

Cancer-before-cancer

Mythologies of cancer in everyday life

Sara Marie Hebsgaard Offersen, Mette Beck Risør, Peter Vedsted,
Rikke Sand Andersen

Abstract

Approaching the presence of cancer in everyday life in terms of mythologies, the article examines what cancer is and how cancer-related potentialities are enacted and embodied in the context of contemporary regimes of anticipation. Based on ethnographic fieldwork in a suburban Danish middle-class community among people who were not immediately afflicted by cancer, we describe different and paradoxical cancer mythologies and show how they provide multiple ways of understanding, anticipating, and dealing with cancer in everyday life. Special attention is paid to the relation between biomedically informed notions of symptoms and bodily processes, and a ghostly and muted presence of cancer, particularly when people are faced with more tangible cancer worries. We explore how contemporary cancer disease-control strategies emphasising ‘symptom awareness’ interweave with and add to cancer mythologies. We suggest that these strategies also carry moral significance as directives (be aware of early signs of cancer and seek care in time), and create an unintended illusion of certainty that does not correspond with everyday embodied forms of uncertainty and ambiguity. We argue that paying attention to the continuous cultural configurations of cancer that exist ‘before cancer’ will increase understanding of how the public health construction of ‘cancer awareness’ relates to everyday health practices such as symptom experience and health care seeking.

Keywords

cancer, mythology, knowledge, uncertainty, symptoms

Introduction

Of course I am afraid of it and I often think of it when I feel some kind of twinge or stab of pain or a symptom from my body. And I think of my future: When will I get this kind of sentence? It is a kind of a – what can we call it? A scary monster that attaches to your life with this disease. Because I am this age and I feel really lucky that I have come this far without discovering anything. But that is the thing: that this disease, it is not something you notice until it reaches a certain stage. It is a coincidence if someone discovers it before it starts giving symptoms. So it is a scary disease. A sneaking one that you can carry around without knowing it.

– Christine, sixty-five years old

In spite of the growing scientific understanding of cancer and an increasing array of treatment opportunities, cancer is still in many aspects considered an enigma and, as the quote above shows, a monstrous creature threatening to rupture and alter lifeworlds and societies. The former president of the United States, Barack Obama, in his final State of the Union address characterized America's effort to find a cure for cancer as a moon shot, implicitly invoking Neil Armstrong's famous words of 'a giant leap for mankind' (Obama 2016). The 'war on cancer' metaphor and the rhetoric of a cancer cure unite across countries and cultures the many uncertainties and interrelations of the cancer complex into one single, almost caricatured, global quest of eradicating the disease. But defeating – and understanding – cancer is anything but a unified quest. As Julie Livingston (2012) aptly shows in her depiction of cancer care in Botswana, cancer manifests very differently under different social conditions. In Denmark, and more generally in the global North, the complexity of cancer disease control has increased during the past decades. In terms of aetiology, prevention, and treatment, cancer has become an increasingly multifaceted social field where the focus on lifestyle factors and carcinogens in our environment interacts with knowledge about genetic dispositions and viral infections. A sense of fate and notions of morality are often read into this complex field as well. Preventive measures in the effort to take charge over cancer play into this complexity, resulting in various biomedical discursive arenas of genetic testing and counselling, screening, vaccination, and the 'behavioural sciences of medicine' (Good 1994), focusing on lifestyle changes, symptom awareness, and health care-seeking practices. Cancer is at the same time a highly political and economic field, where decisions and prioritizations provide a framework for what counts as significant in what we call 'cancer mythologies'.

Building upon fieldwork among the Danish middle class, we suggest that cancer mythologies emerge in the friction between the complexities and uncertainties of cancer as an object of science, of cancers suffered and lived, and the ‘cancer caricature’ where the monstrous, heroic, and miraculous characters of cancer stories are amplified to illustrate cancer as a battle to be won or lost. The illness experiences of cancer among people directly affected by cancer have been widely investigated globally (Manderson, Markovic, and Quinn 2005; Henriksen and Hansen 2009; Livingston 2012). Yet, between caricature and complexity also lies the everyday lives of the ‘noncancerous public’ whose health practices are subject to exhaustive interest among health promoters and a diverse range of interventions aimed at cancer prevention, cancer awareness, and health care seeking in response to symptoms of cancer.

Cancer, then, does not just affect its victims. It is a cultural phenomenon that reaches far into society at large and into intimacies of everyday life (Stacey 1997); as a ‘total social fact’ cancer is present in most aspects of social life in the global North (Jain 2013; McMullin 2016). Cancer mythologies carry moral significance in their ultimate dichotomy between life and death. As argued by Sarah Lochlann Jain (2017) in her semi-autobiographical work, cancer’s complexity lies between these polar endpoints pointing towards imagined futures and counterfactually questioned pasts. Jain investigates (2007, 79) the temporality of cancer in the United States through the perspective of ‘living in prognosis’, and we argue, with her, that ‘all of us in American [and Western European, we would add] risk-culture live to some degree in prognosis’. In a similar vein, Vincanne Adams and colleagues point to a state of anticipation as a defining characteristic of our time (Adams, Murphy, and Clarke 2009). As an attempt to predict and foreclose uncertainties, anticipation is a way of actively orienting ourselves towards the future. In this way, the future sets the conditions of possibility for action in the present; potential health crises such as a cancer diagnosis thus already impact our lives regardless of whether they are actualized. This state of anticipation manifests in the weighing of different potentialities when people sense their bodies and interpret embodied sensations on a continuum between ‘normal’ and ‘possibly alarming’ (Offersen et al. 2016). Thus, with the contours of impending disease that we implicitly assume in titling this article ‘Cancer-before-cancer’, we point to the presence of anticipated cancer in everyday life that can exist even without the actual presence of disease.

