



# LUND UNIVERSITY

## Alcohol abuse in cancer patients: a shadow side in the oncological field and research.

Glasdam, Stinne; Oye, Christine

*Published in:*  
Medicine, Health Care and Philosophy

*DOI:*  
[10.1007/s11019-013-9541-x](https://doi.org/10.1007/s11019-013-9541-x)

2014

[Link to publication](#)

*Citation for published version (APA):*

Glasdam, S., & Oye, C. (2014). Alcohol abuse in cancer patients: a shadow side in the oncological field and research. *Medicine, Health Care and Philosophy*, 17(3), 437-446. <https://doi.org/10.1007/s11019-013-9541-x>

*Total number of authors:*  
2

### General rights

Unless other specific re-use rights are stated the following general rights apply:  
Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal

Read more about Creative commons licenses: <https://creativecommons.org/licenses/>

### Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

LUND UNIVERSITY

PO Box 117  
221 00 Lund  
+46 46-222 00 00

**Title page:**

**Title: Alcohol abuse in cancer patients: a shadow side in the oncological field and research**

Running head: Alcohol as a shadow side in the oncological field and research

Article type: Scientific article

Stinne Glasdam

Associate Professor, Ph.D, MSc in Nursing, RN

Division of Nursing, Health Sciences Centre, Lund University, Box 157, 221 00 Lund, Sweden.

Email: [Stinne.Glasdam@med.lu.se](mailto:Stinne.Glasdam@med.lu.se)

T: +46 46 222 1937

Mobil: +45 30296617

Corresponding author

Christine Øye

Associate professor, Ph.D., MSc Anthr.

Division of Health, Stord/Haugesund University College, Postboks 5000, N -5409 Stord,

Norway and Centre for Care Research, Bergen University College. Bergen, Norway

E-mail: [christine.oye@hsh.no](mailto:christine.oye@hsh.no)

T: +46 97410039

**Biographical note:**

*Stinne Glasdam* is associate professor at the Faculty of Medicine, Lund University, Sweden, since January 2012. She is responsible for the one year master programmes in oncology nursing and works in the research group, called "Health in an interdisciplinary perspective". Through many years she worked at Universities and University Colleges in Denmark. She has published a numbers of scientific articles, both national and international, and is editor and author to five national textbooks. Her main interests are sociological studies in the medical field, especially oncology, gerontology and education.

*Christine Øye* is associate professor at the Department of Health Sciences at Stord/Haugesund University College, Norway. Since January 2012 she also has a post doctorate scholarship at Bergen University College, where she works in an interdisciplinary research group doing an implementation study in nursing homes. She is a social anthropologist (PhD) from University of Bergen, Norway. In her Ph.D. thesis she did an ethnographic study on milieu therapy in a psychiatric hospital.

**Acknowledgements:** Thanks to all the informants and the collaborative oncological clinic. Thanks to Lise Bjerrum Thisted for clinical assistance. Thanks to Sidsel-Marie Glasdam for transcriptions. Thanks to Penny Bayer (UK) for proof reading. This work was partly supported by the Danish Nurses' Organisation and Institute of Nursing, Metropolitan University College.

## **Alcohol abuse in cancer patients: a shadow side in the oncological field and research**

### **Abstract:**

This article aims to foreground alcohol abuse by cancer patients and explore how alcohol abuse functions as a biographic master motive and at the same time is a shadow side in the oncological field and research. The research is based on a single case study which draws on empirical material from interviews, field notes and staff policy, with analysis using Bourdieu's concepts of trajectory of life and *habitus*. The findings show that the cancer patient's alcohol abuse is an important part of the trajectory of his private life and spare time. In social life with family and friends alcohol is given and normal and acts as a *socialisator*. Alcohol abuse provides both stability and instability in the cancer patient's life. When cancer results in work breaks and retirement, and spare time often is used as drinking time, then all daily life becomes drinking time for the cancer patient. Alcohol is often a hidden abuse at the working place and in the oncological field. In meetings with healthcare professionals, the patient chooses not to speak about his alcohol abuse to avoid further medicalisation. The challenge for the healthcare professionals is to see and accept alcohol abusers with cancer and their social lives without always trying to change their 'unhealthy' lifestyles.

Key words: cancer, alcohol abuse, life history, Bourdieu, case study, medicalisation

## Introduction

Studies show that there is a significant increased risk of head and neck, liver, kidney, lung and cervical cancer through high levels of consumption of alcohol (Thygesen et al, 2007, 2008, 2009; Danish Health and Medicines Authority, 2009; Groenbaek, 2009). In most parts of the Western world alcohol consumption at a moderate level is an accepted stimulant found in many social contexts. Alcohol is also considered to be a poison that harms the body when consumed in large quantities and/or over a long period. High levels of alcohol consumption are associated with development of a number of diseases such as cancer and diabetes (Gutjahr et al, 2001; Groenbaek, 2004; Rehm et al 2010).

There is increasing political and medical concern about harmful alcohol consumption among young and middle-aged people in other Western countries, for example in the UK and Denmark, which can lead to cancer (Ekholm et al., 2006; Danish Health and Medicines Authority, 2008; Hvidtfeldt et al, 2008; Office for National Statistics (ONS), 2011; Emslie and Mitchell, 2009; Leyland et al., 2007; The Scottish Government, 2008). High levels of alcohol consumption seem to be independent of social status, education and income, but most of the “high level consumers”, including those with harmful use and alcohol dependency, are men. Only a small number of the “high level drinkers” are visible in society; for example, in Denmark 66 % of adult “high level consumers” of alcohol are working in the labour market (Hvidtfeldt et al, 2008).

