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The Psychogenesis of Cancer in France

Controlling Uncertainty by Searching for Causes¹

Aline Sarradon-Eck

The exploration of suffering can illuminate how people interpret their lived experiences in relation to the social world. In contemporary French society, for example, the majority of people believe that mental and emotional processes, the experience of psychic traumas, and the stresses of modern life can cause cancer or impact the development of the disease. The results of the *Baromètre du cancer* survey conducted in 2010 on a cohort of 3,120 people over 15 years of age showed that most people in France believe that the following factors certainly or probably contribute to the occurrence of cancer: the “stress of modern life” (73.3% of the respondents), having been “perturbed by previous painful experiences” (60.9%), being “embittered by emotional or professional disappointments” (49%), or not managing to express one’s emotions (38.9%) (Peretti-Watel, Amsellem, & Beck, 2012). These figures had changed very little since the previous survey conducted on similar lines in 2005, in which it was observed that only 18.8% of the respondents did not agree that psychological problems are liable to influence the occurrence of cancer (Peretti-Watel, 2006).

This paper will investigate why the psychosomatic model for the etiology of cancer is so widely adopted in French society by patients and by several healthcare-providers (Ménoret, 1999; Bataille, 2003; Sarradon-Eck, 2009), outline the forms this cultural representation takes at present, and explore the effects of these beliefs on the individual’s experience of cancer and uncertainty about recurrence. As complementary and alternative methods of treatment are becoming more available in France, many cancer patients are consulting practitioners such as “biodecoding” therapists, not to have their cancer cured, but to prevent the risk of recurrence² (Cohen et al, 2010). I hypothesize that people blame psychological factors for causing cancer because engaging in therapy enables them to regain a sense of control over the management of disease and of their daily lives and decreases uncertainty about prognosis which may relieve anxiety and suffering for them.

Manderson (2011) points out that cancer is a unique disease in the level of fear it engenders and in the levels of uncertainty that surround determinations of risk and predictions of survival. In many ways talk about cancer is a way of talking about uncertainty and control. The context of suffering, however, is dynamic and multilayered. Just as people in contemporary French society are beset by social and economic uncertainties, they also have

¹ The article is based on surveys funded by a grant from the Fondation de France and Institut National du Cancer (INCa). I would like to thank Dr Jessica Blanc, who translated the original French version of this paper into English.

² A minority of cancer patients consults to have their cancer cured, but the majority consults to reduce the side effects of the cancer treatments, to reinforce the body (“*le terrain*”) to fight the disease, to prevent the risk of recurrence and to regain control over the management of the disease (Cohen et al, 2010).

access to a medical system often said to be the best in the world. Yet this universal healthcare does not promote patient involvement. Cancer patients in France, unlike those in other countries, do not organize for collective action and do not form social groupings based upon biosocial factors (Rabinow, 1992). Jeannine Coreil (2010) has explained the lack of cancer support groups in France in terms of six factors: 1) an authoritarian, paternalistic medical system and a monopolistic national cancer organization (*La Ligue Contre le Cancer*); 2) the belief that in Mediterranean societies that support should be provided by the family; 3) the national ethos of “one country”, that is “we are French”, and diversity is therefore not an appropriate basis to develop special programs for specific subpopulations; 4) dependence on the State and the health insurance system to deal with all medical problems; 5) cancer patients’ guilt and isolation prevent them from organizing collective movements of the kind existing for HIV patients; and 6) mainstream cancer populations are less ready to contest biomedical dogma than more marginal groups such as homosexuals and drug users. Because biomedicine does not admit the psychogenesis of cancer³, I hypothesize that sharing explanatory models of illness (Kleinman, 1980) focused on psychological and emotional causes for cancer, is a form of *peerjectivity*. This neologism was first used by Dupagne (2009) to refer to the concept of peer-to-peer networks on the Internet. Peerjectivity means pooling the subjectivities to lead a form of expertise whose validity is based on sharing and recognition as widely as possible, but also on the balance of medical and scientific figures or media personalities (as artists or sportsmen). Peerjectivity is a sharing of micro-expertise and subjectivities (cultural representations, advice, opinions) in a virtual community of people – here, persons who are sharing cancer experiences because they (or their relatives) are sick. In this sense, peerjectivity is not only related to the Internet users but can be extended to the users of all medias (press, books, television). Peerjectivity is being used here to illustrate how the wide-spread sharing of a psychosomatic model of cancer shapes the ways that individuals then make sense of suffering, take action to reassert personal control over risk and uncertainty and, as Herzlich (1969) showed in a past survey, express the conflicting nature of social relations. This peerjectivity does not take place in biosocial support groups for patients, but rather, emerges from ordinary conversations and encounters with the media (press, movies, television, internet) that convey testimonies of cancer patients who believe in a psychosomatic model for the etiology of cancer and who in turn create the “myth” of the psychogenesis of cancer (Darmon, 1993).

