Title
The importance of contextualization
Anthropological reflections on descriptive analysis, its limitations and implications

Abstract
This paper regards a concern for the quality of analyses made on the basis of qualitative interviews in some parts of qualitative health research. Departing in discussions on studies exploring 'patient delay' in healthcare seeking, it is argued that an implicit and simplified notion of causality impedes reflexivity on social context, on the nature of verbal statements and on the situatedness of the interview encounter. Further, the authors suggest that in order to improve the quality of descriptive analyses, it is pertinent to discuss the relationship between notions of causality and the need for contextualization in particular. This argument targets several disciplines taking a qualitative approach, including medical anthropology. Especially researchers working in interdisciplinary fields face demands of producing knowledge ready to implement, and such demands challenge basic notions of causality and explanatory power. In order to meet these, the authors suggest an analytic focus on process causality linked to contextualization.

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Introduction

Medical anthropologists and qualitative health researchers in general find themselves confronted with elaborate discussions on quality criteria in qualitative health research (e.g. Stige, Malterud & Midtgarden, 2009; Pope, Van Royen & Baker, 2002; Mays & Pope, 2000). Many suggestions of quality criteria often start by taking a position that either supports a fundamental paradigmatic difference between qualitative and quantitative research or supports the idea that quality may be assessed by using common criteria for all research, although different methods and perspectives exist and applied criteria must be modified to each research goal (Mays & Pope, 2000). As pointed out by Lambert and McKevitt, a tendency exists to deal with design and methods more than with the interpretive process of knowledge production and its knowledge base, in particular among qualitative health researchers (Lambert & McKevitt, 2002). It is not the intention of this paper to choose or argue for one or the other set of proposed criteria or agendas in order to assess analysis of qualitative interview data within the health sciences. Rather, this paper is concerned with the quality of the analyses present in many interview studies, which have become a dominant research method among qualitative health researchers, and it is emphasized that there is more to quality than merely proper design and presentation. The authors see this concern as one that targets several disciplines, also in the social sciences, where medical sociologists, anthropologists, psychologists, etc. often operate in health settings as part of an interdisciplinary health care team. These researchers often struggle to position themselves and research collaborations often end in analytical compromises, for better or worse (see e.g. DiGiacomo, 1995; Forsythe, 1999). In some cases, disciplinary hierarchies rule and in other cases research agendas may change and transform in accordance with the dominant interdisciplinary influences. However, resulting analyses frequently leave the reader with the feeling that important aspects are missing; depths or contextual inferences that may linger as well as the feeling that conclusions on 'what-works' may be a little too simplistic. For a classic social anthropologist, discussions of causality are overall concerned with demonstrating as many levels of contexts as required to highlight structures or representations that connect and determine different social or cultural phenomena (Hammersley & Atkinson, 1983; Anderson & Scott, 2012). For example, one could refer back to the legendary Zande witchcraft discussion (Evans-Prichard, 1937). Causality and context are inextricably related to each other and is only one dimension of what Lambert and McKevitt point to when they call for an incorporation of conceptual frameworks in multidisciplinarity, where a lack of contextualization is seen as a pitfall in research (Lambert & McKevitt, 2002); a pitfall that is elaborated on in this paper. Overall, it is argued that parts of qualitative health research neglect the role of context as an

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essential component of causal explanation (Anderson & Scott, 2012). This results in the reproduction of local or common sense cultural models of behavior, disregarding how social action and the constitution of subjectivities are shaped by social, financial and political forces (ibid., 677). The approach fundamentally delivers 'thin' one-way explanations of behavior based on, for example, the regularity theory of causation (Maxwell, 2012). An alternative to this theory is "a process approach that sees causal explanations as fundamentally a matter of identifying the actual processes that resulted in a specific outcome in a particular context" (ibid., 556). In line with Anderson & Scott (2012) and Donmoyer (2012), it is argued that qualitative health research would benefit from adopting a process view of causality which would allow making connections or analytic inferences between micro- and macro-levels of analysis and eventually contribute to interdisciplinary agendas of clinical usefulness.

To illustrate the important role of context and causality, interview studies on patient delay[1] in health seeking for cancer symptoms are brought forward as examples for discussion. For anthropologists and other qualitative health researchers engaged in patient delay research, an overall and implicit agenda is to explore and uncover reasons for this delay in healthcare seeking; reasons that may be possible to alter or intervene on. Hence, patient delay is chosen as a point for discussion as it is highly illustrative of underlying notions of causality in qualitative research. The studies discussed are not selected on the basis of a systematic review, but merely function as critical examples of current research practices drawn from the first author's long-term knowledge of the field. The studies have all been published recently; some of them in distinguished journals.