A complex social discursive practice surrounds individual alcohol consumption. Alcohol consumption is variously regarded as a medical health problem, as a taboo in the family and in

society, and as a social practice. Society confirms that drinking is acceptable if carried out in the right way, at the right place, and in the right amount that does not interfere with the person being able to meet his or her responsibilities as workers, parents, etcetera (Groenkjaer et al, 2011; Emslie et al, 2012). Studies show that people with alcohol abuse often cause harm to others, especially in their close relationships (Peled and Sacks, 2008; Room et al, 2010; Casswell et al, 2011). Doing harm to others and to oneself is often related to a taboo (Järvinen, 1998), which means that it is often difficult to articulate an alcohol abuse in different social contexts, including an oncological healthcare context.

This article aims to foreground alcohol abuse by cancer patients and explore how alcohol abuse functions as a biographic master motive and at the same time is a shadow side in the oncological field and research. Furthermore, the article will highlight issues faced by cancer patients with alcohol abuse in the oncological healthcare system.

## **Method**

This article is based on a single case study drawing on empirical material from another study, which aimed to understand the implications of getting cancer for people in the labour market (Glasdam and Thisted, 2010; Glasdam, 2011). During the interview period of the main study the researcher noticed that alcohol abuse seemed to play an important, but hidden, part of some of the informants' lives. The single case study has been shown to be a valuable method to analyse how people frame, live and solve life challenges: a single case can illuminate and explain a single unit for the purpose of understanding a larger class of (similar) units (Barzalay, 1993; Gerring, 2004; Flyvbjerg, 2006; Thomas, 2011). Inspired by Williams (1984) the specific case is a pragmatic

choice of the researcher to illustrate the complexity of the appearance of the biographic master motive 'alcohol abuse' when living with cancer.

### **The single case study**

The case consists of interviews and observations during the interviews of one cancer patient and his significant others assessed from the perspective of himself, namely his mother, a colleague, and a work leader; the interviewer's field notes and reflection on the situations, written immediately after the interviews; and relevant staff policies and reports handed out by the work leader. The research project took place in an oncological outpatient clinic in Denmark, from April 2008 to May 2009. The cancer patient met the inclusion criteria of the research project: he had cancer without metastasis in the brain, which could have made the interviews impossible; he had been diagnosed 1-1½ years previously and was in principle curatively treated; he was aged between 30 and 60; and was working at the time of diagnosis (Glasdam and Thisted, 2010; Glasdam, 2011). The selected primary informant chose his closest relative, colleague and leader.

The interviews were carried out through a narrative life story approach with the purpose of discovering connections and the different ways in which these connections were manifested. Several researchers argue that this can be done with even a relatively small number of informants, for example using in-depth interviews (Williams, 1984; Bourdieu et al, 1999; Sayer, 2000; Horsdal, 2012). Accordingly, the interviews covered a variety of themes but had a specific focus on the informants' life stories and their working life. By interviewing the cancer patient (the key person in the case), and the persons around him it was possible to grasp a relational perspective on a situation and to illuminate it from different positions. The interviews lasted between 1 to 2 hours.

The informants decided the place in which the interview was held in order to create a safe and comfortable framework for the informants. The interviews were recorded and transcribed in full length.

### **Ethical considerations**

Subsequently the researcher experienced the challenge and ethics of researching the hidden sides of the informants' lives in the oncological field. All participation was voluntary. Interviewees were informed about the aim of project both orally and in writing and they gave informed consent. The first contact with the cancer patient was by a nurse in connection with a follow-up control of the cancer at the hospital, where the patient was invited to participate in the study and was asked if the researcher might contact and inform the patient about the study. The researcher did not get the name of the patient before the patient accepted this.

All data was anonymised and kept inaccessible to anyone other than the research team. In publication, the study seeks to maximise anonymity where names, person-specific job names and toponyms have been removed. The study has been accepted by the Danish Data Protection Agency, J.no. 2008-41-2069 and obeys Danish Legislation.

### **Analytical strategy**

The analysis was grounded in sociological theory inspired by Bourdieu and rests on the basic assumption of the homology. Homology means, according to the understanding of Bourdieu, that the way people are socialised and socialise through the upbringing and daily life in the family, among friends and in the public sphere also manifests itself in *habitus* as a way of living and

handling life in general, including the way persons handle disease (Bourdieu, 1984; Glasdam, 2003).

Firstly, a naive reading of the transcribed interviews, the staff policy at the working place and the researcher's notes was carried out to understand the content.

Secondly, the case was constructed by the use of the life narratives provided by the key informant, the narratives and multiple perspectives provided by the other informants, field notes and reflections made by the researcher performing the interviews and relevant staff policies and reports from the working place. According to Bourdieu, a narrative biography could be regarded as a discontinuity story where breaks, chaos and contradictions are compatible with all the different tracks of life (for instance family, work, spare time) that together form the whole complexity of a person's life. Bourdieu shows that human life is incoherent; it consists of elements standing alongside each other or following each other, without necessarily being related (Bourdieu, 1995; Järvinen, 2000). The complexity of the empirical material in this study can be seen as a possible way of understanding the mainly tacit existence of alcohol abuse of a cancer patient from multiple perspectives and different positions in the social context within which the alcohol abuser lives (Bourdieu, 1999). The perspective of differently positioned persons, which means using other persons' narratives to understand the life of a person, brings into question the taken-for-granted and eventually leads to a perception of a reality that had been in the shadow (Saukko, 2000). In this way, a life history is a social construction, created by the narrator, his social relations and the researchers (Järvinen, 2000). A new narrative does not replace the former one, but the gap and the divergences between these narratives provide new material for analysis and reflection. The researchers interlaced the life narrative of the key person, the narratives of the

other informants, the staff policy at the working place and her own observations about the interview situations. Consequently, the analysis focused on the biographic master motive 'alcohol abuse' when living with cancer. This mode of analysis attempted to foreground a sensitive narrated topic, which was almost hidden in empirical material. It regarded narratives and storytelling as performance and social acting (Williams, 1984; Leibing, 2007; McLean, 2007; McLean and Leibing, 2007; Hydén, 2010).