It is a different landscape in terms of uncertainty, morality, and temporality when we turn our focus from the ‘village of the sick’ (Stoller 2005) to explore cancer in the village of healthy (Andersen 2017), but it is no less relevant since most cancer stories begin in everyday life with people experiencing bodily sensations as symptoms of potential illness. In Denmark, political and scientific attention to cancer symptom awareness and ‘timely’ health care seeking has intensified in recent years, marking a change in public health rhetoric towards a reconceptualization of cancer as an acute condition (Tørring 2014) and what can

be termed ‘symptomatic management of cancer disease control’ (Andersen 2017). Public health interventions have been criticized for creating a causal link between recognizing cancer symptoms and health care seeking based on underlying assumptions of decontextualized rationality (Andersen and Risør 2014). We argue further that these interventions and assumptions of rational causality create an illusory certainty about what cancer symptoms are (Douglas 2001), which is not easily translated into the ambiguous and uncertain sensorial experience of health, illness, and everyday life (Offersen et al. 2016).

We aim in this article to show how cancer is imagined, anticipated, and manifested in everyday life among Danish middle-class citizens who, although presenting various other health problems, did not have a cancer diagnosis at the initiation of fieldwork. Cultural studies of cancer tend to focus on people just diagnosed with or living with cancer, but given the increasing societal focus on preventive strategies for controlling cancer, we should also attend to the role cancer plays in everyday life among the ‘healthy’. To begin with, we elaborate on our use of the concept of mythologies.

Defining ‘mythologies’

In Susan Sontag’s (1991) classic critique of cancer myths and metaphors (first published in 1978), she predicts that with an increased understanding of cancer and improved treatments, cancer will be partly demythicized. Her prediction has been widely criticized in cancer culture literature, with some claiming that her argument has itself been turned into the latest mythology on cancer (Clow 2001; see also, for example, Lock 1998; Stacey 1997). Our analysis partly follows Sontag’s work in focusing on mythology and metaphor to conceptualize cancer manifestations in everyday life, and partly joins the questioning of her predictions and the sharp distinction she draws between objective, scientific knowledge and mythicized metaphorical conceptualizations of cancer in the public (Sontag 1991, 3–9, 86–87). Our empirical material shows that various bits and pieces of objectified knowledge, such as survival rates, risk factors, and genetics, become entangled with emotions, narratives of hope and tragedy, sensorial perceptions, and morality. Facing what Levi-Strauss (1966) might call a bricolage of knowledge, experience, and attention at hand, we treat cancer mythologies as diverse cultural representations of cancer configured in the interface between biomedical objectified forms of knowledge and individual everyday life experiences, which mirror their cultural contexts.

Writing at the crossroads of anthropology, biomedicine, and public health, we wish to emphasize that mythology should not be understood as something that is false, subjective, or based on beliefs, or as something opposed to positivist objective knowledge that is based on science about the true nature of things. This distinction has long been dissolved within

anthropology and may in itself be considered a myth when considering the epistemological grounds of scientism (Loughlin, Lewith, and Falkenberg 2013), the processes and implications of scientific reductionism (Lock 1994), the idea of local biologies (Lock 1994), and an empiricist theory of medical language (Good 1994). Turning to classic structuralist perspectives on mythology, we find that Lévi-Strauss (1955, 444) also reminds us that ‘the same logical processes are put to use in myth as in science’. Instead, we take up the concept of mythology in an attempt to ‘account for the synthesizing activities by which disease is made an object of personal, social, political, and medical significance’ (Good 1994, 167) from the perspective of Danish middle-class everyday life.

Margaret Lock (1994) subtitled her groundbreaking comparative analysis of menopause ‘Mythologies of Menopause in Japan and North America’. In it, she looks at menopause as ‘a concept with boundaries and meanings that shift depending upon the viewpoint and interests of speaker and listener’ (Lock 1994, xviii). The same can be said about cancer and the expression of a fundamental uncertainty surrounding the disease, an uncertainty that has not diminished with increased knowledge as predicted by Sontag. It can be argued that increased understanding of cancer and scientific breakthroughs merely rearrange the landscape of uncertainty and ambiguity, rather than reducing it (Offersen et al. 2016). You can know your statistical risk and genetic disposition of getting cancer. You can calculate the probable effect of your years of cigarette smoking on your average life expectancy. You can be aware of cancer symptoms, you can go for a run every day, and you can undergo screenings, health checks, and HPV vaccination. But you cannot know if you will get cancer or why you did or did not get it. The area between statistical probabilities and individual lives and bodies is the locus of this uncertainty (Gould 2013; Lock 1998). Thus, life in some general sense can be considered lived ‘in prognosis’ (Jain 2007) but individual life is lived in the variation. The magnitude of cancer as a disease worldwide makes its inherent uncertainty and ambiguity an essential cultural matter, something with unstable boundaries and meanings that synthesizes, as Good puts it, ‘personal, social, political, and medical significance’ in its culturally specific everyday life manifestations. This is what we call ‘cancer mythologies’.

Accessing cancer mythologies among the suburban middle class

The analysis in this article is based on eighteen months of ethnographic fieldwork in a suburban middle-class community in the outskirts of a major city in Denmark. Fieldwork consisted of a minimum of six visits to each participating household, with three of those visits including a semistructured interview. Beyond interviews, Offersen did participant observation, following everyday life activities in the house and in the neighbourhood, health-related activities such as visits to the general practitioner (GP) and physiotherapist, hospital appointments, and trips to the pharmacy. Eighteen key informants (eleven women and seven

men) participated in the project. Some of them were married couples who were interviewed together, while participant observation could follow one or the other. All informants were older than forty; most were aged between sixty and seventy, and were retired or on the verge of retirement.