Bridging case, causality and context

Within the patient delay literature, there is a growing awareness of the importance of applying context-sensitive methodologies as well as of studying healthcare seeking as a social and cultural phenomenon (e.g. Facione, 1993; Corner & Brindle, 2011; Scott & Walter, 2010). Some of the interview studies on patient delay are well situated within psychological theoretical frameworks (e.g. Ristvedt & Trinkaus, 2005; Facione & Facione, 2006; Pedersen et al., 2011), and a few studies are based on theories or conceptual frameworks from the humanities or the social sciences (e.g. Alonzo, 1984; Levealahti, Tishelman & Ohlen, 2007; Andersen et al, 2010). However, as will be critically explicated below, a large part of the delay studies present varying forms of descriptive analyses, limited to text-near identification of recurrent themes, categories and interrelations. In the following, it is argued that such descriptive analysis depart in an

[1] The conceptual framework embracing this research is of interest and has been subject to discussion elsewhere (see e.g. (Andersen et al., 2009; Weller et al. 2012; Scott & Walter, 2010)

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implicit and simplified notion of causality, which impedes reflexivity on social context, on the nature of verbal statements and on the situatedness of the interview encounter.

Re-contextualising symptom experiences

The patient delay literature is highly concerned with patient responses to symptoms. In presenting causal explanations as to why people did not seek medical advice, research papers often re-present a series of patient-elicited negations like 'I did not think it [the symptoms] meant anything' or 'we do not have cancer in our families' as causes of delay in healthcare seeking. Without directly presenting patient-elicited statements, one study presents a series of descriptive summaries under the heading "Interpretation of Symptoms",

> Symptoms were either interpreted immediately as cancer symptoms or attributed to common ailments (misinterpretation). Some patients reported that when they had first detected an abnormality they had immediately associated it with cancer [n=11]. [...]. When symptoms were attributed to common ailments, like rectal bleeding to haemorrhoids or weight loss to a diet, patients did not link the symptoms directly to cancer or did not consider the symptoms to be serious [n=12] (de Nooijer, Lechner & de Vries, 2001, 152).

Another Scottish study, exploring delay among a group of adolescents who had been diagnosed with oral cancer, quotes informants for saying "Well, I heard about oral cancer, but I do not know anything about it ... I was aware it was one of the cancer sites" and "Well I knew about cancer, but I didn't know specifically about oral cancer... it just came out of the blue" (Grant et al., 2010, 468). The authors summarize these statements to imply that,

> In the majority of the cases, the responses seem to suggest that the participants had a prior knowledge of oral cancer. However, this prior knowledge was neither instrumental for them to suspect they may have mouth cancer nor did it prompt them to visit a healthcare professional (Grant et al., 2010, 468).

The authors also present a series of other headings such as "Reactions to the detection of unexplained symptoms", "Consulting important others about symptom(s)" or "Fear" (de Nooijer et al., 2001, 152-153), and these are described as immediately connected events or reactions, even though event and statement are separated in time. The headings are all recurring themes in

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the literature (Scott et al., 2009; Corner, Hopkinson & Roffe, 2006; Tromp et al., 2005). A large synthesis of qualitative research summarizing statements from 32 interview studies and published in the Lancet concludes,

> The status of patients with well-recognized specific symptoms (e.g. a lump) changed from symptom awareness to serious illness attribution most promptly. Symptoms were often perceived to have developed suddenly, which led to panic. Illness recognition was also faster in patients with severe symptoms such as seizure. By comparison, patients with vague or non-specific initial symptoms frequently delayed attributing these signs to illness. They recognized changes in their bodies but sought alternative everyday explanations such as trauma, skin problems indigestion, menopause, childbearing, old age or piles. They therefore did not take action because of fear, because they had very little awareness of cancer symptoms, or because of cancer not being something they initially considered because they were apparently fit, healthy or too young (Smith, Pope & Botha, 2005, 827).

