


Social Interactions and Cultural Repertoires as Resources for Coping With Breast Cancer

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Abstract

The article aims to better understand the role of cultural and social resources for coping with cancer as a disruptive experience. Fourteen women who had recently received a diagnosis of breast cancer and started a treatment in an Italian hospital have been interviewed individually to elicit narratives regarding the interactions with the other patients. The analysis focused on the role played by social interactions and cultural repertoires as devices for making sense of and facing the illness. Results show that patients use both interactive as well as noninteractive strategies. In both cases, however, the other patients are an important reference in the interviewees' accounts. Even for noninteracting patients, the others and specific groups are taken into account and displayed in their narratives either directly or indirectly (i.e., typified or imagined), contributing to interpret and address what they experienced as cancer patients. Moreover, results provide empirical evidence of the various cultural repertoires (including examples retraceable to popular culture) on which people rely to address and cope with the illness. These results widen the individualistic framework commonly used in the understanding of coping strategies by including psychosocial phenomena that are created outside the individual in the complex interactions with the social and cultural world.

Keywords

cancer, coping, cultural resources, community of patients, informal interactions

Introduction

Cancer is considered to be a traumatic event that abruptly alters the balance and social life of a person (Aydin, Gulluoglu, & Kuscu, 2012; Bury, 1982). It is an event that reconfigures many aspects of life (relations with the body, family, society, and profession) and activates processes of revision of the meanings of life, suffering, illness, and death.

Many studies have analyzed the coping strategies that patients adopt when they face this disruptive experience (recently, Sarenmalm, Browall, Persson, Fall-Dickson, & Gaston-Johansson, 2013; Silva, Crespo, & Canavaro, 2012) mainly with a focus on individualistic coping strategies such as positivity, fighting spirit, or other stable personality traits, such as “sense of coherence” (Antonovsky, 1979).

The symbolic resources that members of culture use to interpret life events are also at stake, as far as breast cancer is concerned. The literature has shown also how these cultural repertoires are in evolution, including debates on the meanings of stigma, shame, and confidentiality, as well as repertoires that enhance both determination and willingness to survive (Fosket, Karran, & LaFia, 2000; Klawiter, 1999; Patterson, 1987; Sontag, 1978).

Breast cancer often involves mutilating treatments and is frequently associated with some issues about feminine identity, especially body image and sexuality. The objectification theory (Fredrickson & Roberts, 1997) has been recently proposed as a framework for understanding the array of psychological consequences that women experience as they are raised in a culture that so persistently objectifies the female body. Women, as they have been socialized to view themselves as objects, are preoccupied with their own physical appearance; a psychological effect that Fredrickson and Roberts (1997) have termed “selfobjectification.” Langellier and Sullivan (1998) have highlighted how in a sample of breast cancer's narratives, the patients seem to fight the cultural objectification; the latter is usually present in both the social and medical discourse as the breast is seen as an essential component of the sexuality and the women's body image.

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These women built a more complex and holistic picture of their experience as breast cancer patients, which overcomes the consideration of the given “body’s part.”

Some studies have explored the cultural peculiarities of how the illness is faced in non-Western ethnic minorities (such as Black women, Muslims, and so on). Goldblatt, Cohen, Azaiza, and Manassa (2013) described how Arab women cope with breast cancer and how their coping strategies are affected by cultural norms, beliefs, and perceptions. Findings stress a duality in participants’ cancer coping experience according to the traditional cultural norms of concealment, while encountering more open Western attitudes through interactions with health care providers and Jewish women receiving treatment alongside them.

Also Bache, Bhui, Dein, and Korszun (2012) described African or Black Caribbean patients’ lay explanations of how illness and their coping styles are influenced by ethnicity-related cultural beliefs and expectations. The need to be resilient and think positively was widely acknowledged as coping strategies. Some coped by avoiding contemplation of their condition or diagnosis. Religious beliefs and practices provided coping mechanisms for avoiding their distressing condition. Family, friends, and charitable groups also provided emotional and practical support.

Thuné-Boyle, Stygall, Keshtgar, Davidson, and Newman (2013) investigated the role of religiosity, showing that spiritual resources provide benefits in challenging the illness in the first year after a breast cancer diagnosis, having a moderating effect on anxiety and depression. Patients may benefit from having their spiritual needs addressed as experiencing some form of religious/spiritual struggle may serve as a barrier to illness adjustment. Moreover, the study of Aydin et al. (2012), approached from a psychoanalytic perspective and using a qualitative and narrative method with a group of six Turkish breast cancer patients, indicate how participants consider the diagnosis of breast cancer as one of the main events of their lives and how religious beliefs and practices provided coping mechanisms for them.

