Of particular interest within Bernadette's account is her acknowledgment that the experience of cancer has changed how she views the world yet she does not talk of the experience changing who she is. Bernadette may be looking at the world "*with different eyes*" but they are still first and foremost the eyes of a mother. In other words, who she defines herself to be has not changed. Any changes are incorporated into this identity. For Greg the dilemma arises in constructing a coherent identity that does not contradict the changes in attitudes and motivations that he also described. A notable feature of Greg's account is a theme of positive changes that followed his cancer diagnosis and treatment. This could be interpreted as an example of benefit finding or attributing positive changes to a traumatic event such as being diagnosed with cancer (Davis, Nolen-Hoeksema, and Larson, 1998). Benefit finding helps to mitigate negative consequences such as threats to one's self-concept. For Deborah, the experience of cancer was constructed as an episode that was now over. Implicitly, she was still the same person she had been before this interruption to her life.

Chapter 6 Findings: Negotiating new identities

Introduction

In this chapter I focus on some of the discursive work that is undertaken in negotiating new identities following cancer. Arguably all of the participants were renegotiating their identities during our interviews, either in constructing post-cancer versions of their pre-cancer selves or in renegotiating themselves as being the same person in light of any challenges that their diagnoses may have presented. I am not looking to identify discrete processes of identity construction. Rather, my focus is on different (though not necessarily discrete) actions that are achieved as part of the identity work that occurs in self-talk about one's cancer experience. Unlike the previous chapters all of the extracts come from the same participant, Alan in Interview 1. I have chosen to focus on these extracts because they illustrate two key aspects of identity that I have yet to address. The first of these is the notion of embodied experience and how such experience may challenge how we construct ourselves in everyday talk. The second is how identities are constructed not only within a local interaction between speakers, but also within a wider political and cultural context. Whilst Alan was not unique in orienting his account towards talk of embodiment or the political context, I consider these aspects of his talk to be central to the identities that Alan constructs for himself. As such I have chosen to focus on them in detail.

Constructing the terms of the debate

Alan was diagnosed with a brain tumour aged 30, around two years before our interview. At the time of his diagnosis Alan was told the tumour was benign and only discovered that it was malignant after travelling overseas for specialist treatment. Alan's account of his cancer experience was initially oriented towards his misdiagnosis (*"Well what happened to me, I got misdiagnosed quite a bit"*, Interview 1:7-8; *"they knew it was cancerous all along"*,

Interview 1:149; *"a different doctor in Britain (.) It'd have been different"*, Interview 1:195-196). However, throughout his account Alan makes reference to the importance of work and his personal ideology of working hard and paying your way. This is central to how Alan defines himself in talk of his pre-cancer life, and to the challenges that no longer being able to work in the construction industry presents to his identity. For example, in Extract 6.1 Alan is chronicling when his symptoms began:

Extract 6.1, Interview 1

247. Alan: (1.5) Just started one day (.) I woke up with it and I actually
248. carried on working
249. Michael: Right
250. Alan: I was (.) I was always brought up that you work (.) for (.) you
251. work and you pay your way (.) If you want something nice you
252. buy it out of working
253. Michael: [Yeah]
254. Alan: I mean nothing against anybody on benefits 'cause
255. unfortunately I'm on that now (.) Can't help that (.) but (0.6)
256. I've done (.) I've made certain choices with my life since (0.7) I
257. mean I volunteer for a charity (.) doing houses up for people in
258. need now (.) So I'm still (0.3) working in the construction
259. industry which I was doing before

Extract 6.1 begins with an example of what Horton-Salway calls 'constructing the terms of the debate' (2004:358). This passage is part of a sequence of talk in which Alan was comparing his own case with that of another patient treated at the same facilities, by the same medical team. Rather than limiting his comparison to talk of symptoms and treatment, he orients it towards work and benefits. The 'endogenous concern' (Wetherell, 1998) within Alan's account, here, is with work and benefits. He describes how his symptoms *"Just started one day (.) I woke up with it and I actually carried on working"* (lines 247-248). Within this description working takes priority over concerns for one's health. Despite the symptoms appearing without warning they do not merit immediate investigation and missing work. Elsewhere in the interview Alan describes how *"being ill's a weakness in a way in the building trade"* (Interview 1:1074) and how illnesses such as coughs and colds or stomach trouble do not warrant time off (*"You still go in (1.3) I mean it doesn't matter if you're running back and forth to the toilet you're still in and you're still trying to get on 'cause otherwise (.) you could be off that job"*, (Interview 1:1078-1081). In identity terms Alan is not only constructing an individual identity with this description but also a social identity, identifying himself as a member of a social group who view being ill as *"a weakness"*. This presents a challenge to Alan's identity since, unable to work, he is no longer eligible to claim membership of this group. His social identity is lost.

Alan warrants continuing to work in light of his symptoms when he describes his personal philosophy as being *"you work and you pay your way"* (lines 250-251). There are two features of this description that I wish to highlight. The first is how Alan attributes this philosophy to how he *"was always brought up"* (line 250). In identity terms this characterises Alan's philosophy not only as something he believes now, but as something he has *"always"* lived by. In other words, his account is rhetorically constructed to imply that this it is not only a part of who he is now but also a part of who he has always been. This presents an unresolved challenge to Alan's identity, since he is no longer able to work due to the sequelae of his surgery. This identity challenge is not limited to Alan redefining

himself in terms of something other than his work. He also now finds himself unable to live the way he *"was always brought up"* (line 250), a philosophy that he has *"always"* used to define himself. Alan also finds himself on the other side of a dichotomy implicit within his philosophy, the dichotomy between those who *"work and pay your way"* and *"anybody on benefits"*.

Austerity politics and benefit claimants

It is worth setting Alan's account in a social and political context here. The interview took place in early 2016 at a time when anyone seen not to be working hard was frequently demonised by both the Conservative Government and large sections of the mainstream media for not 'paying their way'. This shaming of those on benefits is neatly encapsulated in a speech delivered to the 2013 Conservative party conference by George Osborne, the (at the time) Chancellor of the Exchequer. In it, Osborne posed the rhetorical question "Where is the fairness, we ask, for the shift-worker, leaving home in the dark hours of the morning, who looks up at the closed blinds of their next-door neighbour sleeping off a life on benefits?" (2013). The effect of such rhetoric is to place each of us under the scrutiny of each other, a Foucauldian form of discipline that arguably controls behaviour. Unless we are seen to be working hard we are taking advantage of our shift-working neighbour. We are not paying our way. We are skiving while others are striving to get on. Elsewhere in the interview Alan orients his account towards this type of rhetoric, in particular towards his appearance and how he looked like he could (and should) be able to work (*"Cause to look at me you'd never know that's the worse thing"*, Interview 1:1466-1467; *"I know (0.7) people here⁴ don't judge me (1.1) They don't think 'Oh bloody lazy git I'm not happy with that I'm slaving my guts out (0.7) and he sits around' (.) 'Cause they all know that I'm actually (.) that it's a genuine thing with me"*, Interview 1:1478-1481). Such talk supports

⁴ Alan is referring to his neighbourhood when he says 'here'

my interpretation that differentiating himself from the stereotypical benefit claimants of political discourse was an endogenous concern within Alan's talk.