Bringing forth discussions on peoples' knowledge of cancer symptoms or making analytical distinctions on how people experience what they refer to as trivial or malignant symptoms is, however, not necessarily a useful analytical distinction. Rather, it builds on a series of medico-centric inferences, which, in line with the thinking of Byron Good (1996), highlights the rather empiricist assumptions underlying much qualitative research on patient delay. According to Byron Good, when applying the concept of belief (or non-recognition) as an analytic category in the exploration of human experiences, we naturally come to introduce a distinction between medical scientific knowledge and rational behavior on the one hand and irrational and erroneous beliefs and behaviors on the other (Ibid.). Similarities are easy to draw between Byron Good's critique of empiricism and the many references to non-recognition as a cause of delay in healthcare seeking in the patient delay literature (Ibid). When simply referring to non-recognition as a cause of delay, verbal statements on symptom experiences are reduced to a set of propositions ('I did not think it meant anything'), which in turn are evaluated in relation to biomedical knowledge (here cancer symptoms).

This is troublesome for several reasons. Merely referring to non-recognition or misbelief of cancer symptoms as a cause of delay blurs the fact that cancer symptomatology is highly complex (e.g. Hamilton, 2009b; Hamilton, 2009a). Within the bioscience literature exploring the predictive value of symptoms and cancer, no conceptual definition of what constitutes an alarm

symptom exists, and the positive predictive value of symptoms[2] referred to as being alarming varies (Hamilton, 2009a; Jones et al., 2007). In contrast, the patient delay literature often refers to symptoms such as rectal bleeding or unexplained, longstanding coughs as alarm symptoms. Only one person in a thousand experiencing a single episode of rectal bleeding is, however, eventually diagnosed with colon cancer. Similarly, a person presenting in primary care with unexplained, longstanding coughs has less than 1 per cent risk of suffering from a lung cancer, while hemoptysis indicates a risk of cancer of approximately 3-5 per cent (Ibid.). This reflects a generally high level of uncertainty in regard to defining what counts as alarm symptoms of cancer. It may therefore be argued that references to non-recognition of alarm symptoms as a cause of delay in healthcare seeking is an analytic construct launching the illusion that that clear criteria for healthcare seeking decisions can be made.

Moreover, application of non-recognition as a causal-analytic category may result in a simple intertextual, descriptive analysis, in which the wealth of meanings and experiences relating to bodily experiences is simply left unexplored (e.g. what did people think it was?) and leaves no space for reflections on the embodied or embedded nature of bodily experiences and how these are transformed into symptoms of ill health (e.g. what line of reasoning informed their interpretation). Two strings of contextualization may be called for as suggestions to improve analyses.

Firstly, most anthropological research suggests that experiences, social practices and knowledge should be considered within a continuous feedback relationship, where a specific time horizon and a political or social context may contribute to different expectations and experiences that influence when and how bodily sensations are understood and acted upon as signs of illness. Lots of examples may be drawn from the literature (Lock, 1993; Hay, 2008; Good, 1996). Cameron Hay has done fieldwork among the Sasaks in Lombok and illustrates how sensations are experienced and transformed into symptoms in a sociocultural context informed by cultural notions of vulnerability, normative time frames and tolerance for disability. The sense of vulnerability can vary according to for example a person's past experiences, but it also entails what she calls 'common cultural arenas' such as dangerous times of the life cycle (e.g. pregnancy and old age), religious festivals and gender-specific acts such as alcohol consumption, which may increase women's vulnerability (Hay, 2008). Others have explored similar issues conceptualizing the contextual transformation of sensations to symptoms as processes of containment (Alonzo, 1984; Andersen et al., 2010) or symptomatization (Risør, 2011).

Secondly, most qualitative interview studies exploring the causes of delay in healthcare seeking are carried out retrospectively. This implies that people are asked to reflect on practices

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[2] The positive predictive value refers to the precision rate or the probability that a person will have a given cancer if experiencing a given symptom.

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and experiences that engaged them before they became cancer patients. Re-presenting retrospectively elicited interview statements as congruent with 'what took place' may, however, result in a failure to consider how illness episodes and verbal statements hereof are regenerated due to the informants' new status as cancer patients. To avoid such decontextualized analyses, narrative researchers have introduced a way of conceptualizing problems related to retrospective interviewing on illness episodes (Hunt, 2000; Garro, 2000; Williams, 1984). They emphasize that remembering is a generative mode of thought and that illness narratives provide a window for exploring how individual experiences of illness are related to preexisting explanatory frameworks available within a cultural setting (Garro, 2000; Williams, 1984). Williams, in his studies of people suffering from arthritis, argue that peoples' illness experiences and the causes they pursue in order to understand their falling ill are established in an intricate relationship between subjective biographies and the social and political worlds they inhabit. Reflecting on the analytic value of illness narratives and respondents causal explanations, he states that

> ...the 'causes' to which my respondents refer are seen, in part, as points of reference within the process of becoming ill [...]. It is an analytic construct through which the respondent can be seen to situate a variety of causal connections as reference points within a narrative reconstruction of the changing relationships between the self and the world, a world in which the biographical *telos* has been disrupted (Williams, 1984, 180).