Other works have investigated the role of social resources in coping with cancer. Within the framework of conversation analysis, Beach (2009) investigated conversations among members of a family whose mother had been diagnosed with a malignant tumor, focusing on how the meaning of cancer’s experience is largely revealed and created in the interaction with others (i.e., relatives and friends).

There is also evidence that direct interactive practices among patients through formal groups active on websites and in chat rooms are resources for patients in facing their cancer treatment (Kroenke, Kubzansky, Schernhammer, Holmes, & Kawachi, 2006; Rini et al., 2006; Yoo, Levine, Aviv, Ewing, & Au, 2004). According to Rini et al. (2006), this interaction performs three main functions: (a) enhancing self-efficacy in coping with the treatment, (b) normalizing patient’s experiences (comparing with others), and (c) giving information about survivorship and psychological issues.

Also Kim et al. (2012) described the process and effect of social support exchanges within computer-mediated social support groups for breast cancer patients, showing that receiving and giving exchanges play positive, but different, roles in predicting psychosocial health outcomes.

To sum up, the outlined literature highlights the following key points:

- Cultural repertoires are used to interpret and cope with a life event as a diagnosis of breast cancer
- There are differences and peculiarities in how patients cope with cancer in different sociocultural context
- Groups and social interactions play an important mediating role in facing with cancer

Nevertheless none of these previous studies has been focused on the role played by informal interactions among cancer patients nor on the role of cultural repertoires in understanding cancer diagnosis and in coping with illness, which will be the contribution we aim to make in this article.

Participants, Methodology, and Analysis

In this study, we chose to use the narrative interview as a particularly suitable method with which empirically investigate social and cultural resources for coping with cancer (Bury, 2001; Mathieson & Stam, 1995; Mattingly & Garro, 2000).

The participants were 14 women receiving adjuvant (postsurgical) treatment or neo-adjuvant (presurgical) chemotherapy for breast cancer in a medium-sized public hospital in one of the major city in central Italy. The hospital had more than 150 overnight beds and more than 15 day-hospital sets. It employed about 800 workers. Cancer care was one of the many services provided by the hospital. Four oncologists and six nurses were employed in the oncology ward.¹ About 5,000 outpatient visits and 2,000 chemotherapy administrations were delivered per year. Breast cancer was the main pathology treated in the ward.

All study procedures were approved by the Hospital Ethical Board, and the patients signed informed consent forms regarding their participation in the research. Participants were all native Italian and living in the same city of the hospital. They were aged 59.8 years on average (with an age range from 36 to 72 years). The majority of them were housewives. Only one woman had a university degree (she was a medical doctor) and two other women had an upper-secondary school diplomas. All of them were married or widowed and had received the diagnosis recently (within 6 months before the interview).

The narrative interviews were elicited by an open question about the presence and importance of social interaction with others: “Since the time of your diagnosis, what people, apart from the medical staff, have had a significant/particular

role in helping you face this new situation?” Starting with the answer to this question, the narratives developed in various directions, bringing up subjects such as the discovery of being ill, the choice of the hospital, the changes in the everyday life of the patients and their families, concerns about the illness, the therapy, and future prospects. The interviewer’s main role was to produce continuers and mirroring of patients’ sentences (Rogers, 1980) to invite them to elaborate more deeply their narrative. The interviewer was also asking about patients’ attendance of breast cancer women’s blogs or online communities.

The interviews were realized in a private room of the hospital by one of the authors (C.Z.) who presented herself as a researcher in social psychology. They lasted 10 to 20 min. Italian was the language used, as it was the mother tongue of both the interviewer and interviewees. The interviews were audio recorded and completely transcribed. We will assign pseudonyms to the patients to protect their privacy.

In the analysis, we considered narratives as modes through which people project, reconstruct, and make comprehensible their actions and their own selves while they narrate them (Edwards, 1998).

In particular, the analysis developed along the following steps: (a) recurring and independent readings of transcripts to identify the presence and features of interactions with other patients, (b) development of interpretative categories for the cultural repertoires in patients’ accounts, and (c) highlighting of the categories’ empirical evidence in the transcripts. We selected representative extracts of the variety of the topics raised. This was a “prototypical” sampling (Toulmin, 1996) of the extracts so as to produce “rich” and “dense” descriptions of the phenomenon under investigation while preserving the respondents’ meanings and viewpoints.