In line 254 of Extract 6.1 Alan orients his account towards *"anybody on benefits"*. He makes use of a discursive technique called a stake inoculation in order to defend the stance that he is about to take in relation to being on benefits. Edwards and Potter (1992) highlighted how the particular construction of an account may lead to dilemmas of stake or interest. An account could be dismissed as being motivated by the self-interests of the speaker, by their prejudice against a particular group, or other motives that could serve to undermine the legitimacy of the account. As such the speaker may attempt to 'inoculate' their account against attempts to undermine it, prefacing the account with an explicit rejection of potential criticisms. For example, a criticism of immigrants might be prefaced with the stake inoculation 'I'm not a racist but...'. In Alan's case he inoculates his stance towards people on benefits by saying that he has *"nothing against anybody on benefits"* (line 254). At stake here is his own need to claim benefits, a situation that could see Alan accused of being hypocritical.

Alan differentiates himself from *"anybody on benefits"* in general, marking himself out as an atypical case. He does this by describing his own situation of being on benefits as unfortunate, that he *"can't help that"* (line 255). This is dilemmatic, since the notion of *"can't help that"* is at odds with the agency inherent within individual responsibility for working and *"you pay your way"* (line 251) as well as the philosophy of *"being ill's a weakness"* (Interview 1:1074). Alan manages this particular dilemma by describing how *"I've made certain choices with my life since"* (line 256). Implicitly those same choices, and the agency to make them, are available to all people on benefits. In other words, while he himself *"can't help that"* the implication is that some other people *can* help being on benefits. Indeed elsewhere this is something that Alan explicitly expresses in relation to benefit claimants (*"I've not been on benefits all me life like certain people have...Cause*

there's a few out there who try to play it", Interview 1:565-568). Later in the interview Alan further differentiates himself from others on benefits by describing how, unlike some, he has contributed to the benefits system and is entitled to the benefits that he now finds himself receiving (*"You shouldn't be automatically (.) allowed to take take take...I paid for what I've took back"*, Interview 1:1596-1598). Alan's social context may have changed but to a large extent who he constructs himself to be, and the ideology he lives by, are unchanged. His belief in individual responsibility is still there (*"I've made certain choices with my life since"*, line 256). The work ethic that was a part of how he defined himself pre-cancer is also still present in how he defines himself now (*"I volunteer for a charity (.) doing houses up for people in need now"*, 6.1:257-258). Arguably his pre-cancer identity of a hard worker, accepting responsibility for himself and expecting nothing without hard work, has been renegotiated in his new role as a volunteer builder. Or to use Alan's own words: *"So I'm still (0.3) working in the construction industry which I was doing before"* (lines 258-259).

Work roles as identity

The next extract further illustrates how Alan's working life was central to how he defined himself, and introduces a contrast that he draws between his pre-cancer identity and how he describes himself post-cancer. In Extract 6.2 I asked Alan how he would have described himself in the years before his diagnosis:

Extract 6.2, Interview 1

1088. Michael: If (.) If I'd asked that question 'Who are you?' (0.8) Ten years
1089. ago or five years ago before you were
1090. Alan: [Builder] (.) [inaudible] there'd be Skilled Labourer (.)

1091. Supervisor (.) Finisher (0.8) I'd be listing off things that (.)
1092. what's defined me 'cause I've done so many hours (1.2) I mean
1093. I'm a Dad as well I didn't mean that to be ((laugh)) (0.9) But
1094. most the time now I just feel like a cancer patient when I'm
1095. struggling on bad days I feel that way

Here Alan defines himself in terms of the job titles that he has previously held, going as far as to describe these roles as *"things that (.) what's defined me 'cause I've done so many hours"* (lines 1091-1092). Alan's reference to having done *"so many hours"* was a topic that he expanded on elsewhere in the interview, describing how working long hours meant that he had no time for a social life outside of work (*"you can forget about seeing your mates and stuff when you're in construction"*, Interview 1:1528-1529; *"Nobody will see you Saturday Sunday 'cause you spend all Saturday Sunday in bed recovering to get ready for the following week of doing it (3.2) So you don't really have time for many mates in construction"*, Interview 1:1544-1547). Unable to engage in paid work, Alan can no longer draw upon the roles that he describes as *"things that (.) what's defined me"* (lines 1091-1092) to construct his identity. They can be drawn upon in defining who he used to be, but not in defining who he is now. Also changed are the people in relation to whom Alan's pre-cancer identity was constructed. We define ourselves in interactions with other people and, as such, our identities are co-created by other people (Sparks and Harwood, 2008). For Alan the workmates that he previously spent his time working *"so many hours"* with (*"Other than your family they're the only people you're around 'cause you haven't got time for anybody else"*, Interview 1:1521-1522) are no longer there as a point of reference against which to define himself. Alan renegotiates his identity in relation to the people he now works with by incorporating his past work roles or *"things...what's defined me"* (lines 1091-1092) into a new role of 'professional builder' volunteering with a charity (*"I'm the first*

person they've ever had who's professional", Interview 1:364; *"I had to teach people who's in charge how to do the job"*, Interview 1:360). This provides continuity with the identity that Alan has always assumed. The *"things...what's defined me"* are still drawn upon to define him now, only as constituent parts of the role of 'professional builder' rather than the trade specific labels that he previously drew upon (*"[Builder] (.) [inaudible] there'd be Skilled Labourer (.) Supervisor (.) Finisher"*, lines 1090-1091).

Embodied experience and constructing a coherent identity

I now turn to another aspect of identity, that of embodiment. Howson described embodiment as "a dialectical process between embodied experience and the language available to articulate such an experience. Hence, the notion of embodiment refers to a process of transformation and mediation in which embodied experience is authentic and articulated through cultural categories" (1998:237). In discursive terms these cultural categories are made available through discourses and can be drawn upon in everyday talk. What is of interest, and accentuated, within Alan's identity talk is the importance of his embodied experience in defining who he constructs himself to be. His pre-cancer life was one of an exhausting work schedule. In Alan's own words, *"Nobody will see you Saturday Sunday 'cause you spend all Saturday Sunday in bed recovering to get ready for the following week of doing it"* (Interview 1:1544-1546). Post-cancer, the effects of his tumour and brain surgery mean he can no longer work for a living let alone work at the same rate. In the following extracts I wish to explore how this change in Alan's embodied experience is negotiated in identity terms.