Through the analyses different life trajectories of the key person were constructed. This construction of the narrative fell into four main themes related to alcohol as a *socialisator*:

1. Social position and trajectory of working life and cancer: disease and injury occur and will be overcome
2. Social relations in the trajectory of the family life: an unstable stability with unspoken alcohol consumption
3. Social relations in the trajectory of spare time and life outside the home: the stable stability with alcohol as an admission card
4. Social relations in the trajectory of working life: an alcohol free zone

A trajectory of life consists of a range of positions, successively acquired by one and the same agent (or group of agents) in a space. Biographic events can be defined as a number of places and movements in the social space that is in the different successive conditions of the structure and in the distribution of the different types of capital which are active.

Through construction of *habitus*, which is understood as the practical sense of the agent, built up through family history and the lived life, the analyses aimed to show the active principle that

unites practice and the agent's way of articulating practice (Bourdieu, 1984,1995,1999). This was done by interlacing the narratives of the key person and the other informants and at the same time taking the structural frames into account. The analyses were written as a narrative, and as such a newly constructed narrative emerged (Bourdieu, 1999).

### **Findings: Alcohol as a *socialisator*, a social capital in private life and a hidden abuse at the working place and in the oncological field**

The initial inclusion of the key person, Ole, in the project, was complicated by reactions from nurses at the hospital. Our assistant, who recruited the cancer patients to the project, found that Ole met the criteria of inclusion, but the nurses did not find him suitable for interview. The nurses deemed his physical condition to be good considering that he had been treated with radiotherapy, but they found he was always mute, unable to maintain a dialogue, and regarded him as an alcohol abuser and a bit of a loner. But when asked directly they responded that they had not talked to him and did not know anything about him and his life. We insisted that the interview by Ole was just as important as the other possible informants and invited him into the project. He accepted immediately by telephone; he asked that to meet after lunch because he slept late in the mornings and had trouble waking up. I met Ole in the corridor at my office. Initially I passed by him, because my own picture of a 51 year old man was not in accord with the man I saw sitting on the sofa. When I passed again he smiled, and I understood it was Ole, patiently and silent waiting for me.

## **Social position and trajectory of working life and cancer: disease and injury occur and will be overcome**

Ole was 51 years old, unmarried and grew up in a working-class family where his father supported the family financially and his mother was a housewife. Ole was a skilled worker, following an apprenticeship he worked in the same factory as his father for 27 years. When the factory closed down, Ole was unemployed for 1½ years. He was then employed as an unskilled worker in a medical industry, from where he had been absent, due to the cancer, for more than two years – and he was still absent.

Ole had had several interruptions in his working life: during his apprenticeship Ole suffered an accident at work where he lost two fingers, though it had never stopped him from working: *"It has never bothered him. He can carry three beer crates"* (Ole's mother). He was hospitalised for a long time and was off work sick for a year. During the past 4-5 years he had been hospitalised several times as he had undergone surgery for an ulcer and had had several accidental falls, resulting in a broken jaw, broken wrist and broken hip:

*"He broke his hip while he was cycling. And now he dare hardly sit up on a bike. He had probably had too much beer."* (Ole's mother)

Two years ago he was diagnosed with and treated for cancer in the throat:

*"It's two years ago [...] It continued to hurt, it was not an ordinary throat infection [...] I visited the specialist [...] then I was referred to the hospital [...] they made a biopsy: it was cancer. And then radiotherapy [...] 33 times."* (Ole)

Ole had been through a fatiguing and painful radiotherapy. He still suffered from weight loss, irritating cough and pains of the throat. Ole had always been skinny but had lost a further seven kilos since he was diagnosed with cancer. During the interview Ole talked quite a lot about his disease, but he described it as insignificant in his life despite the fact that cancer is life-threatening: it was more a casual state of life. Ole's *habitus* was marked by the experience that disease and injury occur and will be overcome in life – it passes or it does not pass, but you live with it; and you live well with it. Ole had been off work sick since the beginning of the radiotherapy and now he spent his days without work.

### **Social relations in the trajectory of the family life: an unstable stability with unspoken alcohol consumption**

Throughout his childhood Ole had lived in different flats with his parents and sister, the majority of his life in a working-class neighborhood in a city suburb. He had a small co-housing flat:

*"I could not resist. After all, it was more than a single room. I lived in the studio flat for 12-13 years. Now I have lived in the two-roomed flat for 20 years."* (Ole)

During the interview Ole disclosed that he seldom stayed in his flat by himself, instead he lived with his father in his two-roomed flat where Ole slept on the floor in the bedroom: *"We sleep in the same room; I have a mattress on the floor"* (Ole). He only visited his own flat once a week:

*"Ole goes home every Tuesday. Always. He stays overnight and goes back to his father on Wednesday. Then they spend the whole week together again."* (Ole's mother)

Ole's relationship to his father seemed conflict-ridden and filled with quarrels:

*It's almost like a married couple. It's okay [...] but they bite each other heads off; wrangling" (Ole's mother)*

*Sometimes, the noise level is loud [...] He is old and peculiar, and my cancer does not help the situation. [We argue about] many different things [...] Trivial matters. (Do you do other things together?) No, we take care of ourselves". (Ole)*

Ole indicated that life on his own was not always easy for either him or his father. Therefore they spent time together in a way where they could be just who they were; enjoying their loneliness in togetherness. They watched television together (often satire programmes).