This article is based on data collected by the author in previous studies (Sarradon-Eck, 2009; Pellegrini et al, 2010) that investigated explanatory models of cancer among French cancer patients and examined how they managed the disease and its treatments (biomedical treatments, complementary and alternative treatments) and the relationships between patients and physicians and with the health-care system. I conducted 45 in-depth interviews with cancer patients (36 women, 9 men) with different disease status or recurrence in the south of France. Moreover, I conducted hospital ethnography at two French cancer centres (6 months each between 2006 and 2009) in south of France (Marseille, Nice).

³ The documents published by organizations such as the World Health Organization, the French National Cancer Institute and the French Anti-Cancer League in which the known (and scientifically established) causes and risk factors are presented make no mention of psychological factors. Nor does the psychogenesis of cancer feature among the processes possibly responsible for cancer mentioned in the biomedical literature. This topic has been mainly addressed in the fields of health psychology and psychiatry, where the authors of many studies have attempted to prove or disprove the validity of the psychosomatic hypothesis about the etiology of cancer. However, none of the reviews of the literature in which it has been attempted to prove scientifically that there exist causal links between presumably distressing events and the development of cancer have led to the conclusion that psychic processes affect either the occurrence or the evolution of the disease (Garssen, 2004).

In this paper, I follow the theoretical proposition of Dan Sperber (1982) who invites anthropologists to explain cultural representations by identifying the factors that define selection and sharing of some cultural representations in a social group, and by describing their transformations. In the first part, I describe contemporary reinterpretations of ancient beliefs and the meanings they carried. This analysis allows distinction of three forms that psychosomatic cultural representations of cancer take at present. The last part explores the cultural and social factors that could explain why the psychosomatic model of cancer persists in French society and how it shapes health identities and subjectivities (Whyte, 2009).

Lay psychosomatic interpretations

The narratives I have collected about how people who have undergone trial by cancer experienced the disease provide a good picture of how their imaginations respond to their bodies being subjected to the various aspects of this trial. By examining the causal factors mobilized and put into words by these patients, I propose to analyse not only the personal experience recounted, but also the syntax underlying the interactions between the patients' psyches and their afflicted bodies, reflecting the general culturally determined picture of how the experience of cancer becomes embodied.

Various ways of imagining pathogenic interactions between mind and body can be detected in these patients' narratives. The humoral theories which formed a bond of common knowledge between patients and doctors for more than twenty centuries (Rosenberg, 1979)⁴ seem to have left some persistent semantic traces such as the use of the verb "to secrete" ("secreting cancer"); whereas other semantic features shed light on these views of physiopathological disorder.

Thinking about disease in metaphorical terms

Some people picture disease as if it were a language serving as a means of communication between body and mind, the social environment and the body. Physical lesions and organic deficits act like biological "words"⁵ that make individuals aware of their ill-being, as expressed by a 48-year old male patient undergoing treatment for cancer of the tongue, which he attributed to bottling up all the vexations which were "stuck in (his) throat".