In Extract 6.3 Alan describes his frustration at not being able to put up a shelf, a process that he describes as being simple since it *"is like six screws"* (Interview 1:1050).

Extract 6.3, Interview 1

1047. Alan: I used to have a shelf (0.7) before we put the new fireplace we
1048. used to have a shelf above the old one (0.8) and (1.1) I think
1049. that took me about (0.7) forty five minutes and hour (0.8) to
1050. put a shelf up which is like six screws (0.9) Because I'm just
1051. struggling to do it (.) I've no (.) no confidence in myself and I
1052. just struggled and it's like now some days I can do things some
1053. days I can't (0.6) It (0.8) varies day to day (1.1) You get quite
1054. angry (0.5) with yourself
1055. Michael: (1.1) Angry with yourself or angry with the
1056. Alan: [It's angry with yourself] that you're not
1057. doing it right
1058. Michael: Right
1059. Alan: It's one of those "Why aren't I (.) why aren't I doing it right?"
1060. I've done this hundreds of times why can't I do it today?
1061. Michael: (0.8) Even though you know
1062. Alan: [It is the tumour] but I'm angry with me
1063. Michael: Right
1064. Alan: Because it's like I'm better than this sort of

Within this passage Alan resists the changes in his physical and cognitive (embodied) abilities, judging himself against his pre-cancer (healthy) self ("*I've done this hundreds of times why can't I do it today?*", line 1060). Despite acknowledging that "*it is the tumour*" (line 1062) he describes how he is "*angry with me*", emphasising the pronoun. He is not angry with the disease or the sequelae of his treatment. He is angry with "*me*", with himself. Alan then attributes the cause of his anger as being "*because it's like I'm better than this sort of*" (line 1064). Implicit within this judgement is the importance of embodied experience to Alan's identity. His declaration that "*I'm better than this*" conflates his skills (his embodied experience) with who he is. He does not say that he *used to be* able to accomplish the task much more easily before cancer, nor make a causal attribution that this loss of expertise is due to having a brain tumour. His inability to perform a task that he has "*done...hundreds of times*" presents a challenge to who Alan has always constructed himself to be, the person who is "*better than this*". While Alan is describing his post-cancer physical limitations he is doing so through the lens of his pre-cancer, healthy abilities. In doing so he creates continuity with his pre-cancer identity.

Elsewhere in the interview, I asked Alan how he thought the people whom he used to work with would have described him before his illness. His answer focused on his abilities now, post-cancer, rather than the period I had asked him about. Alan described how "*I was a grafter then and I can't graft as much now (0.9) So if I went to work with them now I'd be (.) called a lazy bastard*" (Interview 1:1333-1334). Here he draws upon a category of 'grafters', acknowledging that he "*can't graft as much now*". The implication is that he does, however, still graft as much as he is able to do. He still belongs to that category of grafters, and still defines himself in relation to the other grafters that he used to work with. What interests me about this description is how Alan's account defines him in reference to his former work colleagues or his pre-cancer self, a definition which leaves him open to being "*called a lazy bastard*". Indeed these are not the words of his former colleagues, but of Alan

himself. It is Alan's own judgement of himself, presented as the judgement of the people he used to work with. He chooses to position himself within the category of 'grafters' rather than a category of disability or being physically or cognitively impaired ("*my brain doesn't want to work sometimes and I get confused doing things*", Interview 1:1033-1034) either through illness in general or through cancer specifically. Again, constructing his account in this way creates a coherent identity for Alan. It serves as an 'anchor point' (Little et al, 2002:173) or strongly held belief that Alan can orient towards as a method of negotiating the discontinuity of his pre- and post-cancer identities. He is still a grafter, albeit in a diminished capacity. He still lives by his philosophy of hard work, as far as his physical limitations allow. In Howson's terms, Alan is articulating his embodied experience through the same cultural categories that he draws upon to articulate his pre-cancer, healthy embodied experiences.

The final extract of this chapter is from a sequence of talk in which Alan is describing how his cancer experience has changed him. In contrast to the benefit finding within Greg's talk in Chapter 5, Alan's focus is still on benefit claimants:

Extract 6.4, Interview 1

1548. Michael: (2.4) Would you say then that all (.) so far this experience (.)
1549. it's probably a silly question but (.) would you say it's changed
1550. you? And if it's changed you how's it changed you?
1551. Alan: I would (.) I don't think it has changed me that much (0.9) I'm
1552. still the same inside still got the same ethics and that (.) A little
1553. bit of (0.9) towards people with benefits me views have

1554. changed slightly

1555. Michael: Right

1556. Alan: But then (.) there's still quite a lot of them that do (0.9) get to

1557. me and they do peeve me off a bit (.) 'Cause their attitude's

1558. that (0.8) "We've got a bad back so we need all this" (.) I've

1559. not asked for anything (.) I don't want (0.5) to live on benefits

1560. (0.9) I mean I'm not arguing (.) It's like we keep hearing about

1561. benefits cuts that this with the Tories I know it's a bit political

1562. but (.) This affects me

1563. Michael: Yeah

1564. Alan: I'm genuine and none of this is affecting me ((laugh)) Nothing

1565. so far that all this that (.) It's going to affect all the people

1566. that's on (.) that's disabled all this (0.6) Not a single thing has

1567. actually affected me yet

The feature of this passage that I wish to focus on is Alan's reference to disability and how he includes himself in that category. Alan describes how *"a little bit of (0.9) towards people with benefits me views have changed slightly"* (lines 1552-1554), the implication being that he has a more positive attitude towards people on benefits. This echoes his earlier description of how *"I mean I've had to change me attitude a bit the sort of people I work with I didn't realise but (1.5) I always looked at people who was on benefits and think you know what you can't be arsed to work"* (Interview 1:491-494). However, Alan adds the caveat that *"there's still quite a lot them that do (0.9) get to me and they do peeve me off a bit"* (lines 1556-1557). In warranting his attitude towards these individuals Alan orients

his account towards the political context of benefit cuts and the debate over the effect of such cuts on people with disabilities. He explicitly acknowledges how *"This affects me"* (line 15620) before justifying being on benefits himself by describing how *"I'm genuine and none of this is affecting me"* (line 1564).