The ethnographic study behind this article began with the question of how people ‘read’ their bodily sensations as possible symptoms of disease (Hay 2008), and when these ‘readings’ moved them to seek medical assistance. Thus, the fieldwork in itself was not concerned with cancer but with bodily sensations, the cultural indexation of sensations as symptoms, and health care seeking in general. However, the underlying reason for conducting this fieldwork was to deepen our understanding of how to improve cancer diagnostic strategies, by exploring how and when Danes seek medical assistance; this project is also part of a larger multidisciplinary research portfolio exploring cancer diagnostics in Denmark. Given this context, it was inevitable that the fieldworker, Offersen, was attuned from the outset to how cancer was verbalized and enacted within the myriad of health and illness concerns in everyday life. This way of paying attention to the subject as a ‘side focus’ of the main project is precisely what enabled us to perceive the everyday presence of cancer in mythologies composed of and embedded in medical, political, social, cultural, and moral concerns. A principal part of the analysis in this article derives from Offersen’s perception of a nonverbalized cancer presence, like an ‘elephant in the room’, derived from her sense of the situation or habitual feel for the game. While this ‘side focus’ on cancer can influence how cancer becomes present in the mind of the ethnographer during fieldwork, the ‘absent presence’ of cancer also was overwhelmingly clear while reading and re-reading interview transcripts. Scholars have also noted the frequent difficulty in saying ‘the C-word’ as part of the cultural phenomenon of cancer (Stacey 1997; Broom et al. 2017). The empirical descriptions we present of a nonverbalized cancer presence are thus grounded in tacit knowledge (Polanyi 2009) and in what Michael Taussig (1984) calls ‘implicit social knowledge’.

Cancer, prevention, and the promotion of health in Denmark

As the leading cause of death in Denmark (Sundhedsdatastyrelsen 2015), cancer has immense impact on the organization and priorities of the Danish health care system, the welfare economy, research funding, and the everyday lives of the Danish people. Given Denmark’s significantly lower cancer survival rates compared to similar countries, political and scientific attention towards cancer, and particularly early diagnosis, has intensified during the past two decades (Andersen, Tørring, and Vedsted 2015). This focus culminated with a reframing of cancer as an acute condition in 2007 by Danish governmental and health authorities (Tørring 2014), emphasizing the role of early detection in relation to improving

cancer prognosis. Concretely, this resulted in organizational changes in the health care system with the implementation of fast-track cancer pathways where diagnosis and the initiation of treatment are guaranteed to happen within a narrow timeframe (Probst, Hussain, and Andersen 2012). In an effort to reduce ‘waiting time’ among citizens who might ‘delay’ seeking health care with symptoms of cancer, media campaigns have been regularly launched. Slogans such as ‘Know the 7 Signs of Cancer’ and ‘Real Men Go to the Doctor’ encourage people to seek medical advice when experiencing bodily sensations that could be potential symptoms of cancer. Symptoms people are encouraged to look out for are: difficulty in swallowing, unexplained weight loss, persistent cough or hoarseness, unexplained bleeding, change in the appearance of a mole or sores that do not heal, change in bowel habits, and lumps and swellings. Many of these are everyday bodily experiences that are widespread among healthy people and as such have a low positive predictive value of cancer. Denmark also has a free HPV vaccination programme for girls and three national cancer screening programmes: 1) for cervical cancer (since 2006, pap smear every third year for women twenty-three to forty-nine years old; every fifth year for women fifty to fifty-nine years old; since 2012, an HPV test for women sixty to sixty-four years old), 2) for breast cancer (since 2009, every second year for women fifty to sixty-nine years old), and 3) for bowel cancer (since 2014, every second year for everyone between fifty and seventy-four years old).

Historically speaking, relying on early diagnosis as a means to control cancer is not new (see, for example, Toon 2008), but the increased focus on early symptomatic detection of cancer along with a continuously expanding epidemiological delineation of potential symptoms and risk factors present us with a different form of regulation that entails a new sensorial orientation in everyday life among healthy (but also always potentially ill) citizens (Andersen 2017). The recurrent slogan of ‘the sooner the better’ in these public health endeavours was echoed in informants’ statements, illustrating the anticipatory regimes that expand their temporal domain to still earlier moments before potential cancers, in order to manage these future threats (Adams, Murphy, and Clarke 2009).

Cancer mythologies in the Danish suburban middle class

The welfare state of Denmark has an extensive redistributive system, which seeks to ensure that basic needs such as education and health care are free and accessible to all, and that differences between rich and poor are diminished, regulated by social benefits and high income taxes. As such, Denmark is known as a supposedly egalitarian society where an ‘indeterminate “middle-classness” has almost become the norm’ (Jenkins 2012, 44), and where ‘good citizenship’ is negotiated and embodied in moral relations of rights and

responsibilities between individual and society, particularly with regards to when and how to use the free health care system (Offersen 2017).

A sense of this ‘middle-classness’ can be obtained by walking around the neighbourhood where our research participants live: people are mowing their lawns, weeding their flower beds, and helping neighbours pack a trailer with garden waste to take to the disposal site. You can almost hear the chirping birds in this idyllic, somewhat stereotypical image. The elderly informants have struggled to maintain a standard of living that is markedly above their own upbringing. They are unskilled workers, nurses, artisans, and teachers. They do not lack anything, but moderation is a key value in most matters such as personal spending and use of the welfare system (for further elaboration, see Offersen 2016). Cancer is present in different ways in the everyday lives of these members of the Danish middle class. It resides in the warm hug given to a friend who has not been seen for a long time at the golf course where he and his wife used to play before cancer and illness uprooted their routines of golfing and lawn mowing. It ‘runs’ in families, in the worries about inherited risks, and it is articulated in glamorous TV shows collecting money for the fight. People face it every day when confronted with health-promoting commercials at bus stops; hanging on their own kitchen bulletin boards are leaflets with phone numbers of where to call if you are affected by cancer, next to lists of phone numbers for acute medical assistance.

