Making Sense of Our Cancer Fears

Patient Ahead — Episode 3

Dealing with the Long Term

Part of raising the bar of cancer care is understanding and managing fear.

Walk into the lobby of a place like the Dana-Farber Cancer Institute on any given morning, and you will see a particular kind of stillness. Patients sit with folders of scans and lab results pressed to their chests like shields. Some scroll their phones too quickly to actually be reading anything. Others stare at the elevator doors as if the numbers ticking upward might tell them something the doctors haven't yet. This is an understandable, almost universal reaction: walking toward a diagnosis, or a treatment, or a follow-up scan that could change everything, produces a very specific kind of dread. It is not quite the same as fear of a car accident or a fall on the ice. It is bigger, vaguer, and harder to shake. Call it what you like — I call it ominous anxiety — but anyone who has sat in that lobby, or loved someone who has, knows exactly what it feels like.

The strange thing about this feeling is how disconnected it often is from the actual odds. A patient with a highly treatable cancer can feel just as consumed by dread as one facing a graver prognosis. A person who has just finished a successful round of treatment can lie awake at 3 a.m. more terrified of recurrence than they were of the original diagnosis. Fear, in the world of cancer, rarely behaves the way probability would predict it should.

The Anatomy of Dread

This mismatch between actual risk and felt fear is not unique to cancer. In a recent essay on public anxiety about artificial intelligence, the journalist John Prideaux pointed to the work of the psychologist Paul Slovic, who spent decades studying why people fear some things far more than the statistics justify.[^1] Slovic's research found that we are relatively calm about risks we understand and feel some control over — heart disease, car crashes, the slow accumulation of everyday choices — even when those risks are, by the numbers, the more likely ways we will die. But we become disproportionately afraid of risks that feel unfamiliar, invisible, and outside our control: nuclear war, terrorism, and — in Prideaux's telling — artificial intelligence.[^1] He called this "dread risk," a fear that has less to do with actual probability and more to do with how incomprehensible and uncontrollable a threat feels.[^1]

Cancer belongs unmistakably in this category, and arguably it is the original template for it. Long before AI or nuclear weapons entered the public imagination, cancer occupied the same psychological territory: a threat that could appear without warning, that operated by rules most people didn't understand, and that seemed to answer to no one's control. A 2017 systematic review in the journal Psycho-Oncology, led by researcher Charlotte Vrinten and colleagues, analyzed more than a hundred qualitative studies from over two dozen countries and found a strikingly consistent picture.[^2] Across cultures, people described cancer not as a disease with a known mechanism and range of outcomes, but as something closer to a character: a vicious, unpredictable, and nearly indestructible enemy.[^2] That framing — reinforced for decades by public health campaigns that speak of "battling" cancer and "wars" fought against it — shapes almost everything about how people respond emotionally to the disease.[^2]

The review identified a few recurring clusters within that fear. There is fear of proximity — the worry of getting cancer in the first place, often disproportionate to actual personal risk. There is fear rooted in a sense of powerlessness — the feeling that there is no reliable strategy to keep the disease at bay, no matter how many precautions one takes. There is fear of the social and personal fallout of illness: disfigurement, dependency, the burden placed on family, the loss of identity that can come with being seen as "a cancer patient" rather than a person. And beneath all of it sits the oldest fear of all — the fear of dying, and of how that death might unfold.[^2]

What makes this pattern so consequential is that it does not only make people feel bad. It changes what they do. The same review found that fear can push people in two opposite directions at once.[^2] For some, the anxiety of "getting cancer" becomes a spur to action — a reason to get the mammogram, the colonoscopy, the routine screening that offers a small measure of reassurance and control. For others, fear of what a diagnosis might mean — the treatments, the disfigurement, the loss of independence — becomes a reason to avoid the doctor's office altogether, to put off the very screening that might catch something early enough to treat.[^2] Ominous anxiety, in other words, is not a single force pushing in a single direction. It is a current that can just as easily carry someone toward protection as away from it.

When Fear Doesn't Come Once, But in Waves

If a single diagnosis can generate this much psychological weight, consider what happens over the course of a long treatment journey — the kind increasingly common in blood cancers such as leukemia, lymphoma, and myeloma, where stem cell or bone marrow transplantation is often the treatment of choice. These are not quick interventions. They can stretch across many months, sometimes years, encompassing induction therapy, the transplant itself, a fragile period of engraftment and immune reconstitution, and a long tail

of monitoring for complications like graft-versus-host disease. For patients and families living through this arc, ominous anxiety is rarely a single, static feeling. It is something closer to weather — it comes in waves, changes shape, and returns in forms nobody expected.