This is similar to the identity work in Extract 6.1, where Alan marks himself out as a special case when it comes to being on benefits (*"Can't help that (.) but (0.6) I've done (.) I've made certain choices with my life since"*, lines 255-256). What is different about this passage is Alan's implicit inclusion of himself within the category of 'disabled' (*"it's going to affect all the people that's on (.) that's disabled all this (0.6) Not a single thing has actually affected me yet"*, lines 1563-1564). He acknowledges that *"this affects me"* (line 1560), that benefit cuts are *"going to affect all the people that's on (.) that's disabled all this"* (lines 1565-1566), yet also describes how *"Not a single thing has actually affected me yet"* (lines 1566-1567). Alan orients his judgement of benefit cuts towards *"all the people that's on (.) that's disabled"* not towards people on benefits in general. The endogenous concern within his talk is with *"people...that's disabled"*. More specifically, Alan's concern is with differentiating himself from people that he judges not to be genuinely disabled. In identity terms Alan situates himself within the category of disabled benefit claimants, but it is a category of genuinely disabled claimants.

Chapter summary

In this chapter I have highlighted the interrelated nature of Alan's work and who he constructs himself to be, as well as giving examples of the often complex discursive work that he undertakes in renegotiating his identity. The need to renegotiate his identity not only arises from Alan no longer being able to work post-cancer, but also in relation to his having to claim benefits and the contrary position that this places him in regarding his personal ideology of working hard and paying your way. There is one final point that I would

like to make about this chapter and my reasons for including these extracts. This is in regards to how Alan's renegotiation was as much about how he constructed his post-cancer (voluntary) work setting as about himself. This was possible since Alan was able to draw upon his professional skills (and past identity) in his voluntary role. However, in Extract 6.3, when physical and cognitive impairment interfered with his ability to perform a task he had done "*hundreds of times*", Alan's frustration was explicit. The ambivalence towards disability discussed in Extract 6.4 illustrates an ongoing 'process of transformation and mediation in which embodied experience is authentic and articulated through cultural categories' (Howson, 1998:237). What particularly interests me about Alan's account is the way that he draws upon 'cultural categories' that are rarely cancer related. Instead he draws upon categories of grafters, "*lazy bastards*" and, on one occasion, disability.

Despite the seriousness of his prognosis, Alan's account was oriented towards warranting his need to claim benefits within the context of austerity Britain. The endogenous concern within his talk is not having an inoperable brain tumour or of being made acutely aware of the fleeting nature of life. Rather it is a concern with differentiating himself from other benefit claimants, with justifying being a benefit claimant himself. It is neither the aim, nor within the scope, of this thesis to offer a disquisition on current political discourses (for scholarly criticisms of austerity politics see Goodley, Lawthom, and Runswick-Cole, 2014 and Runswick-Cole, Lawthom, and Goodley, 2016). However, the influence of such discourses on Alan's identity talk warrant the inclusion of the extracts used in this chapter. The dominant discourse within his account, and with which he constructs his identity, is not one of being a cancer patient. It may well be that Alan's focus on talk of benefit claimants and justification for not paying your way is a means to not have to talk about what his future may hold. Though, equally, it may well illustrate that even a diagnosis of cancer no longer warrants not paying your way in austerity Britain.

Chapter 7 Discussion

Introduction

This thesis explored the research question of 'How do people construct themselves in talk about their experience of cancer?'. The focus has been on how individuals position themselves within our cultural discourses of what it means to be diagnosed with cancer, to be a cancer patient, and to be a cancer survivor. A consistent feature of all the accounts was that participants drew upon multiple discursive strategies to construct post-cancer identities that were consistent with their pre-cancer identities. All of the participants described themselves as being the same person they were before cancer even when, as in Margaret's case, this was unwanted (she did not want to be a widow). Often participants also described ways in which the experience of cancer had changed how they viewed the world or how it influenced their decision making. None of the participants identified as being a cancer survivor. The only time this identity was called upon was in Bernadette's account, to explicitly reject being identified in such terms. For two of the participants, Alan and Greg, cancer had resulted in them being unable to work. Before being diagnosed with cancer work had been a significant part of their lives and who they considered themselves to be. Post-cancer the influence on their identities of being unable to work was markedly different. In this chapter I discuss these findings in terms of how they relate to previous research.

7.1 Continuity of identity

A common feature within all the interviews was continuity of identity. Participants employed numerous discursive strategies to construct themselves as being the same person pre- and post-cancer. Often this involved negotiating contradictions within their account to ensure coherence between the person they described themselves as being at different points within the cancer experience. The contradictory nature of the identity talk of cancer patients has

previously been highlighted by Baker et al (2016). My own research differs from that of Baker et al in several ways. I will highlight these differences as they are important to demonstrating how my findings further contribute to our understanding of the identity challenges cancer survivors may face.

Baker et al (2016) noted how cancer patients often drew upon both their pre- and post-diagnosis identities when interviewed about their emotional experiences post-diagnosis. They found that those closest to time of diagnosis tended towards maintaining continuity with their pre-cancer identities by maintaining pre-existing routines. Those unable to resume pre-cancer routines talked of 'new normals' discontinuous with their pre-diagnosis routines and identities. In contrast to the participants in Baker et al's study, all of the participants in the current research had completed treatment and were considered to be cancer free rather than yet to begin or be receiving treatment. Their time since diagnosis was also considerably longer (2-10 years) than the time since diagnosis for Baker et al's group (<18 months). This difference is important because it illustrates that even once treatment has been completed (in two instances up to 10 years prior to the interview) continuity of identity was still an endogenous concern within participants' talk. Just as importantly, analysis of the action orientation of talk of being the same person suggests that such talk is not exclusively directed towards what Little et al (2002) called *existential disruption* or a sense of continuous identity.

For two of the participants (Sarah and Bernadette) I would argue that talk of being the same person was oriented towards creating a sense of continuous identity. They had accommodated the experience of their illnesses into pre-cancer identities and, arguably, did not define themselves explicitly in terms of having experienced cancer. However, for the other participants such talk achieved very different actions. For Greg it was used to defend his pre-cancer focus on self-interest and materialism, arguing that he had always been empathetic towards other people only less so pre-cancer. For Alan, talk of being the same

person was a means to negotiate the threat presented to his social identity by finding himself on the other side of a dualism of grafters and benefit claimants. While the talk of being the same person employed by these participants could be described using the types of discontinuity identified by Little et al (2002), doing so solely in these terms risks ignoring the endogenous concerns of the individual. For example, Greg's description of himself as having always been empathetic towards other people could be interpreted as making use of what Little et al (2002) called an *anchor point* or enduring belief resilient to challenge. Yet by considering the action orientation of his account I have highlighted that this talk of being the same person is also used to mitigate Greg's pre-cancer self-interest and materialism. Similarly, Alan's talk of being the same person could be described as making use of an *anchor point* and what Little et al (2002) called *resumption* or accommodating his pre-cancer identity of a hard working builder into a new version of that identity as a hard working volunteer builder. Yet, once again, by considering the action orientation of Alan's account I have highlighted that talk of being the same person is also a means to differentiate him from other benefit claimants. In the case of Margaret's talk this can be interpreted as an example of what Little et al (2002) called *a loss of future memory* or how she may have imagined her future self looking back on defining moments in her life such as the shared rewards of retirement after a lifetime of her and her husband's hard work. However, by examining the action orientation of her talk it is clear that she does not attribute talk of being the same person to her experience of cancer. In Margaret's case analysis of the action orientation of her talk of being the same person illustrates that she does not want continuity of identity. Whilst Little et al's (2002) research can provide an accurate description of where the discontinuity arises in Margaret's identity, a focus on the action orientation of this talk highlights that the discontinuity is not her concern. Her concern is with being a widow.

