Personhood, belonging, affect and affliction

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Abstract

What does migrancy mean for personhood, and how does this flow through caring relations? Drawing on life history interviews and photo elicitation with 43 people who identify as migrants and live with cancer, here we argue for the significance of recognising complex personhood as it inflects illness and care. Drawing on social science theory around temporalities, moralities and belonging, we assemble a series of cross-cutting themes at the intersection of personhood and care; relations that transcend cultural origins yet are vividly illustrated in relation to migrant pasts. In seeking a multidimensional view of personhood, we attend to the intersecting layers of complexity that make up care in this context vis-a-vis an emphasis on forms of difference, vulnerability and otherness. In this way, we develop an approach to personhood and care that broadens the lens on migrancy and cancer, but also, one that speaks to the importance of recognition of complexity and how it shapes care more generally.

Introduction

People are complex. While this is universally true, some forms of complexity are more readily recognisable than others. Migrants, in particular, are often ascribed a degree of complexity that positions them as 'other'. Yet what unfolds at the nexus of migrancy and care is an important illustration of personhood as always deeply embedded in particular assemblages of histories, geographies, subjectivities, vulnerabilities and complexity. This article offers a visual and narrative journey into the biographies of migrant cancer patients living in Australia, piecing together intersections of past and present, here and there, us and them. We embarked on this project to engage with a particular set of problems that are often (but not always) endemic in care contexts – how to embrace culture *yet* accommodate complexity, how to recognise difference and specificity, and how to do so without creating a sense of othering and distancing. We do not seek to resolve all of these tensions here, but rather to offer a series of conceptual considerations, driven by the accounts of participants/patients/persons themselves. In doing so, we hope to help make sense of how personhood *acts* in care, and ultimately, to help move the field of cancer care, in particular, toward engaging personhood more effectively.

In the context of migrancy, particular themes around complexity tend to matter more than others. Migrancy offers important implications for the experience of illness, treatment and recovery, and it is these dimensions which we seek to elevate here, striking the (admittedly precarious) balance between recognition of the specificities of migrant subjectivities, and the universality of complexity. Personhood in the context of migrancy, we posit, often brings certain things to the surface, including the multidimensionality of distance, spectres of the past, and the moralities of the present.

Here, we draw on the experiences and stories of people from a wide range of migration journeys. By assembling people from diverse backgrounds, we aimed to circumvent the pull of 'ethnic coherency' that is pervasive across much scholarship, and to capture some of the themes operating silently across and beneath the predominant framings of

culture-in-practice. Moreover, we sought to recognise 'working with culture' as requiring much more than an enhanced understanding of 'needs', education, literacy or better communication (see e.g. Dein, 2004, 2006). That is, we sought to reframe the 'problem' of culture, in cancer settings and beyond, as a challenge of complexity and multidimensionality *within* care, rather than as amenable to solutions via therapeutic acts of 'accommodation'.

Below, we begin to develop a conceptual understanding at the intersection of migrancy and personhood, that is attuned to cancer care, but which is likely to have resonance far beyond it. Drawing on sequential life history interviews and photo elicitation with 43 people who identified as migrants and were living with cancer in Australia, we explore the intermingling importance of temporality, moralities and belonging (e.g. Ahmed, 2003; Gordon, 2008; May, 2017; Probyn, 1996), as emergent from these participants' accounts. We seek to add further visual and narrative nuance to the existing humanities and social science scholarship on temporality, relationality and belonging, and to explore how this corpus of work may be usefully employed to understand, and better engage with personhood within care.

Temporality/Spectrality

Migrant, as a term, simultaneously denotes something about one's past travels, and something about one's present identity. In this sense, the term itself spans temporal registers, referencing the spectral presence of the past within the present. Such a relation is captured by Derrida's ideas around hauntology; a term he used to conceptualise how presence and temporality are more entangled than our mutually exclusive categories of absent/present or past/present/future typically afford (Derrida, 1994). Hauntology emphasises the spectral qualities of existence; emphasising that experiences of before are always alive in the living present and thus can never be relegated exclusively to the past. Hauntings, in this context, denote an absent-presence, inflecting personhood with a kaleidoscopic temporality, and adding complexity to particular situations where 'things' act when they are not supposed to. This occurs across all persons and lives but has a certain affective pull for many migrants, as we shall see below. Building on Derrida's hauntology, various scholars have drawn on the figure of the ghost to represent particular forms of presence that are *eerily felt* or *concealed in their presence* (e.g. Davis, 2005; Gordon, 2008). As these scholars have emphasised, revealing these 'intrusions' represents one important facet of the project of deconstruction, decentring the emphasis on 'being' and challenging dominant explanatory frameworks:

> Hauntology supplants its near-homonym ontology, replacing the priority of being and presence with the figure of the ghost as that which is neither present nor absent, neither dead nor alive. (Davis, 2005, p. 373)

Whilst the figure of the ghost is most commonly taken to mean an eerie presence, Peim (2005, p. 79) usefully highlights how spectrality can also emphasise absence:

> The spectre signifies a restless presence, both haunting and haunted, but also an absence or gap. There is something unanswered, something incomplete in the very nature of the spectre

(Abraham & Torok, 1994). In its familiar guises, the spectre is the past returning, sometimes to inform, sometimes to indicate unfinished business: an incomplete life, an unresolved issue. The spectre is revenant, a past figure that keeps coming back, disrupting the smooth logic of time . . .

