

6th Annual MAYS Meeting

"Emotions in/and Medical Anthropology" University of Amsterdam, 11-12 June 2015, Abstracts

SPEAKERS	University	
Andrea Buhl	<i>University of Basel, Switzerland</i>	<p>Researching end of life in a Tanzanian cancer clinic – Everyday emotions</p> <p>Conducting research in a field where most people are seriously ill, in pain and/or far away from their beloved ones is challenging – for patients and researchers. Drawing on experiences from my PhD research in Tanzania's only specialized cancer hospital and its patients' homes in Dar es Salaam, this paper aims to depict emotional challenges in this field. Unlike most studies about cancer prevention and disease control, this research focuses on what comes beyond all that, where cure is no longer an option. It shows the role of end-of-life care in a hospital environment where cure and prevention is the first and almost only priority. Palliative care seems a luxury as most of the patients are dying anyway and financial and human resources are needed elsewhere. Furthermore, the research project is intended to show how and in what extent professional and private care is provided and realized – in the hospital and also at home. Since cancer doesn't particularly affect the weak or old, but also hits businessmen, or women who make their families living on the fields, it severely affects whole families all over the country. Long distances between most family homes and the only cancer hospital enhances special role and necessity of professional care givers. But what if this care is not provided? How do patients cope with a lack of social, emotional and spiritual support? Looking at patients' struggles between hopes and uncertainties, also challenges my research integrity between closeness and distance.</p>
Anna Fox	<i>University of Vienna</i>	<p>"Post-traumatic negotiating. Emotions in doctor-patient communication during processes of facial reconstruction."</p> <p>What feelings do patients with severe facial injuries tend to encounter when agreeing treatments with doctors? How are these emotions typically experienced and expressed? These are among the key questions posed by the author's PhD project. The thesis will also address the wider issues as to how medical and scientific discourse influences doctor-patient interaction in the course of facial reconstruction, and how this affects patients' self-view and subjective experience. The proposed paper would however focus on the emotional dimension of the topic. As the research project is still at the formulation stage the paper would not present any empirical outcomes but centre on methodological considerations. It would look at the theoretical tools to be applied in investigating the above research questions. This would involve consideration of Sara Ahmed's examination of the cultural politics of emotion¹ and the way it impacts on bodies, as well as Helmuth Plessner's philosophical anthropology, including his concept of Leibsein and Körperhaben², and Deleuze's and Guattari's critique of the cultural production of the face³. At the practical level of methodical implementation, the paper would ask which research techniques are appropriate to grasping the emotions engendered by the severe challenges of facial injury and facial reconstruction. It would investigate how such research can be conducted in a sensitive manner, with sufficient respect for the personal boundaries of the respondents.</p>

<p>Annelieke Driessen</p>	<p><i>University of Amsterdam Amsterdam Institute for Social Science Research (AISSR) Centre for Social Science and Global Health (SSGH)</i></p>	<p>E-motion: being moved by movement on the dementia ward</p> <p>'Claiming behaviour' is described as a form of 'problem behaviour' in dementia, which is defined through the environment experiencing the behaviour as problematic. Although there seems to be no clear definition for claiming behaviour, Dutch care workers in the two nursing homes for people with dementia under study are all familiar with the concept, and a text book names "Constantly ask[ing] (unclear) questions; [...]continu[ing] to ask for help, even if it has just been offered; urgently demand[ing] help with less urgent matters" 1 as defining examples.</p> <p>This paper explores two ambiguities brought about by this framing of claiming behaviour. Firstly, the tension between the quasi-clinical terminology (defining claiming behaviour as a "problem") and the social terminology (defining it as deeply relational, as the environment seems to determine when something is claiming behaviour) is explored. Secondly, the tension within 'being a good care worker', between attending to the claiming resident's needs and managing one's (negative) emotions to ensure a client-centred approach is looked at. Different objects of care are competing here: there is care for the resident who is claiming, care for the other residents and care for self.</p> <p>Based on eight months of fieldwork in two nursing homes, this paper asks the following questions: In what situations is the behaviour of a person with dementia defined as claiming behaviour, and how do the care workers' responses figure in these situations? How do various objects of care conflict and align in these situations? The analysis shows that emotion work often involves taking a distance from the claiming residents. The paper considers what this means, theoretically, for the concept of emotion work and, practically, for person centred care for people with dementia living in residential care settings.</p>
<p>Beatriz Aragon Martin</p>	<p><i>Max Planck institute for the study of ethnic and religious diversity - University College London</i></p>	<p>Doing fieldwork at home: emotions and reflections</p> <p>This paper addresses the influence of emotions during fieldwork and how these emotions affect the research project and the anthropologist's position in the field. Drawing on my own experience carrying out fieldwork 'at home' in clinical settings where I used to work as a medical doctor. I examine how my shift in roles -from GP/ colleague to anthropologist/researcher- prompted different emotions in my colleagues, patients and myself. First of all, I analyze the emotions my colleagues expressed in relation with my dual role (mistrust, curiosity, ambivalence) and they ways they showed those emotions (through jokes, inquisitive questions, defensive attitudes). Secondly, I look at the emotions displayed by patients when they learn about my research, which were mainly of indifference as long as I continue being their GP. Feelings of sadness and fear were also displayed when I was to leave the field and 'abandon' them again to go to a different healthcare setting. Finally, I look at my own emotions while doing fieldwork and repositioning myself in a context where previously I engaged with as a medical doctor. I look at how the fear of deception was one continuous emotion I had during fieldwork, the way this fear mobilized me into some routines and how I overcame this fear by the renegotiation of my role with my colleagues and patients during fieldwork. I argue that in the process of explicit and implicit manifestation of those emotions triggered by doing research in a familiar milieu, the relationship with the 'objects of study' became more collaborative and reflexive. Therefore, the account of emotions benefited the research.</p>