How do all these various cancer manifestations, both concrete and abstract, mould cancer mythologies and how they are dealt with in everyday life? Let us begin with a look at the case of Elisabeth, a retired woman in her sixties:

Interviewer: Is cancer something you can be worried about when you sense something in your body?

Elisabeth: Yes, yes. . . . Skin cancer and things like that. I believe one of our friends, she has had – she had something on her nose that she went to get scraped and stuff a couple of years back. . . . And one of our other friends, I think she has had a little bit of this skin cancer. But they say the thing about – if you are fair-skinned, rather reddish perhaps – if you – I can’t count the number of times I had sunburns as a kid, so, yes. . . . There is something sometimes. You should look after yourself. That thing about the sun. Yes.

Later Elisabeth relates one of her visits to her GP, where she has gone to have her cholesterol checked. When pressed a little she hesitantly starts describing how she had given birth to some very big babies, which resulted in her having occasional troubles with haemorrhoids. Her story continues to unfold in still more vague and downplayed

formulations: ‘but at that time I also thought that I – I felt that I had had some kind of problem. I thought that I had gotten some blood where I – I guess I believe that I had that. . . . But I don’t think that I told this to the secretary when I made the appointment, no’.

There is a pronounced paradox in the ways that Elisabeth relates to cancer. These range from talking matter-of-factly about the risk of getting skin cancer and recalling how a close friend had it, to discussing her actual worries of cancer with a simultaneous hesitancy to use the word ‘cancer’. Elisabeth earlier had mentioned rectal bleeding as a well-known symptom of cancer, but as the conversation narrows in on her concrete but ambiguous personal experience of the same symptom, she talks about ‘some kind of problem’. Throughout our empirical material we find this paradox between how cancer manifests as a disease you are statistically likely to get, especially as you get older, and how cancer manifests as a more concrete threat when bodily sensations may be symptoms and an illness potentiality is evoked (Offersen et al. 2016). There is a marked change of prognostic character, from the statistical probability of getting cancer at all to the likelihood of *this* symptom being a sign of cancer. Interestingly, we find that the more abstract the perception of risk is, the more concrete are the cancer manifestations, whereas the more concrete worries people have, the more abstract, ambiguous and uncertain cancer seems to be. As Jain (2013, 2) phrases it: ‘The word’s tangibility dissolves in sheer bafflement, for doctors and patients alike, over what, exactly, it describes’. In our perspective, the paradoxes and contradictions in how cancer manifests in everyday life emerge from the ‘bricolage’ of cancer mythologies, and these frame the embodiment of risk and cancer symptom awareness as well as people’s agency in preventive strategies, such as health care seeking when faced with potential cancer symptoms. We now turn to a description of some of the most profound mythologies expressed by people in this community.

‘Uncontrolled cell division’

Our cells start to divide uncontrollably. And they generate metastases and tumours. Untreated, this can continue and then it can infect organs. It can infect the brain and it can destroy the bones. Yes, it can destroy it all. (Erik, seventy-five years old)

As if singing a well-known chorus, almost every informant responded to the question ‘what is cancer?’ with a version of the ‘uncontrolled cell division’ story. The few who did not took a more characterological and consequential approach, telling us that cancer is ‘ugly’, ‘serious’, ‘deadly’, and ‘frightening’. Being able to account for an abstract fear and for bodily processes involved in cancer is, however, not the full story of cancer-before-cancer in everyday middle-class life in Denmark. ‘Cancer is a lot of things’, as several informants told us, but it is also such a singular powerful phenomenon that many, like Elisabeth above, resort to talking

around cancer, not phrasing it as an explicit worry. Cancer, we argue, should be seen, following Lock's (1994, xviii) phrasing as a cultural representation 'with boundaries and meanings that shift depending upon the viewpoint and interests of speaker and listener'. So what forms and figures do cancer mythologies take between the rather mechanical recitation of the cell division story and the spooky sense of a ghostly figure that is too terrifying and too elusive in its appearance to name?

Death, suffering, and a positive attitude

Death and suffering take a prominent position in describing cancer. During fieldwork, a friend of one the couples, Finn and Doris, was diagnosed with and died from lung cancer. They described the course of their friend's illness as 'violent' in terms of how quickly he became really sick and died. Doris said, 'It went so fast that we couldn't – we couldn't even imagine. . . . Every time we spoke with him, which was once a week – good heavens! We couldn't even count till three before – it just went so fast'. This is also a story of cancer as a matter of time. In fact, the relation between cancer and time is so strong that Doris in this story ultimately euphemizes this close and shocking encounter with cancer and death solely in terms of its temporal unfolding. Jens and Sonja, who housed Jens's brother when he was ill with cancer, focused on the horrors of the cancer and the suffering it caused: 'He was not well. Actually, it was horrible. It started in the throat, all the way from the tongue bone. Tube feeding and things like that'. Participants also commonly related the story of coping with cancer with a positive attitude and 'fighting back', the moral attitudes of a good cancer patient. One informant, Christian, was diagnosed with prostate cancer during fieldwork. Talking about the process, he said that he wanted to 'take it like a man' like his father did when he was diagnosed with and died from cancer. This accords with what we call the cancer caricature, where cancer heroism is praised (see also Stacey 1997; Harris 2015). The cancer heroism is evident in several accounts of people 'living positively with cancer', perhaps best exemplified in this statement from Jette, another informant, who concludes after telling us about a friend with bone cancer: 'Of course you will also get the dark thoughts. But to get the most positive out of it, I believe that is life-prolonging'.