Other respondents stated that traumatic personal events or their unbearable mode of life had "undermined" or "gnawed away" at them, depriving them of ("pumping away") their energy. Here the semantic register focuses on the loss of "energy" and "stamina". Either because the perturbed psychic processes take up too much energy, or because the speakers are exhausted by the modern way of life, they believe that their bodies are weakened and form a suitable breeding ground for cancer. Both weakness and strength are sometimes regarded as inherited characteristics ("that's just how one is made"), as suggested by the discourse of a female patient, who hinted at the strength which had enabled her to survive cancer and other diseases from which other members of her family had died. However, weakness is usually thought to be acquired as the result of traumatic personal events or depression, which have undermined the body. The concept of strength ("internal resources", "the strength we possess") is also used by some individuals in connection with the healing or remission of

⁴ The Hippocratic humoral theories, revisited by the physicians during the period of Enlightenment, attributed the origin of cancer to sadness, anger, worry and other emotions and mental disturbances (the term "stress" had not yet been coined) which trigger the production of melancholic humour "loaded with acid and a vicious carcinogenous yeast" (Darmon, 1993).

⁵ There is a play on words here because "words" in French ("les mots") is homonymous with "les maux", which means diseases, pains and evils: the teachings of Lacan have often been quoted in connection with this commonly used psychosomatic pun.

disease and the need to fight it and “*not give in to it*”, as if they regarded the body as a kind of battlefield.

Metaphors can also be used as a means of depicting the transmutation of social pressures into physical symptoms (Benoist & Cathebras, 1993). Thinking in terms of analogies sets up a system of correspondences between body and mind, which has been popularised by common psychoanalytical jargon. This system of correspondences is based on analogical and metaphorical associations between colourful French expressions and patients’ diseases and symptoms, forming symbolic and semantic bridges between a patient’s disease and the various events and experiences which occurred during his or her lifetime.

Cancer as a metonym for social experience

Many of the respondents interviewed perceived cancer as resulting from a chain of traumatic personal events (a separation, the death of a family member, legal proceedings, etc). These people spoke about “*being submerged*” by a “*series of painful events*”, as if their bodies had incorporated these unhappy experiences and transformed them into cancer. Anthropologists have frequently described disease as an event in a chain of misfortunes (Augé, 1984). People link together all the painful events they have undergone as if they formed a single causal chain and could all be interpreted in terms of the same etiological scheme, including those concocted by believers in witchcraft, which have often been described (Favret-Saada, 1977; Zempléni, 1985). It has emerged from the surveys I have conducted, in line with Saillant (1988), that cancer is often taken to constitute the end of the painful chain, either because it is the end of the road (“*the endpoint*”) or because it causes a break in the cycle.

However, cancer is usually perceived as resulting from the internalization of deleterious social pressures. In the interviews I recorded, the respondents mostly spoke about the “*pressures*” from which they had suffered at work (heavy workloads, long hours, moral harassment, conflictual relationships) as well as in their personal relationships, and about family problems. The body was consistently perceived as a vessel which could only hold a certain number of pressures: “*they go on accumulating, and one day everything explodes and you’ve got cancer*”. Whereas the use of metaphor makes it possible to think about physiopathological issues, attributing the occurrence of cancer or its onset to stress mainly constitutes a means of denouncing the conflicts and processes of domination encountered in the world of work. In this sense, cancer can be seen as an idiom of social suffering (Bourdieu et al. 1999). The verbal and symbolic violence to which people have been subjected in their social interactions is thought to be incorporated and inscribed in their bodies in the form of cancer. The disease thus becomes a metonym for an individual’s personal physical and social experience.

In common usage, the word “stress” is generally taken to mean an emotional shock or a state of anxiety induced by social pressures and the economic or social problems that overwhelm people when they can no longer cope. The respondents in my surveys and those questioned by Manderson, Markovic & Quinn (2005) who explained that their cancers were due to stress tended to perceive their bodies like passive objects beyond their control, just as their whole lives had escaped their control because of the conditions under which they were living. Cancer, the uncontrollable development of cells in the body a metaphor for social disorder (Sontag, 1978), had therefore come to represent their loss of control over their own lives as well as the misery caused by social pressures and the degradation of family and occupational relationships (Manderson, Markovic & Quinn, 2005).