As part of the intervention of spectral geographies, Wylie (2009, 2017) notes the particular temporalities of spectrality push us toward attention to the physical and tangible aspects of memories in the present, and to its disruption of assumptions about the smooth logic of time. Such (sometimes) unsettling temporal relations, we argue, are present across all our lives, but have particular traction in the context of migrancy. This includes ontological questions of what constitutes the 'present' self, what is self and what is other, and the role of the past therein. We note that in talking about spectres of the past in the present, there is the potential to situate all migrants as existing within fractured life history narratives – as temporally dislocated. This, as is shown in our data, is certainly not the case. Rather, there are threads of unravelling temporalities, particularly vivid in our participants' narratives, that are important to account for without reifying migrant subjectivities.

Moralities

One of the reasons why migrant personhood is so important to discuss in relation to care is because of its potential for marginalisation from the normative (Nelson & Macias, 2008). The sociological literature more broadly has examined in some depth the moral valences of illness (e.g. Bury, 2001; Frank, 1997; Williams, 1998), yet has not, in large part, focused on the nexus of migrancy and care. Moralities of gratitude, responsibility and obligation – many of which are already present and powerfully structure the context of cancer – take on additional normative dynamics in the context of migration. Migrants' feelings of belonging (or non-belonging) within particular contexts of care, and the attendant feelings (or expectations) of entitlement, gratitude, responsibility and obligation that arise, inflect experiences of care and treatment. In this climate, expressions of gratitude for healthcare in the country of settlement, even when such care is inadequate, can link into ideas about successful integration (Bradby et al., 2020), and may interplay with migrants' 'tenuous sense of entitlement to question' the care received (Nelson & Macias, 2008, p. 30). These dynamics are particularly interesting in the context of cancer, where existing dimensions of affliction (e.g. desire for resilience, omnipotence of hope, individualisation of recovery) interplay with the complexities of biographies more generally (see also Sinding & Wiernikowski, 2008). Moralities intersect and converge – such as the construction of the 'lucky migrant' and the valorisation of the 'intrepid cancer patient' – and are concurrently productive and reductive, moving across such categories over time, and with mixed effects across subjects and illness contexts. They are layered over experiences of illness, with particular affective outcomes across time and space.

Distance and belonging

Finally, we focus on the structures, relations and affects of distance and belonging (May, 2017). Following May (2011), we take a person-centred approach, to avoid reifying social structure and, instead, to illustrate how the relationship between the self and the

social is 'actively lived' (May, 2011, p. 363). We present a multifaceted understanding of distance as geospatial, affective, temporal and relational, positing that migrant subjectivities can reflect a tussle with these intersecting modalities, moving from deep historical forms of (dis)embeddedness and community dislocation/integration, to a sense of distance in therapeutic encounters. This is not to suggest that distance is linear. Indeed, as Wylie (2017, p. 4) notes, we increasingly 'inhabit spaces characterised by complex, wounded and vulnerable senses of distance and proximity'. This is vividly evident at the nexus of migrancy and care. We suggest that such dynamics can be more closely related than is often considered, with the here and now – perhaps partially or in incomplete ways – articulating the past and distant, and vice versa. This also brings to the fore the reverse – closeness and connectedness – and how people find new forms of closeness, dependency and intimacy (Ahmed, 1997; Williams Veazey 2021). As May (2017) and others have pointed out, and as we unpack further below, nostalgia can bridge migrants' experiences of 'past belonging' with present 'non/belonging' and mediate between a (simultaneous) sense of closeness and distance. In circumstances such as those described by our participants, which often involve histories of displacement or dislocation (and where the present may offer limited opportunities for belonging), nostalgia is not merely a longing for what has been lost or a desire to detach from the present, but can also be mobilised to create a sense of belonging in (and to) the here and now. This emphasis is captured by Massey's (2005, p. 125) 'thinking time and space as mutually imbricated and thinking both of them as the product of interrelations'. And further, as considering distance and belonging, as 'intimate entanglements of cultural memory and social practices' (Wood & Martin, 2020, p. 2). The intersecting analytic lenses of distance and belonging, and the moralities and temporality of illness provide a novel vantage point from which to appreciate how migrancy inflects people's experiences at the nexus of personhood and care.

Fieldwork

We designed a qualitative study using a biographical life history approach (e.g. Jackson & Russell, 2010), to document subjective experiences of migrants living with cancer. We deployed a combination of life history interviews and photo elicitation methods to record rich narrative accounts of participants' lives, capturing their past and present experiences of migration, illness and care. Photo elicitation facilitated narrative and visual life history telling (Harper, 2002; Oliffe & Bottorff, 2007), allowing participants different 'ways of telling' their personal experience (Harrison, 2002, p. 858; Poudrier & Mac-Lean, 2009). The research team consisted of university-based qualitative sociologists, four of whom conducted the interviews and analysed the data on which this article draws.

Sampling and recruitment

We employed a purposive sampling strategy focusing on patients who were migrants to Australia. We sought to capture a diversity of experiences by including participants from a range of cultural backgrounds, who had been living in Australia for different periods of time, and with different migration pathways and experiences. We sampled iteratively as the project evolved, to ensure depth and diversity of insight and adequate inclusion of differences among participants (Palinkas et al., 2015). Following ethics approval through

a large metropolitan hospital, people living with cancer who were born outside of Australia were approached by research team members at hospitals and health centres in two Australian states.

Data collection

After providing informed written consent, 43 patients participated in up to three life history interviews. Interviews lasted between 25 minutes and 3 hours and were conducted at a time and place convenient for the participant. The option of a professional interpreter was available to all participants. Five participants had a professional interpreter present, while six participants chose a family member to interpret for them. Aware of the challenges around using interpreters to discuss potentially 'emotionally charged' topics of cancer and care (Kirby et al., 2017), interpreters were fully briefed beforehand, and both interpreter and participant were asked about terminology or topics requiring particular sensitivity, related to culture and illness (e.g. taboos around the word 'cancer'), or because of the presence of the interpreter. After the interview, interpreters were asked about any issues they encountered in the interview, including possible moments of miscommunication. In this way, while interpreters followed the standard 'conduit model' (Wallin & Ahlström, 2006) during the interviews, they were also positioned as cultural brokers, enhancing the production of cross-cultural knowledge through the 'triple subjectivity' of researcher, participant and interpreter (Temple & Edwards, 2002). Interview questions explored experiences of migration, engagement with health services and professionals before and after moving to Australia, past experiences of health and illness, experiences of living with cancer, and beliefs about health, illness and wellness.