His mother visited Ole every Tuesday to clean up his flat and sleep over. She had done so since he was diagnosed with cancer:

*"Ole said: "you cannot visit me; this place looks terrible". Damn, I have seen misery before in my life; I don't care. He only used his flat one night a week. There were spider webs everywhere, and the floor needed washing. Ole is meticulous with his things; they have to be put in the right place [...] I did it because he had cancer, and he was happy when I came. In the beginning, because of my cleaning [...] Later, because I stayed overnight." (Ole's mother)*

In this way the cancer diagnosis united mother and son once a week as in Ole's childhood when they were living together. One of the stories Ole told was about his family and their relations. The family had been through a lot. His father and mother divorced when he was 18. Ole had a younger sister, who was 48 years old, single, a drug addict, disability pensioner and lived with the mother. Ole had no contact with her. He also had a younger half-sister who married twice and has three children, whom he visited rarely despite having a good relation with her. Both his parents had

married and divorced twice, his 74 year old mother divorced recently. Ole knew that family is important; regardless of the problems of the family, the family was there as a stable structure throughout life. This could be seen as stable to know that everything is unstable. In spite of all the apparent disordering, disruptions and instability in his family Ole narrated a story of order and stability. In spite of the periodic chaos of his family's life the family's life story was translated into 'good relations within the family': *"We (Ole and half-sister) have the best relation, also my father and mother"* (Ole). Alongside the apparent chronology and order of his narrative, also supported by the interviewer, lurked the different traumas of the family. And as the interview progresses another sensitive topic and unspoken matter came up in Ole's orderly narrative. Without him speaking directly about it, the interviewer got a sense that the father and Ole both abuse alcohol and that in their twosomeness they socialise a lot through alcohol consumption. An observation of Ole's body indicated a year-round alcohol consumption, with, for instance, grey complexion and skinny body. An observation of numerous remarks such as "I am not able to eat" implied "It is easier to drink". After radiotherapy Ole had eating problems because of pain in the throat and he was only able to eat liquid food which meant it seemed more legitimate to drink alcohol; it was liquid. Ole knew he lived a life with much alcohol and insufficient food: *"Yes, I'm short of vitamins"* (Ole). But it was his way of living, and he found that he had a good life with a good job, good family and friends and he never felt lonely. Offhand and unproblematic, he seemed to accept his cancer disease, life had taught him to cope with difficult situations and create a new, meaningful stability in life. There was a sense that those difficult social events included alcohol and Ole narrated such events in terms of drinking, for instance:

*"It was a stupid bike; I stumbled over the kerb and landed at the hip [...] I lost direction. Maybe I got too much."* (Ole)

Looking and listening at Ole, you were not in doubt: he was drunk when the accident happened, but he never talked about it. Afterwards, his mother confirmed that sense in her narrative:

*"He was on a bike when he broke his hip. Now, he doesn't dare to go by bike again. I think he drank too many beers."* (Ole's mother)

Hence the interviewer slowly begins to realise how Ole and his family were, and always had been, influenced by heavy drinking. In an oncological context, including the interview context, alcohol abuse was a shadow side of Ole's life. The interviewer tried to get into the unspoken matter of heavy drinking in daily life but failed in this attempt: only once in the interview Ole mentioned his beer-drinking, and only as a subordinate clause: *"Yes, we drink a few (beers) at billiards."* (Ole).

But even as his mother spoke about what could be regarded as a quite substantial alcohol abuse in the lives of Ole and his father, she still tried to cover it up and at the same time she legalised the drinking:

*"(At the hospital) I asked if he was allowed to drink beer and so on. He has to know. I admit he drinks too much, but lately it has decreased. He is not drinking that much any longer [...] I must admit it has been a big part of the life (of the father) and Ole. But he never drinks when he drives the car [...] When they relax they buy aquavit and put it in the coffee [...] Of course it is bad [...] the heavy drinking [...] But if it soothes the pain and he gets more relaxed, then it is worth it."* (Ole's mother)

Ole and his father had a daily high rate of alcohol abuse in each other's company at home. Even if Ole lived at his father's, he felt lonely most of the day. The alcohol had always been the companion of Ole and is a big part of his life; apparently the alcohol consumed had increased since

he had spent most of his time at home after the cancer diagnosis. Ole's circadian rhythm was to be late to bed and late up in the mornings. He was used to being on his own and enjoys being awake at night. For both Ole and his father the day was characterised by regularities and routines such as watching television and reading newspapers. Regularities, both in order and disorder, could be seen as a key word in the life of Ole, a substantial part of his daily life - and his *habitus*.

### **Social relations in the trajectory of spare time and life outside the home: the stable stability with alcohol as an admission card**

Ole played billiards in his spare time; an interest he had been enjoying since he was 15 years old when he started a local billiards club. In the club he met friends and also his father: *"I have always played billiards [...] It's my big hobby."* (Ole). Billiards is often – as for Ole - connected to pubs and alcohol intake. In the billiards club they played for beer:

*"I have a friend. He also lives here (close to the father), and he is also a member of the billiards club. He is also my colleague."* (Ole).