Mariella Pandolfi has spoken about the body as the locus where social communications occur and social norms are interiorised, as well as being that where social malaise is transformed in the organs into suffering and disease (Pandolfi, 1993). This

“memorial body”, as Pandolfi has called it, is a place where individuals resist society and its constraints (Pandolfi, 1993). However, it is not a passive body, because by telling the story of their disease, individuals are able to make a new start after all their failures and defeats: their etiological explanations are often a story of revolt about how their relationships with society and the world have been transformed. In their discourse about their disease, many respondents mentioned the changes they had made in their lives as the result of the disease. In many cases, cancer, via the workings of the psychic processes it triggered, “*showed*” what was wrong with their lives and subsequently brought about some salutary changes: feeling more detached from social constraints; adopting a way of life which left more scope for leisure activities, relaxation and spiritual enrichment; taking greater care of themselves (“*thinking about myself*”, “*looking after myself*”, “*attending to my own needs*”); changing their working patterns, or even making a change of occupation. These individuals made an effort to break away from the previous social constraints and became responsible for managing their own lives.

Beyond this phenomenological approach, psychological explanations for cancer can be seen as a way of making new identity claims: being a victim of the modern world damages people’s roles and identities because of the “covert aggressions of working life” (Bourdieu, 1999, p. 629). Individuals in contemporary France often associate their experiences of cancer with the pressures of modern life and the structure of post-industrial labor. To transform one’s identity to “a person with a disease” is a symbolic strategy employed at the individual level because French cancer activism does not advocate for recognition of social pressures as a factor in the disease process nor do patients have access to collective forms of social support as mentioned above. Lay explanations that blame illness on the modern lifestyle, moreover, are deep-rooted in French society and these have been a language used to express the conflicting relationships between individual and society, as Herzlich (1969) showed. The idea that contemporary society, and its institutions, is a source of social and psychological suffering is a generalized opinion in France (Ehrenberg, 2010). As Alain Ehrenberg (2010) wrote, discourses about “civilization and its malaise” can be summarized by the double assertion: the social link is weakened and, in return, the individual is overladen by new responsibilities and hardship (p.13), especially in today’s world of work. This paper explores the psychological results of experiencing cancer in a situation where patients have access to universal health care but not to collective support and activism. Their attempts to reassert control over the disease and the body often leads them to locate the link between cancer and labor in the mind rather than outside the body in the social and physical environment. Explanations for the cause of cancer then are often traced to psychological stresses or traumas that must be dealt with in order to prevent future recurrences of the disease.

Contemporary cultural etiological models

In these respondents’ narratives, the psychological factors responsible for cancer were rarely taken to be the sole etiological explanation. Other factors incriminated included collective risk factors (pollution, electromagnetic waves, medication, poor diet, etc.), individual behavioural risk factors (alcohol, smoking, overeating, etc.), and some people put forward more fatalistic explanations, blaming the occurrence of the disease on the hand of destiny (heredity, bad luck). Regardless of the other factors put forward, psychogenetic explanations for cancer dominated most narratives and were found to correspond to three models which have been widely adopted by present-day French society.

Cancer attributed to individuals’ inability to express their emotions

In this model, cancer patients have a distinct personality with a “high strung” character, unexpressed emotions, emotional instability, and psychological vulnerability, all of

which lead to the development of the disease. People spoke about “*giving themselves cancer*”. They had “*produced*” their tumours, as the deleterious result of their psychological make-up. This cultural model, which has been described by Susan Sontag (1978), predominated in 1970-80, in North-American society as well⁶. This interpretation was still present in the narratives I recorded, but it tended to be superseded by the other two cultural codes described next.

Cancer regarded as the scar produced by a traumatic event

According to this interpretation, patients have suffered from a psychic trauma as the result of an untoward biographical event or unbearable social conditions. Their cancer is therefore regarded as a physical scar inflicted by this trauma, the bodily counterpart of a painful social experience. Patients, therefore, frequently attempt to pinpoint the biographical event that triggered their cancer, which is then raised to trauma status *a posteriori* because, as one of the respondents put it, “*cancer is attributed only to people who have problems [family, occupational or sentimental problems]*”. Apart from the need to find an explanation for the onset of the disease, this process of inquiry is driven by a more pragmatic urge to repair the damage: these people were often trying to repair their psychic lesions in order to prevent the risk of recurrence.