Results

Interactive and Noninteractive Strategies

Analyses of the narratives showed that patients have very different views on the interaction with the other patients as a strategy for coping with cancer.

Some sought it and engaged in it intensely, while for others, avoiding such direct contacts was a strategy to protect themselves against the disease and the fears associated with it and the treatment. We now describe in detail how these positions were expressed in the patients’ narratives. For some patients (young, 56 years on average, and with a higher education level), interacting with other patients while waiting for the visit or while undergoing chemotherapy was an active and deliberate strategy (see Extract 1).

Extract 1

Milva: Yes, I ask and ask a lot, I ask . . . I’m a real chatterbox. I realize that among patients

Researcher: Eh

Milva: It’s a sort of defense, right? Because it’s almost as if we have the same problem, and it gives you you get strength, right? So this is what I think it is.

The patient Milva underlined both the “amount” of her social and discursive interaction with others and the usefulness of comparing and sharing experiences of the illness, thereby receiving “strength.”

This sharing enabled the patients to construct a framework in which they could conceive each individual cancer story as “regular” and “ordinary,” and to take positive account of the stories of survivors (see Extract 2).

Extract 2

Marzia: First of all it makes you feel less unique, and also less unfortunate. I mean, there are so many people who come out of it well. So it’s a positive attitude, in my opinion.

Moreover, these patients considered the exchanges as being positive also in helping to “reduce” and downgrade certain problems connected with the illness.

These patients described regular interactions with other patients. These interactions, marked out by the weekly schedule of the chemotherapy sessions, took place during the long periods that the patients spent waiting in the corridors and in the ward’s therapy rooms (see Extract 3).

Extract 3

Milva: Let’s say, at first I talked much more here, and now I talk in there as well because we meet on the same day, right? So meeting again is like, you leave at last and then you meet again and (here and there) how’s it gone this time? and so, you know

Researcher: Yes = yes it’s a sort of rhythm

Milva: It almost turns into a friendship, right?

Researcher: Yeah

Milva: Because it’s a long time.

These emergent and informal interactions with those called by some patients their “hospital friends,” besides fulfilling the patients’ needs for social cohesiveness and mutual recognition, were the social “loci” in which stories and pieces of information were described using the metaphor of the hairdressing salon (see Extract 4).

Extract 4

Florinda: It’s a bit like being at the hairdresser’s, we’re stuck there and . . . because we’re all sitting, most of us women,

though there's sometimes a man . . . sitting still with helmets on our heads

Researcher: That's right

Florinda: It's a bit like being at the hairdresser's, we're stuck there and it comes out what's happened to you, what hasn't happened to you, and you get to know things, so what's happened is confirmed, and it's more or less like that.

These local conversational routines seem to act as the social fabric of resources supporting patients, in particular chemotherapy effects—especially those that the medical staff had not talked about.

Many of the topics of conversation were those typical of small talk or gossip (Coupland, 2000, 2003; Dunbar, 2004): how to cope with the side effects of chemotherapy and ways to face and manage complications, in particular hair loss, practical matters, stratagems, sharing information, problems and solutions, and strategies to deal with day-to-day life as a cancer patient (see Extract 5).

Extract 5

Florinda: Of course the first thing is your hair, your wig, what we do, the addresses of hairdressers, these are the first things. The second things are how ill you are, how ill you feel because then the illness takes over, the physical pain, at first you bear it better. But then the stomatitis starts, because of the platinum that they shove into us, they stuff us with so much platinum that we'll become precious (she laughs)

Researcher: You'll set the metal detectors off (she laughs)

Florinda: In the end we'll be quoted on the stock exchange, so you start with the stomatitis, you start with the nausea, the stomatitis means that you can't swallow, but as you talk while waiting for the therapy you realize that it's like this for everybody.

These patients made their path through cancer not as an individual and solitary challenge but as a process of social participation. Their regular interactional practices enabled the patients to inhabit and build a community in which they shared "war stories" (Orr, 1990), pieces of information, and strategies for coping with the illness and the chemotherapy's side effects.

By contrast, for other women, being a cancer patient seemed to be a purely individual enterprise, which apparently did not involve any recourse to systems of social support. They deliberately avoided interactions with the other patients, as the patient Aurelia stated, "In my opinion, it's better if I don't talk to them." These patients showed the belief that being "free" and "clear" from preconceptions, information, and expectations would help them cope better with the therapy and the disease (see Extract 6).