While Little et al have very eloquently described different challenges to continuity of identity and various methods of dealing with those challenges, they (explicitly) assume personal

identity is made up of '*embodiment, continuity, and memory*' (2002:171, emphasis in original). In contrast to Little et al's methodology, the methodology that I have adopted in this research seeks to situate these constructs within a sociocultural context. Focusing on the action orientation of talk has not only illustrated the social actions being achieved by such talk but also towards whom or what those actions are directed, whether that be myself as interlocutor, a cultural positioning of benefit claimants as the opposite of hard workers, or a cultural expectation that life will become meaningful after surviving cancer.

Although all of the participants described themselves as being the same person pre- and post-cancer, most also described ways in which the experience had changed how they viewed the world. In other words, the person stays the same while their beliefs or behaviour may change. Implicitly there is a dualism here between the person and their behaviour. This is a common sense understanding of the nature of our individual existence, that we are the sum of our experiences but essentially the same person, changing or growing as we get older (and hopefully becoming wiser). Analysis of the action orientation of the participants' accounts, in particular analysis of attributions, shows that in Bernadette's case changes in behaviour were indeed attributed to being older and wiser. This contrasts with our common sense understanding of cancer as a life changing event. What is not clear is why Bernadette should choose to attribute some (though not all) changes in behaviour or how she views the world to the more prosaic process of growing older and wiser rather than to the experience of cancer. Defining herself in terms of more commonplace discourses may simply be a means of moving past the illness, though this would not account for why changes in beliefs or behaviour sometimes were attributed to the experience of cancer. Speculatively, attributing changes in behaviour and beliefs may also be a means of managing the expectations of others. The moral obligation to show a fighting spirit that Willig (2011) suggested follows a diagnosis of cancer also extends to the period of survivorship, with survivors expected to display perennial positivity and no longer be troubled by everyday tribulations (Cantrell and Conte, 2009). To attribute changes to cancer could potentially be

interpreted as dwelling on the illness. Miller (2015) has highlighted how the expectation that an individual should be 'over' cancer can result in survivors communicating in terms of this expectation rather than in terms of their endogenous concerns. Attributions of being older and wiser may be an example of communicating in terms that manage the expectations of others that the survivor is over cancer.

7.2 Survivor Identities

Another common feature of the accounts of all participants was the absence of talk of being a cancer survivor. Bernadette was the only participant to draw upon the term 'survivor', doing so explicitly to reject defining herself as such. Multiple reasons have been suggested for resisting the identity of cancer survivor (Khan et al, 2012a; Khan et al, 2012b; Miller, 2015; Cho and Park, 2015; Jagielski et al, 2012). The first one that I wish to discuss in relation to the findings of this thesis is the lack of a socially validated discourse of survivorship on which participants could have drawn (Little et al, 2002). What it means to be a cancer survivor is contested both within our common sense understanding of the disease and within the accounts of those who have survived cancer. Without consensus on what it means to be a cancer survivor, survivors can 'fit only into pre-existent and inadequate paradigms of the normal or the chronically ill, into metaphors of the victim or the hero' (Little et al, 2002:176). In discursive terms it may be that as well as facilitating the construction of a coherent identity, and the social actions described earlier, a separate social action achieved by negotiating continuity of identity is that it allows one to fit into the 'paradigm of the normal' post-cancer. In other words, it facilitates a return to the pre-existing normality of one's pre-cancer self. What is not clear is whether the participants would have described themselves as a cancer survivor if different discourses of what it means to be a survivor were available to them. What is clear from the findings I have presented is that none of the participants oriented their accounts towards 'paradigms...of the chronically ill' or 'metaphors of the victim or the hero'. Had the interviews taken place

immediately following their diagnoses or during treatment this may not have been the case. However, post-cancer participants defined themselves largely in terms of their pre-cancer identities. Given the pervasiveness of metaphors of heroic battles in everyday talk of cancer this begs the question why the participants would not describe themselves as victorious, if not heroic. Once again analysis of the action orientation of their talk may offer some insight into why this could be, specifically when attributions of agency and accountability are examined. None of the participants constructed their accounts in terms of themselves being responsible for the successful treatment of their tumours. Responsibility for being free of cancer tended to be attributed to their treatment in general and occasionally explicitly to their doctors. In other words, the participants did not construct themselves as having played a part in becoming cancer free beyond accepting the treatments they were offered. Metaphors of heroic battles do not fit their accounts in terms of agency and accountability. They have not battled the disease (or the treatments) but rather have been passive recipients of medical treatment. While accountability for successful treatment was attributed to the treatment or doctors, the participants described themselves as having the choice to go along with or reject these treatment option. This is incompatible with 'metaphors of the victim'. Similarly, 'paradigms...of the chronically ill' do not fit the situation of someone who has been declared cancer free or in remission. To construct oneself in such terms would be to continue to be identified in terms of cancer rather moving past it (Miller, 2015; Kahn et al, 2012a).

Metaphors of victims and heroes have received much criticism for the constraints that they place on cancer patients (McCartney, 2014; Hurley, 2014; Granger, 2014; Willig, 2011; Demmen et al, 2015; Semino et al, 2015; Ehrenreich, 2009; Hauser and Schwartz, 2015). Whilst I have highlighted the incompatibility of such metaphors with the agency and accountability identified within the talk of cancer survivors we should not assume that this is the case for those still receiving cancer treatment. The one participant (Alan) who drew

upon the battle metaphor in his account is also the only participant to still describe himself as a cancer patient. This is one area that future research could look at.

