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ABSTRACT

This paper is based upon the findings from the qualitative element of a mixed-methods study into the response of Black women aged between 25 and 50 to a public health intervention relating to breast cancer. The focus groups were conducted in the London Borough of Hackney, UK, between 2013 and 2016 and were part of an evaluation of the effectiveness of a breast awareness DVD. While the content of the DVD was generally well received by the participants, the focus group discussions revealed a complex and at times contradictory response to the women's construction as an 'at risk' community. As the paper highlights, for many of the women breast cancer remains a disease of whiteness and the information provided in the DVD prompted a range of emotional responses; from anxiety and fear to a desire to become more knowledgeable and active in the promotion of self-care. As the paper argues, of particular importance to the women was the need to feel a much stronger emotional connection to the information presented in the DVD. The paper concludes by arguing that placing greater emphasis on feeling and emotion is an important dimension of future research in this area.

Keywords

Breast cancer, breast awareness, DVD intervention, emotion, risk, embodiment, qualitative, UK

INTRODUCTION

The epidemiological picture of breast cancer in the UK appears significantly changed. Since the introduction of the National Health Service Breast Screening

Programme (NHSBSP) in 1988, and the advances in systemic adjuvant therapies in the late 20th century, deaths from breast cancer have declined by 40% in women (Evans et al, 2016). Although improvements in therapy and the introduction of a comprehensive screening programme are an important part of the explanation (Advisory Committee on Breast Cancer Screening, 2006), there are many other factors which may have influenced this decline, including breast cancer awareness campaigns and the removal of barriers to early treatment. As Niksic and colleagues (2016) suggest, the assumption underpinning the national response to previously poor short-term cancer survival rates, especially when compared with other European nations (Autier et al, 2010), was that improving people's awareness of symptoms and encouraging them to seek medical advice before developing advanced-stage cancer would improve short-term survival. This approach appears to be paying dividends at the population level, but there remain significant disparities in mortality from breast cancer. For example, while breast cancer incidence is lower amongst Black women in the UK – used here to reflect ethnic classifications employed in this study, which included Black African, Black Caribbean, White and Black African, White and Black Caribbean, and any other Black background – survival rates remain lower (Bowen et al, 2006; Jack et al, 2009; Møller et al, 2016); a picture which mirrors the experience of African American women in the USA (see Chlebowski et al, 2005; Grann, et al, 2006; DeSantis et al, 2016).

The poor survival rates from breast cancer for Black women as compared to women from other ethnic backgrounds has, at least in part, been explained by differences in the biological characteristics of the tumours that many women develop (Jack et al, 2013; Januszewski et al, 2014). The interplay of age, ethnicity and risk is

slightly complicated. Jack et al (2012) show that up to around age 45, Black women have similar absolute incidence rates to White women and that, at later ages, incidence is lower. Thus, while the overall incidence of breast cancer is lower in Black women, for those who do develop the disease, they are more likely to develop it at younger ages than their white counterparts. This implies that the cancers they present with will be more likely to be oestrogen receptor negative and therefore more aggressive. Jack et al (2013) have shown that they are more likely to present with triple negative disease. Bowen and colleagues (2008) have argued that it is crucial to target this group of women to raise their awareness regarding the risks of breast cancer, the importance of early stage at presentation, and the consequent importance of awareness of breast symptoms and prompt seeking of medical advice in response to these. Consistent with the lower overall incidence in Black women, the Million Women study in the UK has found that Black women are more likely to breastfeed and less likely to drink alcohol or have a family history of breast cancer (Gathani et al, 2014). For some women, this is incorrectly interpreted as meaning breast cancer is a 'white woman's disease' (Pfeffer, 2004; Jones et al, 2015).