Ben Belek	<i>University of Cambridge</i>	<p>I feel therefore I matter: Emotional rhetoric in the context of autism selfadvocacy online</p> <p>My paper engages with autism self-advocacy and activism online. On 11 November 2013, Suzanne Wright, co-founder of the U.S. based autism advocacy organisation Autism Speaks published a ‘call for action’ on the organisation’s website. This was aimed to raise public awareness to a highly publicized ‘national policy and action summit’; an event organised by Autism Speaks, scheduled to take place the next morning in Washington D.C. In her text, Mrs. Wright regards autism as a tragedy and a national emergency, and asserts that families of autistic children are not living, but ‘merely existing’. Her text was punctuated with the recurrent phrase ‘This is Autism’. My paper focuses primarily on the outraged reactions of members of various online autistic communities to Wright’s ‘call for action’; reactions which, I will show, included an extensive use of a rhetoric of emotions. While emotions are often thought to denote reactivity rather than activity, and softness rather than strength, I will argue that in the case of autism online self-advocacy emotions, on the contrary, denote power. I will suggest that autistic self-advocates’ use of emotional rhetoric is highly political; that it demonstrates autistic people’s belonging to society, and is further employed to substantiate their humanity. More broadly, this paper will illustrate the ways in which autistic self-advocates work together to mobilize emotions as political instruments, creatively occupying various online platforms in order to ultimately introduce societal change.</p>
Emilia Perujo	<i>Universidad Nacional Autónoma de México</i>	<p>The bodily presence of absence: Negotiating emotions along anthropological fieldwork</p> <p>Emotions are present all along ethnographic fieldwork. Even when they are not on the foreground as a topic, emotions appear from the earliest stages of our research processes; in the way we chose our topics, how we approach them and, what I would like to focus on this paper, during our fieldwork interactions with others. They shape, to some extent, what we find and how we find it, especially in emotionally charged topics and interviews.</p> <p>This paper draws from my PhD research experience as an anthropologist exploring what divorced fathers who are not allowed to see their children go through and how they manage it. About the emotional field of absence and frustration and how I as an anthropologist encountered it within a research originally focused on power and negotiation. Divorce and father-children separation is a process with close similarities to what medical anthropology calls “patient careers”: fathers enter an uncertainty realm, which includes legal battles, health problems (hypertension, panic attacks) and healing (going to psychotherapy, religious activities, solidarity groups). Anthropological interviewing comes to an arena where emotions are at different levels in people’s accounts and everyday activities, and therefore both researcher and informers begin to move along the presence of emotions in their interactions.</p> <p>During therapeutic interviewing, it is assumed emotions will be there, their boundaries and how to manage them, whereas it is not always the case in anthropological research. This paper aims to focus on what we usually leave unattended or unreported in non-emotional based research: the bodily presence of emotion and sentiment as generators and products of research interactions.</p>
Emmaly Berghuis	<i>University of Amsterdam</i>	<p>Pained expressions: exploring emotions of migrant women with chronic pain</p> <p>The focus of this paper is on the emotions of migrant women living transnationally and their experience of chronic pain. In the nineteen-nineties it was debated whether migrants could distinguish between somatic and psychological complaints. Cultural differences were emphasized to the degree of stereotypes that limited effective health care. While this has been rightly nuanced since then, the challenge of adequately helping migrant women with vague, chronic pain remains today, as high drop-out rates from rehabilitation among non-western migrants indicate. This paper draws on fieldwork and interviews with migrant women in the Netherlands about their perspective on chronic pain. Respondents expressed emotions such as stress, grief and frustration in accounting for their pain, showing that they themselves do relate this to living transnationally.</p>

