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Discourse, affect and affliction

Eeva Sointu

Abstract

While much recent theorizing into affect has challenged the primacy of discourse in understanding social life, this paper is premised on the intertwining of affective experience with discursive meaning. Furthermore, appreciating the entwining of affect and discourse facilitates broader understanding into the illness experience, medical decision-making and experiences of healing. Today, the biomedical discourse carries particular affective weight that can saturate experiences of affliction. Cultural understandings of disease similarly shape affect that may emerge in affliction. Social meaning, more specifically stereotypes pertaining to identities, interweave with emotion also in the context of medical practice. The doctor-patient relationship is an affect-laden encounter where the entwining of affect with social assumptions carries important, yet poorly understood, repercussions for treatment decisions and for the furthering of health inequalities. Both the elusiveness and the power of affect that unfolds in relation to discursive meaning rest on the way in which affect dwells in and resounds through the body.

Keywords: Affect, discourse, illness experience, doctor-patient relationship, healing

Introduction

Affect has emerged as an important theme in social and cultural theory in recent years (Wetherell 2012; Blackman and Cromby 2007; Cromby 2007a; Leys 2011; Burkitt

2014; Papoulias and Callard 2010). The term affect features in a wide array of scholarly writing, developed in disciplines ranging from neuroscience to cultural studies and from philosophy to human geography. Much of this work centres on outlining and analysing the manner in which affect – ranging from ‘basic emotions’ such as anger, joy and fear, to more ineffable and fleeting affective experiences of, for example, apprehension, pity, disappointment, shame, excitement or hope – permeates lives and bodies, yet also eludes conscious reflection as well as more traditional means of interpreting social life (Wetherell 2012; Leys 2011; Papoulias and Callard 2010). Much theorizing into affect has posited that ‘affects must be viewed as independent of, and in an important sense prior to, ideology’ (Leys 2011:437). Accordingly, as Leys (2011:437) summarizes, affects are thought to exist and exert influence ‘below the threshold of conscious awareness and meaning.’ The ‘turn to affect’ has thus centred on leaving behind theoretical landscapes where discourse occupies a paramount position; the affective dimensions of being-in-the-world are thought to escape poststructuralist analyses of social dynamics. Within these arguments, discourse is seen to constitute ‘the *conscious*, the *planned* and the *deliberate*’ other to affect that is conceptualised ‘as the *automatic*, the *involuntary* and the *non-representational*’ (Wetherell 2012:52). Affect promises something novel because it ‘seems to index a realm beyond talk, words and texts, beyond epistemic regimes, and beyond conscious representation and cognition.’ (Wetherell 2012:19; see also Leys 2011; Papoulias and Callard 2010; Burkitt 2014).

Despite the desire to leave discourse behind that is expressed in some scholarship into affect (Thrift 2008; Clough 2008, 2010; Massumi 1995), rather than ‘proceeding *directly* from the body’ (Papoulias and Callard 2010:35 emphasis original), affect

entwines with the social and the representational. Affective responses from happiness to abhorrence dwell in and suffuse the body, but also intertwine with changing social and cultural meaning. Feelings, as Sara Ahmed points out, ‘rehearse associations that are already in place’ (Ahmed 2004a:39) and emerge ‘from the thickness of sociality itself.’ (Ahmed 2004:28). Affective experience ‘intertwines with cultural circuits of value’ as social and cultural ideas about people, behaviours and issues imbue embodied affective responses (Wetherell 2012:16; Cromby 2007a, 2011). Affect thus echoes through the very personal – bodily and ordinary – at the same time as seemingly private affective responses capture broader social and cultural interpretations attached to people, bodies, and places (Wetherell 2012; Seyfert 2012; Ahmed 2004a, 2004b). Affect calls on previous experience and social meaning even when it bypasses conscious representational registers (Cromby 2007a, 2011; Clough 2008; Blackman and Venn 2010).

Affect suffuses the flow of everyday life, shaping even the most seemingly rational decisions and choices (Cromby 2007a). The manner in which feeling permeates experience and thinking is, however, antithetical to the valorisation of the rational agent in Western science and philosophy (Cromby 2007a; Wetherell 2012; Faircloth 2011; Reber 2012). However, despite the capacity of eluding conscious reflection, and despite the historical marginalization of emotion especially in the West, affect is central to the lived experience (Cromby 2007a, 2011; Illouz 2007). We feel our way through the world (Cromby 2007a) even when the role of emotion in individual action is cast in negative terms and even though the importance of affect in shaping personal experience, as well as the social, may be hidden from conscious deliberation.