After their initial interview, participants were asked to take photographs, using a digital camera provided or their mobile phone, relating to their experiences of living with cancer and/or care. Participants were asked to capture moments, things or places that were personally meaningful, and which would help them to tell their story about coming to and living in Australia, and their experience with cancer. Participants were also asked to collect photos from their past which had personal significance, and/or helped them to reflect on their experiences of migration and cancer (e.g. photos before coming to Australia and/ or before having cancer). We note that photos from the past have the potential to elicit feelings of nostalgia and thus elicit processes of creative remembering (before) alongside accounts of being (in the now). As such, they speak to the active production of pasts and presents in our own, and in the collective, imaginary. The second and third interviews focused on discussion of the photographs, which were used as reference points for discussion, rather than as objective visual representations of facts or realities (Frith & Harcourt, 2007). Participants were asked to describe each photo, why they had taken it and what meanings it had for them. This allowed us to explore how (and why) participants made visible certain events, activities, relationships and symbols, providing an additional layer to their accounts. Data generated through a combination of *participant produced* photographs of the present (shown in simple frames below) and *participant collected* photographs from the past (shown in polaroid frames below) enabled the bridging of relational and/or affective gaps between 'then' and 'now' in accounts of living with cancer (Frith & Harcourt, 2007; cf. Rapport et al., 2005). We obtained written permission from all

participants for the use of their images, and discussed their preferences for how their images might be presented in publications. Wherever possible we also obtained consent from other people depicted in the photographs. Although some images depict participants' faces, we assigned pseudonyms to all participants to minimise identifiability beyond their personal networks. In selecting and discussing the images below, we remained attentive to the complex ethical navigations intrinsic to visual research (Wiles et al., 2008).

Analysis

Data analysis was based on four questions adapted from Charmaz's (1990) approach to qualitative analysis, emergent from the principles of constructivist grounded theory: What is the basis of a particular experience, action, belief, relationship or structure? What does this implicitly or explicitly assume about particular subjects and relationships? Of what larger process is this action/belief and so forth a part? And what are the implications of such actions/beliefs for particular actors/institutional forms? We approached data collection iteratively, which enabled us to establish initial themes and then challenge, compare and develop them through later interviews. We approached the analysis by conducting an initial thematic analysis of interview transcripts, collating associated photographs, writing notes and discussing ideas within the research team. Within this process, we continually sought to retain the richness of the respondents' experiences, documenting atypical cases, conflicts, and contradictions. After identifying initial themes, we returned to the sets of photographs to discuss their relevance to particular themes, and how each photograph was explained and positioned by the participant. This approach allowed us to consider how participants spoke about the activity of taking each photograph and the activity of collecting their existing photographs, giving further insight into participants' priorities and issues of importance (see also Radley & Taylor, 2003). The final step involved revisiting the literature and seeking out conceptual tools that could be employed to make sense of the patterns we identified in the data.

The past travels: Complex histories of the present

Costa: . . . to become an immigrant is not an easy thing, let me assure you. We are uprooted. [When I came to Australia] I refuse to do anything with the Greek community with the essence of don't go and affiliate some organisations and this and that. Just remain neutral.

I: Why was that?

Costa: A lot of people when they immigrate first they seek safety in numbers, and that's when they become part of the thing that they left behind. Now, what I left behind was no good for me, so I wanted something new, and I *had* to embrace that something new. I'm not anti-Greece, don't take me wrong, I'm more Greek than any other Greek that you meet in your life. [When I got cancer] I did not panic . . . because my philosophy is . . . when your number's up, when the time comes, you go with dignity. [Later, in interview 2] So people, they tread very carefully around the question of cancer when it

comes to that. Me, on the other hand, I just put a smile on my face and I said, 'Fellas, this is what it is. I'm dealing with it. So that's what I have. When my number's called, I go.' It's as simple as this, because how else can you think about it? [Later, in interview 3] This is the Greek dialectic. You have to go in circles to find the truth, as you know. Right, did you hear about the Socratic [method]? Socrates never gave an answer in his life. Socrates answered your question with another question. That's how I approach [this process of cancer]. That's how I approach all my life. The way it is, if I try to give a solution to *your* problem it will be *my* solution, it won't going to be your solution.