Simply referring to non-recognition of symptoms as a cause of delay in healthcare seeking is thus an act of simplification which indicates that symptom experiences can be methodologically approached as objective clinical realities of which meaning and appearance can easily be re-presented in an interview setting. The explication of causality, when held within the text, thus impedes the analytic act of contextualization and reflectivity.

Re-contextualising 'the taken for granted'

The problem of accessing what happened before receiving a diagnosis of cancer should also be seen in the context of a wider underlying problem related to accessing information on social life through verbal statements elicited in an interview setting. Some interview studies on patient delay seem to be born out of misconceptions such as 'if you want to know why people do what they do, just ask them'. In order to grasp contingent circumstances of social practice, healthcare

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seeking decisions and other responses to symptoms should be considered as social responses, which informants may not be able to verbalise or meaningfully paraphrase. As explicated by Bourdieu's concept of *doxa,* the logic that drives social life is often implicit and taken for granted by the people living it (cf. Myles, 2004).

In probing reasons for delay in healthcare seeking, interviewees are asked to present reasons for non-action. When explaining reasons for not seeking care, the patient delay literature often argues that many people hesitate to seek care because they have other social responsibilities (Scott et al., 2009; Lund-Nielsen et al., 2011) or do not want to bother their doctor (Burgess, Hunter & Ramirez, 2001; Scott et al., 2009; de Nooijer, Lechner & de Vries, 2001). A British study for example states that

> Another major theme to emerge from the data related to feelings about when it was justified or appropriate to request an appointment with a GP [general practitioner]. The accounts of those who delayed consulting a GP reflected many more inhibitions about 'bothering' the doctor (Burgess et al., 2001, 969).

In order to exemplify, a patient is then quoted for saying,

> I mean some people are health conscious, they keep examining themselves and go to the doctor about their toenail, you know, stupid things, ear-ache or sore throat, things you could treat yourself, they waste peoples' (doctors') time (Ibid., 969).

Under the heading "Perception of competing priorities", the same study argues that

> A theme running through the many accounts of women who had delayed help seeking related to the effect of competing events and difficulties, which were prioritized over and above their personal health (Ibid., 969).

A woman is quoted for saying,

> It sounds awful to neglect your body, but life was busy and I'm a bit of a martyr, I don't necessarily put myself first (Ibid., 969).

While the analyses presented may be an illustration of what actually took place, it could also be argued that the many negations presented in the quotes explicate the difficulties people experience in representing and not least explaining past reflections and practices. Many social

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scientists would probably agree to the fact that particular social and cultural settings provide people with the premises that underlie what they do, and people are not necessarily able to make presentations of these premises. For example, it is known from studies that healthcare systems inform cultural assumptions and to some extent define the fields of possible actions in respect to healthcare seeking decisions and in establishing what are normal bodily experiences and what are signs of illness (Kleinman, 1980; Risør, 2011; Rose, 2007). When establishing a causal link between 'not wanting to bother the GP' and delay in healthcare seeking, we are not informed about the wider social and historical setting of these statements, and the causal explanations established may very well be too simple.

The same lack of reflection is prevalent in the analysis brought forward in the case of the woman who 'did not put herself first'. Some researchers illustrate how the symbolic importance of health and its impact on the shaping of cultural values have become an opportunity to express and negotiate gendered identities (Courtenay, 2000). Following this string of theoretical thinking, it may be reasonable to ask whether the woman could be said to have delayed seeking professional medical care because she, in her own terminology, acted as a martyr? Or whether further explorations into gendered roles and values in British society were in fact a prerequisite for an understanding of healthcare seeking practices? Other theoretical insights may provide an understanding of the quotes presented. Merely referring to verbal statements with non-reflexive and simplistic presentations of causal relations when exploring peoples' practices and decisions is not the same as providing a valid, analytical overview of an empirical phenomenon. In other words, to combine what is said with statements on why things are done within the same interview and argue for an explanatory relationship is leaving aside both empirical and theoretical possibilities of contextualization (Hammersley, 1992; Hastrup, 2004).