Eva Cynkar	<i>University of Cologne, Department of Cultural and Social Anthropology</i>	<p>Cultural Models and (Ab-/Normal) Emotions: A Cognitive-Anthropological View</p> <p>Recent anthropological contributions to the study of emotions advocate an integral theory of emotion that defines human feelings as complex bio-cultural processes, thus overcoming reductionist assumptions of prior biological-universalist and cultural-constructivist paradigms. Taking such holistic understandings of emotions into account, this paper discusses the cultural foundations of the human ability to experience emotions. From a cognitive-anthropological perspective, emotions are understood, on a conceptual level, as specific forms of cultural knowledge (cultural emotion models) embedded in complex meaning-systems of a culture. It is argued that a comprehensive understanding of emotional phenomena requires an investigation of the manifold connections between one cultural emotion model and other cultural models which are intersubjectively shared by members of one cultural group. In order to illustrate this theory, the author demonstrates the cultural specificity of the Tongan conception of “anger” (Bender et al. 2007) by analysing its complex entanglement with other mental models dominant in Tongan culture (i.e. ideal of harmony, social stratification norms, idealistic conception of personality). Another emphasis of this paper lies on the elicitation of emotional responses. Following cognitive appraisal theories, the author assumes that mental judgments over person-environment-relations both trigger emotional episodes and contribute to the unique, culturally shaped quality and differentiation of an emotion, characterising it as “anger“, “love“ and so forth. Finally, the author aims to integrate the cognitive-anthropological approach on emotion into the medical-anthropological discourse on mental health/illness. The paper offers insight into theoretical considerations regarding the “normality“ and “pathology“ of emotions. Furthermore, it is argued that emic perceptions of mental health/illness in general, and of emotions in the context of mental health/illness in particular, are influenced by culturally dominant cognitive models.</p>
Florin Cristea	<i>National School of Political Science and Public Administration, Romania</i>	<p>Desirable Emotions. Negotiating Personhood in a Psychosocial Integration Center in Romania.</p> <p>In this paper I will explore the role of emotions in the integration process of people diagnosed with schizophrenia. The fieldwork is carried out in a centre for psychosocial integration, within a state Psychiatry Hospital in Bucharest, Romania. People attending this centre are usually no longer hospitalised. A recurrent matter that appears in their discourse is the necessity to control the intensity of their emotions as part of their healing process. They distinguish between some emotions that are good and others that need to be annihilated completely. In the interaction between attendees, or in the one with the staff of the centre, contexts are being generated where expressing the good emotions is being encouraged, through artistic processes, usually, but also within meetings or other events. I will examine which emotions are considered to be good and beneficial in the healing process, and which are the ones that are associated to sickness and hence need to be controlled. I will also focus on their classification, on the processes that lead to a geography of emotions. Dealing with emotions, in the narratives about themselves, or the ones concerning their sociability evokes a desirable condition that they wish to reach, maintain or obtain, related to what they consider to be acceptable from a social point of view. In this light, their personhood is shaped by building on emotions, during their integration process and this is reflected in their social relations inside and outside the centre.</p>

<p>Francesca De Luca</p>	<p><i>Universidade de Lisboa, Institute of Social Sciences (ICS)</i></p>	<p>Uma Hora Pequena! Childbirth pains in an anthropological perspective</p> <p>This paper is grounded on my on-going research on childbirth pain(s) in Lisbon, Portugal. The initial questions with which I first drafted the investigation revolved around what shapes women’s experience of pain during labour, how it is managed in different settings and what do these practices tell us about the social constitution of childbirth pain itself. Then fieldwork proved the starting purposes problematic. The International Association for the Study of Pain (IASP) defines pain as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage”i. Pain in childbirth arises, I argue, as a complex and shifting category where the physiological “certainties” of contractions mingle and blur in the emotional narratives of labour that it triggers. Different perspectives in the biomedical landscape I research, define the pain of childbirth as a “medieval occurrence”, an unnecessary burden or on the contrary, a functional, bonding feature and an empowering experience. Birthing women’s narrative, too, disclose contrasting dimensions of embodied emotions when asked about their childbirth labour: some express how they felt lost in a foreign setting, or suffered from the treatment of health professionals; others felt anxiety and feared to be physically unadapt to give birth. Some women were thrilled throughout delivery; others felt the pleasure of the labouring “journey”. The multiplicity of meanings and emotions that emerge in the birth scene, their intersubjective dynamics, undermine the idea of childbirth pain’s enclosed, visceral nature as much as it being a stable, fruitful analytic category in medical anthropology. The aim of this paper is then to critically redeem childbirth pains from a dualistic body/emotion definition and engage with their relational aspects as they unravel in fieldwork.</p>
<p>Froukje Pelleboer</p>	<p><i>KU Leuven</i></p>	<p>Emotions of suffering in women in West Papua</p> <p>West Papua suffers from structural and political violence. Military forces from Indonesia are constantly present in West Papua and seen as the source of violent oppression, Papuans are structurally discriminated against, economically marginalised and their resources exploited; there is a lack of basic healthcare while HIV infections are exploding, yet this is neglected by the Indonesian government. Additionally, increasingly higher levels of alcohol are consumed, resulting in violent impacts on relationships, the disruption of social bonds, and an increase in gender-based violence. I am interested in how the social suffering fueled by alcohol use affects women, their roles, and their relationships. What emotions do women experience as a result of this social suffering? Considering emotion as an intersubjective experience, what meaning do these women give to emotions in their cultural and relational context? How do they use their emotions to stand firm? How do they express their emotions and with whom? Emotions can be a great force for action; (how) do they use emotions to resist structural and gendered violence? What role does religion play in how women experience emotion, especially with Christian West-Papua as opposed to Islamic Indonesia and the presence of mainly Islamic transmigrants in West Papua? Like culture, emotion is dynamic; it transforms and adapts when circumstances change. In what way are emotions influenced by changing social bonds, and societal and political forces in West Papua? My aim for this paper is to relate these questions to the current debate in anthropology on the emotions of suffering, in order to better understand the emotional experiences of women in West Papua during my fieldwork.</p>