Costa, a 73-year-old Greek-Australian, draws on his Greek heritage to explain his disposition in life and how it ripples through his approach to cancer. Yet, as he states, he actively sought to distance himself from the Greek community upon arrival to Australia. His selection of photos (Figure 1) articulates a journey into independence. The first and last photos depict contrasting experiences of illness. In the first, he lies in a hospital bed, surrounded by family, highlighting passivity as well as collective, familial care. In the last, Costa, now an adult, is shown engaging in consultation with his doctor. Between these two images are depictions of Costa's migration experience; a solo endeavour that fractured his family and
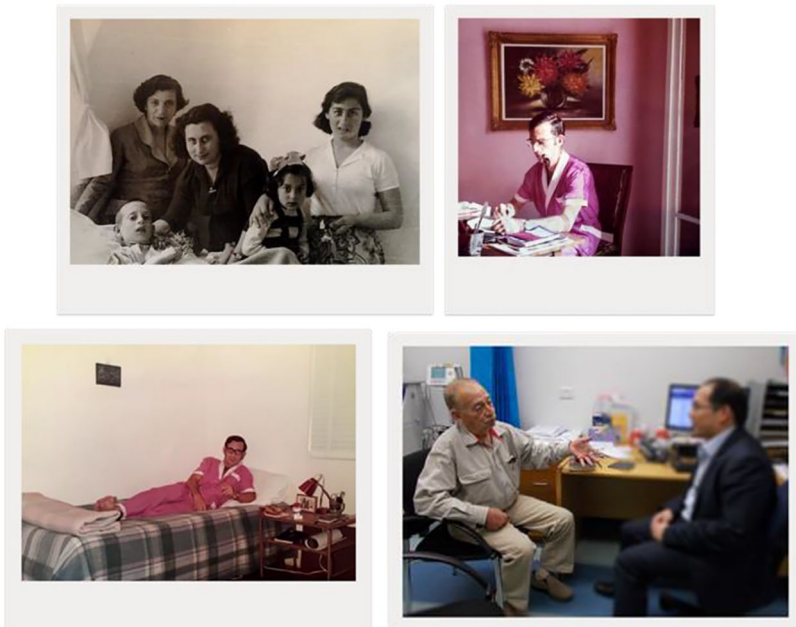

Figure 1. Costa (left to right, top to bottom).
Photo (a) First experience of hospital as a child in Greece surrounded by family.
Photo (b) Preparing for the boat ride to Australia: '. . . three days before I left to come to Australia'.
Photo (c) Two months after arriving in Australia.
Photo (d) Thirty years after immigration, consulting with the doctor post cancer diagnosis.

social ties. For Costa, the process of settling in Australia has involved an 'untying of the connection' to Greece, a spatial and temporal distancing, and yet, there is a 'lingering' of the previous place and time that continues to shape his present (Wood & Martin, 2020, pp. 5–6). His images capture the attempt (and sometimes necessity) to distance, to *become* something/someone else, to *embed* in new/local social relations (Ryan & Mulholland, 2015), and the fracturing and repair that this process can entail. As Costa's narrative illustrates, distancing is never complete, it always retains something. That is, attachments or connections (to home, to the past, to people) can never be completely removed. Things *stick* (cf. Ahmed, 2013); Costa's connections with home remain and re-emerge in his present encounters within the Australian healthcare system.

Costa's ambivalence, in his desired distance from, yet affective entanglement in, his homeland and associated ways of thinking, resonated with the experiences of many of the participants. For those whose migration experience was enmeshed with traumatic memories, spectres of the past were even more palpable now. At times these spectres were traumatic. Omar, a 59-year-old survivor of the Serbian-Bosnian conflict, recounted his experience of 'being on the frontline' in Sarajevo, and how this continued to haunt him decades later, including while receiving chemotherapy at hospital (Figure 2):

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Omar (Bosnian, Interview 1):	On frontline [of the war] we had sandbags on the window to protect from the bullets.
Wife:	He always ask if it's possible to have a bed close by window because he likes to see the star.
Omar:	I don't like blinds. When it blinds down I feel like I'm back in the war. [. . .] When I come back in hospital they put me in the bed next to window.
Omar [Later, in interview 2]:	It is very important for me [to be by the window]. [. . .] From the beginning there is four beds and they put me on this side where is the curtain. I couldn't see light, sun.
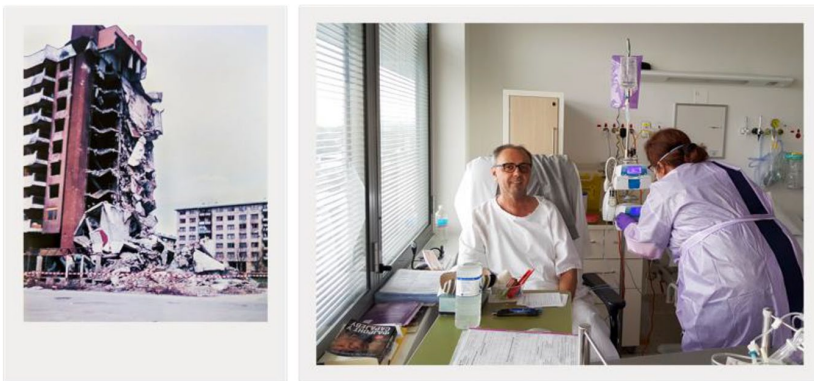
Figure 2. Omar (left to right).
Photo (a) 'This one is Sarajevo. That building was on the frontline and you can see how it look like . . . It remind me of a bad time that I don't like to talk and think about it.'
Photo (b) Omar sits near the window with the blinds open in his hospital room.

This account of closed hospital blinds triggering traumatic memories vividly illustrates 'the physicalities and haunting tangibilities of memories' (Wylie, 2009, p. 279), that shape present approaches to living with cancer, as well as broader subjectivities within the lifeworld. As this excerpt, and Omar's other photos (see Figures 2 and 5) illustrate, his past haunts his present in his embodied response to the cancer ward.

Migration and chronic illness have been conceptualised as uniquely disruptive biographical events, yet, as Sinding and Wiernikowski (2008) note, cancer patients more generally may draw on a myriad of difficult life experiences when considering the meaning and consequences of their illness. For our participants, the story of migration was an important dimension of this meaning-making.