The “psyche” regarded as a cancer risk factor

Many of the people interviewed seemed to be inordinately bent on identifying the risks to which they had been exposed, not only in order to explain the reasons for their cancer, but also to prevent its recurrence. This procedure resembles a kind of lay epidemiological investigation on the various possible real and imaginary risk factors involved, which is conducted by patients on similar lines to medical and public health research. However, lay epidemiological investigations tend to favour the risk factors that seem to be the most “acceptable” in the light of current social norms. They tend to neglect or minimise the behavioral factors for which present-day society might have held them responsible (poor dietary habits, smoking, lack of exercise, etc.) and to focus rather on risk factors such as heredity and painful biographical events, which free them of personal responsibility for their disease and lay no blame on their personal habits.

This “lay epidemiology” (Davidson, Davey Smith & Frankel, 1991) placing the emphasis on psychological cancer risk factors, is worth examining more closely because it leads people to develop certain kinds of risk prevention strategies: they often attempt to prevent the recurrence of cancer by seeking treatment for their psychological conflicts. For example, they may undergo conventional forms of therapy with a psychiatrist or a psychologist, group psychotherapy, or seek out alternative and complementary forms of care (physical methods of therapy, energy boosting treatment, relaxation, etc), or treatment (such as “biodecoding”, in particular: see later in this chapter). They reconstruct or reorganise their lives by changing their lifestyles in order to reduce social pressures, seek spiritual fulfillment, and invest more strongly in leisure activities. These preventive measures help to reduce the uncertainty about whether they have been cured for good. They are driven by pragmatic motives, which can be summarized in the phrase “to get rid of the disease, one must get rid of its causes”.

How did the shift occur from cancer being attributed to repressed emotions to it being attributed to traumas or psychological risk factors? The explanation seems to be that this change was induced by various mutually reinforced social and cultural processes.

⁶ For lack of previous studies on French society, it is impossible to say whether there exist any differences between the North American and French representations of cancer, and whether the cultural models adopted during the last thirty years or so have changed in any way.

From the repression of emotions to psychological trauma

In *Illness as Metaphor* (1978), Susan Sontag denounced interpretations of cancer that blame the victim and devalorize or even reject sick people and all those who do not pursue the moral goals of self-accomplishment. According to these interpretations, cancer is not so much a sign of transgressive behavior (as in the case of AIDS) as it is an indicator of the individual's many weaknesses and failures: the inability to express emotions and to symbolise experience; poor imaginative powers; and the lack of ability to form mental representations, articulate feelings, and cope with stress.

During the 1970s, psychosomatic medicine became very popular in France, where the writings of Pierre Marty and his followers were well received by both general physicians and specialists. One might say that one of the social rules pertaining at that time was the need to keep a stiff upper lip and control one's emotions. The cultural revolution which broke out in the 1970s was all about denouncing these social norms, which were harmful to individuals, and challenging law and order, constraints and hierarchies. In proclaiming the right to spontaneity, authenticity, non-submission and informal forms of conviviality, this countercultural movement was promoting individuals' right to express both their positive emotions and their quandaries. Because cancer was thought by the proponents of psychosomatic medicine, in line with Georg Groddeck (1977), to result from repressed emotions, this interpretation was widely held during the 1970s, as shown by the success of Fritz Zorn's novel *Mars*, first published in 1976 (see Zorn, 1982).

As the sociologist Robert Castel (1981) has explained, the success of psychosomatic medicine reflected the "new psychological culture" which emerged in the 1960s. This phenomenon was characterized by "an increase in the consumption of psychology" by "normal" subjects and by "the promotion of working on oneself in a continuous fashion so as to produce an efficient and adaptable subject" (Rabinow, 1992, p.242). This "psychologization of society" was accompanied by overemphasis on the psyche and psychological factors in all the spheres of social life. People were being encouraged to express themselves more freely, in keeping with the new social norm of narrativity.