<p>Giulia Scioli</p>	<p><i>University College London, UK</i></p>	<p>“Feelings kill; feelings heal”: Working on Emotions in Eating Disorders Treatment</p> <p>Innovative treatment approaches to Eating Disorders view Anorexia and Bulimia Nervosa not only as mental illnesses but also as an existential issue, a problem of relation to one’s self and to the world. The solution to an existential problem – whatever it is – cannot focus solely on eating re-education and psychotherapy, but needs to involve the subject in its totality, mind through body. From this follows a therapeutic approach that is defined as ‘integrated’, i.e. made up of different and complementary disciplines and practices that aim at ‘attacking’ the eating disorder from its different angles at the same time. The goal is to facilitate the re-appropriation of the body as a resource to be in the world and in relation to the world. In this perspective, one of the key issues addressed during treatment is patients’ contact with their emotions. How are emotions conceptualized within these treatment centres, and what does this imply for treatment? Drawing from both existing anthropological literature and from personal fieldwork in a residential treatment centre in Italy, the paper will explore how this notion is translated into treatment practices both in terms of therapeutic activities and in terms of the ‘affective’ attitude of healthcare workers towards patients. The paper will show that finding a balance in the way both patients and caregivers negotiate emotions within themselves and between each other is considered critical for a successful recovery. Since “Feelings kill; feelings heal” (Scheper-Hughes and Lock 1987:29), finding a balance between emotional involvement and detachment is fundamental for 1) patients to manage a ‘healthy’ relationship with the surrounding world and with the suffering that necessarily comes from it; 2) for the healthcare workers to take care of the patients; and 3) for the anthropologist to reach an embodied understanding of what goes on during treatment.</p>
<p>Jennifer Infanti</p>	<p><i>Norwegian University of Science and Technology</i></p>	<p>The emotional dynamics of expectations and promises in global health research</p> <p>Throughout my PhD research I was privy to children’s testimonies of emotional pain, loss and abuse, but I came away from the study feeling energised and hopeful. I took comfort in knowing I was able to relieve some of the burden of my participant’s suffering through compassionate and empathic listening, even if I could not ensure they would live violence-free futures. Intuitively, I suspect such research is satisfactory because it fulfils a humanly inclination to care for and connect to others. The same feeling of ethical responsibility to care for others motivated me to apply for my current position in a multidisciplinary global health collaboration seeking to improve antenatal care for women living with domestic violence in Sri Lanka and Nepal. The rhetorics of the emerging global health movement are deeply emotional; they compel those of us with the power and privilege to address the innumerable health inequities which transcend national borders in order to relieve the global burden of suffering, cure disease and save lives. Such promises seem distant in my current research, which is characterised by necessarily short and intense periods of fieldwork and the use of language interpreters for communication with participants. In this reflective paper, I share some examples from recent fieldwork in Sri Lanka where I felt discomfort and awkwardness in being a bystander rather than a ‘full participant’ during research interviews and, worse, ashamed of my incapability to fulfil obligations to my participants. By examining this tangle of emotional states, obligations and experiences, I draw implications for fieldwork methods and anthropological understanding and representation, particularly for anthropologists working in applied settings. My focus is on how we can respond practically and constructively to negative emotions experienced during fieldwork, an area which has thus far been inadequately addressed in the literature on emotions in anthropology.</p>

Julien Grard	<i>École des Hautes Études en Sciences Sociales, Paris and - Équipe MARSS</i>	<p>Death, emotions, fieldwork</p> <p>Based on a 4-year ethnography conducted in a GEM ("groupe d'entraide mutuelle", i.e. mutual help group) located in a major French city, my PhD dissertation (2011) focused on the institutional and social construction of experiences and subjectivities of people suffering from mental illness.</p> <p>Relying on a long lasting fieldwork, close to the ordinary, within non-medical settings – and from there, following people in their daily wanderings –, I focus on their experiences, taking what matters to them as a starting point. Reversing the standpoint, I approach those who are usually labelled and defined as "users", "patients", "lunatics" or "consumers" as persons. Their experience of illness is set in the context of their life trajectories and of their other social experiences, examining the tension between structural constraints and agency.</p> <p>By questioning the dialectic relations between those experiences, institutional technologies, as well as moral, political and semantic networks that surround them, I show how social statuses interact and contribute to shape persons' daily lives and experiences. Little by little, studying everyday practices and discourses, and observing ways of being-in-the-world, I unravel the social, moral and institutional shaping of subjectivities.</p> <p>This work has been made feasible, and it becomes clearer as times passes, by the confrontation and the meeting of subjectivities and of course, of emotions. One topic I addressed in my dissertation, promising myself to write a paper that I would submit to a journal on it, is the excess mortality rate and the lower life expectancy among this population. Indeed, I have read articles, mostly based on quantitative data, showing it. But during my investigation, people I was in contact almost every day died, and even if I analysed this in my dissertation, I have never been able until this year to start working on it. What “pulled the trigger” in my mind was the violent death last month of one of my informants, whom I was still in touch with. It freed a flow of emotions that freed me and made me able, at last, to start writing this important (to my eyes at least) paper.</p> <p>I propose in this communication to reflect on the way emotions on and out of the field are heuristic, but also on how they can ‘freeze’ our reflection and writing, despite the important implications our publications might have.</p>
Jyoti Gupta	<i>University of Delhi, India</i>	<p>Enacting the experiences advertisements based on patients’ narratives</p> <p>Negotiation of emotions can be seen at various stages and occasions in healing processes. However, it is direct but mass communication media that presents itself with many possibilities of negotiation and enactment. Public service advertisements on television are examples of inter-mixing of emotions that seek to bring behavior change. While referring to the smokeless tobacco control campaigns in India, the proposed paper will discuss a case where narratives of patients can be seen as both experienced and enacted emotions. The process of advertisement creation at the same time is guided by the emotions of two different moralities possessed by the local creators and global funders of those ad campaigns.</p> <p>The gestures, relationships and culture- all play a role in the experience and enactment of emotions. In this paper, I aim to explore the same through the negotiations that happen between the patients, doctors and the media creators. How their separate positioning gets exposed in the form of a common message? Since the media format is not restricted to India and has been applied in many other countries, can we conclude that when it comes to fear, duty and welfare, similar emotions are observed? What are global and what are local emotions? To what extent these are guided by profession, social class relationships or problem at hand?</p>