Extract 6

Camilla: No, I haven't talked to anybody

Researcher: Because you prefer not to talk or because it hasn't happened yet?

Camilla: Okay, because it hasn't happened yet, and then I'm not someone who talks a lot, and in my opinion it's better not to hear these things because I'm very sensitive, so . . .

Researcher: I mean, you'd (inaudible word) you're afraid that it could be more

Camilla: Maybe (inaudible words)

Researcher: I mean, instead of helping you

Camilla: Right, I mean, saying bad things would make my situation worse

Researcher: You'd be more frightened, let's say

Camilla: Yes.

Avoiding direct contact with other patients made it possible not to hear and know "bad things" and therefore to protect oneself against further worries and fears. This deliberate avoidance of contacts with the other patients was thus a strategy to cope with the disease.

Other patients assumed an ambivalent position toward direct interaction, which they considered an activity with both positive and negative aspects. A problem frequently mentioned was choosing the interlocutor (see Extract 7).

Extract 7

Researcher: So your advice is to be careful who you talk to, if I can put it like that?

Maria Grazia: People who keep on whining, perhaps it's something silly, but it's not silly because everyone lives with these things. But they make it tragic, so then you say oh God! When it's my turn, to use other people, what I've been trying to do is to take positive things, to use people that are positive for me

Researcher: So let's say this is

Maria Grazia: You have to be a bit selfish, because if I get too close to a person who's harmful for me, I'll ruin myself, and that's not a good idea (she laughs).

This ambivalent "interactive caution" was described by the patients as a deliberate strategy to protect themselves against possible bad news. The information about future complications and distress caused by the cancer and the

chemotherapy that spread out among the patients at such an initial stage was painful, and it exacerbated an already difficult situation. At the same time, these patients also acknowledge that talking to others, when these people were “positive,” could be useful and in a certain sense beneficial. As one woman said, “You must look for the right person to speak to, avoiding the negative ones.”

Being Part of a Community

However, analysis of the narratives showed that, even in cases of little or no direct interaction, the patients deployed social resources and cultural repertoires to understand their recent cancer diagnoses and to cope with it. Such resources and repertoires, which incorporated and reproduced “crystallized” social interactions, performed an important, though more mediated, role in the patients’ definitions of their positions in regard to the disease, and in laying down partial coherences of self to self and others. A “generalized other” (Mead, 1934) was involved, more or less concretely, in making sense and interpreting the experience of the illness.

In some examples, the others were explicitly mentioned in the narratives so as to define the patients’ own positions in facing the experience that they were living through. For example, the presence of others was evident in the narrative of Florinda (see Extract 8), in which the interviewee described her first days as an “ill person.”

Extract 8

Florinda: The first time, practically the first days, one looks around and the first thing that one thinks is “Oh dear, how many we are.” And already perhaps in a certain sense the pain wanes, the preoccupation wanes a little.

The presence in the narrative of the category “community of patients” (and membership of it) is salient, concrete, and rhetorically significant in Florinda’s experience as an ill person. This is an example of how the discursive categories that “activate” particular configurations of group membership (Zucchermaglio, 2005; Edwards, 1998) in the discourse become strategies for coping with and mitigating fear and pain. Not being alone in the disease is described as a factor furnishing protection and potential emotional support.

The presence of other patients was again made important for coping with the illness when Florinda, at the end of her interview, referred to a cultural repertoire that can be summarized with the saying “a trouble shared is a trouble halved.”

Such comparison with other ill people is not always comforting and positive, however. Maria Grazia (see Extract 9) used the rhetorical device of group membership to avoid to positioning herself as a member of “this community of ill people.” For Maria Grazia, who was at the beginning of the path, this community was also represented through the voices

of the ill people still trying to find a cure after many years, and who had undergone numerous cycles of chemotherapy because of metastases. These voices, reported in her narrative as direct discourses (as she had heard them in the corridors of the ward), represented the possibility that the disease could be enduring and without a positive outcome.

Extract 9

Researcher: Other people in her situation told me that they make much use of online communities, blogs . . .

Maria Grazia: I don’t like it (she laughs)

Researcher: You don’t like it

Maria Grazia: (she laughs) I don’t like being in this community of ill people (she laughs)

. . .

Maria Grazia: “I’ve been in treatment for six years.”

