

# Noisy Lives, Noisy Bodies

## Exploring the Sensorial Embodiment of Class

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**ABSTRACT:** Social inequality in cancer survival is well known, and within public health promotion enhancing awareness of cancer symptoms is often promoted as a way to reduce social differences in stage of cancer at the time of diagnosis. In order to add to our knowledge of what may lie behind social inequalities in cancer survival encountered in many high-income countries, this article explores the situatedness of bodily sensations. Based on comparative ethnographic fieldwork, we argue that the socially and biologically informed body influences how people from lower social classes experience sensations. Overall, we point out how the sensorial is tied to the embodiment of the social situation in the sense that some bodies make more 'noise' than others. It follows that standardised approaches to improving early care seeking by increasing knowledge and awareness may overlook essential explanations of social differences in symptom appraisal.

**KEYWORDS:** body, early cancer diagnosis, Denmark, local biology, sensations, social inequality

This article is situated within the context of growing social differences in cancer outcomes in Denmark as well as most other affluent countries (e.g. Dalton et al. 2008; Lyratzopoulos et al. 2013). For instance, studies have shown a significant social gradient in cancer stage and one-year survival among socially deprived compared with affluent Danish populations (Dalton et al. 2008), which may indicate social differences in how and when healthcare is sought. The current public health rhetoric on cancer disease control is strongly focused on early disease detection as a form of disease control, and rests on assumptions of how increasing awareness will lead to early care seeking. However, in order to explore the ways in which experiences of sensations are turned into symptoms and how people move from feeling fine to feeling sick, we explore the situatedness of the body and its meaning in the making of symptoms. Inspired by what has

been referred to as a medical anthropology of sensations (e.g. Hinton et al. 2008), which focuses explicitly on the experience and articulation of embodied sensations, or in the words of Mark Nichter 'how the spaces and places in which bodies are situated predispose perceptions of sensation that are associated with feelings of fear and vulnerabilities, well-being and protection' (2008: 164), the overall aim of this article is to add new perspectives to the dominant discourse on symptom awareness shaping current public health approaches to cancer prevention. Thus, by exploring how physical and social circumstances shape bodily meanings, interpretations and practices, and become fundamental for the attentiveness to and transformation of bodily signs and sensations into symptoms, we hope to bring new dimensions to understandings of early cancer diagnostics, where social differences in cancer stage at diagnosis and in



survival are often ascribed to lack of knowledge and understanding (e.g. Whitaker et al. 2015).

We draw on ethnographic fieldwork carried out in a socially deprived suburban neighborhood in Jutland, Denmark, and we analyse experiences of sensations with reference to Margaret Lock's concept of local biology (Lock 1993). Lock introduced the concept of local biology to illuminate the interplay between the sociocultural environments and biology, and she points out how experiences of sensations are grounded in both the biological and the social (2001: 484). The concept of local biology thus allows us to approach the interplay between physiological condition, social context and experiences of how the body feels, and we argue that the local biology is intrinsically linked with both the experience and the interpretation of embodied sensations. This allows us to explore how people invest their bodies with meanings, and how these meanings are influenced by the 'noise' that the body does or does not make. This is of importance, while, as argued by Lock, standardised medical interventions [in the widest sense encompassing for instance disease control through knowledge and awareness] run the risk of overlooking the significance of local biologies (Lock 2001: 487–89; Lock and Nguyen 2010: 90–92).

## The Field and Context

The empirical material that provides the basis for this analysis was generated during one year of fieldwork carried out by Merrild among two different social classes in Denmark. The fieldwork was comparative and informants resided in two different geographical areas, which were selected based on a combination of population composition and context analysis (Larsen 2010). In this article we draw only on empirical material from what we have termed the lower working class (LWC) in order to add to current understandings of why cancer survival may be significantly poorer in lower social classes. We have discussed practices of healthcare seeking in the two social classes elsewhere (Merrild et al. 2016b) and found, along with other studies, that people from higher social classes sometimes more easily appropriate and practice health promotion and illness prevention as prescribed by the dominating discourses (e.g. Cockerham 2005; Williams 1995).<sup>1</sup> Importantly, however, it must be stressed that this article has grown out of continuously stepping in and out of different social and cultural worlds which empirically demonstrated how the social inscribed itself into the body. And it

was by being there, observing, feeling, sensing, learning, tasting, listening and discussing – in both social contexts – that our understanding of the interplay between the physical and social in bodies was essentially developed (see Merrild 2015 for a more detailed description of methodology).