*"Often I am out of the house [...] in the club and sometimes at the pub. Ole seldom goes to the pub [...] once in a while, but then it is on Saturday when they (Ole and father) are shopping [...]. Then they can drink a beer or two, before they go home again. When he goes to the club, he drinks beer."* (Ole's colleague)

Ole's father lived close to the club, so it was easy to get out. A friend and colleague of Ole had the same interest, and after work they had often played and drunk beer together. Billiards was a way

for Ole to retain a community comprised of friends, colleagues and his father. In the billiards club beer was inevitable, and as Ole put it:

*"When I visit the club 3 to 4 times a week, there is a bit of drinking going on".* (Ole)

*"They have been so nice to include "Daddy" [Ole's father] in the billiards. They say: Daddy here and Daddy there, so he has always been a part of it with Ole."* (Ole's mother)

People with approximately similar lifestyles, dispositions and *habitus* met in this sphere; everything seemed to happen unproblematically and without the urge to question anything. Everything went on as usual; and usual was good and safe.

### **Social relations in the trajectory of working life: an alcohol free zone**

Throughout his life Ole had been taught that alcohol belonged to life outside work as a tacit, natural, common occurrence. It had never been spoken of as a problem; it was just as it always had been. Ole's alcohol consumption had never taken place at work, only in other social contexts where alcohol was legitimate; at home, in the pub and the billiards club.

The workplace could be regarded as socially responsible. For example it did not have a tradition of dismissing an employee when someone was absent due to long term sick leave:

*"I can't remember that we have dismissed anyone because of illness. Sometimes we have made the job more flexible for people with a reduced ability to work when they have [for example cancer, sclerosis, epilepsy]." (Ole's work leader)*

The general management attitude was that it was incorrect to be alcohol dependent and it was incompatible with an employment. The workplace was a 100 % alcohol free zone:

*"Work and alcohol intake are separated. (Name of the workplace) has an alcohol ban which means: there is an alcohol ban in the company; [...]; the alcohol ban also involves external collaborators visiting (Name of the workplace); employees having alcohol or other abuses are offered help and support. Call [...]"*. (Written Staff Policy at the workplace)

*" It is very rare we have dismissed anyone because of [alcohol]), but as a part of our health insurance we have an option to offer people treatment, for example for alcohol abuse. And we have a well-functioning HR where the staff is trained to notice the abusers and they have qualified person who intervene. [...] We also have a relatively powerful alcohol policy; it means that alcohol is forbidden. And there are no possibilities for dispensation."* (Ole's work leader)

Ole explained that he expected to be dismissed because of his long absence. It felt chaotic to him returning to the labour market, as he would have to re-establish a new pattern of day-to-day life again: he was relatively controlled and structured in his everyday patterns and he was disturbed by simple changes to his lifestyle:

*" I thought they had given me the dismissal notice long ago, but apparently they are not allowed to. [...] I'm not going back to work [...] Now I've got used to being at home. (You sleep late?) I do and go to bed late, about 1-2 AM. (Father) can't be awake that long. Then I can watch a film and maybe (drink a beer) [showed by a gesture]"*. (Ole)

It seemed impossible for Ole to return to work after his cancer diagnosis and treatment. The implication would be that he should re-establish a new pattern of everyday life once again. During

and after the cancer disease, alcohol intake was a significant part of Ole's life and going back to work would demand a change in his lifestyle. Ole had recovered quickly previously when instability had occurred in his life, for example when his parents divorced, when he experienced an accident at work, as well as when he was unemployed. He had never taken a conscious choice about radical changes in his life. It seemed insuperable for him to change his routines and practices. Ole's everyday life –and his *habitus* - was marked by stability. When changes in his life had been inevitable, he re-established the disorder into a new order as soon as he was able. He had learned that life was best when he had fixed habits and changing habits seemed difficult for him to tackle. Despite changes in his surroundings and life circumstances, he had always fallen back into a safe and well-known framework for his life.

Ole considered applying for disability benefit (pension), but he did not know how to make the application. Even if Ole regularly had contact with the hospital, no healthcare professional had ever talked to him about a pension, despite his poor physical condition. It could be regarded as a habitual strategy for Ole not to disturb others, and therefore he had not asked for help to apply for a pension; he did not want to be a burden to anyone. Ole's *habitus* was marked by not attracting much attention. According to Ole, the healthcare professionals had not given attention to the pension problem:

*“(Pension) I consider applying. I have no idea how to do so [...] There are some offices close to where I live; maybe I should ask them [...] I think my physician has to be involved as well”.* (Ole).

*“I don't believe he will be at work again [...] I don't understand why they don't give him a pension [...] Ole can't do anything at the present; he can hardly walk”.* (Ole's colleague)

Ole knew that a pension implied lower income, but it did not seem to be a problem for him. He was able to live on a shoestring and he was generally satisfied with his way of living:

*"Life is going fine, but maybe because I'm not spending money at all. My interest in going out and having fun has decreased and so on". (Ole)*

Regularity and stability were common features of Ole's life, both in relation to the social network, hobbies, work, housing and economy. When working life stopped, Ole got back spare time: the meaning and content of spare time was drinking alcohol. During the interview Ole was not silent and mute, but was obviously unaccustomed to talking about himself. He explained that it was the first time someone inside the healthcare system had shown interest in him and his life. This was an experience he had shared with his mother who told the same story in her interview.

## **Discussion**

To choose a sociological framework means to choose a perspective for the study, while knowing that other perspectives could have been chosen. It is a way to manage and direct the analysis. The analysis consists of detecting correlations and patterns, and at the same time, the analysis tries to understand and illuminate how alcohol abuse of cancer patients can be seen as a shadow side of the oncological field and research.