Another lady: “It’s the fourth time I’ve had chemotherapy.” Well, it is not pleasant because I’m only at the beginning of it.

Researcher: Mh

Maria Grazia: Couldn’t that happen to me? Also because here you only see relapses, people who have further complications, and perhaps those who have solved . . .

Researcher: They aren’t here

Maria Grazia: Right, you don’t meet them here, of course.

Maria Grazia’s narrative gave salience to another community of which she would have liked to be a member: the community of those who had recovered, so that they no longer met in the hospital. In this case, not considering oneself part of the community of the ill and wanting to become a member of the invisible community of “those who have solved” became a resource for thinking and coping positively with oneself through the path of illness. The opposition that Maria Grazia created in her narrative between the community of ill people and the “virtual” community categorized her as a patient in a rich and variegated social world populated by communities and characters which one could see (i.e., the ill), or that one imagined might exist somewhere (i.e., the healed). The navigation among these different communities allow patient to develop, contrast, or imagine different identities as cancer patient, but at the same time to maintain a coherent sense of self across contexts and activities (Lave, 2012). Even when others are not physically present, we act and think in a field of intersubjectivity in which they are imagined and taken into account (Duranti, 2010).

Popular Culture, Appearance, and Fatalism

Another community of patients was made concretely visible in the polyphonic account of Maria Luisa, a 68-year-old housewife (see Extract 10), who described herself as a member of the category of those ill people who “have taken it quite well”: that is, ill people who manage the illness optimistically (“after all, it can be cured today”) and cheerfully (with jokes and laughter). The narrative of her “happy” coping with the disease was also enriched with references to repertoires of popular culture to which she belongs: the beliefs that despairing is pointless, and that there are events that make people suffer but eventually strengthen them.

Extract 10

Maria Luisa: And when I was told that there was no great trauma. I took it quite well, thinking that perhaps after all it can be cured today, so I accepted that, without making a drama of it, without things, also because crying, despairing, is pointless . . . I've seen people here who've taken it like I've taken it, between a joke and the other, between laughing about the wig. This has perhaps been the most traumatic thing . . . I believe that, after all, I wonder why I believe that this disease strengthens people

Researcher: Mh

Maria Luisa: Because I see that they all laugh, they joke, that they have this courage. You'll tell me that this is just an appearance

Researcher: No

Maria Luisa: Also the appearance matters.

Anticipating a possible objection by the interviewer (“You'll tell me that this is an appearance”), Maria Luisa gave an explanation of the potency of these cultural resources in coping with the difficulties of life as an ill person (“Also the appearance matters”). The notion of appearance refers to the fact that there are cultural prescriptions on which one can rely to address the disease appropriately. In Maria Luisa's narrative, the relationship with the disease was denoted as a social and public behavior being described as more important than the invisible psychological and introspective dimensions.

By contrast, Milva drew precisely on such interior dimensions to highlight how chemotherapy had been the cause of her “psychological destruction” (see Extract 11). Milva, a 65-year-old housewife, described how she had coped with the destructive effects of the chemotherapy using the cultural resource of fatalism. This resource had emerged from an internal dialogue that she had conducted with herself.

Extract 11

Milva: But for me, the chemo has destroyed me then psychologically. Even if then afterwards what I, within myself,

just say “Nobody can make you avoid it” and then you take that path and go, and whatever happens, it happens.

Particularly evident in this narrative is the intersection between psychological and cultural dimensions: fatalism (if you cannot do anything to change the situation, you might as well accept it and wait and see “whatever happens”) is represented as resulting from an interior dialogue (“Within myself, I just say”), stressing that cultural repertoires are always accessible resources, and that they can be used to cope with the traumatic events of life. This point underlines how artificial it is to mark a boundary between the individual brain and external world or between individuals and culture (Hutchins, 2012; Ratner, 1996; Subbotsky & Cole, 1993).

Furthermore, Milva explicitly recalled this repertoire of fatalism in the account of her relationship with death and fear of dying (Extract 12).

Extract 12

Milva: Instead, now I realize, well, look, I have this big trouble, I mean I hope not to die. But I'll be under the sword of Damocles for a long time. That's normal, right?

Researcher: Yes, yes

Milva: We are already there when we do not have it, but you can imagine when . . .

Researcher: Yes, sure

Milva: Anyhow, I can't think of anything. I see good things . . .