It has long been known that levels of cancer, including breast cancer, awareness are lower amongst UK ethnic minority populations. Evidence suggests these groups have lower levels of knowledge relating to breast cancer symptoms and related to this a greater range of barriers to accessing healthcare services, including breast cancer screening programmes (Scanlon and Wood, 2005; Waller et al, 2009). Despite Bowen and colleague's call for action, a recent systematic review suggests that this pattern persists (Jones et al, 2014; Jack et al, 2014). Furthermore, there has been a greater attempt to nuance understanding by considering differences within

and between Black ethnic groups. Of particular relevance to this paper is a recent qualitative study of the barriers to early diagnosis of breast cancer in Black African, Black Caribbean and White British women in England (Jones et al, 2015). The study, which was conducted in two phases and involved interviews and focus groups with women in London and other major British cities and regions, concluded that there continue to be important differences in barriers to diagnosis for breast cancer for this group of women. More specifically, the study suggested that first generation Black African women, more than any other women included in the survey, were particularly vulnerable because of conservative attitudes and cultural taboos relating to breast awareness. Moreover, that '[w]omen from all ethnic groups were confused about what they needed to do to be breast aware' (2015, p. 17).

We report here on the qualitative findings from a mixed-method evaluation of a breast awareness intervention targeted at Black women living in the Borough of Hackney, London, UK. The quantitative element of the project involved the evaluation of the effectiveness of a short, 7-minute breast awareness DVD in encouraging early presentation of breast cancer in black female patients aged under-50 years old. Conducted in two stages – a pilot study carried out between January and June 2013 was followed by the main study from June to November 2014 – the quantitative evaluation involved the participation of general practices in the Borough (4 at pilot stage and 10 in the main study). At each stage, the general practices were randomised with all Black women aged between 25-50 registered with the intervention practices receiving a copy of the DVD. The quantitative evaluation involved the analysis of data on consultations for breast symptoms by age and ethnicity (black or non-black populations) for all practices for 6 months prior to and

after the intervention. The results of this aspect of the evaluation project have been reported on elsewhere (Authors, 2016; Authors, unpublished results).

The quantitative evaluation of the DVD's effectiveness was supported at each stage by focus group discussions with women from both the intervention and control practices. The focus groups were primarily set up to explore the women's responses to the DVD content and its delivery method (the DVD's were posted to the women in this intervention) and their perceptions of the DVD's possible effect on women's breast awareness and associated behaviours. As is often the case with focus groups, the women participating in the discussions shifted the direction of conversation beyond the prompts included in the focus group schedule. In what geographers Mike Crang and Ian Cook (2007) refer to as the 'liveliness' of doing focus group research, these shifts in direction provided additional insights into the women's understanding of breast cancer, their awareness of and response to their heightened risk for forms of breast cancer that have poorer prognosis and the importance of generating a greater emotional connection between the DVD intervention and its target audience. In order to confirm and further develop understanding of these emergent themes, an extension to the main study was granted by the project's funders and involved additional focus groups being conducted with a similar cohort of women (that is, Black women aged 25-50 living in Hackney). This report draws on all the collected focus group material to consider how the women responded to the DVD as a public health intervention and to wider questions about their construction as women at risk.

METHODS

As noted in the introduction, this paper is based upon focus group research conducted with Black women aged between 25-50 in the London Borough of Hackney between 2013 and 2016. The women were recruited to the study in one of two ways; either through general practices in the Borough (n = 69) or for the extension study through a variety of community organisations based in Hackney (n = 32); the latter included black women's support groups and faith-based organisations. Given the potential for participant drop-out and as a partial compensation for their time the women received a nominal cash payment of £20. Additionally, the focus groups were conducted either in the general practices from which the women were recruited or in the case of those women recruited through community organisations in the places where the organisations regularly met. It is recognised that this might have impacted upon some women's willingness to engage in discussion with people already known to them; however, with the exception of one focus group the discussions were described as 'lively' by the researchers facilitating them and attendance for just over half met the desired threshold of between 5 and 10 participants. Those focus groups where only two participants attended (n = 2) were not included in the analysis.