Kristin Engh Førde	<i>University of Oslo.</i>	<p>Accommodating “the Medical Baby”. Experiences of Gestational Surrogacy pregnancy in Mumbai, India.</p> <p>This paper explores how the notion of a “medically conceived” foetus gives meaning to and motivates practices during the pregnancy for women who act as gestational surrogates in Mumbai, largely on behalf of Western commissioning parents. The surrogates – who usually have limited knowledge of biogenetics and reproductive technology – understand the foetus as “conceived through medicines” and sustained by injections and other medicines throughout the pregnancy. This creates a notion of the foetus as alien (“not mine”) and the pregnancy as radically different from the surrogates’ previous experiences of childbearing. The Medical Baby is also presented by the fertility clinics as vulnerable – due to its “unnatural” conception – to an extent where the surrogate’s pregnant body is not a sufficient provider of protection and nourishment. The surrogates’ practical knowledge is dismissed in favour of medical surveillance on the hands of the fertility clinics. Their everyday lives are portrayed as too risky in terms of hygiene, nutrition and workload. The perceived vulnerability of the Medical Baby motivates practices which severely restricts the surrogates’ personal autonomy and alienate them from their everyday lives.</p> <p>In sum, these practices can be seen as constructing a surrogate-foetus relation of responsibility without relatedness; ensuring that the needs of the foetus are prioritized during pregnancy on the one hand, and the acceptance of a complete relinquishing of the baby at delivery on the other. However, although most of the surrogates do indeed adjust their practices as required, they do contest their legitimacy and the notion of unrelatedness to the foetus.</p> <p>The paper is based on an extensive ethnographic fieldwork among former, current and future surrogates in Mumbai, India, conducted as part of my PhD project “Win- win or Exploitation? An Ethnographic Study of Surrogacy in India”.</p>
Laura Vermeulen	<i>University of Amsterdam</i>	<p>“It’s losing the person I knew”: ‘Emotions’ and remaking life in the context of dementia care support therapeutics in England</p> <p>In this paper I introduce Mr and Mrs Anson, an English couple whose life had been affected by Mrs Anson’s forgetfulness for about ten years when I first met them in 2012. Drawing on life history interviews I conducted with Mr Anson, and participant observations I did with both him and his wife, I trace how affect works in the way they remake their shared life in the face of Mrs Anson’s ‘Alzheimer’s Disease’. I use both an anthropological study of moralities that takes moments of breakdown in everyday courses of events as a starting point for analysing the way life courses move in different directions (Zigon 2007), and Sedgwick’s observation that affects ‘can be, and are attached to things, people, ideas, sensations, relations [...], and any number of other things, including other affects’ (Sedgwick following Tomkins in: Hemmings 2005). Moments indicated by Mr Anson with the words ‘hurt’, ‘denial’, ‘upset’ and ‘love’ can be seen, I maintain, not only as moments in which a rupture takes place in the familiar relationship he and Mrs Anson live in, but also as moments in which affective attachments are reconfigured, and transform what being together means to both of them. As such, tracing the movements of what I came to understand as a ‘narrative about something shared’ (Berlant 2000:1), I will especially pay attention to how a biomedical understanding of dementia on the one hand, and narratives on being a ‘long-standing couple’ on the other, directs this shared life towards the expression of either more publicly shared feelings of loss or (embodied) narratives of affection.</p>