Re-contextualing the interview-encounter

Another important issue concerns assessment of the nature and contingency of informants' elicited illness experiences and how these are reproduced in interview settings. For decades, social science researchers have emphasized that representation of experiences and practices are co-produced during the interview encounter and influenced by power asymmetries between the interviewee and the interviewer (Kvale, 2006). More recently, there has been an increased awareness among researchers of the cultural immersion of the interview method, suiting various forms of 'modern confession cultures'. According to sociologists Atkinson and Silverman (1997), the interview serves as a social technique contributing to the construction of the self, and the discourse of individualized subjectivity has prepared – or incline researchers – to

reproduce illusions of individual perspectives and experiences as something that may exist in isolation from distant social and political institutions.

In addition, writings on Western mainstream culture have drawn attention to the symbolic importance of health and its impact on the shaping of cultural values and peoples' sense of self (Lupton, 1995; Crawford, 2006; Rose, 2007). In particular, researchers have pointed to the existence of proactive discourses on how to preserve healthy bodies (Lupton, 1995) or on the 'productive healthy citizen' as important for defining cultural norms and values (Crawford, 2006, Rose 2007). Health has so to speak become the norm; a cultural imperative, which is highly influential on social practices and the shaping of the self. When analyzing interview material on healthcare seeking, it is therefore pertinent to ask to what degree people may feel obliged to, or unwarranted tend to, provide certain kinds of stories; stories they regard compatible with the interviewer ('the health worker'), and which conform to wider cultural notions on health and illness-related behavior, or stories in which informants confess how they relate to particular discourses on health through their health consumer role.

The formerly mentioned Lancet synthesis on patient delay, for example, refers to fear as a major barrier to seeking professional help. This fear consists of various sorts; fear of getting cancer, fear of embarrassment or fear of being turned down are often reported as causes for delay in healthcare seeking,

> Fear predominantly manifested as fear of embarrassment and fear of cancer. Fear of embarrassment was a strong theme. Men and women who delayed especially those with diverse symptoms, worried about being labeled as neurotic, a hypochondriac, or a time waster. (…) Men associated consultation with weakness, and thought that the admission of illness was not masculine and therefore should only be done under extreme circumstances. Some patients with lung cancer were afraid that their symptoms would not be taken seriously because they were smoke related (Smith et al., 2005, 828).

In reference to the above, when drawing lines of causality between different sorts of fear and delay in healthcare seeking, it is of equal importance to consider asking why people worry that they might be seen as hypochondriacs? Or why men express worries about presenting with illness? Do the interviewees reflect on their failure to meet dominant cultural norms rather than on their decision to seek professional health care? Which kinds of knowledge or insights are offered on the basis of these statements? Do they provide information on healthcare seeking decisions? Or do they reveal something about the value structure of a given society (the imperative of health) and the flexibility with which epidemiological knowledge increasingly

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influences the general moral codex (e.g. smoking is not good for you). In line with this, normative statements may be used by interviewees to retrospectively legitimize actions taken and to demonstrate that they know right from wrong in matters of illness and health (Pelto & Pelto, 1996). As pointed out by Hammersley and Atkinson (Hammersley & Atkinson, 1983), the process of analysis must also take into account not only the interviewer as audience to an interview, but also other audiences. An informant may talk differently according to the targeted audience, consciously or subconsciuosly, and taking this into account when making causal inferences is crucial. Also, it is important to notice the temporal framework in which people locate their actions (ibid.). When analysing interview material on healthcare seeking, it should be kept in mind that interview material is generated in a particular relationship between two people (e.g. interviewee and health worker), but is also situated in a particular socio-cultural setting (e.g. health as a norm) in which people may have certain capacities and needs for discoursing on medical subjects. The particular perspectives that people have will generate a certain understanding and knowledge of the world, and attention must be paid to social locations, situations and identities (ibid.). Not to do so is equivalent to letting conclusions on causality rest on a decontextualized analysis.