The focus group discussions were facilitated by a single researcher with previous experience of conducting qualitative research of this nature; although the identity of the researcher changed across the course of the project, they were all female and had been directly involved in recruiting participants to the study. The focus groups were conducted using a pre-agreed focus group schedule which was designed by the qualitative research team (made up of geographers with extensive health-related

research experience) and ratified by the project steering group as well as by appropriate NHS and university ethics boards. At the beginning of each focus group session, the participant's awareness and knowledge of breast cancer were recorded using a questionnaire survey based on the Breast CAM survey instrument developed by Cancer Research UK, King's College London and University College London in 2009 (Cancer Research UK, 2011). Additionally, each focus group discussion opened with the researcher playing the DVD to the women; this acted as a reminder for those women in the intervention groups and as a prompt for women who had not previously seen the DVD. The focus group discussions lasted from between thirty minutes to over an hour in length and all were audio recorded, transcribed and cross-checked by at least one other researcher on the project before being entered on to QVR NVivo V.10 for coding and analysis.

Analysis of the focus group transcripts was developed using both deductive and inductive approaches and was based upon the framework method often employed in multi-disciplinary health-related research (Gale et al, 2013). With regards the former, deductive codes related to the study's primary goal of evaluating the women's response to the DVD, its mode of delivery and their perceptions of its effectiveness. However, in keeping with the flexibility of this analytical approach inductive codes were also developed by each of the researchers involved with the qualitative strand of the project. This entailed reading a randomly selected transcript line by line and applying codes to a much broader range of the text than in the deductive approach. This approach significantly broadened the range of themes that emerged for subsequent analysis and interpretation. Following group discussion, both the deductive and inductive codes were refined and applied to a further sample

transcript and the process repeated on several occasions until the team were satisfied that the codes were thorough and could be accurately used for the analysis of all the focus group material; anonymised codes for identifying individual focus groups are employed in the following analysis.

FINDINGS: FEAR, FAMILY AND THE PLACING OF EMOTION

A total of 101 women were recruited to 20 focus group discussions across the different stages of the study. Although the majority of women met the inclusion criteria (Black women aged between 25-50), a small number (n = 4) were aged over 50 years old. These women were not directly recruited to the focus groups and attended because they accompanied friends; so as not to compromise the atmosphere of the focus group discussions these women were allowed to participate and have been included in the analysis. With regards ethnicity, the women self-identified as either Black African (49%), Black Caribbean (37%), Black Other (7%) or of mixed ethnicity – White and Black African (3%) and White and Black Caribbean (4%). A small number of women choose not to identify their ethnicity. The women were fairly evenly distributed across the focus groups, though in a small number of instances (n = 4) the groups were made up of women from similar ethnic backgrounds.

The way in which the message of collective risk was communicated by the DVD was of particular relevance to the women's discussion during the focus groups and to the themes that emerged from them. The DVD was created in collaboration with the Homerton Hospital and featured a black female TV presenter and women from

the surrounding area. These women, like those watching the DVD, were represented as individuals from a collective black community seeking information about a shared risk. In the DVD, the TV presenter acted as the narrator, guiding the audience through various sites of encounter: a discussion about breast cancer risk between Black women and a local GP; a local street scene which helped identify the scale of women's risk for breast cancer, the consequences of getting it and the level of awareness amongst women of all ethnicities; the hospital as a space for encountering medical expertise and health education; and, a group discussion between Black women living with breast cancer or having recently been treated for it (see Figure 1).

****Figure 1 about here****

It was against this backdrop that the women were asked to discuss their awareness of breast cancer, their response to the DVD and their perceptions of its effectiveness as a public health intervention. Our interpretation of the focus group material begins with the women's immediate response to the DVD contents as well as to their at-risk status before we move on to explore a series of equally important and closely entangled themes relating to fear, family and the significance of emotion to the women's ability to connect with the messages being communicated to them.