The LWC informants all lived in rented apartments, which were situated in a socially deprived public housing association in an area with high unemployment rates. They had all left school after primary and lower secondary level, some had short vocational training; and at the time of their participation in the study, they had all been living on welfare benefits for at least the past year. They were above 40 years of age and a mix of men and women; some were single, some cohabiting and some married. Our description of their social class was grounded in them being tenants in a public housing association as well as being outside the labor force. All were recruited through the community house, which was a house for joint activities, located in the middle of the high rise buildings which made up the neighbourhood. A lot of social activities went on here, people from the area dropped in and out to socialise, and it was a place to go if one felt like hanging out with others.

Fieldwork consisted of participant observation such as hanging out in the community house; in the homes; or taking part in everyday social situations; of endless informal conversations on family relations, practical day-to-day business, local gossip and so on – all the things that occur in the small-scale community where everybody more or less knows each other, where time is in abundance and socialising is highly valued. Semi-structured interviews were conducted with six key informants. The first interview was a narrative life story interview; the following two focused on symptom experiences and the practice of healthcare seeking. In addition, the informants filled out symptom diaries over a period of three months in which they recorded any experiences of symptoms or discomforts and their management of these experiences. The entries in the symptom diaries were used as empirical points of departure in the second interview, which explored specific symptom experiences.

## Noisy Lives and Bodies

The overall state of health among the informants was poor, and they all suffered from a number of psychiatric and somatic diseases. As such they reflected epidemiological statistics showing higher levels of

multiple illnesses, physiological and social stress among the lower social classes in Denmark (Larsen et al. 2014). As a consequence, illness, pain, discomfort and physical irregularities were part of their everyday life and were brought into the social setting as graphic descriptions of illness experiences. Narratives of psychiatric disturbances, virulent illness episodes and varying forms of bodily distress due to chronic disease, among others, were often thematised in everyday discussions and conversations, and challenges of failing health and physical and social misfortune were displayed and dealt with socially and as a natural part of life. Particularly the community house was a place where these issues were often discussed, in random social situations and as part of everyday conversation.

One example of this may be how one day, when Merrild was hanging around in the community house, Jackson, who is a member of the board in the housing association, drops by and sits down to chat. Jackson probably weighs around 150 kg. His complexion is pale, almost yellowish, and he only has two teeth in his mouth. He is a well-known figure in the neighbourhood, and he is very active in the community house, where he usually spends most of his time helping out and keeping track of things. Jackson and his wife Mona are famous in the neighborhood for assisting young local girls who are in trouble; for instance in situations of pregnancy, fall-outs with parents, boyfriends or the authorities and so on. Often the Jacksons had one or two girls staying in their apartment, and they accompanied the girls when they were summoned by social services. Both Jackson and Mona are living off disability pension and early retirement. Mona is severely ill with cancer, and although Jackson has a number of responsibilities in the housing association, lately he has been spending most of his time at home. Jackson has worked as a truck driver for more than 25 years, driving in all of Scandinavia. But he eventually had to stop because of his back, which he ruined during his youth when he was delivering grain and food stuff and later driving for a coal company.

On this day he is telling stories from his many years on the road. While he is talking he is huffing and puffing, as if he is having trouble catching his breath, while he is vividly describing how during his last trip as a truck driver he had zero per cent vision in one eye and 16 per cent in the other. This was when his wife and kids told him to stop. As we are sitting around, Brian (another informant) suddenly comes out of the stairway in front of his flat. We are watching him through the window across the park-

ing lot, almost holding our breath, but he just takes his mail and disappears back inside. This is the first time we see him since Christmas a few weeks ago, when he had a total breakdown and isolated himself from everyone. We chat about Christmas and another informant, George, comes up. He is not leaving his flat much these days either. He is still coughing and it was very bad when they were at church on Christmas Eve, one of his daughter's friends, who has also dropped by, tells us. After a while I get up and put on my winter coat as I make a comment on the cold weather. 'I am walking around with pneumonia', Jackson remarks, and explains how he was helping his son-in-law remove some wood from their garden a few weeks, and was only wearing a thin jacket and a t-shirt. 'So that landed me pneumonia' he adds almost triumphantly.