The analyses show how alcohol can be a *socialisator* and a form of *social capital* in private life and a hidden abuse in the oncological field. We show how alcohol can be a natural and inevitable part of a person's social life and spare time outside work when living with cancer. Nowadays, work and

staff policies more or less define work as a non-alcoholic zone with a visible opening and willingness to help and treat staff with alcohol problems (Danish Health and Medicines Authority, 2008). When persons with a relatively large alcohol abuse outside of work get cancer – or get ill at all– and have to go on sick leave for long time, maybe half a year or more, all life converts to spare time. According to Bourdieu (1984) a person's *habitus* forms and creates a person's life which he has learnt through his life. This means that if a person is used to drinking alcohol in his spare time, alone or together with others, this pattern could have become habitual. When the spare time, because of cancer and cancer treatment, extends to 24 hours every day, alcohol drinking increases, as well. In this way a cancer disease and its medical treatment consolidate and exacerbate a person's alcohol abuse by notification of illness and absence from work, when the workplace is the only place in the life without alcohol abuse. In that way, medicine produces social *iatrogenesis*, as Illich (1979) stated. Furthermore, the social implications of healthcare professionals' interventions and treatment of alcoholics must be discussed. There is no doubt that alcohol abuse is harmful to a person's health and directly causes diseases such as liver cirrhosis, diabetes, and cancer (Danish Health and Medicines Authority, 2009; Groenbaek, 2009; Rehm et al, 2010), but it is also obvious that a person, who lives life as shown in this study's case, is in danger of being lonely and insecure because the stability and predictability in the person's life will break up in the medicalisation of the 'unhealthy' way of living. The remaining question is simply what is most "unhealthy"? From the inclusion phase of the project, it is clear that the nurses had categorised the informant as an alcohol abuser and only had contact with him when absolutely necessary in order to run the oncological treatment and control. From this and from the perspective of the patient, it appears that some healthcare professionals ignore the alcohol abuse of their patients, but at the same time healthcare professionals argue in favour of trying to change

their patients' unhealthy lifestyles. This seems to be an obvious paradox, and therefore an obvious question arises: do the healthcare professionals not notice Ole and his like because they know they will do more harm by intervening than not, or do they not notice the persons because they represent the suffering of the world and are regarded as being outside the therapeutic range; they are abnormal by definition (Glasdam, 2003)? The healthcare system may see cancer patients with an alcohol abuse as persons with an unacceptable way of living. When the healthcare professionals do not notice or reach the alcohol abuser, they keep the abuse in the shadow side of life and the shadow side of hospital practice: they keep it tacit and non-articulated. A further discussion could be from a social class perspective, in which Ole and his like represent a different social position from the healthcare professionals. Ole's position is subject to the professionals' positions, both in the social space in general and, specifically, at the hospital.

Alcohol could be regarded as an incorporated part of a person's *habitus* and daily life with family, friends and in his billiards club and as a form of *social capital* in those social arenas. The life of all informants in this study can be regarded as happy and content with life despite miseries such as alcohol abuse, drugs, divorces and diseases. Alcohol is not taboo among Ole's family and friends. Alcohol is a part of the routines and salient daily life, and a part of the *habitus* of persons in the surroundings. What is understood as a happy and good life comes in many packages and is intrinsically part of where and when we are born; a part of a class structure. Actually, Bourdieu (1984) showed how people from the working class all in all are satisfied with their ways of living and have an ability to make a virtue of necessity: life is life, and life is good. The medical field has its own way of understanding what is a good life and gives advice in line with their understanding

of a good life; at the current time health and healthy living is understood as “healthy” food, no tobacco, low alcohol intake and physical activity (Christensen et al, 2009; World Health Organization, 2002). People in this study challenge the medical professionals and the health authorities’ understanding of a good life. If people like Ole changed their way of living to a life without alcohol following cancer diagnosis, life would probably become miserable and lonely since social life consists of shared cultural activities in which alcohol is an important part.

The construction of the single case is based on the key person’s perspective of his relations to family, colleagues and work leader. The method of this case study has to be discussed since the perspective of the healthcare professionals and the father of the key person are not included. The perspective of the professionals could have shed another light on the analysis, especially the meetings between the key person and the professionals at the hospital. The father seems to be an important person to the key person and an interview with the father could have varied the analyses further. The informants are recruited through the hospital, and this can also be seen as a weakness in the study since alcohol abuse is seen as a pathologic disease in the medical field, not as a social necessity in some people’s way of living. It means that the alcohol abuse has to be hidden, if the patient does not want to be diagnosed and treated for his abuse.

Finally there are some methodological reflections on and limits in exposing a shadow side of life through interviews and reading in-between the lines, sensing the explicit and implicit narrated in the situations, observing the body expressions. This is the case even if more disturbing elements were included from the perspective of differently positioned persons who bring into question the taken-for-granted and could lead to a perception of a reality that had been hidden. It is not the case that a new narrative replaces the former one, but that the gap and the divergences between

these narratives provide new material for reflection (Saukko, 2000; McLean and Leibing, 2007).

Interviews will always be a self-constructed narrative about the life and living of a person, created in interaction with the environment (Järvinen, 2000); if we want to come closer to learning about life with hidden dimensions as for example alcohol, anthropological field studies following persons in their lives are an obvious research method (Terp and Glasdam, 2010; Glasdam et al, 2013).

## **Conclusion**

Some cancer patients are alcohol abusers and alcohol functions as an important part of the trajectory of their private life and spare time. In social life with family and friends alcohol is shown as a given and normal *socialisator* and as a form of *social capital*, and functions as a stable side of life and as part of the person's understanding of a good life. Thus the analyses also show that alcohol abusers can have an ability to make a virtue of necessity: life is life, and life is good, despite living with cancer and alcohol. Cancer and alcohol appear as unstable stabilities in social life together with family and friends; they meet around an unspoken, apparently unproblematic and socially acceptable alcohol consumption when living with cancer. Alcohol has never been mentioned as a problem; it is just as it always has been. It seems incorporated in the bodies that alcohol belongs to life outside the workplace as a tacit, natural, common occurrence. When work ends or pauses because of cancer disease and treatment, all day and night convert to spare time. When working time has been a person's only alcohol-free arena and spare time is similar to drinking time, it means that all life converts to drinking time: the meaning and content of spare time is drinking alcohol. The analyses show how the life of alcohol abusers can be very controlled and structured in everyday patterns and every simple change can disturb their way of living. It is obvious that it is impossible for some people to return to work. The implication would be that a

new pattern of everyday life should be re-established. Some people have never taken a conscious choice about radical changes in their lives; they act best in stability. It is overwhelming to change routines and practices for them.