Experiences of affliction and impairment are also saturated with affect. As John Cromby notes:

There is a stark affective dimension to our responses to illness and mortality, within which both our own experiences and those of our loved ones come to figure in ways that are inescapably and often profoundly emotional. (Cromby 2011:81).

Illness can set one afloat in a world traversed by the healthy only by association, a world controlled by medical appointments and procedures and, in many cases, by limitation and loss. Affect imbues episodes of ill health because illness can disrupt so much of what is ordinarily taken for granted; ill health accentuates the lack of control and predictability in life (Frank 1995; Charmaz 1983, 1995). Ill health can restrict activity, as well as give rise to experiences of isolation. These features of ill health can amount to nothing less than a ‘loss of self’ as identities built upon old capacities and possibilities crumble away (Charmaz 1983). Ill health not only alters one’s relationship with oneself and with one’s body, ill health can also change the manner in which we relate to others (Frank 1995; Charmaz 1983). Affect in affliction entwines with the profound change, uncertainty, loss and chaos that illness can generate. Affect in affliction also captures the body – that ordinarily silently facilitates and grounds being (Leder and Krucoff 2008; Williams and Bendelow 1998) – claiming a more prominent position in conscious experience through embodied as well as emotional discomfort and dread.

Despite the centrality of emotion in responses to ill health, and in processes of recovery, the affect that suffuses affliction escapes definitions of disease generated

through the biomedical discourse – the dominant means of making sense of health and illness today (Stacey 1997; Lupton 2012). Affect that saturates affliction remains marginal, if not invisible, in biomedical definitions of diseaseⁱ. While powerful and valuable, the ‘physicalist’ (Harrington 2008) understandings of affliction sidestep the affective valence of ill health that often constitutes the very core of the illness experience.

Importantly, social scientific understandings of discourse can also fall short in capturing the deep emotional resonance of illness; the lived experience of ill health entails more than discourses through which ailments are produced. Even though pain may be ‘culturally shaped’ it simultaneously ‘resists language,’ escaping capacities for expression (Scarry 2007:65). Affect in affliction can remain an uncharted territory in poststructuralist analyses that, similarly to the biomedical discourse, lack the conceptual means of recognising and making sense of the affective depths of illness. While illness entails more than discourses naming and defining forms of affliction, discourses are, however, acutely relevant in the generation of affect in affliction.

This paper highlights the importance of discourse – the representational and ideological – in the generation of affective experience. I argue that affect in affliction unfolds in relation to discursive meaning. Furthermore, understanding the ways in which affect and discourse intertwine facilitates broader understanding into the illness experience as well as the reproduction of inequality in medicine. To show how discourse and affect intertwine, I will discuss diagnosis, stigma, and the doctor-patient relationship. These examples relate to central themes within the sociology of health

and illness: the illness experience, the therapeutic encounter, and the reproduction of inequality.

In a social context where biomedicine constitutes the primary framework for defining and treating ill health (Stacey 1997; Lupton 2012) the biomedical discourse carries particular affective weight. Cultural interpretations of affliction – including health-related stigma – are also important in the generation of affect during episodes of illness. Social and cultural understandings of affliction are not, however, the only forms of discourse that shape the affective landscapes of illness and medicine. Social assumptions related to identities matter also. The doctor-patient relationship is an affect-laden encounter where the social subtly entwines with the emotional. The intertwining of affect with assumptions – related to, for example, understandings of responsibility, deservedness and capacity – carries important repercussions for the doctor-patient relationship and for treatment decisions. Furthermore, the entwining of affect with medical decision-making can serve to further health inequalities. Finally, I consider *how* affect saturates affliction. I argue that the manner in which affect dwells in and resounds through the body makes the affect emerging in illness and in medicine both powerful as well as elusive. The discussion into the manner in which affect imbues affliction draws from affective neuroscience and, in particular, the work of Antonio Damasio (1994, 1999). I draw on this work to provide tentative avenues for analysing how affective experience unfolds, also after the original affective event has passed. I am, however, mindful that there are problems in Damasio's account of affect, especially in terms of his understanding of emotion as an automatic and universal evolutionary biological process (Papoulias and Callard 2010:41; Wetherell 2012; Burkitt 2014).

In my argument, following Wetherell (2012), I understand discourse as institutionally located systems of knowledge, such as the biomedical discourse, as well as discourse as meaning-making that patterns everyday life. I conceptualize affect to encompass the ‘basic emotions’ of psychological frameworks such as sadness and anger.