Disease and suffering are natural and integral parts of the everyday lives of Brian, George and the Jacksons. In many ways their deprivation marked their bodies; bodies which told stories of social class; of carrying out physically demanding jobs in the manual sector; and of the physical wear and tear of having lived a tough life. Sometimes the everyday presence of illness, bodily dysfunctions and uncomfortable sensations were treated with a sense of unaffectedness, as part of their lives. At other times they ridiculed and disgraced their own as well as each other's unfit bodies; for instance by making jokes about someone's obesity, or by associating their own weak physical capacities with their poor sexual performances, which always called for a lot of amusement within the group. Emphasising the prominence of disease and failing health among our informants is not to suggest that they were 'ignorant' of dominant public health discourse. In fact, quite to the contrary, numerical measurements were continuously used as points of reference and brought up in social situations in order to keep track of their sometimes failing health and bodies. This in many ways resembled the situation described in a recent study of elderly people in Denmark, which argues that numerical standards and measurements have become integral to the way in which people relate to their bodies (Oxlund 2012: 53). In this social setting, however, measurements were also used to emphasise the seriousness of conditions; and bodily deficits were many times used for rivalry and to impress – comparing deteriorating blood sugar levels, dwindling blood counts or other bodily weaknesses.

Overall, the informants' ailments were most often intrinsically linked with their social situations. Let us consider for instance another informant Nichole,

who was diagnosed with breast cancer ten years before Merrild met her, and who is now living on early retirement disability pension due to radiation damages. Nichole had worked hard all of her life until the day she was diagnosed with cancer. She started to work as a *smørebrødsjomfru* (a sandwich maker) the day after she finished primary school; and having been raised by her single, unskilled mother in the 1960s, she was used to working hard in order to make ends meet. Trying to break free from her disadvantaged situation, she continuously strove to do better; and hard work and no fuss seemed to be the mantra she lived by. Even now, ten years after she stopped working and lost much of her social life with it, she still struggles to fill her days with various activities because she just cannot stay still, no matter how much her body aches. And when Nichole talks about how she for instance stays in bed for half a day, waiting for the tingling numbness in her arm and her dizziness to pass, she is not necessarily ignoring her body. Although she cannot stand up, speak or eat, she lies still in bed and waits, because she has an appointment with her doctor a few days later, and it usually passes when something seems wrong with her body, she explains. Likewise, when asked to reflect on how she experienced her body prior to her cancer diagnosis Nichole describes it like this:

Back when I was diagnosed with cancer, I also told my GP that I was SO tired. And she asked me if I got out every day, and I did, I had to. She thought that it seemed wrong if I was so dead tired, right. But I just have that drive in me, right. I just have to get out and do something, right. Even if I have to crawl on my damn knees, right. Then I just have to get out. She didn't understand that at all, so she just thought that it was a winter depression. But it turned out to be cancer.

## Socially Embedded Bodies

For Nichole, Jackson and the other informants, the economic and social politics of the welfare state played a prominent role in the organisation of their everyday lives; and their social, domestic and financial situations were fraught with uncertainty, shaped by the social stress of deteriorating family relations, the challenges of being poor in an affluent society, marginalisation from the workforce, and social exclusion due to psychiatric and physical inabilities. The noises were by no means restricted to their bodies; their social situations also roared.

Consider for instance the case of Fanny, who has been living on welfare benefits for the past four years, and is suffering from chronic pains in her hand, arm and shoulder. During those four years she has continuously been sent to various forms of job trainings in order to clarify how much work her body can put up with. One day when walking to work, Fanny and I are discussing some of the things that are going on in her life. She tells me about how her stepdaughter's child is being forcefully removed from home by the social services, how her mother-in-law is dying from some form of cancer, how she worries about her trouble with the social services, and fears that she will continue to be 'thrown around in the system for the next four years'. On top of it all, she has a grown daughter who is seeking her attention 'in a very negative way', by for instance texting Fanny about how she has been pregnant with some random boyfriend and has lost the child. And then there are all of her physical troubles, for instance with her stomach and her abdomen. She has a lot of pain, and has had loose stools for many months now. She really needs to get herself together and go and see her doctor, she sighs.

As the above cases make clear, well-being, health and illness are in part informed by the material body, but at the same time socially conditioned (Lock 2001: 483–84). Thus, returning to the public health focus on symptom awareness as a way of improving early care seeking, we suggest that the social and physical conditions shaping the lives of the lower social classes produce 'local biologies', which potentially make some bodies more 'noisy' than others. In order to further illustrate this, let us return to George's cough, which was briefly introduced above. George, an unemployed manual worker who was recently diagnosed with COPD, was coughing during the entire fieldwork period; and after an episode of pneumonia, he had an x-ray of his chest, which showed reduced lung capacity, which was ascribed to his COPD. Of course he worried about it and he thought about cancer, he explains. His cough continues, and after a few months he fills out the symptom diary. Although his cough is still there, he does not refer to it at all in his diary entries. Instead he writes about virulent stomach problems, muscular tensions and headaches which prevent him from sleeping at night, but which are all bodily signs and sensations with which he is familiar. He is diagnosed with a sleeping disorder during the period in which he has the symptom diary, to which he subsequently ascribes the constant tiredness, heart problems, depression and difficulties sleeping from which he has been suffering for the

past 25 years. The cough is filtered out, albeit not in a physical sense. It is crossed off as COPD, as George has so many other physical ailments (noises) potentially muddling his bodily attention.