Moving past the experience of cancer

A further reason that has been suggested for resisting the survivor identity is that it ties one to the experience of cancer (Miller, 2015). Within some of the accounts there was a degree of ambivalence about moving on completely from the experience of cancer. For Deborah, two years post-treatment, the experience was 'just an episode' tempered by the caveat that she would rather not repeat it 'but it wasn't that bad while I was going through it really'. Bernadette spoke of approaching being 'signed off' after 5 years in remission. When asked to explain what being 'signed off' meant Bernadette described it as her doctor considering her situation to be 'that there's no more cancer' and that 'I'm done'. While they both clearly talked in terms of the experience being in the past or of being 'done', Deborah and Bernadette both also spoke of changes in how they viewed the world post-cancer. They each oriented their accounts towards a sense of urgency and not knowing what was around the corner. This was couched not in terms of fear of recurrence of the disease (another reason that Kahn et al, 2012a, have suggested for resisting the cancer survivor identity), but rather as something they described as motivating their decisions and behaviour. So while both accounts contained talk of moving past the experience of cancer, Deborah and Bernadette both accommodated changes attributed to cancer into their post-cancer identities. Similarly, Sarah spoke of how she still embraced the friendships that she had made during her cancer experience yet also how she had 'shut away' some parts of the experience in her mind, telling herself to 'just shut that away'. For these participants moving on from cancer did not mean totally disconnecting themselves from the experience. It would appear that moving on is not necessarily a binary choice, that individuals may assimilate aspects of their cancer experience, such as not putting off doing things, into their post-cancer identities while still constructing themselves as largely the same person they

were before the illness. A common feature of the accounts of the three participants discussed above is that they were all able to resume the lives they had expected to live once treatment was completed. In contrast both Greg and Alan found themselves unable to resume their pre-cancer lives and faced the challenge of negotiating new identities outside of the work roles that had been large parts of their identities pre-cancer.

For Alan cancer was still very much a part of his identity. Although he was in remission his prognosis was that the tumour was expected start growing again within a specified time frame. While Miller (2015) and Kahn et al (2012a) both highlighted that the thought of recurrence was a reason that people resisted the survivor identity, for Alan recurrence was more of a certainty. Indeed Alan described himself as being a cancer patient. Greg resisted the identity of cancer survivor despite being heavily involved with cancer charities and NHS cancer teams in various voluntary roles. Ostensibly this could be interpreted as Greg being tied to his experience of cancer. However, when talking about these roles his descriptions were oriented towards the relationships he was able to form with healthcare professionals and both cancer and non-cancer patients. Rather than being tied to the experience of cancer I would argue that Greg had accommodated the experience into his post-cancer identity.

Margaret made little reference to her own cancer experience, instead being concerned with what had happened to her late husband and the lack of meaning she felt in her life as a widow.

There are two further brief points I wish to make in reference to none of the participants identifying as a cancer survivor. The first is that cultural differences in the acceptability of the term cancer survivor have previously been identified by Kahn et al (2012b). The British way is simply to keep calm and carry on. Participants of different nationalities, such as Americans, may have identified with the term cancer survivor (the term has its origins

there). The second point is regarding the local interaction of the interviews, with myself being a fellow cancer survivor. Previous researchers have suggested that people may resist identifying as a cancer survivor due to a sense of not having been close enough to death or having received harsh enough treatment (Cho and Park, 2015; Jagielski et al, 2012; Kahn et al, 2012a). Whilst all of the participants knew that I had been diagnosed and treated for cancer none of them knew what form that treatment had taken. In other words, constructing themselves as a survivor could potentially have been undermined by my own experience had I chosen to talk about it. Not identifying as a cancer survivor may have been a means of managing this issue of stake or interest (Edwards and Potter, 1992).

7.3 Austerity politics and marginalisation

The last finding that I wish to discuss is the influence of discourses of austerity politics on the identities available to those unable to work after cancer. Austerity is the name given to the policies of the UK Coalition Government formed in 2010. These policies are centred on spending cuts ostensibly aimed at reducing the country's structural deficit. Critics of austerity have argued that the true aim of these spending cuts is to shrink the public sector and the welfare state (Runswick-Cole and Goodley, 2015). Austerity is founded upon the neoliberal ideology of individual responsibility for oneself and one's dependents. This responsibility extends beyond the financial realm as individuals are also morally accountable for being seen to be playing their part and paying their way (Runswick-Cole, Lawthom, and Goodley, 2016). Goodley and Runswick-Cole (2015) have argued that the neoliberal agenda depends upon the creation of categories of 'us' and 'them', the former being those citizens who accept their individual responsibilities and the latter the 'shirkers' and 'skivers' who do not. Within austerity Britain anyone claiming state benefits over the past seven years has become synonymous with this latter group. Benefit claimants have been demonised by large sections of the UK media as well as becoming the subject of 'poverty porn' mainstream television programmes such as 'Benefits Street' (Channel 4 Television, 2014). The focus of

such programmes is the individual rather than any structural constraints that may have placed them in, or be preventing them escaping from, poverty. The implicit (and sometimes explicit) message is that these individuals have nothing to blame for their predicament but their own fecklessness and idleness (Runswick-Cole and Goodley, 2015).

Cancer not only entails long periods of being unable to work during treatment but also, as in Alan's and Greg's cases, may result in being unable to work even after treatment has been completed. For the participants in this study treatment necessitated up to a year off work. Five of the six participants were either in employment that provided sick pay during their treatment, were covered by private insurance policies that included critical illness cover, or were retired. The exception was Alan who, as a self-employed builder, could be considered the archetype of the responsible citizen in austerity Britain. Before his cancer diagnosis Alan was flexible in where and when he worked, accepting financial responsibility for himself and his family. Post-treatment, he was no longer able to work and was reliant on state benefits to support his family.

Alan's account in particular illustrates the identity constraints that discourses of austerity can place on cancer survivors. Rather than orienting his account towards the existential threat presented by cancer much of his identity work involved differentiating himself from other benefit claimants. Within the discourse of austerity you are either working and paying your part or taking advantage of the welfare state. The positive contribution that Alan continues to make as a volunteer builder working for a charity is not recognised within the discourse of austerity. Only paid work is recognised as contributing to society. The impact of austerity and how it positions those outside the normative assumptions of what it means to be a responsible citizen has already begun to receive learned criticism (Runswick-Cole, Lawthom, and Goodley, 2016; Goodley and Runswick-Cole, 2015). The findings from my analysis of Alan's account contribute to this nascent body of knowledge and contribute to being able 'to question, destabilize assumptions that marginalize and exclude bodies and

minds that are judged to fail to meet the expectations of ableist normativity' (Goodley and Runswick-Cole, 2015:11).