However, rather than something internal, and primarily neuropsychological, affect and emotion arise from and entwine with ‘a context, a set of circumstances and relationships with others and things.’ (Burkitt 2014:8). While I often use terms affect and emotion interchangeably, by affect I am referring to ‘a feeling or emotion that *takes us* or *moves us* in ways that we cannot help or prevent.’ (Burkitt 2014:10 emphasis original). Affect denotes visceral and at times ineffable feeling that resonates through individual and social life (Wetherell 2012). Simultaneously, I understand affect, feeling and emotion as central to experience. As Cromby (2007a:102) notes, feelings amount to ‘the raw stuff from which experience is primordially constituted’, so much so that ‘the very fabric of our being is thoroughly imbued with their texture, valence and affordances.’ (Cromby 2007a:102).

Context: biomedical dominance

Much of our capacity of making sense of health, illness and healing is shaped by the dominance of biomedicine as the primary means of defining and treating ill health. The biomedical manner of understanding disease is premised on conceptualising disease as ‘an intra-corporal lesion or abnormality’ (Armstrong 2011:802) that ‘can be located within the anatomical frame’ (Nettleton 2006:1168; see also Foucault 1973).

Clearly, the above summary constitutes a flagrant simplification of a complex and fragmented field (Berg and Mol 1998). The history of biomedicine is marked by critiques of the kind of reductionism that locates disease solely within the physical frame and that understands the key to addressing ill health to lie solely in the expert hands of the doctor (Lawrence and Weisz 1998; Harrington 2008). Today, various sub-fields of medicine, such as public health and behavioural medicine, underscore the social and environmental causes of ill health (Keefe 2011; Porter 1999; Wilkinson and Pickett 2010). More psychologically oriented specialties have also long recognised the complex and blurry relationship between the social, the emotional and the biological. To add to the ontological diversity within biomedical institutions, different medical specialties and medical practitioners, from surgeons to nurses, to midwives, to physiotherapists, to psychologists – the list could be extended considerably – can hold widely differing views of illness, health and suffering (Berg and Mol 1998). However, while there is, as Berg and Mol have pointed out, ‘multiplicity even inside medicine’s biomedical “core”’ (Berg and Mol 1998:3), biomedical knowledge is predicated upon an emphasis on scientific certainty and an impetus to not only locate disease within the body but also to understand it in terms of physiological functioning that is captured, in its most truthful form, in the knowing gaze of a biomedical expert (Nettleton 2006; Armstrong 2011; Foucault 1973, 1977). Disease is, as such, produced as a specific malady through the application of biomedical knowledge; the biomedical discourse translates a concern into biomedical language and, through this, bestows an ailment biomedical meaning and significance. Classification of ill health is, simultaneously, intertwined with social categories as well as socially situated assessment of what constitutes disease (Jutel 2012:3). Both, the biomedical manner of locating disease within the physiological body (Nettleton

2006; Armstrong 2011) and social meaning associated with disease are meaningful for the generation of affect in affliction.

Importantly, within the context of biomedical dominance, experiences of illness and healing that escape biomedical explanatory frameworks risk being rendered invisible (Nettleton 2006; Jutel and Nettleton 2011; Jutel 2012); as Foucault has argued, ‘[t]hat which is not on the scale of the gaze falls outside the domain of possible knowledge’ (Foucault 1973:166). Furthermore, despite its social, cultural and institutional importance, the biomedical discourse can fall short in capturing the affective magnitude of experiences of affliction. Ill health can be imbued with affect – loss, disappointment, pain, shame and fear – the depth of which cannot be met through ‘physicalist’ interpretations of illness (Harrington 2008:17). While biomedical attention is given to how an illness bears on the body physiologically – also through assessing how the body feels – the emotional reverberation of an ailment through the body often remains marginal. The affective and, in some cases, non-conscious emotional valence of ill health is, simultaneously, rendered medically meaningless.

The affective clout of discourse

Even though the biomedical discourse tends to be inattentive to the ways in which affect features in experiences of illness, the biomedical discourse is central in the constitution of affect in affliction. The affective clout of biomedicine is embodied in the symbolic as well as practical significance of biomedical diagnosis. The exclusion of an affliction from the confines of biomedical discourse – as is the case with, for example, medically unexplained symptoms or MUS – can have a profound effect on

people suffering with a condition that cannot be named and, consequently, biomedically legitimised and treated (Nettleton 2006; Jutel and Nettleton 2011; Jutel 2012). A lack of a diagnosis often serves to connect an affliction with psychological and, within the context of western modernity, immaterial and fictitious origins. The meaning of an official diagnosis, as Nettleton (2006) argues, thus exceeds therapeutic and practical help, or access medical procedures. A diagnosis negotiates and, ideally, erases accusations of deception and delusion that dealing with an undiagnosed illness can give rise to. It is through diagnosis that the validity of the narrative and, ultimately, of the self of the ill person, is implicitly assessed (Nettleton 2006). As such, lack of diagnosis ties not only with diminished access to treatments but also with self-doubt and uncertainty. Accordingly, the lack of diagnosis can bring up deep-seated anxiety over being a fraud, a hysteric or a time waster (Nettleton 2006:1170).