For Matteo, an Italian migrant, the most significant absent-presence in his life and one that rippled through his cancer experience, was his daughter, who had recently died following a lifetime with severe disability. This profoundly shaped his experience of cancer and his approach to survival. In his view, the grief associated with her severe disability was central to the origin of his cancer, and her ongoing spiritual presence was critical to his hope within care. His interviews and the photos he chose to talk about revolved around his late daughter:

Matteo (Italian):	I think [the brain tumour] it's too much stress. Because I worry [about] my daughter. I was so upset. For five years I don't know what I'm going to do. My daughter not here anymore. Think too much. [. . .] My daughter was there in the corner there in the wheelchair. Now I look that corner there always. Empty. Empty. The corner, empty. Yeah. I think that's what it is [why I got cancer]. The doctor said to me, 'You have an upset for something bad?' 'Yes,' I said to him . . . My daughter. When my daughter born, I was happy then. We lost. We lost her life. [Later, in interview 2] I reckon my daughter help me a lot. [She] is an angel. For me, [she] is an angel. My daughter help me a lot.
Wife:	He reckons she's looking down to him and she's angel.
Matteo:	We've done a lot for my daughter and my daughter do a lot for me.
I:	So, it helps you with living with the cancer and with the illness that you've had to know that she's like an angel?
Matteo:	For me, yes. I don't know. A lot of people doesn't believe in angel, doesn't believe in God. I believe.

Matteo's photos (Figure 3) reflect the continuity of his relationship with his daughter and the care he feels in her absent-presence. Figure 3a depicts Matteo surrounding his daughter with love and care, while Figure 3b shows the physical manifestations of her ongoing presence, as a caring 'angel' helping him through cancer.

Costa, Omar and Matteo's accounts illustrate the importance of complex histories and the traces they leave in experiences of care and practices of survival in the present. We note that all patients/people have complex histories and that these multidimensional aspects of personhood inflect the present and experiences *in* care (of whatever kind). And
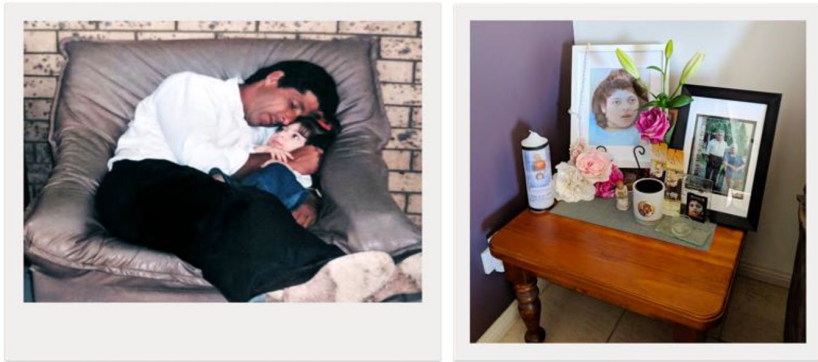
Figure 3. Matteo (left to right).
Photo (a) 'Now I look that corner there always. Empty. Empty. The corner, empty.'
Photo (b) 'The photo from my daughter is there . . . That one there help me. That one there . . . She comes to me and I feel better.'

in this context, such complexities are not reducible to particular scripts or determining factors associated with migrants and migrancy (e.g. ethnicity, language, time, place). Indeed, migrant complex biographies evade one 'determinant' or another, and yet there are consistent threads which help make visible the complex interplay of personhood and care. And that life histories and *what sticks* are critical in understanding these participants' experiences of illness and care. They illustrate idiosyncratic layers of complexity moving across time, bodies, families and cultures.

The moral life of migrancy: Gratitude, responsibility, nostalgia

Serious illness, as we know from the body of scholarship within this field (e.g. Frank, 1997; Williams, 1998), evokes particular normative orientations and encourages or discourages certain trajectories and feelings, albeit varied across time, place and context (Broom et al., 2018; Nelson & Macias, 2008; Sinding & Wiernikowski 2008). In the context of migrant histories, moralities, it emerged from these interviews, can take on additional layers of significance, and complicate those already deeply embedded in care and survivorship in cancer (i.e. gratitude, fortitude, courage and responsibility). Matteo's account and photos articulated both struggle and the moral imperative he felt to survive. While the memories of his daughter heavily shaped his experience of cancer, so too did his current and close relationship with his granddaughter. In Figure 4, his granddaughter and daughter (the photographer) stand behind him, casting long shadows beyond Matteo. His family, both in their present embodiment and their foreshadowed future, drive his determination to 'keep going'.
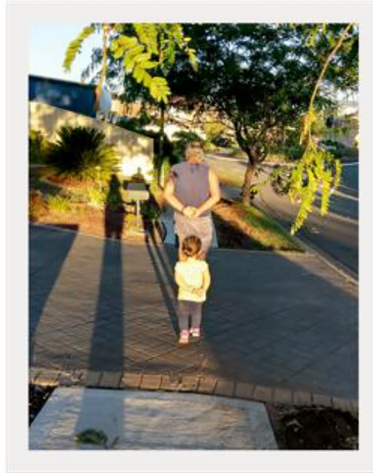
Figure 4. Matteo.
'How are you going to give up? How are you going to give up a beautiful family like that? You know what I mean? You can't give up.'

The moral fabric of our participants' lives often emerged in accounts of the Australian healthcare system, alongside a more universal cancer morality that centred on persever-ance and survival. We routinely heard comments on the benefits of migrating and the enhanced care that participants felt they received as Australian citizens. For some, grati-tude for the quality of care provided by the Australian system was overlaid with a sense of indebtedness and a need to take responsibility for their care:

> The health system here is number one. Something like I haven't experienced or have the knowledge of in other part of the world. [. . .] Last year, I spend particularly all summer in hospital, and I never been in hospital before. I tried to be the most patient I could. The nurses, they were very good. [. . .] I'm very happy for what he [doctor] done. And also grateful, most grateful than anything because he took my case here . . . (Alonso, Chilean).

Alonso's reflections were echoed by Omar's comments and images of his treatment (Figure 5).