Concluding remarks

The quality of qualitative research relies on how knowledge is constructed in the process of generating empirical material and of deciding between what the psychologist Steiner Kvale refers to as "possible competing and falsifiable interpretations" (Kvale, 2002, 307). This involves a process of continually exploring the social phenomena under study in its social and cultural context, while remembering that the data generation is situated both in relation to the theoretical frameworks and a specific research setting. In the above discussion of patient delay, it has been exemplified how a contextualisation process is based on reflectivity and not a simplistic notion of causality. Using instead a causation theory "that identifies process as a necessary and central aspect of causation" (Maxwell, 2012, 657) is a possibility that will be fruitful and adaptable to most qualitative health research. Process causality makes context intrinsic to causal explanation. This extends causality to include not only physical objects and events, but also values, intentions and positions, etc. (ibid.). The concept of causality is not unknown to e.g. anthropology, but the concept should receive more attention on the analytic agenda, also in the field of anthropology, and thereby highlight the reciprocal relationship between e.g. health policy, user organisations and everyday care activities. Basically, such focused attention may provide all qualitative health researchers with an argument and a tool for

engaging in research agendas exploring causes of actions. Ability to combine this notion of process causality with a social context analysis that looks for inferences and reciprocity between levels of structures at both micro-, meso- and macro-level may provide qualitative researchers with tools for guiding health interventions (Anderson & Scott, 2012). However, this would require research representations adhering to process causality and contextualization to produce at least thick descriptions of case studies. Following Donmoyer (2012), the intention of this paper was to emphasize the significance of presenting thick descriptions that are closely attached to clinical problems and to demonstrate a thorough analysis of different levels of the problem while using process as the explanatory model. Together with this, analytic arguments at a general level based on contextual inferences may also be presented.

Although this may sound familiar to many social science researchers, qualitative analyses is rarely considered a robust and relevant method in interdisciplinary settings, and this poses a continuous challenge to social scientists working in interdisciplinary research groups. As Kleinman stated in a recent paper,

> This new era…[…]….is an increasingly interdisciplinary era in which anthropologists must become more comfortable in collaborating across methodological and professional divides. It is an era in which anthropologists also cannot avoid contributing directly to public health and clinical interventions. And it is a time when we must create our field through new theories, new research questions and new approaches" (Kleinman, 2012, 195).

The era he refers to may be a challenge for anthropology, but it may also present a more general challenge which warrants brushing up and maintaining anthropological strengths and virtues, epistemological underpinnings and theoretical knowledge bases. Further, the production of knowledge in itself tends to be embedded in political and financial agendas, and the authors are aware that this forms another challenge to social scientists or anthropologists working in medical institutions or with health professionals. The aim of this contribution to the dilemmas relating to interdisciplinary health research is to bring a revisited and critical notion of causality into the discussion, and to argue for the notion's processual character and multi-leveled complexity. The authors further believe that this will create a platform for constructive discussions on current health issues or clinical problems, for example by demonstrating complex causalities. Modern research requires more than single and decontextualized causes; all scientific disciplines (including genetics, medicine, pathology, etc.) operate with multiple causalities and see human life and biological expressions as complex intertwinements of incidents, factors and histories.

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REFERENCES

Alonzo,A.A. (1984). An illness behavior paradigm, a conceptual exploration of a situational-adaptation perspective. *Soc.Sci.Med. 19*(5), 499-510.

Andersen,R.S., Paarup,B., Vedsted,P., Bro,F., & Soendergaard,J. (2010). 'Containment' as an analytical framework for understanding patient delay, A qualitative study of cancer patients' symptom interpretation processes. *Soc.Sci.Med 71*(2), 378-385.

Andersen,R.S., Vedsted,P., Olesen,F., Bro,F., & Sondergaard,J. (2009). Patient delay in cancer studies, a discussion of methods and measures. *BMC.Health Serv.Res. 9* 189.

Anderson,G.L., & Scott,J. (2012). Toward an Intersectional Understanding of Process Causality and Social Context. *Qualitative Inquiry 18*(8), 674-685.

Atkinson,P., & Silverman,D. (1997). Kundera's Immortality, The Interview Society and the Invention of the Self.*Qualitative Inquiry* (pp. 302-325).

Burgess,C., Hunter,M.S., & Ramirez,A.J. (2001). A qualitative study of delay among women reporting symptoms of breast cancer. *Br J Gen Pract 51* 967-971.

Corner,J., & Brindle,L. (2011). The influence of social processes on the timing of cancer diagnosis, a research agenda. *J Epidemiol.Community.Health 65*(6), 477-482.