The ghostly presence of cancer

One of the most profound mythologies of cancer in everyday life related to its simultaneous apparent absence and ghostly presence. More or less everyone had a sense that cancer could be invisible, hide, and grow in the body; this combined with the imperative of discovering cancer at an early stage. Karen, newly retired, explains how she had precursors to breast cancer some years back discovered through the breast cancer-screening programme. She had not felt anything herself. She had some tissue surgically removed and had preventive

radiation therapy, and guessed that she is ‘one of those people where it would not have grown into something serious’. Nevertheless, she started wondering about how cancer could be present without any signs, and about how it might even miss detection through screenings:

At that time I thought: ‘then it can happen anytime and with anything! . . . When you find it here, where else do I have cancer? Do I have it somewhere else? And will it not just return? Am I predisposed?’ . . . I didn’t feel ill at that time before. Not at all. I couldn’t feel a thing. So that is the scary part. For that reason, I go to all the screenings as you are supposed to. But it is not everything in the body that gets screened, right?

The sneaking, lurking, hiding character of cancer was the most profound fear among these people, and this is perhaps what most markedly differs from cancer mythologies in the village of the sick, where cancer is an enemy being actively fought, out in the open, at least to some extent. This ghostly presence of cancer is at the same time reinforced by focus on the early detection of cancer, which conveys the understanding that cancer can be detected by paying attention to early signs and sensations (Andersen 2017; Tørring 2014). Karen continued her puzzling over how you can feel completely well and be very ill at the same time:

We are told so much about all the illnesses you can get. My goodness, a lot can be wrong! And if you don’t see the doctor in time it is really bad! But well, our health care system budget is busted if everyone goes to their doctor even when they don’t feel anything wrong but they are afraid that there might be something. Well, you can call it hypochondria. You can get that from all the things we are told. . . . But you also hear about all these people who are suddenly fatally ill without having sensed that something was wrong. That is worrying indeed. . . . It is about figuring out a compromise between being alert but not hyperalert, if you can be that. I find this a little difficult to balance sometimes.

The conflict between alertness and hyperalertness is a conflict between the ability to live a normal life, one that is not continuously interrupted by fear of illness, and the fear that fatal illness could ultimately disrupt this same everyday life. It marks an uncertainty about how to live ‘in prognosis’ (Jain 2007), in a ‘present that is held hostage to the potential violence of the future’ (Adams, Murphy, and Clarke 2009, 255). The ghostly presence of cancer, particularly manifest in stories of cancer-afflicted people in our informants’ social networks, not only spurs on hyperalertness and fear but also moral resistance to excessive health care seeking and medicalization (Offersen, Vedsted, and Andersen 2017).

Aetiology and risk

When I am feeling well I consider my risk small. And this relates to two things. It relates to the fact that I have not consumed – at least not consciously – excessive amounts of toxins in my lifetime. I have kept myself in good shape. And then it relates to what my sister told me: that it doesn't run in our family. And I can look backwards and onwards and ascertain that this is not what they died from. (Erik, seventy-five years old)

A final aspect to be touched upon are the middle-class mythologies of aetiology and risks of cancer. First, many emphasized that cancer is not something new. People agree that there is increasing focus on cancer but many stress that it is more a matter of focus than a matter of increasing cancer incidence, saying things like 'we just didn't know before' or 'it was called something else'. Cancer is also widely considered hereditary. When informants told stories of cancer in their family, they almost automatically stated whether the cancer-afflicted family member was on their 'side' of the family, meaning genetically related to them. But just as readily, many told the story of carcinogenesis, of environmental circumstances external to the body that cause increasing cancer incidence in contemporary society. Toxins and pollution, and the lax governing bodies that allow these to penetrate our lives and bodies, become the culprits.

Vanishing war metaphors and mythological multiplicity

What we did not find in the everyday life cancer mythologies was an abundance of war metaphors, as have been described at length in cancer culture studies among people affected by cancer (Sontag 1991; Stacey 1997; Williams Camus 2009). They were not completely absent but they were remarkably vague in comparison to what is described in the literature. This is perhaps an expression of difference between the metaphors found in the 'kingdom of the ill' (Sontag 1991, 3) where cancer becomes an 'enemy' to fight (Stacey 1997, 172), and the mythologies in 'the village of the healthy' (Andersen 2017), where prevention efforts and ambiguous bodily sensations do not connote the same epic sense of an ultimate, and individual, fight, but rather a sense of anticipation (Adams, Murphy, and Clarke 2009) and potentiality (Offersen et al. 2016). In a call to turn an anthropological lens on all the different forms cancer takes and their social impact, Lenore Manderson (2015, 245) mentions 'precancers that are not yet, but might be' as one of the cancers that need attention. Our study field was characterized exactly by all the different shapes and sizes cancer comes in, or can come in. Being not there yet, it can still be anything. Or nothing at all.