The gratitude common to many living with cancer is overlaid with a specific gratitude for Australian healthcare:

> That's something that they [parents] make a point of very often, to be grateful that after all of the challenges that they had to go through. [. . .] *I'm very grateful to be here.* I know that there were a lot of people who didn't make it, basically. [. . .] I feel fortunate. I feel like in my circumstances I was given a lot. I didn't have to go on a waiting list. [. . .] They're [the radiation team] just fantastic. Like, I go in and I don't feel like I'm a bother. They're very friendly, personable [. . .] It's very internal, where I just want to navigate this, and take on the experience
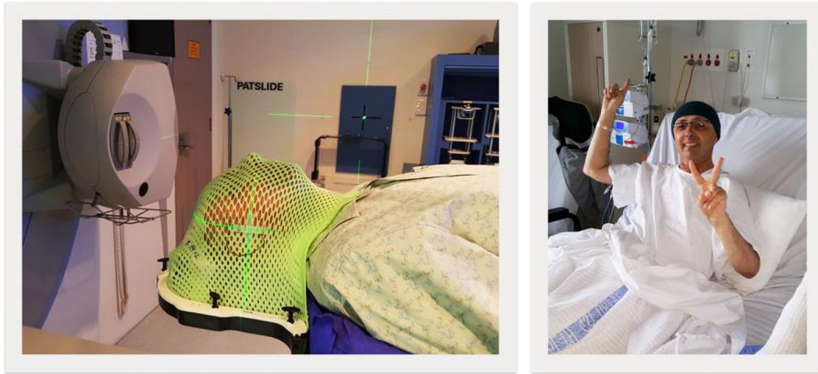
Figure 5. Omar (left to right).
Photo (a) 'I couldn't wait to start with chemo and this is my first day with first chemo . . . I was happy because I just want to fight for my life.'
Photo (b) 'I always want to be happy and look happy . . . I want to win this battle with cancer.'

on my own [. . .] There's that heaviness, that responsibility of the sacrifices, like the journey, that trip, the whole, 'I've left my life behind for this new life.' So, that weighs heavily on my decisions and how I am. (Ann, Vietnamese).

The *gratitude–responsibility* dialectic was a key mediating logic across many of these stories. The moralities of care – in this case from migrant cancer patients – interplay with the normative dimensions of cancer more broadly (Broom & Kenny, 2021; Broom et al., 2020), including ideas about the intersections of the *privilege* of getting (good) care and the *vitality* of a positive attitude. In pointing out the moral layers of participants' narratives, we seek, not to challenge their importance/effects, nor valorise the migrant experience, but rather, untangle how they can be subtly involved in the formation of personhood at its intersection with care.

Another key theme across the interviews was how narratives of gratitude were complicated by nostalgia (the wish to return home) and, sometimes, nostophobia (the fear of returning home). This, we argue, reflects the conflicts and contradictions that arise between past and present, absence and presence, belonging, morality and home (Massey, 2005; Wylie, 2017). These nostalgic feelings, on one level, are a shared experience across all people, as moments gone by inflect the present – as one remembers the benefits of a past life. Yet, this also makes up the (conflicted) story of migrant personhood, as nostalgia challenges the idea of 'a better life' and reveals the (sometimes) secret desire for what was before:

I was very happy at first. Very happy thinking that I was coming to Australia, joining my family, but when I arrived something happened. I started to feel nostalgic and I started to miss my country. Language was a problem, because as soon as I arrived here I started to work in factories and there were Australians, Greek, Italians, but no Lebanese, very few Lebanese. The language was a problem and that made me a bit nostalgic. With my family. (Raafe, Lebanese).

These accounts of before subtly intersect with the lived experience of the moralities of care. Ideas about Australia, 'the good life', 'the fair go', 'the lucky country', 'the responsible citizen' and 'the autonomous patient' construct valued identities for participants, but are *also* accompanied by expectations *in* care (Pickard, 2010; Sinding & Wiernikowski, 2008). For some participants the idea of *now* as *better* than *then* was in contrast with their lived experience. This revealed the assumptions sometimes present around migration (the lucky migrant), particularly if the new country is perceived to be comparatively 'better off', and the flow-on effects to expectations in care (e.g. the intrepid patient) that do not match the identities of patients themselves (Nelson & Macias, 2008). This was poignantly illustrated in Amira's narrative:

> Life was actually quite good. Very good actually. There was no war or anything. Even the doctor's treatments and everything there [. . .] I came from a very wealthy, well-respected family as well . . . So, us girls, when we used to go out, everyone used to treat us with respect . . . So we lead a king or queen's lives, you can say. As soon as the conflict started, they start slaughtering people, we had to get out and leave. [. . .] I lived an extra-special life. So I was spoiled because we were wealthy. I was well-raised, well-eaten, well taken care of, everything. [. . .] But because ISIS came, and I had to escape here. But we were happy back home.(Amira, Assyrian).

Amira's photos (Figure 6) depict the care, community and class position she left behind, challenging the narrative of migrant progress proffered by some of our participants, and shown above.

The idea of migrancy as 'progress' or 'improvement' was unsettled within the narrative and visual accounts of many of our participants, framing the moral structures circulating around personhood, belonging and care. These accounts are a vivid illustration of complex affective dynamics of distance and belonging (there/then/worse; here/now/better), and how such seemingly distant affects shape experiences *in* care. And as Massey (2005, p. 139) articulates, albeit in a different context, '"here" is an intertwining of histories in which the spatiality of those histories (their then as well as their here) is inescapably entangled'.