Corner,J., Hopkinson,J., & Roffe,L. (2006). Experience of health changes and reasons for delay in seeking care, A UK study of the months prior to the diagnosis of lung cancer. *Soc.Sci.Med. 62*(6), 1381-1391.

Courtenay,W.H. (2000). Constructions of masculinity and their influence on men's well-being, a theory of gender and health. *Soc.Sci.Med 50*(10), 1385-1401.

Crawford,R. (2006). Health as a meaningful social practice. *Health 10*(4), 401-420.

de Nooijer,J., Lechner,L., & de Vries,H. (2001). A qualitative study on detecting cancer symptoms and seeking medical help; an application of Andersen's model of total patient delay. *Patient.Educ Couns. 42*(2), 145-157.

DiGiacomo,S.M. (1995). A Narrative Deconstruction of 'Diagnostic Delay'. *Second Opinion 20*(4), 21-35.

Donmoyer,R. (2012). Can Qualitative Researchers Answer Policymakers' What-Works Question? *Qualitative Inquiry 18*(8), 662-673.

Evans-Prichard,E.E. (1937). *Whitchcraft, Oracles and Magic Among the Azande.* Oxford, Oxford University Press.

Facione,N.C. (1993). Delay versus help seeking for breast cancer symptoms, a critical review of the literature on patient and provider delay. *Soc Sci.Med 36*(12), 1521-1534.

Facione,N.C., & Facione,P.A. (2006). The cognitive structuring of patient delay in breast cancer. *Soc.Sci.Med. 63*(12), 3137-3149.

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Forsythe,D.E. (1999). "It's Just a Matter of Common Sense", Ethnography as Invisible Work. *Computer Supported Cooperative Work 8*(1-2), 127-145.

Garro,L.C. (2000). Cultural Knowledge as Ressource in Illness Narratives. Remebering Through Accounts of Illness. In C.Mattingly, & L.C.Garro (Eds.), *Narrative and the Cultural Constration of Illness and Healing* (pp. 70-87). Berkely, University of California Press.

Good,B. (1996). *Medicine, rationality and experience , an anthropological perspective.* Cambridge, Cambridge University Presse.

Grant,E., Silver,K., Bauld,L., Day,R., & Warnakulasuriya,S. (2010). The experiences of young oral cancer patients in Scotland, symptom recognition and delays in seeking professional help. *Br Dent.J 208*(10), 465-471.

Hamilton,W. (2009b). Five misconceptions in cancer diagnosis. *British Journal of General Practice 59* 441-447.

Hamilton,W. (2009a). The CAPER studies, five case-control studies aimed at identifying and quantifying the risk of cancer in symptomatic primary care patients. *Br J Cancer. 101 Suppl 2,S80-6.* S80-S86.

Hammersley,M. (1992). *What`s wrong with Ethnography?* London, Routledge.

Hammersley,M., & Atkinson,P. (1983). *Etnography. Principles in practices.* London, New York, Tavistock.

Hastrup,K. (2004). Getting it right, Knowledge and evidence in anthropology. *Anthropological Theory 4*(4), 455-472.

Hay,M.C. (2008). Reading Sensations, Understanding the Process of Distinguishing `Fine' from `Sick'. *Transcultural Psychiatry 45*(2), 198-229.

Hunt,L.M. (2000). Strategic Suffering, Illness Narratives as Social Empowerment among Mexican Cancer Patients. In C.Mattingly, & L.C.Garro (Eds.), *Narrative and the Cultural Construction of Illness and Healing* (pp. 88-107). Berkely, University of California Press.

Jones,R., Latinovic,R., Charlton,J., & Gulliford,M.C. (2007). Alarm symptoms in early diagnosis of cancer in primary care, cohort study using General Practice Research Database. *British Medical Journal 334* 1-8.

Kleinman,A. (2012). Medical Anthropology and Mental Health, Five Questions for the Next Fifty Years. Durham, Duke University Press.

Kleinman,A. (1980). *Patients and healers in the context of culture.* Berkeley, CA, University of California Press.

Kvale,S. (2006). Dominance Through Interviews and Dialouges. *Qualitative Inquiry 12*(3), 480-500.

Kvale,S. (2002). The Social Construction of Validity. In N.K.Denzin, & Y.S.Lincoln (Eds.), *The Qualitative Inquiry Reader* (pp. 299-325). Thousand Oaks, London, New Delhi, Sage Publications.