In this way everyday cancer mythologies are full of bits and pieces of the whole spectrum of cancer variation, and the paradoxes and contradictions between these. Consider, for instance, the contrasting perceptions of cancer as invisible, growing unnoticeably in the body, and the embodied focus on cancer as something that can be detected by being aware of early signs and sensations; this contradiction creates a difficult balance between being alert and hyperalert, understood in Karen's explanation as being too alert to live a normal life. Or look at the paradox between recoiling from cancer as ugly, horrible, and frightening and cheering on cancer heroism, a positive attitude that may prolong life, revealing a body-mind entanglement that leaves the responsibility to sustain a positive attitude with the individual sufferers and those who are not suffering yet but might in the future. The contrasting mythologies of cancer shape different moral responsibilities and involve different actions towards prevention. The question then is how certain parts of the mythologies gain significance, become amplified, or get downplayed in specific contexts. Everyday cancer mythologies, we argue, adapt to situations; they are not fixed. Rather, they are used in contextualized individual bricolages to deal with the immense uncertainty and ambiguity these contradictions and paradoxes create.

To build a case for exploring symptom awareness in everyday life, we now look at how people employ cancer mythologies when experiencing and attempting to articulate ambiguous and uncertain bodily sensations and worries, which we understand as an absent and muted presence of cancer.

Dissolving cancer potentiality

In Elisabeth's case we see that the cancer presence in her life markedly changes character when she, after a long explanation about the size of her children at birth and her subsequent problems with haemorrhoids, 'admits' that she has been worried about some episodes of rectal bleeding. The casual and commonsensical way of talking about cancer, symptoms, and risk is replaced by a fumbling expression of uncertainty and ambiguity. In this interview, and in many more like it, we were, it seemed, implicitly discussing cancer without saying the word. One informant, Michael, even explicitly refuses to say 'cancer' when talking about a work colleague who has been coughing heavily for a long time and now is on sick leave: 'Well, I am not going to say what I think it is!' It was as if voicing the potentiality of lung cancer would actually make his friend sick with cancer. But, as Jackie Stacey (1997, 64) points out: 'as the subject is avoided, it enters everyone's mind'. Cancer thus often is read between the lines: there is no doubt about what Michael's colleague's unspeakable potential illness is about, and in many cases like this, it does not take the clearly demarcated shape of a word said aloud (see also Broom et al. 2017). 'How can we know, then?' we might ask. The short answer is that we cannot know in the fact-finding sense of the word. And we would

not be able to derive this knowledge from a survey or the interview transcriptions alone. This knowledge is of a different texture, one that can be most eloquently described as what Kathleen Stewart (2007, 1–2) calls ‘ordinary affects’ as ‘the surging capacities to affect and be affected. . . . They can be experienced as a pleasure and a shock, as an empty pause or a dragging undertow, as a sensibility that snaps into place or a profound disorientation’. Our ability to sense an unvoiced cancer worry is thus based on such surging ordinary affects, which create intensities of significance (Stewart 2007) in fieldwork situations, as well as on subtle clues from previous discussions or stories told at another time and in another context.

People are not unaware of these processes that dissolve worries about cancer into other everyday life concerns. In an example of a kind of meta-awareness of cancer and symptoms, Karen expresses hope that she will be able to act on even vague cancer worries instead of ignoring them, and then, during the same interview, states that she has noticed a bodily sensation that may be a symptom of cancer that she has had for the last couple of years without ever presenting it to her general practitioner:

Well, yes, if I had a lot of pain which I could not find explanations to, then I would react. I would definitely do that with all the horror stories I have heard about people who have been really sick without knowing it. They have been walking around with stomach discomfort for some months and then they actually have incurable cancer. . . . I think about it but there just has to – well, there would have to be some symptoms before I would react on it. But then I would react. I would do that for sure.

We then continued talking about situations in which she thinks about this, and she gave an example where a headache made her wonder whether she has had a stroke or whether she has just slept in a wrong position. This leads her to wonder about her ability to distinguish between things normal and severe:

Karen: But I hope that I will react, actually. I hope I would be attentive to it and not just shrug it off. I guess I have a tendency to do that, also when something hurts. I shrug it off then.

Interviewer: When you say that you hope that you will react in that way. . .

Karen: Yes, I hope so. That I don’t just think that ‘well, this is nothing. Don’t be hysterical’. But I actually think that I have encountered so many who suddenly have started to fall ill without having felt anything other than stomach discomfort or just feeling a bit different in some way. So . . . but I actually don’t know if I then would think that it was just something I ate or something I did or –

After discussing different signs and symptoms of disease, and Karen telling us about a mole or a freckle or a brown spot on her eyelid that worries her a little bit, the following conversation takes place:

Interviewer: When were you last in doubt about whether you should consult a doctor?

Karen: Actually, right now.

Interviewer: Because of this thing on your eye?

Karen: Yes, and I am glad that you kept on asking because I forget it sometimes. But lately I have been noticing this a little bit. And then suddenly I see in the mirror that I have such a brown blot there, which I don't believe I had before until a couple of years ago. And then I have forgotten about it all winter and then I have thought about it again. Perhaps I should do it. Go there and hear what she [the general practitioner] would say –

Interviewer: So when you think about having it checked, what is it you want to have it checked for?

Karen: Well, if it is something that can develop into cancer or if it is just a sun fleck or ordinary ageing. Or what on earth it is –

Interviewer: But aren't you then exactly where you told me before that you hoped that you would react?

Karen: Yes, yes, I am precisely there.