'I don't hear of black people dying of breast cancer'

For a majority of the women in the focus groups breast cancer remained a disease of whiteness. The following was fairly typical of the women's responses, 'I was really

surprised because I didn't know, I assumed, I assumed it was more white women than black women' (SMHB) and 'it's like everything we see, it's like breast cancer is definitely something that white women have' (IBHGP). In other focus groups, some women talked about their inability to relate to the idea that they were at risk of breast cancer. As one participant indicated, 'I don't know anyone who'd had breast cancer in my immediate family or my friend's circle, so for me the video was really I think trying to say, you know, black women get it more and I was like, really?' (IBHGP). Across the focus group discussion, the women appeared to challenge even the idea that their ethnicity was a risk factor for breast cancer. As one participant recalled, 'I remember the day I came to the GP, when he told me about black people, that they are the most common people to get [breast cancer]' (CLP). As she went on to state, 'I was shocked because I know ... it's only white people who have breast cancer most'. This sense of disbelief was echoed elsewhere:

Researcher: Do you accept it? [the women's at-risk status]

HCD, Participant 1: No, because we haven't seen any evidence.

Researcher: No?

HCD, Participant 1: I would say, for me, I hear more white people dying of breast cancer. I don't hear of black people dying of breast cancer.

Researcher: So it sounds like you question whether this risk really exists, because you haven't heard about it before?

HCD, All: Mm hm.

'Yeah, it is quite frightening 'cause I'm black'

Learning that their ethnicity placed them at heightened risk for specific forms of breast cancer, identified in the DVD as more aggressive, prompted a range of responses from the women. Being frightened or scared was one of the more emotive of these and came up in different ways during the focus group discussions. For some of the women in our focus groups the fear of breast cancer appeared almost overwhelming; as one participant stated, 'I've heard so much about a breast cancer. It's an area that has frightened me and because of that I don't think I have any information about it 'cause when I hear it I just block my mind out of it, out of sheer fear' (CLPS). This participant was clearly not only very worried about cancer but even the very mention of it prompted her to try and ignore it; to 'block it out' as she mentioned.

Though only a few of the women expressed this very high level of anxiety, others were fearful that their ethnicity appeared to place them at higher risk of more aggressive forms of the disease, as this exchange reveals:

CESS, Participant 1: I have heard that black Afro-Caribbean you do get it earlier, but never heard the aggressive part ... it's like, okay I might get it earlier but ... the assumption was always that you had the same chances as everybody else.

CESS, All: As everybody else.

CESS, Participant 1: But to hear that you get earlier, and you get it more aggressively that's [pause], that's a bit of a scare.

CESS, Participant 2: Yeah, that's a more, oh okay, I need to pay more attention to this.

Women in other focus groups shared this elevated anxiety. As another respondent stated, 'yeah, it is quite frightening 'cause I'm black, I'm Afro-Caribbean so you think to yourself, okay (CGP)'.

In addition to being frightened because of their heightened risk status, some of the women also discussed their fear of finding symptoms associated with the disease and with the consequences of this. The discussion was not only associated with the emotional responses that women faced when confronted with a potentially life-limiting disease, but also with the fear that they associated with the effects of the treatment itself. This was most clearly expressed by a respondent whose mother had been treated for breast cancer:

ISMP, Participant 2: Yeah, and they don't tell you when you have breast cancer and then you have chemotherapy or radiotherapy, there's not enough information out there about the devastating effect ... They tell you that there's a danger but they don't go into what the dangers are. But people should know but I don't know whether it would be too frightening, too much information.

'I want to know about the breast cancer because my mum...'

Despite the association of breast cancer with whiteness, many of the focus group participants revealed that they had personal experience of the disease. There was a tension in the women's discussion here. On the one hand, it was quite apparent that many perceived breast cancer as a disease that largely affected white women. Yet, on the other hand, many of the women did identify a close family member or close friend as having been affected by breast cancer. When asked why they had agreed to take part in the focus group discussions, which was a fairly typical ice-breaker question, many of the women recounted personal experiences that suggested a much more intimate knowledge of the disease. As the following extract indicates:

CLPS, Participant 3: I'm attending the breast awareness today because I have daughters, I have three daughters and in the past, I've had issues with my breasts ... [also] their grandmother has presently got breast cancer.

CLPS, Participant 4: I want to know about the breast cancer because my mum, they invited her to the hospital to check and she's very afraid so I want to know more so that I can explain it. Because my aunty had breast cancer, she's dead now, they cut it and after that she's dead so I want to know more about it so that I can explain it to my mum, that's why I'm here.