Distance, absence and emerging community

Participants' stories and photos revealed the various and entangled dimensions of distance (temporal, social and geographical) including distance from *now* and from *before*, distance from *family*, from *self*, from *community*, from *place*, and distance from *belonging*. How participants experienced distance informed their relations with disease, care, survivorship, and community. For Diane, a migrant from South Africa, the biggest challenge was finding connections and acceptance in her new community: 'Australians don't invite people over. [. . .] You're basically left to fend for yourself.' Cancer diagnoses were talked about as highlighting some participants' enduring sense of distance from family, while treatment led to further distancing from workplace and friendship networks:

Figure 6. Amira (left to right).
Photo (a) 'We were happy in Iraq and had to escape to Syria [to start] having a new life. We were happy. We had the best life.'
Photo (b) '. . . we lead a king or queen's lives'.

> When I was diagnosed with cancer it's really hit me [. . .] I don't have my family here. *I'm by myself, really, with my partner* [. . .] I didn't tell [my family back home] because at that time I don't know anyone who's been sick. (Angela, Filipina).

While Angela chose not to discuss her cancer with family back home, Sofia's attempts to share her experiences with friends were rebuffed. Both women described a renewed sense of affective isolation, amplified and brought to attention in the context of serious illness:

> I did try with a few friends and everything, but I did notice that actually everyone will actually say the same answer, 'But you're alive'. And that make you feel – So, *I had to be grateful. I am grateful I'm here.* But the psychological part I had to deal with myself, and that's what I'm trying to do. I'm trying to do as best as I can. [. . .] I didn't even say to actually to them nothing. I just shut up. (Sofia, Chilean).

To counter her sense of affective isolation in the present, Sofia turned to memories of the past (and her strong attachment to her community in Chile from childhood) to foster a sense of belonging or connection in the now; reminiscent of May's (2017, p. 401) 'nostalgic belonging from afar'. It also connects us to Dyck and Dossa's (2007) articulation that migrant wellbeing remains firmly embedded in 'interlocking questions of cultural identity and belonging, embodied practices and memories of home'. In Sofia's lifeworld, this was evident in the felt social pressure to appear grateful and how it foreclosed opportunities to foster new forms of belonging or intimacy, contributing to enduring feelings of displacement and distance.

The global dispersion of family and friends offered another form of geographic-affective distance. For example, the details of everyday life that might otherwise be shared

were kept quiet ('we're trying to protect each other by not telling'), and visits from or to family were infrequent (though also sometimes more intense):

> Here, I don't have any as a family because we are only first-generation migrants to Australia, myself and our family. [. . .] My mum comes in for a visit. That's all. Currently she's here. A short visa. So, we don't really have a good support system based as a family here. [. . .] but mums, they can't take the intensity of what we're going through. She's 74, so I don't want her to feel so much of pain that I am going through. So, I don't tell her everything. She asks me, 'How is the pain and all that?' and I said, 'Yeah, I can bear with it. Don't worry'. So I just kind of fake [it]. (Anjali, Indian).

> . . . it's hard, and going back to being here, I never feel like I'm here on my own, since I have four children here, they're growing up with us, but *you still need your sisters, you still need your mother* . . . They're very much a part of our lives. So you don't have that. So you have to kind of stand up, dust yourself, and just say, 'Okay, this is going to be fine. We're going to do it.' (Camila, Mexican American).

> When [my husband went] back to India he told everyone there that everything has become all right. 'My wife is perfectly fine.' (Jayamala, Indian).

Absence encouraged a performativity of normality and in some cases deliberate shielding of family from the realities of cancer. The geographical distance exaggerated experiences and practices of affective distancing, perhaps further underpinned by the sense of responsibility incumbent on the migrant vis-a-vis the family 'left behind'.

While various forms of distance were prominent in participants' accounts, they also revealed the forms of connection that could emerge within a new place/home. Amira's narrative and photographs (Figure 7), for example, centred on finding a hybrid community and new ways of belonging since arriving in Australia as an asylum seeker. Her photos depict her local supermarket selling Syrian foods; her community church; and her treasured traditional Syrian food that she shared with neighbours. Her visual and spoken account captures ideas about becoming part of a community within her local melting-pot suburb of Sydney, while also retaining an attachment and affinity to home through connections with other Assyrian migrants.

> We go to [suburb in Sydney]. We see people, familiar people, unfamiliar people, and people from my [local] community actually. So, I am happy that I'm here and I feel happy for the people who actually managed to get here as well. I am happy for them. [. . .] Of course, if they didn't need to leave their own country, they wouldn't be here. [. . .] I love my people to be around, especially when they fled war, they fled hunger and they fled actually poor, poorness as well. So of course, that's what I want. (Amira, Assyrian).

The affective salience of these community connections became apparent during Amira's cancer treatment:

Figure 7. Amira (left to right).
Photo (a) At the local supermarket: 'We see people, familiar people, unfamiliar people, and people from my community actually. So I am happy that I'm here.'
Photo (b) 'I'm very happy with my [Assyrian] community and they showed how much they have love [for me].'
Photo (c) 'Our neighbour here are Syrians [and] we've got one Chinese here . . . We talk, we share food.'

Daughter: She's saying, I'm very happy with my community and they showed how much they have love for her. They cared about her. They all came to see her and she came to see her as well. So, she felt she's not alone. Everyone came, everyone was involved, everyone was supporting her in a way that, 'Congratulations, you get better' and these words, 'Hope you recover soon.' All these words made her feel that she is a part of them.

As Amira's account and photographs show, belonging or closeness can be felt by being among both the 'familiar' and 'unfamiliar', strangers and acquaintances, those from the here and now (Australia and other migrants/refugees) and those from 'home' (the Assyrian community). She used the term 'my community' to describe both her local geographic area and to refer to fellow members of the local Assyrian community, illustrating the diverse dimensions of distance, likeness, community and belonging. While participants often expressed a desire to remake community and forge a sense of belonging amongst people and practices with familiar signifiers of connection (e.g. similar history, nationality, values, language, religion), the experience of cancer emerged as another potential signifier of commonality ('everyone has been touched by cancer').