Lex Kuiper	<i>Amsterdam Institute for Social Science Research</i>	<p>Methadone and time: on (the absence of) hope in the forever-now</p> <p>In Indonesia unsafe injecting drug use is a major mode of HIV/AIDS transmission. While upholding many of the restrictive and punitive laws on drug use and illicit trafficking, the Indonesian government has in recent years also partly adopted a human rights- and health-based harm reduction approach to prevent HIV/AIDS infections. This paper uses participant observation and interviews to explore the experience of users in one of these prevention programmes within a largely restrictive regime, namely a methadone clinic in Java.</p> <p>Methadone is an oral heroin substitution that is intended to ‘stabilise’ heroin users by taking away the pleasure of heroin and negating (some of) the withdrawal symptoms brought about by a rapid abstinence. Policy makers and doctors – and sometimes drug users themselves – hope that the regular admission of high methadone doses (once daily) lessens the need for heroin, and, as an effect, reduces criminal behaviour and improves (ex-)users’ health. While ‘traditional’ rehabilitation aims at recovery and often assumes addiction can – and should be – overcome, methadone takes addiction to be a chronic relapse disorder that needs continuous and indefinite substitution.</p> <p>These contrasting notions of drug use and treatment invoke different temporalities. This paper explores what it is to live in a ‘forever-present’ (see also Allison, 2003) in which one imagines every day in the future to be the same to today. The difficulty of moving away (both temporally and spatially) from both methadone and heroin brings about this forever-now and forever-here. How is it to feel hope-less in the sense that one is deprived of not only the hope for something better, but even for something different?</p>
Lisa Strandroos	<i>Linköping University</i>	<p>Meaning making at a dementia care facility: different understandings and concerns</p> <p>Different persons at a dementia care facility often have different understandings of where they are, what is going on and what matters in the situation. This paper illustrates the different concerns that staff and residents have. The staff understands the residents in relation to the dementia diagnosis they have, a diagnosis that define them as having a disease and therefore as receivers of care. Almost everything that the residents express is understood in relation to this diagnosis. Meanwhile, also the residents try to make sense of their world. Their meaning making is scarcely related to their dementia diagnosis, and their concerns are rarely of a medical or care related character. Their meaning making is made difficult partly by cognitive and linguistic difficulties, and partly by the frames and routines of the institution. These do not hold many of the social and cultural expressions that have been an important part of the residents’ lives, and that still constitute their frames of interpretation.</p> <p>A consequence of the diagnosis in this context is thus that the staff defines the residents as diseased and care takers, and positions them as such in interaction. Emotions that the residents display are often understood as symptoms of the dementia disease, rather than a response to the particular conditions that these persons live under. Particularly behaviour that the beholder cannot make sense of, is easily interpreted as symptoms. Often it may as well be that the “behaviour” is an active attempt to create meaning, or an expression for how the situation is experienced. However, the diagnosis and the understanding it entails of expressions as symptoms, tend to delegitimise these expressions.</p>
Marco Andrade Nêves	<i>UFRGS / FU Berlin</i>	<p>Mobilizing Emotions: The notion of "cases" in assisted suicide and voluntary euthanasia demands.</p>

<p>Maria C. Lo Bosco</p>	<p><i>University of Lisbon, Institute of Social Sciences (ICS)</i></p>	<p>Sensing the field and giving sense to emotions, narratives between a medical anthropologist and autistics' family caregivers</p> <p>The paper I would like to propose aims to present and discuss an aspect of my ongoing ethnographic research on autism and web-activism (Lisbon- Portugal), that is the ways in which caregivers and family members tell and describe - during interviews, informal meetings as well as online interactions - their emotions about the recalling of the diagnostic moment, the difficulties and hopes about therapies as well as about their daily life with their autistic relatives.</p> <p>At the same time and inevitably, I can not but deal with the ways in which - as a researcher in the field - I carry my own emotions and I share them with my interlocutors, influencing as well as they do the flow of our mutual dialogue and communication. Indeed, during the field, I inevitably embody different emotions – such as guilt, compassion, hope, sadness - since my academic position it is not unglued from the phenomenological and bodily experience of me as an human being speaking and engaging with other people.</p> <p>Anthropologist and fieldwork's interlocutors are engaged in a social relation where they are both generating and learning meanings, shaping and being shaped by each other's words, by the intensity and "quality" of their speech as well as by their gestures and bodily movements.</p> <p>I will try to use my personal experience of fieldwork to reflect on how bodily and emotional experience is a valid and powerful sensory way of knowing about our so-called "subject of study" and how emotions let us be open to give sense and “sensing” to that relational experiment that is the ethnographic encounter.</p>
<p>Marion Linska</p>	<p><i>University of Vienna</i></p>	<p>Personal Field-Reflection or how to integrate emotions as an analytical tool in qualitative research institutions</p> <p>Why are emotions as important as our intellectual understanding for the process of qualitative research, especially for fieldwork? If feelings, emotions and tacit knowledge are another kind of measurement, how to deal with them in the in-action-process and in the on-action-process as well?</p> <p>According to the phenomenological approach I transformed methods of Existential Analysis into a tool of self-reflective questions, including emotions and presuppositions, to accompany the inner dialogue of the researcher in an understanding of a dialogical continuum to the field (situation).</p>
<p>Natashe Lemos Dekker</p>	<p><i>University of Amsterdam</i></p>	<p>"Future suffering is also suffering" Euthanasia and Dementia in the Netherland</p>
<p>Samuele Collu,</p>	<p><i>UC Berkeley – UC SF</i></p>	<p>From reflexive modes to refractive moods: being affected behind a one-way mirror</p> <p>Throughout the 70/80s the reflexive turn in anthropology emerged amid both post-colonial and semiotic concerns, placing the ethnographer in front of a critical mirror of self-examination. However, the mirror also triggered a series of mesmerizing impasses where the relational “other” all but vanished behind the reflecting mirror. Contemporary debates on affects and emotions – two distinct concepts – offer new methodological venues to rethink reflexive models of subjectivity and relationality in the field. I propose the notion of “refractive mood”- a state of affection anchoring the ethnographer to a relational and local situation, which cannot be fully grasped through the reflexive paradigm. In physics, refraction describes the change of direction and speed of a wave when it enters a different medium. Thinking through the metaphor of refraction, this paper approaches affects as waves barreling into the presence of the ethnographer, resulting in a series of temporal transformations, and providing flesh to her abstractions.</p> <p>This metaphor arose from my fieldwork on systemic couples therapy in Buenos Aires, Argentina, among the notoriously “psychologized” Argentine middle-class. I undertook critical observation of ongoing psychotherapy sessions behind a one-way mirror, alongside a team of therapists supervising the couple and their attending therapist. Through these sessions, I explore the “labor on affects” performed by psychotherapists and couples, and the emotional imaginaries of identity and</p>