CLPS, Participant 6: I'm really glad to attend because ... my mother died from breast cancer so [pause], and I have two girls, so it's a good thing that you're aware of what's happening.

Closely associated with this response, many of the women suggested that learning more about the disease was a key motivation for their taking part in the focus group discussions; as the following suggests, 'it's a good thing that you're aware of what's happening, that you can educate somebody about it, not just for yourself alone' (CLP). Importantly, here, it was the women's anxiety even fear that a close family member would be affected that appeared to drive this desire to educate themselves. Perhaps the clearest illustration of this came from another participant in this particular focus group, one who was so fearful of breast cancer that she sought to block it out of her mind:

CLP, Participant 8: I have daughters so today I want to learn more, though I am still like, like everybody thinking it's frightening. Yeah, because I remember when my friend's daughter had a little ... the tears, I couldn't sleep, so though that came out of nothing, my initial fear, the crying, you could see, you know, it's like a silly person, the person's going to die anytime.

Though fear evidently had a powerful emotional effect on this particular woman, the need to know more about breast cancer because it might affect her daughters in the future appeared to help her overcome her considerable anxiety. The importance of

having daughters was a powerful motivating force for many other women. As with the previous participant, it was the ability to educate their daughters about breast cancer that was especially important to some of them: 'It doesn't matter what age you are, you know, we should be teaching our girls how to check their breasts ... you know, but how many of us actually do that?' (CESS).

'How does the woman feel'

The information in the DVD as well as the discussion that it prompted clearly had an emotional effect on many of the women. As we have reported elsewhere in relation to the pilot study (Authors, 2016), the use of the word 'aggressive' to describe breast cancer was especially problematic for the participants and promoted an additional sense of fear; although we should also note that some did approach the term with a good degree of humour. For example, in response to one participant's question about why breast cancer in Black women is often described as being more aggressive, the women countered 'It's 'cause you're black!' and "[c]ause we're aggressive!' (CQGP). Outside of fear and humour, the women also responded to the DVD by drawing attention to what they regarded as its lack of 'feeling' or emotion. More specifically, many of the women suggested that in order for them to engage with, and respond to, the information presented in the DVD they needed to be able to 'feel' the emotions women with breast cancer might experience.

There were two specific ways in which emotion emerged within the discussions. For some women, the DVD presented an image of breast cancer that lacked emotional affect. Here the women described their need to connect with the emotions

that a woman diagnosed with breast cancer might feel. As one of the participants remarked:

CQGP, Participant 1: I think it would be really important, as the lady said, if there was like a case study where we could feel their emotions of what it is to go through so that we could almost feel more likely to check ourselves and more likely to go to the doctor if we found a lump.

This apparent interrelationship between feeling and affect was also brought up by other women in this particular focus group. Closely associated with the desire to 'feel' the emotions of women diagnosed with breast cancer was a wish to hear more about their personal stories; even though some personal accounts were included as additional features of the DVD. As one of the participants commented, in order for her to 'feel connected' it was important to be able to identify with the 'personal journeys' that women diagnosed with breast cancer had undertaken. As the woman stated, 'I found I was quite disconnected ... I would have preferred to follow a journey of one of those women or something like that, to kind of connect with what was happening' (CQGP).

For other women, the importance of feeling connected to the women presented in the DVD was associated with culturally specific forms of communication as well as with the busy nature of their lives:

ICS, Participant 1: You've got to hear what the woman has felt in getting it to when she got it to now she's recovered of it.

ICS, Participant 4: Exactly, yeah.

ICS, Participant 1: This is how you have to go with black people, you can't just tell them it's breast cancer, they most likely fry the chicken the same time.

The importance of understanding the personal journeys that women with breast cancer went through extended, at least for some women, to the emotions felt following invasive procedures such as mastectomy. In the following exchange, the same group of women discussed this in some detail:

ICS, Participant 4: But what about, you know, about the breast and the woman? How does the woman feel about the fact that some people might feel that I'm a woman and if my breasts [pause] ...

ICS, Participant 1: Inadequacy.