The 'symptom awareness' that Karen displays in this case is perfectly in accordance with dominant public health rhetoric that emphasizes early care seeking in response to epidemiologically delineated 'alarm symptoms' of cancer. However, even though she is (meta-)aware of the risk of her own 'cancer worry dissolving' and wishes to resist it by reacting to vague sensations, her worry still seems to dissolve, except when it is prompted and revived by the interviewer's questions. This shows how cancer symptom awareness happens in a context where the straightforward black-and-white certainty of public health campaigns dissolves into the nuances and individual concerns of everyday life. It can be argued that Karen's uncertain and ambiguous experience of the mole or freckle on her eye is contingent on impressions of certainty inherent in the list of alarm symptoms of cancer. Yet, even though she recognizes her sensation as a symptom of cancer, her experience does not

correspond to the expected certainty by which such symptoms are often presented in the public health rhetoric. An example is a TV spot from an awareness campaign, which shows a man sitting in his house watching TV. Suddenly an electrical outlet behind him short-circuits and catches fire. He looks at it, smiles and takes another sip of his coffee while the flames reach the curtains. A speaker says, 'Watch out for the small signs and *do* something', and refers to a webpage about 'the 7 signs' that should make people see their GP. Following a public health trend that firmly links people's behaviour to their health (Cohn 2014), the logic in this campaign encourages and places responsibility on people to react 'in time' to 'small (but preferably one of the seven correct) signs'. In doing this, the campaign also implies that this is in fact possible, perhaps even simple, to do. But as the different cancer mythologies and Karen's example of dissolving cancer potentiality show, complexity replaces simplicity as soon as 'cancer awareness' enters everyday life.

Discussion: Symptom awareness in paradoxical cancer mythologies

How can we understand these paradoxical cancer mythologies in everyday life? Many informants were themselves baffled by the obviously self-contradictory explanations they gave. The classic ethnographic differentiation between what people say and what they do became explicit in questions of perception of and reactions to hypothetical cancer symptoms and the everyday tangible embodied sensations that could be potential cancer symptoms. Awareness of public health-defined 'alarm symptoms of cancer' did not necessarily help people sort out whether a grumbling sensation somewhere in their lower body parts could or should be considered an early warning of ovarian cancer or just a grumbling, or if a mole had really changed appearance *that* much. This uncertain and ambiguous embodied landscape is where everyday life cancer mythologies grow and flow, both separately and together. Despite presidents launching moon shots for cancer and people uniting under pink ribbons and yellow wristbands to 'Fight Together', 'Support the Breasts', and 'Livestrong', there is an interesting disparity between the mythology of a unified global quest and the everyday uncertainty of individual cancer journeys that often begin with an ambiguous bodily sensation. In this social field we also find public health rhetoric on cancer awareness and preventive lifestyles, epidemiological representations of cancer and risk as well as the promises and failures of biotechnology for diagnosis and treatment. These all take part in continuously configuring cancer mythologies, shaping the inherent paradoxes in how we understand and react to cancer and potential cancer symptoms in everyday life.

There is an inescapable uncertainty of being that is most often not addressed in public health rhetoric on cancer symptom awareness. Instead, 'awareness', 'early detection', and 'cures', along with war metaphors and the 'unified quest', together project an illusion of certainty that cannot be met in all the nuances of everyday life's essential uncertainty (Douglas 2001;

Andersen and Risør 2014). The epidemiological delineation of cancer alarm symptoms and the symptomatic management of cancer disease control are themselves prominent examples of our social demand for certainty and control in an uncertain world (Andersen 2017). As Lock (1998, 7) argues: ‘in seeking to avoid misfortune we create new ambiguities and uncertainties’. Thus, categorized as ‘alarming’ and used as such in awareness campaigns, cancer alarm symptoms claim a level of certainty that matches neither their high statistical uncertainty in terms of actually predicting the likelihood of a specific symptom being caused by cancer (Andersen, Tørring, and Vedsted 2015) nor the ambiguous experience of an embodied sensation. They become ‘instituted certainties’ (Douglas 2001), which do not mesh easily with the embodied uncertainty of everyday life.

Our research finds that when faced with an ambiguous bodily sensation it is difficult for people to categorize it as a potential sign of cancer because it may not seem certain or even ‘alarming’. The illusion of certainty inherent in the idea of cancer alarm symptoms may thus prove counterproductive and even hinder health care seeking in response to early signs of cancer (see also Jenkins, Jessen, and Steffen 2005). This was evident with regard to the legitimization of health care seeking among our middle-class informants, who evidenced a moral concern about being a good citizen of the welfare state and not making unnecessary use of the free health care system, and how this made it a difficult decision to visit the GP based on uncertain and vague bodily sensations that did not correspond to the specificity of defined ‘alarming’ symptoms (Offersen, Vedsted, and Andersen 2017).

Of course, this does not mean that knowledge of potential cancer symptoms is irrelevant or obstructive. It just shows that cancer is imagined and manifested in everyday life in various ways, and it shows that constructions like ‘awareness’ and ‘alarm symptoms’ do something to our way of understanding and acting upon our bodies in everyday life. Contrary to Sontag’s prediction that metaphors will be replaced by a pure objective way of knowing cancer, mythologies are flourishing in the midst of scientific and technological progress, which is itself part of cancer mythologies. In fact, the scientific and political focus on health care seeking and awareness significantly feeds into mythologies, with their illusions of certainty. These affect not only that we are aware but also how we are aware. This distinction is crucial because it affects available possibilities for how to act on awareness (or how not to act), and consequently renders the causal link between awareness and health care seeking fragile and oddly hollow.

Global perspectives further reveal how cancer is a very different phenomenon in different contexts, with different mythologies to make sense of it. Julie Livingston (2012) vividly describes how she was shocked to experience ‘cancer without oncology’ in Botswana. Oncology is one of our constructions – a biomedical one – to deal with cancer, and how oncology is performed markedly changes what cancer is. In India, Alex Broom and

colleagues (2017) show how cancer is shaped by escalating epidemiological and socioeconomic changes, and how it is affectively experienced through intergenerational and existential karmic relations. Cancer mythologies in Botswana and India are thus different than in the global North, as the knowledge, technologies, culture, and social structures through and in which cancer is performed are different. Even in Denmark, Camilla Hoffmann Merrild, Peter Vedsted, and Rikke Sand Andersen (2017) have shown how potential cancer and the embodied experience of symptoms take different forms in different social classes because experiences of suffering are different. We thus argue that cancer mythologies are what we have when grappling with cancer presence in our lives. Cancer *is* the mythologies. If we consider for a moment how cancer would look ‘naked’, stripped of all its metaphorical and mythical wrappings, we are left with not much more than biological processes, biomedical interventions, and tacit human suffering. We can perhaps express where it hurts, measure the growth of a tumor, and treat and relieve pain, but how we are collectively and individually dealing with the complex presence of cancer among us is much more difficult to describe (Lock 1994, xviii–xix; Broom et al. 2017).