		<p>affective citizenship that emerge. In the paper, I closely examine a scene of emotional breakdown, where a therapist encounters an excess of affective impact during her session, and temporarily retreats to the other side of the one-way mirror, the observational – and I suggest refractive – space where the ethnographer and therapeutic team dwell. Through the presence and circulation of an “affective cloud” of exhaustion between the couple, the therapists, and the ethnographer, I explore the heuristic potentiality of thinking through affectivity and refractivity in ethnography.</p>
<p>Sara Seerup Laursen</p>	<p><i>University of Southern Denmark</i></p>	<p>The meaning of pain. Processes of meaning making at a pain clinic for youngsters with medically unexplained pain.</p> <p>This paper investigates how pain is constructed as a physical, an emotional, and a moral event from the vantage point of youngsters with medically unexplained pain, their parents, and health practitioners. The analysis is based on 18 months of fieldwork with base at an inpatient pain clinic for youngsters (age 8-18), where the treatment and progress of 21 youngsters from the clinic was followed. The professionals at the clinic include psychologists, physiotherapists, pedagogues and nurses, all working according to a ‘biopsychosocial’ model of pain, and the young people are hospitalized for approximately a week accompanied by one of their parents.</p> <p>The analytical starting point is an exploration of how the youngsters, their parents, and the health care professionals each attribute meaning to the youngsters’ pain. Young people with unexplained pain transgress ordinary boundaries between being healthy and being sick, and the analysis reveals how meaning making is engaged in this ‘borderland condition’ and how various meanings are expressed, contested and negotiated at the clinic and in the families of the youngsters. In particular, attention is paid to the ways in which guilt and responsibility are assigned and negotiated during the attempt of establishing an agreement on the meaning and the cause of the pain. It is suggested that emotions and ‘moralities of emotions’ play a key role in the construction and interpretation of symptoms.</p>
<p>Silke Hoppe</p>	<p><i>University of Amsterdam</i></p>	<p>Negotiating emotions in early-onset dementia</p> <p>In my research I focus on early-onset dementia. People who have early-onset dementia receive their diagnosis before the age of 65. I analyse the experiences of people who have been diagnosed with the illness and their family members. In this paper I want to focus on two aspects.</p> <p>First, I explore how emotions are negotiated between family members. How do emotions shape conversations between partners and what are the dynamics between the healthy parent and the child? Although all family members experience loss, the loss takes different forms. The person with dementia might be sad and angry about the diagnosis and all the things he or she no longer is able to do. The partner has to deal with excessive demands and prepare for the loss of the sick person. Children have to deal with confusion, possibly not only the loss of one but of both parents (the healthy parent being too occupied with the care for the person with dementia) and with suffering.</p> <p>Second, I study how in the face of severe suffering cultural norms of which emotions can be displayed are pushed. Furthermore I analyse which emotions are shown to whom. Thus children might express their fears to their siblings but not to the mother who is caring for the father. Or a mother might share all her worries with one daughter, but not with the other.</p> <p>The aim of this paper is to demonstrate the complexity of emotions around early-onset dementia.</p>
<p>Stine Grinna</p>	<p><i>University of Amsterdam</i></p>	<p>Intimately depending: exploring practices of navigating and negotiating relationships with clients among people who sell sex in Cape Town</p> <p>Academic and public discourses on the selling of sex revolve around the degree to which the relationship between ‘seller’ and ‘buyer’ is one of dependency or intimacy. Here, intimacy and dependency are treated as questions of either/or, without problematizing this distinction as such. These issues are particularly contentious in South Africa where one finds a</p>