Along with the "psychologization of society", trauma began to be recognized in the Western world as the result of several combined factors. This was the beginning of the cultural process that Fassin and Rechtman (2009, pp. 6-7) have called "the generalized traumatisation of existence". These authors claim that trauma is no longer a specialized psychiatric term, but has acquired a more general meaning, that of "the new language of events": the painful events and the accidents of life now being vaguely classified as traumas, which leave psychological traces and which implicitly carry the need to obey the latest imperative: to put these events into words.

Among the various unconventional therapeutic approaches focusing on the psychological causes of disease, there is one which subscribes in particular to the wave of interest in trauma. Its practitioners form an oddly assorted category of therapists known as "biodecoders". They contend that disease results from a psychological shock, mainly caused by conflictual relations inside the family, which triggers a biological conflict in a brain region commanding a specific organ or physiological function, damaging the corresponding tissues. This damage can be mended by "decoding" the psychological shock in order to identify and thus resolve the conflict. This decoding process is referred to as biological because the therapist starts with the damaged tissue, working back to the origin of the conflict, using a series of correspondences based on mental associations⁷. These new kinds of treatment (German New Medicine, Biodecoding, Total Biology, Psycho-bio-genealogy, Family

⁷ Breast cancer in a right-handed female patient is attributed, for example, to "a nest conflict" with a child, a childish husband, etc.

constellations) emerged in Europe during the 1990s. They have spread since then to Canada and more recently to the United States via networks of practitioners and thanks to the publicity they have been given by the media (Sarradon-Eck & Caudullo, 2011).

In France, these new unconventional healing methods are becoming increasingly available and feature on many patients' therapeutic itineraries. It is difficult to determine exactly how many "biodecoders" exist because the occupational directories do not specify the fact that many manual therapists (such as osteopaths and Ayurvedic specialists), speech-oriented therapists (such as sophrologists and psychotherapists), physicians (homeopaths) and physiotherapists practice biodecoding. This approach is being used, however, for diagnostic purposes (to identify the "biological conflict") by many practitioners, who then treat their patients using other methods⁸. The large majority of cancer patients who consult biodecoders do not consult these therapists to have their cancer cured, but to prevent the risk of recurrence; biodecoding professes to offer them something that conventional oncology can not: the explanation of cancer and the suppression of *its* cause - one piece of the missing part of biomedicine (Cohen & Rossi, 2011).

In writing about rural Brittany, Badone (2008) argues that when cancer patients seek out alternative and complementary therapies, they are seeking alternative narrative frameworks within which to situate their experiences of illness. She reports that biomedicine in France often structures etiological explanations around metaphors of bodily disintegration and disruption that offer little hope for recovery, scant emotional support for patients, and no meaningful etiologies for cancer. Alternative therapists, in contrast, provide a different way of explaining and conceptualizing cancer that offers support and hope to patients and makes their experiences of suffering comprehensible (Badone, 2008; Begot, 2010; Cohen et al, 2010; Schmitz, 2011).

... and the psyche itself as a risk factor

The field of epidemiology, with its predictive models and the practice of searching for risk factors, has contributed to promoting the idea that disease is a rationally explainable process. Disease is not just the fruit of chance, but results from the exposure of an individual to one or several risks (Berlivet, 2004). Talking about risk factors has gradually worked its way into social discourse about disease.

In addition, since 1970-1980, public health organizations in France have institutionalised the idea that individuals are responsible for promoting and maintaining their own health. Disease, especially cancer, is often taken to result from improper behavior (a poor diet and/or lifestyle) that is not in keeping with medical standards. Authors such as Zola (1981) and Katz (1997) have described public health recommendations as the latest form of "secular morality" based on similar principles of sin, punishment and redemption to those propounded by traditional Judeo-Christian morality. These authors have suggested that public health is now acting as a substitute for religion and the Law (Massé, 2003). The European Cancer Code, drawn up in November 1994 in Bonn, by a group of cancer experts under the aegis of the European Commission contains 10 measures and recommendations for preventing some forms of cancer. The public was informed about this Code in the European anti-cancer campaign conducted in 1995 and 1996. Due to the symbolic allusions associated with the number 10 (10 measures and recommendations) and the style in which these

⁸ Homeopathy, for example. Some homeopaths practising biological decoding methods prescribe a specific remedy for each type of shock: Muriaticum Acidum after the loss of the mother, Hura Brasiliensis after the loss of a child, Urtica Urens after the loss of the father, etc.

measures and recommendations are written, this Code implicitly mimicks the 10 Commandments⁹.