ICS, Participant 4: Inadequacy, so touching on, you know, maybe some woman on the video or the DVD can express that, you know, I'm still a woman, I'm still healthy, do you know what I mean?

ICS, Participant 1: A bit more of the cancer patients talking.

ICS, Participant 4: Identity as a woman, you know what I mean though? Touching on that, you know, I'm still healthy, I'm still a

woman, it doesn't matter whether it's off or on, you know what I mean?

ICS, Participant 1: Hmm, there should have been a little more with those lovely ladies that have had it and gone through it and recovering. They should have been saying more about how they feel on there.

'I'm going to work tomorrow to tell my black colleagues'

Though generally regarded by the women as a useful tool for enhancing their breast awareness, the DVD was felt to be limited in a number of ways. As we have reported elsewhere in relation to the pilot phase of this study (Authors, 2016), despite watching the DVD as a part of the focus groups there remained some confusion about how to perform self-examination and also with regards to what exactly the women should be looking for. Moreover, the question of whether or not a DVD received in the mail would be watched by many women was raised on multiple occasions; some women drew attention to the limitations of the technology itself and the capacity to play a DVD. As one participant commented, 'I would have [watched it] if I had a DVD player [all laugh] but I haven't got a DVD player' (CSGP). This was a common response; and a problem recognised by the research team who have subsequently uploaded the content of the DVD on to YouTube and other social media platforms.

The women also drew attention to other ways in which breast awareness information could be more effectively targeted. Here, emphasis was placed upon the

settings that they occupied in their everyday lives whether churches, community centres, public transport, spaces of employment, social media and professional networking platforms (YouTube, Facebook, LinkedIn, Twitter, WhatsApp) and so on. Outside of these, the women mentioned media outlets and spaces that were quite specific to them. For example, one group of women suggested local newspapers and radio stations that served their specific communities, including NBC Radio which targets Caribbean islanders. More generally, it was hairdressers and nail salons that were identified as important by the women:

CGP, Participant 1: And another focus place where you could go to is hairdressers and nail shops.

CGP, Participant 2: Oh yeah, yeah.

CGP, Participant 4: Everywhere the female goes.

CGP, Participant 1: Even if you just like to put a nice poster, do a nice poster and just ask them, "Would you mind putting this up just behind your till or something?" 'cause when you're sitting in the nail shop and you're and you're sitting there and you've just got nothing else to do but look around you.

However, beyond these ideas for promoting breast awareness within the everyday spaces occupied by the women there was also a clear suggestion in the focus groups that the emotional responses prompted by the DVD encouraged at least some of the women to adopt a more proactive position when it came to raising breast awareness. To an extent, this has been discussed as regards the women's motivation to educate themselves and their daughters. As stated by one woman, the

DVD was a '[n]udge in the right direction' that had prompted her to 'wake up, this is really happening, you know' (CGP). Yet, the desire for greater agency in the promotion of breast awareness outside of close family networks and beyond care of the self was also evident. Perhaps the best illustration of this willingness to get involved came from this woman's response to the focus groups discussions:

CLP, Participant 2: Do you know what? I'm going to work tomorrow to tell my black colleagues, seriously, you know, I want you to go, to check. I feel confident to go and say something. Even if I was scared before that and feeling like, oh they wouldn't touch there just in case I feel something, you know, there's always that fear, which I think from now on I'm going to prod them.

DISCUSSION AND CONCLUSION

Perhaps unsurprisingly given the central message from the DVD that Black women are at heightened risk for more aggressive forms of breast cancer, one of the key areas of discussion for the women in our focus groups was their status as an 'at risk' group. Such constructions of risk, especially as they relate to health, have, of course, become central to public health discourse (Lupton, 1995; Petersen and Lupton, 1996). In contrast to earlier studies which discuss the embodiment of risk in the self-care practices of women with heightened risk for breast cancer (Robertson, 2000), our study suggests that the women we talked to were less likely to embody their 'at risk' status. As we demonstrate, the women responded with surprise to the

information presented to them in the DVD; in part, because there was a widely held belief that breast cancer is a 'white woman's disease' (see also Pfeffer, 2004; Jones et al, 2015). While for some women this response was linked to what they perceived as the whiteness of the media coverage of breast cancer; for others, there was a suggestion that they simply did not believe the evidence presented to them by the experts in the DVD.