An excessive alcohol intake is a ubiquitous part of creating and maintaining social relations and daily routines. Alcohol abusers may become lonely and miserable if they stop drinking alcohol. From the perspective of the alcohol abuser with cancer, in the meetings with the healthcare system and the oncological healthcare professionals, it is necessary to be silent about one's alcohol abuse if the abusers do not want to be caught in the web of medicalisation of the 'unhealthy' abuse. Furthermore, the gaze and attention of healthcare professionals seem to register but not focus on the alcohol abusers with cancer who are not following 'the rules of the healthy game'. There are immediate consequences for a cancer patient with an alcohol abuse in meeting with the healthcare system because he will not be met, advised, or listened to; he can be seen as non-existent even in the physical manifestation of his presence. Accordingly, healthcare professionals ought to regard cancer patients with an alcohol abuse as equals with a meaningful social life without setting the goal of changing their 'unhealthy' lifestyle.

Finally, we can conclude that it is possible to foreground the mainly tacit existence of alcohol abuse in a cancer patient's life through analysing narratives from multiple perspectives and different positions in the social context within which the alcohol abuser lives. In terms of method, this article underlines the importance for researchers to be sensitive to the untold stories and the small passing remarks which may be unimportant at first glance, but which may reveal an otherwise hidden theme or phenomenon. This method must be challenged and developed in further studies.

## Referencer:

Barzelay, M. 1993. The Single Case Study as Intellectually Ambitious Inquiry. *Journal of Public Administration Research and Theory* 3:305-318.

Bourdieu, P. 1984. *Distinction: a social critique of the judgement of taste*. Massachusetts: Harvard University Press.

Bourdieu, P. 1995. Den biografiske illusion [The biographical illusion]. *Social Kritik* 36\_33-38.

Bourdieu, P. et al. 1999. *The weight of the world. Social suffering in contemporary society*. Cambridge: Polity Press.

Casswell, S., You, RQ. and Huckle, T. 2011. Alcohol's harm to others: reduced wellbeing and health status for those with heavy drinkers in their lives. *Addiction* 106(6):1087-1094.

Christensen, Al., Severin, M., Holmberg, T., Eriksen, L., Toftager, M., Zachariassen, A., Ekholm, O., Tolstrup, JS., Grønbæk, M. and Curtis, T. 2009. *KRAM-undersøgelsen i tal og billeder* [The KRAM-study in numbers and pictures] Copenhagen: Ministeriet for Sundhed og Forebyggelsen & Trygfonden.

Danish Health and Medicines Authority. 2008. *Alkoholpolitik og alkoholproblemer på arbejdspladsen* [Alcohol policy and alcohol problems at the workplace]. Copenhagen: Danish Health and Medicines Authority.

Danish Health and Medicines Authority. 2009. *Pakkeforløb for hoved- og halskræft* [Diagnosis and treatment courses for head and neck cancer]. Copenhagen: Danish Health and Medicines Authority.

Ekholm, O., Kjoeller, M., Davidsen, M., Hesse, U., Eriksen, L., Christensen, A.I. and

Groenbaek, M. 2006. *Sundhed og Sygelighed i Danmark -og udviklingen siden 1987* [Health and Morbidity in Denmark - and development since 1987]. Copenhagen: Statens Institut for Folkesundhed.

Emslie, C. and Mitchell, R. 2009. Are there gender differences in the geography of alcohol-related mortality in Scotland? An ecological study. *BMC Public Health* 9(58), doi:10.1186/1471-2458-9-58.

Emslie, C., Hunt, K. and Lyons, R. 2012. Older and wiser? Men's and women's accounts of drinking in early mid-life. *Sociology of Health & Illness* 34(4);481–496

Flyvbjerg, B. 2006. Five misunderstandings about case-study research. *Qualitative Inquiry* 12(2):219-245

Gerring, J. 2004. What is a case study and what is it good for? *American Political Science Review* 98(2):341-354.

Glasdam, S. 2003. *Inklusion og eksklusion af kræftpatienters pårørende i en onkologisk klinik*. [Inclusion and exclusion of relatives to cancer patients in an oncological clinic] Ph.d. Dissertation. Viborg: Forlaget PUC.

Glasdam, S. and Thisted, L.B. 2010. Metodiske udfordringer ved rekruttering af patienter til sociologisk studie - med udgangspunkt i et projekt om arbejdslivets betydning for mennesker med kræft [Methodic challenges for recruitment of patients to a sociological study – based on a research project on the meaning of work for cancer patients]. *Klinisk Sygepleje*, 2,4-15.

Glasdam, S. 2011. Klemmt mellem sygdom og job - om kræftpatienters møde med jobcenters krav om jobaktivitet [Sandwiched between disease and job – on cancer patients' meetings with the requirements of job center in relation to job activity]. *Klinisk Sygepleje*, 25(4), 25-35

Glasdam S, Henriksen N, Kjær L & Præstegaard, J. 2013. Involvement of the Client in Home Care Practice— a relational sociological perspective. *Nursing Inquiry*; 20(4): 329–340

Groenbaek, MN. 2004. Alkoholforbrug i Danmark – folkesundhedsmæssige udfordringer og videnskabelige spørgsmål [Alcohol consumption in Denmark - public health challenges and scientific issues]. *Ugeskrift for Læger* 166:1573-1576.