Lambert,H., & McKevitt,C. (2002). Anthropology in health research, from qualitative methods to multidisciplinarity. *British Medical Journal 325*(7357), 210-213.

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Levealahti,H., Tishelman,C., & Ohlen,J. (2007). Framing the onset of lung cancer biographically, narratives of continuity and disruption. *Psychooncology. 16*(5), 466-473.

Lock,M. (1993). The Politics of Mid-Life and Menopause, Ideologies for the Second Sex in North America and Japan. In S.Lindenbaum, & M.Lock (Eds.), *Knowledge, Power and Practice. In Knowledge, Power and Practice. The Anthropology of Medicine and Everyday Life*, University of California Press.

Lund-Nielsen,B., Midtgaard,J., Rorth,M., Gottrup,F., & Adamsen,L. (2011). An avalanche of ignoring--a qualitative study of health care avoidance in women with malignant breast cancer wounds. *Cancer Nurs. 34*(4), 277-285.

Lupton,D. (1995). *The Imperative of Health, Public Health and the Regulated Body.* London, Sage.

Maxwell,J.A. (2012). The Importance of Qualitative Research for Causal Explanation in Education. *Qualitative Inquiry 18*(8), 655-661.

Mays,N., & Pope,C. (2000). Qualitative research in health care. Assessing quality in qualitative research. *British Medical Journal 320*(7226), 50-52.

Myles,J.F. (2004). From Doxa to Experience, Issues in Bourdieu's Adoption of Husserlian Phenomenology. *Theory, Culture & Society 21(2)* 91-106.

Pedersen,A.F., Olesen,F., Hansen,R.P., Zachariae,R., & Vedsted,P. (2011). Social support, gender and patient delay. *Br J Cancer. 104*(8), 1249-1255.

Pelto,P.J., & Pelto,G.H. (1996). Studying Knowledge, Culture, and Behavior in Applied Medical Anthropology. *Medical Anthropology Quarterly 11*(2), 147-163.

Pope,C., Van Royen,P., & Baker,R. (2002). Qualitative methods in research on healthcare quality. *Qual Saf Health Care 11*(2), 148-152.

Risør,M. (2011). The process of symptomization. Clinical encounters with functional disorders. In S.Fainzang, & C.Haxaire (Eds.), *Of Bodies and Symptoms. Anthropological Perspectives on their Social and Medical Treatment* (pp. 21-39). Tarragona.

Ristvedt,S.L., & Trinkaus,K.M. (2005). Psychological factors related to delay in consultation for cancer symptoms. *Psychooncology. 14*(5), 339-350.

Rose,N. (2007). *The Politics of Life Itself. Biomedicine, Power and Subjectivity in the Twenty-First Century.* Princeton and Oxford, Princeton University Press.

Scott,S., & Walter,F. (2010). Studying Help-Seeking for Symptoms, The Challenges of Methods and Models. *Soc Personal Psychol Compass 4*(8), 531-547.

Scott,S.E., Grunfeld,E.A., Auyeung,V., & McGurk,M. (2009). Barriers and triggers to seeking help for potentially malignant oral symptoms, implications for interventions. *J Public Health Dent. 69*(1), 34-40.

Smith,L.K., Pope,C., & Botha,J.L. (2005). Patients' help-seeking experiences and delay in cancer presentation, a qualitative synthesis. *Lancet 366*(9488), 825-831.

Stige,B., Malterud,K., & Midtgarden,T. (2009). Toward an agenda for evaluation of qualitative research. *Qual.Health Res. 19*(10), 1504-1516.

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Tromp,D.M., Brouha,X.D., Hordijk,G.J., Winnubst,J.A., & De Leeuw,J.R. (2005). Patient factors associated with delay in primary care among patients with head and neck carcinoma, a case-series analysis. *Fam Pract 22*(5), 554-559.

Weller,D., Vedsted,P., Rubin,G., Walter,F.M., Emery,J., Scott,S., Campbell,C., Andersen,R.S., Hamilton,W., Olesen,F., Rose,P., Nafees,S., van,R.E., Hiom,S., Muth,C., Beyer,M., & Neal,R.D. (2012). The Aarhus statement, improving design and reporting of studies on early cancer diagnosis. *Br J Cancer. 106*(7), 126210-1267.

Williams,G. (1984). The Genesis of Chronic Illness, Narrative Re-construction. *Sociology of Health and Illness 6*(2), 175-200.