The fact that people have assimilated the notion of sins and faults because of the teachings of the Church during the Middle Ages and the Renaissance (Delumeau, 1983) has facilitated the induction of feelings of guilt as a means of social control in present-day Western societies. The current secular principle of self-management which has replaced the religious practice of self-reproach has resulted in the “micro-ethic” use of shame for social control purposes, which has been defined as “interiorised shame for not being healthy, energetic and productive, especially shame for not having done all one can to preserve one’s health” (Lecourt, 1996, p. 115). Thus the assertion that psychic trauma or the stresses of everyday life cause cancer can be interpreted as a way of protesting against the attempts of the public heath establishment to blame individuals and their lifestyles for the occurrence and recurrence of the disease. Yet as Badone (2008) writes, the resistance of cancer patients “must be seen in the context of an ongoing dependence on and submission to biomedical authority” (p. 210).

Conclusion

Patients’ interpretations of their disease can help them reconstruct their identities and reorganize their disrupted personal worlds by creating reference points and building symbolic bridges between events, thus making sense of the event of illness (Kleinman, 1980; Good, 1994). Patients’ understandings of their illnesses depends on the types of illnesses in question and on the patients’ cultural context, that is, on the whole universe of representations, norms, values and social relationships that make up their everyday lives. Biographical interviews may of course carry the risk of overestimating the narrative aspects of the causal attribution process. However, the idea that narrativity empowers patients by making them the subjects of their narration is particularly relevant in the field of cancer management, where the latest methods of supportive care (Gagnon & Marche, 2007) consist in asking patients to tell the stories of their own personal experiences of illness. Among the possible causes of cancer, psychological factors lend themselves best to narrative because they make it possible to form links between an individual’s past, present and future. Patients tell their stories in a specially dedicated place with the approval of the care-givers and the institution. This approach focuses on persons rather than on their disease, by allowing the time required to let patients speak and by setting up conditions favouring closer exchanges between them and their care-givers.

Framing the etiological story of cancer around personal psychological traumas provides a narrative of illness that renders the unintelligible and amorphous sense of social distress experienced in postmodern France intelligible and controllable. Telling the etiological story about one’s cancer and its possible psychological causes also makes patients feel that they are contributing to the management of their own treatment. The expertise deployed by patients who have determined the causes of their illnesses through a peerjective approach, when doctors have not expressed an opinion, confirms the rights of patients to produce a specific discourse about their bodies and their diseases (Herzlich & Pierret, 1991), thereby

⁹ The first four measures are presented as follows, for example:

1 – Don’t smoke. If you are a smoker, stop smoking as soon as possible and refrain from smoking in the presence of other people. If you are a non-smoker, do not give in to the temptation of cigarettes.

2 – If you drink beer, wine or alcohol regularly, reduce your rate of consumption.

3 – Increase your daily intake of fresh fruit and vegetables. Eat plenty of cereals with a high fiber content.

4 – Avoid being overweight, spend more time on physical activities, and reduce your intake of fatty foods.

indirectly challenging the hegemony of biomedicine. In addition, focusing on the psychological factors possibly involved enables individuals to face up to the presumed causes of cancer, thus showing that they have the power to act. Blaming psychological causes, therefore, constitutes a means of regaining responsibility for the management of disease by taking control of over one's life, because cancer is a metaphor for loss of control. In this way, adopting cultural representations in which cancer is blamed on psychological factors meets the current societal requirement that people should take control of their own lives (Massé, 2003), but at the same time enables them to escape from attributions of blame embedded in public health discourses that implicate bad lifestyle choices as cause of cancer. At an individual level, the reassertion of control enables patients to participate more actively in their treatment by decreasing the uncertainty about their prognosis and in attempts to prevent recurrence by making lifestyle changes. Yet ultimately, the focus on the psychogenic causes of cancer is a symbolic acknowledgement by patients of the damages caused to them by life in the contemporary social world.

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