7.4 Methodological reflections

This thesis has drawn upon a methodology of Discursive Psychology, which re-conceptualises psychological phenomena such as remembering, personality, and attitudes as performative acts that take place within spoken interaction. Participants' accounts were not analysed for their veracity to the events they describe or who participants 'really are'. Rather, they were analysed for the social actions that they achieved within the setting of the interview. A caveat that needs to be applied to this methodology is that participants were talking postdictively about events that had occurred up to 10 years prior to their interview. Had the interviews taken place around the time of diagnosis or during treatment the accounts offered may have been very different. Equally, had the interviews taken place at a different point in my own cancer recovery (or had I never joined that ubiquitous club) my interpretation of the interviews, or how participants responded to my questions, may have been very different.

Characteristics of the sample

As well as the retrospective nature of the accounts, the positive (physical) prognosis of most participants should also be considered as influencing who they constructed themselves to be. All of the participants were cancer free or in remission at the time of their interviews. As such the stance they take in the world may be very different to individuals with a terminal diagnosis or those facing a recurrence of cancer.

Half of the participants had experienced breast cancer. While this is the most common type of cancer in the UK (Maddams, Utley, and Møller, 2012) it has been argued that it holds its

own unique place amongst our common sense understanding of the disease (Ehrenreich, 2009). This is not to say that the identity challenges faced by breast cancer patients differ from those diagnosed with other forms of the disease. Rather, to recognise that a more varied sample of participants may have highlighted different discourses of what it means to be a breast cancer patient versus a lung cancer or pancreatic cancer patient, which both have much lower survival rates than breast cancer. In turn this may have identified different identity challenges, particularly in relation to the culpability associated with smoking and lung cancer. Breast cancer is also commonly associated with being a disease experienced by women, even though 2,350 men were predicted to be diagnosed with, and 440 men were predicted to die from, breast cancer in the United States in 2015 (Siegel, Miller, and Jemal, 2015). As such there are gendered assumptions about what it means to be a breast cancer patient.

Analysing identities in isolation and in context

Clegg Smith, Klassen, Coa, and Hannum (2016) have pointed out that much previous research has focused on cancer identity in isolation rather than within a broader context of who one considers oneself to be (cf. Park et al, 2009; Kahn et al, 2012a; Miller, 2015). This study differs from such research in two ways. First, its focus on participants' identities before, during, and after diagnosis and treatment rather than focusing solely on being a cancer patient or a cancer survivor. Being semi-structured in nature the interviews allowed participants the freedom to orient their accounts to what was important to them rather than what was important to me as the researcher. While the participants were all volunteers to a research study about their cancer experiences, all of the interviews were replete with talk of life outside of cancer. Such talk offers a glimpse into the social and political context in which the accounts are set. For example, both Greg and Alan oriented their accounts of their cancer experiences towards key tenets of the discourse of austerity. In Greg's case this was to mitigate his pre-cancer pre-occupation with himself and material possessions, in Alan's

case to defend himself against criticism for not working and paying his way. I would argue that the chosen methodology's acknowledgement of the social and political context is a strength of this study. To ignore the context of people's talk is to ignore issues of power relations such as those that have given the discourse of austerity politics such prominence and continue to sustain it. Challenging the normative assumptions of political discourse (of any persuasion) and the constraints that it may place upon subjectivities requires challenging those power relations.

The second difference between this and much previous research lies in my own role within the research and particularly the interviews. The identities constructed by participants in their interviews can be considered to have been co-created in interaction with another cancer survivor (Sparks and Harwood, 2008). This may have been a benefit for participants, engaging with someone with whom they share 'a frame of reference' (Miller, 2015) that allows them to share 'a knowledge that is hard to share with those who have not had similar experience' (Little et al, 2002:176). Though, conversely, my own status as a cancer survivor may have led to some experiences going unsaid: a tacit understanding of a shared experience that does not need to be articulated. My own experience of cancer must also be acknowledged in my interpretations of the participants' talk. The motivation to undertake this research was as much to do with my own dissatisfaction with dominant discourses of cancer as it was with intellectual curiosity. As such there was always the danger that I was looking to confirm these dissatisfactions. However, by adopting a systematic and iterative process of analysis I have guarded against such self-confirmation.

7.5 Conclusion

This thesis has explored how people who have experienced cancer construct themselves within talk of that experience. A common feature of all accounts was continuity of identity or constructing oneself as being the same person before and after cancer. Where this research

contributes to our understanding of the role of continuity of identity for cancer survivors is in its findings that are the result of a focus on the action orientation of talk. Talk of being the same person was not exclusively oriented towards dealing with existential disruption or the sense of being the same person. The findings presented in this thesis have illustrated how such talk may also be used to justify past behaviour or to renegotiate new social identities.

Given the absence of a culturally validated discourse of survivorship I have suggested that maintaining continuity of identity may be a means of returning to the pre-existing paradigms of the normal. Analysis of issues of agency and accountability within participants' talk has highlighted the incompatibility of what Little et al (2002) called 'metaphors of the victim or hero' or 'paradigms of the chronically ill' with the identities participants constructed for themselves. I have also shown how the discourse of austerity politics may serve to constrain the identities available when an individual finds themselves unable to engage in paid work as a result of cancer.

Understanding the identity challenges of being a cancer survivor are important beyond intellectual curiosity. Past research (Miller, 2015) has shown that cancer survivors may compromise on communicating their own concerns in order to maintain consensus with those around them. Such compromises in communication can mean that cancer survivors do not receive support appropriate to the identity challenges of survivorship. By highlighting some of the endogenous concerns of cancer survivors, and how those concerns may be contrary to our common sense understanding of cancer, this thesis hopefully makes a contribution towards achieving a common sense understanding of cancer that more accurately reflects the concerns of the individuals living with and after the disease.

Appendices

Appendix 1: Participant consent form

RESEARCH INFORMED CONSENT FORM

Title of Project:	A discursive analysis of self-identities through and beyond cancer	Ethics Approval Number:	SREP/2016/007
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Researcher Email:	Michael.Ruddy@hud.ac.uk
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Please read the following statements and, if you agree, tick the corresponding box to confirm agreement then sign and print your name at the bottom:

	Tick
I confirm that I have read and understand the information sheet for the above study.	<input type="checkbox"/>
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	<input type="checkbox"/>
I understand that my participation is voluntary and I am free to withdraw at any time without giving any reason or that I may withdraw my data at any time up to one month after the interview.	<input type="checkbox"/>
I understand that my data will be treated confidentially and any publication resulting from this work will use pseudonyms in place of my name and the names of other people, places, or organisations that could identify me.	<input type="checkbox"/>
I consent to the interview being audio recorded.	<input type="checkbox"/>
I understand that no person other than the interviewer, transcriber and academic supervisors will have access to the recording.	<input type="checkbox"/>
I consent to the use of anonymised quotations from my interview being used in the research thesis, academic journals, conference presentations, or for teaching purposes. The University may also use the research to promote itself.	<input type="checkbox"/>

Participant name	Signature	Date
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Researcher name	Signature	Date
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Appendix 2: Information sheet

INFORMATION SHEET

Living through and beyond cancer

Thank you for showing an interest in volunteering to take part in this research project. Below you will find some information about what participation involves, your right to withdraw and when you must do this by, and what will happen after you have taken part.