Such a reaction is not unique to this group of women; it is after all widely acknowledged that lay responses to risk discourses often differ significantly from those of experts (Douglas, 1992). Yet, the women's surprise at, and questioning of, the information in the DVD did not foreclose the development of a wide-ranging discussion about the disease. Perhaps unsurprisingly given the evidence from other studies (Vrinten et al, 2016), a part of this discussion was focused upon the anxiety and fear that the women associated with breast cancer. For some of the women this was an emotion that almost overwhelmed and one that they felt the need to try and 'block out'. However, in contrast to the earlier questioning of their risk status, this aspect of the focus group discussions suggested a much greater willingness on behalf of the participants to become active in promoting awareness of breast cancer risk amongst their family and friends; especially their daughters. Time after time, the women recorded that their attendance at the focus group was prompted by a desire to know more. Further, the boundaries of this ethics of care were not limited to those immediately proximate to them. As we reveal, at least some of the women in the focus groups were willing to extend their concern to other Black women known to them through the work place.

Outside of this ethics of care prompted by the DVD, there were two further aspects of the women's response that stand out. Firstly, the women's emphasis on the importance of feeling an emotional connection to the story narrated in the DVD. As we reveal, many of the women in this study expressed a desire to know more about women's experiences living with breast cancer and of surviving it; including what this might mean for them in terms of the emotional impact of invasive surgical techniques such as mastectomy. Such a desire reflects the wider literature on emotions, which recognises that emotions, and here we include feelings, are fluid, relational and contextual and build on people's individual and collective experiences (Lupton, 2013). Put differently, they are embodied in that they are felt and experienced (Anderson and Smith, 2001; Davidson and Milligan, 2004; Davidson et al, 2005; Murphy et al, 2011). Moreover, as Lende and Lachiondo (2009) suggest, people's willingness to engage with embodied practices such as breast awareness regimes results as much from their personal feelings and experiences as it does from biomedical constructions of risk.

Second, and closely related to this, emotion was also important in terms of the women's suggestions regarding future interventions. Quite tellingly, the woman who articulated the greatest level of anxiety amongst all the focus group participants spoke very clearly of her desire to actively promote greater awareness. In this sense, fear as a felt emotion prompted her to overcome her initial response of mentally 'blocking out' breast cancer from her daily thought processes. The need to educate herself and her daughters proved a strong motivating force. However, we concur with other critically-oriented scholars who caution against the deliberate promotion of fear within public health campaigns (Gagnon et al, 2010; Lupton, 2013; Brookes and

Harvey, 2015); it should not be, nor was it, the intention of this intervention to promote what Gagnon and colleagues (2010) refer to as a state of permanent (in)security. Yet, if we consider emotion as intensities that flow between individuals and things, then it is possible to move beyond this rather negative problematic.

As we reveal, many of the participants in the focus group discussions placed greater emphasis on the production of 'felt' emotions which connected them, as Black women, with the personal experiences of other similar women. It was not only fear that drove this desire to feel emotion but also hope. As we note in the above, the women wanted to hear stories that charted a woman's journey through to recovery. This is not to argue for the promotion of false hope (Coughlin 2006, 2008). However, it seems apparent from our study that sustaining or fostering hope through a greater emphasis on storytelling and narrative might achieve two things. Firstly, the women suggested that they would be more receptive to such stories and secondly that they might act upon them; which mirrors approaches used amongst African American and Latino women in the USA (Wilkin & Ball-Rokeach, 2006; Kim et al, 2011). Such a finding further supports the development of narrative approaches to public health interventions and especially those that place greater emphasis on the use of storytelling as the primary mode of communication (Murphy et al, 2013, 2015). While this study is not able to fully address the importance of emotions to promoting an embodied response to breast awareness interventions such as this, it does point to the need for further research in this area.

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