Participants' stories revealed how shared identities, experiences or affinities may transcend the distance created by geography, ethnicity, time and social ties, fostering collective and connective forms of belonging. What makes up a sense of belonging and connection is complex. Participants' accounts challenge assumptions about closeness and connectedness hinging on specific characteristics or experiences (e.g. a shared migrant journey or cultural background) and how they inflect experiences and practices of care.

Conclusion

What emerged from these life history interviews and photographs was a vivid articulation of how personhood inflects care, and how migrancy adds important layers to the

relationalities of affliction, as they are 'actively lived' (May, 2011). Specifically, thinking through complex personhood, in this context, allows us to weave together emergent threads within care, including complex temporalities, moralities and the undulations of belonging.

In line with previous work across the humanities and social sciences (e.g. Gordon, 2008; Rose, 2006; Wylie, 2017; see also Dein, 2006), our participants' accounts illustrate how the past never remains spatially, temporally or geographically distant, but rather recurs spectrally, haunting the here and now through both its presence and absence. Within this haunting, the various forms of distance that characterise migrant subjectivities inflect the ontological coherence of self and affliction, offering a series of important, often concurrent, and certainly entangled, affective tussles. We posit that this is best captured by the concept of *complex personhood* – which we draw from Gordon's (2008) work as well as Rose's work on personhood more broadly (cf. Rose, 1998). It is, in this context, fundamentally shaped by temporal entanglements and normative moralities, and is productive of particular affects (loneliness, estrangement but in turn a sense of reconnection and belonging). Complex personhood, within many of our participants' accounts of their lived experience, is heavily shaped by a pervasive *absence-presence*. Sayad (2004, p. 215) discusses this dimension of migrant experiences, as an absence of complete belonging, an out of place-ness, a discomfort:

> Always torn between his [*sic*] permanent present, which he dare not admit to himself, and the 'return' which, whilst it is never resolutely ruled out, is never seriously contemplated, the immigrant is doomed to oscillate constantly between, on the one hand, the preoccupations of the here and now and, on the other, yesterday's retrospective hopes and the eschatological expectation that there will be an end to his immigration.

Much more than any individual's grappling with past and present within a (however multidimensional) self, complex personhood is a distinctly collective endeavour; in this case, played out within the moral economy of the 'good migrant', illuminating normative pressures (e.g. migrants as grateful subjects) (Sinding & Wiernikowski 2008). Embodying a grateful and happy disposition towards care, and in terms of echoes of past and future, at a time of serious illness, perhaps reflects the normative (paternalistic) expectations placed upon some migrants to adopt the moral norms of the new place; as Sayad (2004, p. 214) notes, 'to 'live' by the rules of the society of immigration'.

Such pressures can form a coercive dimension to migrant care, with subjectivities shaping and shaped by ambivalence around deservedness, reciprocity, benevolence and burden (migrants as burdensome and/or disposable) (Nelson & Macias, 2008). Resistance (to the normative) was often subtle: for example, in challenging the idolisation of Australia (and its culture(s), people, healthcare provision and so on) and perhaps even in a heightened desire for home. While the necessity to adapt implies a distancing from the past/home – or moving away from one towards another – it can also, as these participants' life histories reveal, be a performative practice of various forms of belonging, *bridging* rather than severing connections between before and now (May, 2017; Nelson & Macias, 2008; Schneider & Lang, 2014).

We note that – and without valorising the migrant – complex personhood contains malleability and, for many, articulates resilience, forms of character-building and cultural strengths (see also Nelson & Macias, 2008). It is, in this context, a constant, seemingly paradoxical production and process of becoming, reflecting, in Wylie's (2009) words, the 'constitutive ambiguities and tensions of the absence-presence nexus' (p. 279). It reflects, as Wood and Martin (2020) articulate, 'how deeply held memories of other times and homes play a part in shaping the ongoing negotiation of identity' (p. 2) – and in this case, experiences of care. That is, connections with previous homelands can be concurrently felt deeply, remain ambivalent, and also surge or dissipate within the undulations of life, illness and care (with or without cancer).

If we are to embrace such complexity (without forgetting underlying forms of normativity), then we might view cancer – its presence and the experience of it – as another site where personhood meets care; where migrants' enduring processes of reorganising the self, of dis- and re-orientations, or what Ahmed (2003) calls uprootings and regroundings, manifest, articulate and inflect illness and care. In this sense, what is perhaps most useful here, given all persons conjure complexity, is the nexus of temporality, morality and belonging, and how a sense of in-betweenness *can* seep into care. Further, to consider how the complex layers of the past – which very often 'occupy' migrants – can accumulate and circulate within and between persons, as *sometimes* welcome and other times unwelcome intrusions on the present (i.e. people, places, events, things, memories of the other) (May, 2017). These spectres, which then make their way through caring and illness relations, thus become key to migrant subjectivities, and yet are located beyond the person, sometimes engendering subtle forms of stigma, othering and exclusion, even if not overtly enacted (Ahmed, 2000, 2006).

The stories and photos we have presented here do not simply offer a picture of temporality, morality and belonging, they provide unique insights into how such relational dynamics can be productive of closeness and connectedness; making visible the often-concealed forms of benevolence, connectivity, intimacy and reciprocity (Ahmed, 1997). In some respects, as Gordon (2008, p. 7) writes, confronting the 'ghostly aspects' of social life 'requires (or produces) a fundamental change in the way we know and make knowledge, in our mode of production'. In this context, by understanding migrant subjectivities within the frame of complex personhood, we can better grasp the multidimensional facets (reductive, coercive, liberative or otherwise) of being and becoming a migrant within care.

Funding

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