If you have any questions about any part of the study please email Michael.Ruddy@hud.ac.uk or call 07817 502 983.

What is the purpose of the study?

Being diagnosed with cancer can be a life changing moment. As well as having to cope with the physical symptoms of the illness and treatment there may be practical challenges, such as not being able to work or take care of dependents, along with the possible psychological challenges of managing different emotions and facing an uncertain future. Many of the aspects of our lives that we use to define who we are – our work, our relationships, our hobbies – may be put on hold while we undergo treatment. The study is looking at how people talk about their experiences of cancer once they have completed primary treatment. This includes the experience of being diagnosed with cancer, through treatment, to completing initial treatment and being cancer free or in remission. The aim is to examine the different ways that people react to their diagnosis and any changes to their life while living through and after cancer. Specifically if or how this affects your sense of who you are and how other people see you.

Who can participate in the study?

The study is open to men and women aged 18 or above who have had a diagnosis of any type of cancer, completed initial treatment for the cancer at least 12 months prior to taking part, and who are now in remission or with no evidence of active disease. There is no upper time limit on how long ago you completed cancer treatment.

Who is undertaking the study?

The study is being carried out by myself, Michael Ruddy, as part of a MSc by Research degree at the University of Huddersfield. My interest in people's experiences of cancer comes from being a cancer survivor myself.

The research is being supervised by Dr Viv Burr, Reader in Psychology, and Professor Nigel King, Director of the Centre for Applied Psychological and Health Research at the University of Huddersfield. Dr Burr can be contacted via email on v.burr@hud.ac.uk.

The study has been approved by the School Research Ethics Panel.

What will participation involve?

Participation will involve an informal interview talking about your cancer experience. The interview will take place at a mutually convenient location (or the University of Huddersfield Queensgate campus if this is convenient for you) and should last around 60-90 minutes.

Interviews will be audio recorded then transcribed. You will be offered the opportunity to review the transcript of your interview. You will not have to answer any questions that you do not wish to answer. There are no right or wrong ways to talk about your experience with cancer.

Who will have access to the information I give?

All of the information you provide will be treated in confidence. Data (the recordings of your interview) will be

Appendix 3: Interview guide

Allow participant to begin to tell their own story

Q: Tell me about your cancer diagnosis and the time leading up to it

Probe: General health? How did you manage any physical symptoms? How did you explain the symptoms to yourself and to other people?

Coping mechanisms and attitudes to overcoming adversity

Q: Thinking back to when you received your diagnosis, what were your first thoughts?

Probe: Some people may immediately worry about death, some people may be more confident that they will survive. What was it like for you?

Q: Did you continue to have those thoughts as time went on, or did you notice a change in your thinking?

Probe: (*If thoughts changed*) How did your thoughts change over time?

(*If thoughts did not change*) What do you think now?

Self identity

Q: If I asked you '*who are you?*' how would you describe yourself?

Q: Thinking back to before your cancer diagnosis, if you had been asked the same question what would you have said?

Q: If other people were asked those same questions – family, close friends, or work colleagues – how would they have describes you before cancer? How would they describe you now?

Probe: How would people say you've changed if at all? How do you feel about the way other people view you now?

Private vs public face

Q: Did you tell people about your diagnosis?

Probe: How did you approach telling people about your diagnosis? When asked or unprompted? Order of revelation/worries about telling people. Were there people you didn't tell?

Q: What sort of reactions did you get from people when you told them? Can you give me a couple of examples of how people reacted?

Probe: Did people react the way you expected they would? Tell me about someone reacting differently to how you thought they would/What type of reaction did you find useful? What type of reactions did you find unhelpful and why? Did you avoid telling certain people because of how you thought they might react?

Treatment and enforced incapacity

Q: (If participant worked) How long were you off work? What was that like for you? How did it make you feel?

Probe: Reaction of employer/financial difficulties/Ability to return to work and do old job/How long in their work role? How big a part of their life is their work?

Q: Tell me about how your treatment affected you

Probe: Being able to do the things that you used to do – work, family role, personal pursuits

Life after treatment

Q: Since completing your treatment are there any ways that your life is different?

Probe: Physical activities/attitude to life (urgency/re-prioritising what's important)/Are there things you used to do that you no longer can?/ Do people treat you differently or do they assume that it's 'all over'?

Q: Since completing your treatment are any ways that your relationships are different?

Probe: With family? With friends? With work colleagues?

Q: Are there things that you miss about your life as it was before cancer? Are there things that you consider are now better since your experience of cancer?

Probe: Activities?

Appendix 4: Online recruitment advert copy

My name is Michael Ruddy and I am carrying out a research study at the University of Huddersfield. I am looking for people who have completed initial cancer treatment to take part in an informal interview about their experience of cancer. This will include talking about being diagnosed with cancer, undergoing and completing initial treatment, and being cancer free or in remission. My interest in this area comes from being a cancer survivor myself.

The aim of the study is to examine the different ways that people react to their diagnosis. It is also looking at any changes to people's lives while they are living through and after cancer. Interviews will be carried out at the University of Huddersfield Queensgate campus in the centre of Huddersfield or at a mutually convenient location.

The research has received the approval of the School of Human and Health Sciences Ethics Research Panel.

To find out more about the study please visit www.withthroughandbeyondcancer.com or email Michael.Ruddy@hud.ac.uk

Appendix 5: Example of analysis coding

Identity	Quotation	Line(s)	Action
Self-sufficient	"I was (.) I was always brought up that you work (.) for (.) you work and you pay your way (.) If you want something nice you buy it out of working"	244-246	Ideology/Stake inoculation against potential criticism that he is claiming benefits
	"I mean nothing against anybody on benefits 'cause unfortunately I'm on that now (.) Can't help that (.) but (0.6) I've done (.) I've made certain choices with my life since (0.7) I mean I volunteer for a charity (.) doing houses up for people in need now (.) So I'm still (0.3) working in the construction industry which I was doing before"	248-252	Disclaimer followed by category construction to position himself apart from the populist category of benefit claimants/Ideological dilemma
	"I got scared to go out (1.0) and closed me self away from the world (1.2) And I picked me self back up through volunteering (0.7) I went to one (.) charity (.) and it was two buses to get there (.) it was too much for me (.) it was too much for me body"	332-335	Ideology Category creation to differentiate between 'me' and 'me body'
	"Since coming back I've always had the attitude (.) I'm going to get back to work"	414-415	

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