Researcher: Mh

Milva: But not because . . . I don't know. Perhaps I am positive myself, or perhaps I'm a fatalist

Researcher: (Words not understood)

Milva: I don't know, perhaps I'm very fatalistic

Researcher: Maybe so, maybe so

Milva: So if it is written that I must die, I'm going to die, but I no longer feel fear.

Receiving a diagnosis of cancer modifies the relationship with this unpredictability, making the possibility of dying more concrete and closer. Having turned a generic danger into a more delimited one, Milva reconsidered her fear of dying and saw things more positively. In this narrative frame, the patient deployed the cultural repertoire of fatalism, which she evidently did not express before the diagnosis, but which had now become an important resource with which to reduce the fear of dying and cope with the illness. Milva used diverse

cultural repertoires (“I’ll be under the sword of Damocles for a long time”) to account for her internal states and their evolution. At the same time, she adapted them to her own narrative requirements, giving them the form of a maxim (“We are already there when we do not have it, but you can imagine when . . .”) with a more general value aligned with a genre typical of popular culture to which she belongs.

Evident here is not only the pervasiveness and power of narratives to give account of, and form to, life events but also, and especially, how such narratives always pertain to a community of narrators (and stories) who incorporate and share cultural meanings and repertoires (Bruner, 1987). The patients used such repertoires to interpret events, act in the world and to locate themselves in that culturally connoted world. Repertoires are thus powerful resources for coping with cancer, highlighting how culture is not an overarching and abstract “thing” (Geertz, 1973) but a complex and established system of resources (meanings, beliefs, symbols, artifacts) that mediates our psychological functioning (Cole, 1996; Ratner, 1996; Scribner, 1984). Both Bruner (1960) and, more recently, Swidler (1986) described this shared system as “toolkit,” a sort of cultural equipment passed on from generation to generation enabling and constraining our meaning-making processes and actions in the world.

This framework, without denying the many influences on our psychological functioning, deliberately focuses on that part of psychological phenomena (such as making sense of and coping with cancer) that are created through our participation in social activities and the use of the culturally available repertoires.

Concluding Remarks

This study highlights three main contributions that broaden our understanding of the role performed by both informal interactions among patients and cultural resources for coping with cancer.

1. Notwithstanding our initial hypothesis that stated that direct interaction with other patients could have been a strategy for coping with illness and therapies, conflicting results and mixed assessments emerged from our analysis. Three strategies have emerged. Some patients rely on interactions to participate in a community in which they share information, support, and coping practices. Some patients deliberately avoid interactions as a strategy to protect themselves from making parallels that might harm their hope and psychological well-being. Finally, some patients use both interactive and noninteractive strategies: they carefully select them taking into account both interlocutors and topics of interaction. Further studies involving larger samples and different types of research participants (for type of cancer, gender, social status, cultural background, and country)

should explore how widely such strategies are used by patients. However, this study clearly shows that, beyond the limited space and time of the clinical encounters (Hesse, Beckjord, Finney Rutten, Fagerlin, & Cameron, 2015), there is a texture of social interactions among patients that is currently understudied.

2. All the patients, including those who interacted little or not at all with the others, give salience in their narratives to categorizations of themselves as members or non-members of specific groups and communities. This socially rich and variegated panorama of real and virtual groups allows patients to position themselves toward their illness by imagining similar or different identities as cancer patients. Identity is defined not only by the group we belong to but also by those we do not belong to and by those we wish to belong to (Wenger, 2000). In our data, group membership is used as a “coping device” through which interviewees build upon similarities or differences to give meaning to and face their illness.
3. Cultural repertoires proved to be resources used by patients to face and cope with an event as disruptive as a cancer diagnosis. The elements of the popular culture (e.g., fatalism, the notion of adverse events as strengthening, the uselessness of despairing, and so on) are powerful tools that they incorporate in their narrative. Such elements give meaning to their recent cancer diagnosis and help them to face the disease. Through these repertoires, the role of culture as a mediating resource for coping is made empirically visible: as cancer (or other illness or adverse events) is not a solitary enterprise (that could be simply measured by a scale), but a “battle” people fight using social tools and cultural repertoires as “munitions.”

Although within the limits in the generalizability of a small-scale qualitative study, these results help to widen the individualistic framework commonly used to study coping strategies of cancer survivors by including psychosocial phenomena rooted in the complex interactions with the social and cultural world we inhabit.

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Note

1. For studies on doctor–patient interactions on this setting, compare Fatigante, Alby, Zucchermaglio, and Baruzzo (2016) and Alby, Zucchermaglio, and Fatigante (2016).

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