Early on, the dominant fear is usually diagnostic: the terror of the unknown, the days spent waiting for biopsy results or genetic markers that will determine the entire shape of what comes next. Once a treatment plan is set and a transplant is scheduled, a different fear often takes over — fear of the procedure itself, of the isolation that comes with a compromised immune system, of a body that suddenly feels foreign and unpredictable. During the discharge and recovery period, yet another wave can arrive: the anxious vigilance of watching for every new ache or fever, wondering whether it signals rejection, infection, or relapse. And even years later, in patients who are told they are cured, a quieter but persistent form of fear can linger — often called "scanxiety" by patients themselves — that reappears around each follow-up appointment, each lab draw, each anniversary of the diagnosis.

None of this is irrational. It is, in fact, a highly rational response to living for an extended period inside genuine uncertainty. But understanding it as a pattern — as waves of ominous anxiety tied to specific transitions in the treatment journey, rather than as a single undifferentiated dread — matters enormously, both for patients trying to make sense of their own experience and for the clinicians and caregivers supporting them. A patient who understands that renewed anxiety around the one-year mark after transplant is common, rather than a sign that something is uniquely wrong with them, is often better equipped to sit with that fear without being overwhelmed by it.

From Ominous Anxiety to Informed Action

The lesson from Prideaux's essay on AI is that dread, left unexamined, tends to displace more useful forms of concern — that generalized existential fear about a distant, poorly understood threat can crowd out attention to problems that are more immediate and more within our power to address.[^1] Cancer fear carries a related but distinct danger: left unchanneled, it can curdle into either paralysis or avoidance, neither of which serves the person experiencing it.

The antidote is not the absence of fear — that is neither realistic nor, frankly, desirable, since a measure of vigilance is part of what drives people toward early detection and adherence to treatment. The antidote is transforming ominous anxiety into informed action: replacing the vague, catastrophizing dread of "cancer as indestructible enemy" with a clearer, more specific understanding of one's own situation, options, and odds. This is precisely where the character of the clinical relationship becomes not a soft, secondary concern but a central determinant of how well a patient weathers the experience.

Why the Relationship Is the Treatment, Too

There is a reason that leading cancer centers increasingly talk about the patient experience in the same breath as clinical protocols. A state-of-the-art treatment plan, delivered without genuine communication, still leaves patients navigating long stretches of fear largely alone with their imaginations — and imagination, unconstrained by information, tends toward the worst-case scenario. But a treatment plan paired with a clinical team that explains what is happening, normalizes the emotional waves that come with it, and invites patients to ask the questions they're afraid to ask, does something more than deliver medicine. It gives fear somewhere to go.

This is especially true in the long-haul world of stem cell and bone marrow transplant care, where the relationship between patient and care team is sustained over months and years rather than a single appointment. The best of these relationships are genuinely cooperative: clinicians who treat patients as partners in decision-making, who explain not just what is being done but why, and who create space for patients to voice fears without being told they are overreacting. Patients, in turn, who feel safe enough to be honest about their anxiety — rather than concealing it to appear strong or compliant — allow their care teams to catch problems, both medical and psychological, earlier.

This is where hope enters the picture, and it is real hope, grounded in something more durable than optimism alone. Survival rates for many blood cancers treated with modern stem cell and bone marrow transplantation have improved substantially over recent decades, a direct result of advances in matching, conditioning regimens, and supportive care. But the technical advances tell only part of the story. Outcomes are also shaped by whether patients stay engaged with their care, show up for the monitoring that catches complications early, and trust their team enough to report the symptom that seems minor but turns out to matter. Ominous anxiety, when it is met with honesty, information, and partnership rather than silence, becomes something patients can actually use — a signal that prompts a phone call to the care team instead of a sleepless night of quiet dread.

None of this erases the fear of a cancer diagnosis, or the long uncertain arc of a transplant journey, or the waves of anxiety that return at unexpected moments. But it changes what that fear is for. It stops being a shapeless enemy and starts being a prompt — toward a conversation, a question, a next step. That shift, from dread to informed action, from isolation to genuine partnership with a care team, is where the real ground for hope lies. The patients who walk into that lobby carrying their folders of scans are not wrong to feel what they feel. But in a setting built around communication, trust, and state-of-the-art care, that fear does not have to carry them alone. It can be met, matched, and — over time — transformed into the steady, grounded resolve that gets people through.

This is Patient Ahead — the map nobody hands you at diagnosis.

References

[^1]: Prideaux, J. (2026, July 24). *Making sense of our AI fears.* The Economist.

[^2]: Vrinten, C., McGregor, L. M., Heinrich, M., von Wagner, C., Waller, J., Wardle, J., & Black, G. B. (2017). What do people fear about cancer? A systematic review and meta-synthesis of cancer fears in the general population. *Psycho-Oncology, 26*(8), 1070–1079. https://doi.org/10.1002/pon.4287