Analysing the cases above using the concept of local biology allows us to consider the interplay between physiological condition, social context and experiences of how the body feels, and indicates how attention towards the body may primarily be raised by the dramatic and intense. And it could be considered one example of the complicated ways in which notions of the normal and the pathological play out in the context of health and illness in disadvantaged lives (Das and Das 2007: 92).

## Conclusion

In this article, we have used the concept of local biology to illustrate how moving between feeling healthy and feeling ill are situated and intrinsically linked with the social and physical bodies. Proactively reacting to irregularities in the body may not always be possible in the local biologies of social deprivation, as living with numerous lifestyle and chronic diseases and mounting social strains can result in bodily noise in the form of abundances of physically and socially informed sensations, which shape experiences and interpretations of the body. Some local biologies do not seem to invite the bodily sensitivity encouraged by for instance the early cancer diagnosis discourses, but may in fact oppose the assumptions and expectations of early disease detection.

Notwithstanding the importance of cancer symptoms, understanding experiences and modes of managing the body is also pertinent if we are to understand the premises of healthcare seeking. Thus, it has been suggested that the increasing diagnostic technological advancement and specificity within the medical sciences, which allows us to look inside the body, places further demands on recognising when to seek care as early as possible in the already complex task of seeking care with what, from a medical perspective, may be defined as the 'right things' (Andersen et al. 2014). The tenet that what may appear as no or 'delayed' reactions to bodily signs and sensations is due to lack of knowledge and awareness rests on what Hay (2008: 198–200) describes as clinically informed assumptions of symptom recognition. However, for people living with multiple illnesses and in difficult social circumstances, adding to these complexities might be the multiplicities of 'noises', which some-

times seemed to defy the bodily sensitivity required in order to seek care early. This illustrates the body's situatedness and indicates how embodied experiences of physical sensations are informed by these local biologies (Lock and Nguyen 2010: 90–91). In other words, the biological and social situatedness shapes, enables or constrains experiences and interpretations of bodily sensations. Attempts to influence care-seeking practices must take these differences into account and recognise that, as we have shown, local biologies provide people from lower social classes with points of departure for seeking care, which may be different from that of more privileged classes. In many ways, our findings point towards what has been termed the embodiment of social inequality (Fassin 2003), which refers to the ways in which biological facts become social facts and vice versa, and how embodied experiences are situated in the social world. Our findings show that bodies are situated in their local entanglements of physiology and social context, and that the meanings of sensations are tied to the physical and social circumstances. Sensations; how they are attended to, organised and articulated are thus embedded in the historical, material and social structures framing people's lives (Nichter 2008); here exemplified by the lived experiences of being an unemployed manual laborer or an early disability retiree living off welfare benefits. However, by suggesting that sensing and reacting to bodily sensations is related with social position, we do not mean to exoticise the LWC ways of giving meaning to their bodies. Quite to the contrary, acknowledging local biologies potentially challenge the ways in which culture has been used to explain poor health and non-compliance with medical regimes (Lock and Nguyen 2010: 103).

These findings invite the conclusion that culturalism, which within anthropology refers to 'culture', (lack of) knowledge or beliefs being used as explanations for non-compliance with medical advice (e.g. Fassin 2001), directs attention away from what may be at stake when local biologies are played out in the realm of the sensorial, and may perpetuate, or even further increase, the social differences in cancer survival. This leads us to argue that the dominating discourses aiming to improve early disease detection, symptom recognition and bodily awareness rest on an image of a standardised body and do not take into account that bodies of people living with multiple diseases and social concerns may not always fit with what could be termed a clinical approach to early care seeking. And so we argue that in order to understand care seeking practices in lower social classes, it is

necessary to recognise that bodies differ, and that the embodied experiences of sensations perhaps sometimes drown in abundances of bodily noise. In light of the mounting social differences in cancer survival, the suggestion that economic inequality and sociopolitical structures produce not only health inequalities but also different bodies, made by scholars writing on the anthropology of biomedicine (Fassin 2003; Lock and Nguyen 2010: 109), thus appears more relevant than ever.

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## Note

1. This is not to suggest that people from higher social classes are always compliant and acting in accordance with the messages of health promotion and illness prevention (see Merrild et al. 2016a for a discussion of practices of resistance towards the dominant health-promotion discourse).

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