Conclusion

This article describes contemporary cancer mythologies in the ‘village of the healthy’, with examples of a range of different and paradoxical cancer mythologies found in Danish middle-class everyday life. However, they should neither be viewed as an exhaustive description of cancer presence, nor as distinct and closed ways of knowing cancer. Rather, we see them as different streams of knowing that merge and divide in people’s diverse dealings with cancer presence, which consequently takes multiple forms. We argue that science and mythology are never separate ways of knowing objectively and subjectively. Instead we concur with Lock (1994, xlii), that these two ways of knowing infuse each other in ‘an ongoing mutually reinforcing feedback loop’.

We have also described how the public health construction of symptom awareness is detached from public health as a lived experience in everyday life. The concept of symptom awareness with its accompanying delineation of alarm symptoms creates an illusion of certainty that is challenged by the essential uncertainty of being and the nuances of everyday life. In the intersection between the illusion of certainty and lived uncertainty, cancer mythologies are configured and reconfigured. It has been argued (Karakasidou 2015; Stacey 1997; Jain 2013) that war metaphors, cancer heroism, and the global quest to ‘find the cure’ and ‘fight cancer’ result in a conspiracy of silence where we do not speak of ‘the elephant in the room’ in terms of carcinogenesis and political and economic structures. We argue that similar mechanisms are at play in everyday life ‘before cancer’ where the illusion of certainty silences ambiguity and uncertainty with a power to turn actual but vague cancer worries into

embodied unspoken uncertainties that only with difficulty are addressed as potential symptoms.

The cancer mythologies laid out in this article suggest there are multiple ways of being aware of cancer and cancer symptoms. This entails that public health efforts to measure and ensure symptom knowledge and awareness as instituted certainties run the risk of overlooking the variation and multiplicity of ways of being aware of cancer, and how they may or may not lead to health care seeking. By use of the concept of mythologies, this analysis has tried to spell out the difference between ‘the level of knowledge and awareness’ that public health research into the early diagnosis of cancer is eager to quantify and how this knowledge relates to the making and management of symptoms and consequently to health care-seeking practices in a not-so-causal way.

This is not to question public health research as such – public health does not deny its inherent uncertainty – but the way we come to reify and believe in its cultural representations as certainties. It is also not to question the worth of the quest to cure cancer but the way this quest comes to portray cancer as a black-and-white caricature. It is definitely not to say that knowledge of cancer ‘alarm symptoms’ is unnecessary, but that we assume causality between symptom awareness and early health care seeking, and we do not question the role that symptom awareness and alarm symptoms play among healthy people in everyday life. We echo recent calls in anthropology and sociology (McMullin 2016; Broom et al. 2017; Cohn 2014) to go beyond studying specific actions or ‘health behaviours’ – such as recognizing a symptom or making an appointment with the doctor – to contextualized explorations in slow motion of cultural configurations of cancer in everyday life. This can enable us to catch sight of subtle clues and unspoken worries as well as embodiments and somatic modes of attention (Csordas 1993) in the synthesizing activities of contemporary cancer mythologies that configure the cultural phenomenon of cancer, the affective experience of the disease, and the accompanying, often paradoxical, possibilities for individual and collective agency. Therefore, this is furthermore in line with the call by Burke and Mathews (2017) and Andersen and Risør (2014) for anthropology to engage in the translation of scientific developments into discussions of relevance for policy work.

About the authors

Sara Marie Hebsgaard Offersen is an anthropologist and postdoctoral researcher at the Research Unit for General Practice and Research Centre for Cancer Diagnosis in Primary Care at Aarhus University, Denmark. Her research interests centre on everyday life perspectives on illness, and health and illness prevention in the context of the welfare state.

She focuses on the moral, sensorial, and uncertain space between being a person and being a patient.

Mette Bech Risør is a professor in medical anthropology at UiT, The Arctic University of Norway. Her research focuses on the configuration of bodily sensations, symptoms, and diagnoses; on diagnostic trajectories of contested disorders, and on health care-seeking practices as morally configured. She links this with an interest in health discourses as mediators of both medical practice and patienthood.

Peter Vedsted is Chief Medical Officer of the Avanaa Health District, Greenland, where he is responsible for health care delivery in the district as a whole. He is also Professor of Primary Care at the Research Unit for General Practice, Aarhus University, and is on leave from his position as Professor of Innovative Patient Pathways at Silkeborg Diagnostic Centre, Aarhus University, Denmark. He is the founder and director of a Danish research group focusing on cancer diagnosis by embracing the pathway from first symptom to treatment of cancer.

Rikke Sand Andersen is Associate Professor at Department of Anthropology and Research Unit for General Practice at Aarhus University, Denmark. Her work centres on care-seeking practices, in particular, how contemporary orientations to cancer disease control in Denmark and the global North provide new moral and interpretative grounds for making distinctions between the normal and the pathological. She is currently the principal investigator on an anthropological work-package at the Centre for Cancer Diagnosis in Practice at the University of Aarhus. E-mail: rsa@ph.au.dk

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