Groenbaek, M. 2009. The positive and negative health effects of alcohol- and the public health implications. *J Intern Med* 265(4):407-420.

Groenkjaer, M., Curtis, T., de Crespigny, C. and Delmar, C. 2011. Acceptance and expectance: Cultural norms for alcohol use in Denmark. *Int. J. Qualitative Stud Health Well-being* 6(4) DOI: 10.3402/qhw.v6i4-8461

Gutjahr, E. Gmel, G. and Rehm, J. 2001. Relation between average alcohol consumption and disease: an overview. *Eur Addict Res* 7(3):117-127.

Horsdal, M. 2012. *Telling Lives: Exploring dimensions of narratives*. Oxon: Routledge

Hvidtfeldt, UA., Hansen, ABG., Groenbaek, M., and Tolstrup, JS. (2008). *Alkoholforbrug i Danmark - Kvantificering og karakteristik af storforbrugere og afhængige*. [Alcohol consumption in Denmark - Quantification and characterization of heavy users and addicts.]. Copenhagen: Statens Institut for folkesundhed, Syddansk Universitet.

Hydén, L-C. 2010. Identity, Self, narrative. In: Hyvärinen, M., Tamboukou, M. *Beyond narrative coherence*. Amsterdam: John Benjamins Publishing Company, 33-48.

Illich, I. 1979. *Limits to Medicine. Medical Nemesis: the Expropriation of Health*. Harmondsworth, Penguin.

Järvinen, M. 1998. *Det dårlige selskab. Misbrug, behandling, omsorg* [The bad company. Abuse, treatment, care]. Holte: Forlaget SOCPOL.

Järvinen, M. 2000. The biographical illusion: Construction meaning in qualitative interviews. *Qualitative Inquiry* 6:370-391

Leibing, A. 2007. The hidden side of the moon, or, "lifting out" in ethnographies. In: McLean, A. and Leibing, A. (eds). *The shadow side of fieldwork. Exploring the blurred borders between ethnography and life*. Oxford: Blackwell Publishing, 138-156

Leyland, A., Dundas, R., McLoone, P. and Boddy, F.A. 2007. Cause-specific inequalities in mortality in Scotland: two decades of change. A population-based study. *BMC Public Health* 7:172 doi:10.1186/1471-2458-7-172

McLean, A. and Leibing, A. 2007. "Learn to value your shadow!" An introduction to the margins of fieldwork. In: McLean, A. and Leibing, A. (eds). *The shadow side of fieldwork. Exploring the blurred borders between ethnography and life*. Oxford: Blackwell Publishing, 1-28.

McLean, A. 2007. When the borders of research and personal life become blurred: Thorny issues in conducting dementia research. In: McLean, A. and Leibing, A. (eds). *The shadow side of fieldwork. Exploring the blurred borders between ethnography and life*. Oxford: Blackwell Publishing, 262-287.

Office for National Statistics. 2011. *Alcohol-related death rates in the UK 1991-2009*.  
<http://www.statistics.gov.uk/statbase/Product.asp?vlnk=14496> (Accessed 03.07.2013)

Peled, E. and Sacks, I. 2008. The Self-Perception of Women Who Live with an Alcoholic Partner: Dialoging with Deviance, Strength, and Self-Fulfillment. *Family Relations* 57(3):390-403

- Rehm, J., Baliunas, D., Borges, GL., Graham, K., Irving, H., Kehoe, T. et al. 2010. The relation between different dimensions of alcohol consumption and burden of disease: an overview. *Addiction*, 105(5), 817-843.
- Room, J., Ferris, J., Laslatt, AM., Livingston, M., Mugavin, J. and Wilkinson, C. 2010. The drinker's effect on the social environment: a conceptual framework for studying alcohol's harm to others. *Int J Envr Res Public Health* 7(4):1855-1871.
- Saukko, P. 2000. Between voice and discourse: Quitting interviews on anorexia. *Qualitative Inquiry* 6(3):299-317.
- Sayer, A. 2000. *Method in social science. A realist approach*. 2. edn. London: Routledge.
- Terp, MØ. and Glasdam, S. 2010. Et liv med indre stemmer[A life with inner voices]. *Klinisk Sygepleje* 2:26–36.
- The Scottish Government. 2008. *Changing Scotland's relationship with alcohol: a paper on our strategic approach*. Edinburgh.
- Thomas, G. 2011. A typology for the case study in social science following a review of definition, discourse and structure. *Qualitative Inquiry* 17(6):511-521
- Thygesen, LC., Keiding, N., Johansen, C. and Groenbaek, M. 2007. Changes in alcohol intake and risk of upper digestive tract cancer. *Acta Oncol* 46(8):1085-1089.
- Thygesen, LC., Johansen, C., Keiding, N., Giovannucci, E. and Groenbaek, M. 2008. Effects of sample attrition in a longitudinal study of the association between alcohol intake and all-cause mortality. *Addiction* 103(7):1149-1159.

Thygesen, LC., Mikkelsen, P., Andersen, TV., Tønnesen, H., Juel, K., Becker, U. and Groenbaek, M. 2009. Cancer incidence among patients with alcohol use disorders - long-term follow-up. *Alcohol and Alcoholism* 44(4):387-391.

Williams, G. 1984. The genesis of chronic illness: narrative re-construction. *Sociology of Health and Illness* 6(2):175-200

World Health Organization. 2002. *The world health report 2002 - Reducing risks, promoting healthy life*. Geneva.