		<p>plethora of forms of exchanging sex for reward. Sex may for instance be exchanged for goods such as cell phones, bus fares, or groceries. Furthermore, the exchange of sex for goods is not always defined as an act of selling, but can also be enmeshed in relationships of other social obligations. The conceptualization of seller-buyer relationship itself is thus a contested one.</p> <p>This paper, based on ethnographic research with people who sell sex in Cape Town, problematizes the distinction between intimacy and dependency, and the way in which they are being produced in the relationship between people who sell sex and their clients. In the midst of a social reality in which “becoming independent” figures as a powerful imaginary for the ‘proper’ South African citizen and dependency is stigmatized, I show that dependency and intimacy is not always separate, nor negating each other, but become entangled in the navigation and negotiation of these relationships.</p>
Tania Kossberg	<i>University of Cambridge</i>	<p>Emotions in Family Therapy in Northern Norway</p> <p>This paper discusses the role of emotions in the context of mental healthcare and family therapy based upon ethnographic fieldwork in Northern Norway. It addresses the methodological challenge of approaching and working with categories of emotion. Although infused with emotions, in the everyday therapeutic process emotions are implicitly embedded in social and therapeutic practice. Therapeutic talk is about social events, how family members feel and behave, and how this produces problems. For example, what leads families to family therapy is often the child’s inappropriate display of patterned emotions and behaviour in school and the family.</p> <p>In approaching family therapy as a mode of healing my focus is on healing performance and narratives. I discuss the expression and performance of emotion within the therapeutic setting, and how the variety of stories reflects the diversity and intangibility of experiences. The problem I have encountered was an apparent clash with the agenda of family therapy and the multiplicity and blend of experiences, emotions, and problems communicated by the family. If the stories told are managed, does it mean that experiences and emotions that infuse those stories are subjects of negotiation as is the ontology of affliction? This leads to the question of the negotiability of these factors, when considering a failure of treatment.</p> <p>Finally, I discuss the spatial dimension of healing narratives and emotions, guided by two aspects, therapeutic space and the diversity of social practice. First, the inbuilt ‘nature therapy’ that focuses on familiar landscapes and activities of the region leads to the (ideological) discourse associated with attachment and certain kinds of emotions to place that may have therapeutic advantages. Secondly, as family therapy works on the level of social practice, negotiated narratives and changes in social practice need to be carried into different places and practiced outside of the therapeutic encounter.</p>
Tanja Ahlin	<i>Amsterdam Institute for Social Science Research</i>	<p>Information and communication technology (ICT) and tension management in elderly care in Indian transnational families</p> <p>Care is often associated with warmth and technologies with cold. However, studies of technologies used in healthcare have argued against this opposition and showed that people engage in social and affective relations with and through technologies (Pols and Moser 2009). In my research, I explore the use of everyday information and communication technologies (ICTs) in elderly care at a distance. I build on my recent fieldwork among Indian transnational families of nurses, migrating from Kerala to other parts of the world. Particularly, I look at how the migrating nurses keep in touch with their family and how they continue to provide care to their parents who remain in their home country. In my analysis, I approach care in terms of relations, which are emotionally invested, between a number of humans as well as technologies. In this paper, I explore how ICTs contribute to sustaining these relations, or disrupt them. Furthermore, I present several case studies in order to investigate how different ICTs influence the emotions of transnational family members involved in intergenerational care by presenting several case studies.</p>

<p>Tereza Mazáková</p>	<p><i>Charles University in Prague</i></p>	<p>Emotional buprenorphine network</p> <p>Buprenorphine medicines have an addictive potential, are cheap, vastly available and guarantee good quality. Its mass prescription competes with and pushes out heroin from the so called 'black drug market' in Prague, Czech Republic. Substitution medicines with an active ingredient buprenorphine and emotional ties between different actors on the buprenorphine market are a central theme of this article.</p> <p>I see substitution therapy as an attempt of biopower to penetrate undisciplined space of illegal opiate market. Due to substitution efforts, some heroin users are shifted from so called illegal drug scene to the health care system and start with the substitution therapy. Some drug users subvert these disciplining efforts to their own regimes of power. Buprenorphine itself is not a passive actor that can be bound or subverted so easily. On the contrary, buprenorphine products are viable and powerful hybrids that resist the health care discourse and start to live a life of its own. Buprenorphine products and the situation in-between discourses create a tense situation and tangle emotional multisided networks across the social positions.</p> <p>I review ambiguity of the medicine itself and consequence of its special position within the health care discourse and illegal drug scene. I capture multiplicity of the issue by the specific example of so-called "Buprenorphine crisis", the situation where the emotions and tension had escalated.</p>
<p>Ursula Probst</p>	<p><i>Freie Universität Berlin</i></p>	<p>But how can you deal with it? – Emotions in Sex Work (Research)</p> <p>In debates on sex work, horrific tales of exploitation and abuse are often used to get audiences emotionally involved and eager to „rescue“ sex workers from harm. These debates as well as the image of sex work they depict are characterised by the politicisation of negative emotions that supposedly define the seemingly emotionless exchange of sexual services to fulfill certain needs, thereby creating a dichotomy between a negative version of sex work and „proper“, „good“ sexuality based on intimacy and mutual positive emotional involvement.</p> <p>While such a portrayal of sex work fits the image of sex workers as passive and suffering victims, the emotional realities of sex workers seem to be much more complex, involving not only emotional harm and suffering, but also positive emotions such as joy and excitement, strategies of dealing with emotions and the use of emotions as a basis for decision making, e.g. whether to accept a client or in choosing an appropriate workplace, leading to the assumption that emotions are not just a negative „byproduct“ of sex work, but can also be an important part of the work itself.</p> <p>Based on my previous research on sex workers' evaluation of support services in Berlin I want to present some thoughts on the various aspects of emotionality in sex work and their relation to questions of sexuality and health in this paper. Thereby I also want to discuss the question of how to study and address these topics in an itself emotionally charged debate and in regard to researchers' own emotional involvement these topics</p>