The biomedical discourse – and what it may include and exclude – thus shapes the illness experience in important ways. Because of the meaning and legitimacy bestowed through diagnostic labels, diagnosis is highly relevant in the affective experience of ill health. Self-doubt, uncertainty, anxiety constitute affective experiences that are, at least partially, generated in relation to the endorsement and explanation offered, or denied, by biomedical institutions and experts. The power of the biomedical discourse is embodied in the affective clout that biomedical diagnosis and treatment possess in a society where science and scientific thinking hold enduring sway and where the scientific method is conceptualised as a primary means of accessing truth and reality.

However, while diagnosis can constitute a ‘road map’ not only to treatment but also to legitimacy, diagnosis can also engender stigma (Jutel 2011:1; Nettleton 2006; Scambler 2009). For example, in the case of conditions such as chronic fatigue syndrome – as is the case with MUS – what patients experience and understand as deeply disabling physical illness is readily cast as a stigmatizing psychological failing (Jutel 2011; Nettleton 2006). Mental illness diagnosis can be similarly stigmatizing and, as such, something avoided, and kept hidden (Scambler 2009; Pescosolido 2013).

The affective significance of health-related stigma provides another avenue for conceptualizing the entwining of affect and discourse. Stigma draws from broader social and cultural meaning and can mark illness with myriad negative connotations (Scambler 2009; Goffman 1963; Pescosolido 2013; Link and Phelan 2014). To discuss stigma further, I turn to Sara Ahmed’s (2004a, 2004b, 2010) work on the capacity of negative affect to ‘stick’ to people and issues. While Ahmed’s focus is on negative affect attached to otherness, her work can also be drawn on to reflect on health-related stigma. In Ahmed’s analysis (2004a, 2004b), some bodies are marked with negative affect as a result of historical ideas of otherness. Historical associations continue to influence social relations: ‘[t]he impressions we have of others, and the impressions left by others are shaped by histories that stick’ (Ahmed 2004a:39). Associations that stick, furthermore, give rise to feelings that resonate through social relations as well as bind people together: ‘how we feel about others is what aligns us with a collective’ (Ahmed 2004:26). Negative affect directed at the other simultaneously fosters belonging to a community united in the exclusion of that which is considered other (Ahmed 2004a; see also Link and Phelan 2014).

Health-related stigma possesses a ‘sticky’ (Ahmed 2004a, 2004b) quality. Stigma draws from the social and the historical and it evokes powerful feeling in those marked with the stigma, as well as in those without (Scambler 2009; Goffman 1963; Pescosolido 2013; Link and Phelan 2014). Like historically located ideas of otherness, stigma can establish boundaries and feed affect that excludes the other as well as binds the non-stigmatized together. For those marked with health-related stigma, however, the means of defining the self as opposed to a stigmatised character or category are more limited. Health-related stigma can, rather, ‘stick’ to the self. The ‘loss of self’ (Charmaz 1983) associated with ill health can become pronounced, as well as more complex, through the ‘sticking’ of stigma to the selfhood of the afflicted. Importantly, the affective power of health-related stigma is not fully captured through analyses that focus on stigma as a form of discourse. This is because feelings like shame and guilt can dwell in the body in a manner that bypasses conscious thought (Probyn 2004a). Yet, social meaning can feature prominently in the constitution of affect; stigma involves socially situated meaning that can generate ineffable negative affect reverberating through bodies. As such, as Lisa Blackman points out, ‘[n]ature and culture are not two separate distinct entities, but rather exist in a complex *relationality* that is contingent and mutable.’ (Blackman 2008:34). The interlinking of social meaning with affective embodied experience captures the complex ways in which the social, the individual and the bodily continually entwine.

Importantly for understanding the affective depth of health-related stigma, there is a particular truthfulness and cogency to embodied affect, in part, because it *is* embodied. Gut wrenching anxiety or cheeks burning with shame facilitate a sense of immediate, embodied affective reality that is difficult to challenge, and difficult to

ignore. Embodied intuition can, furthermore, readily be judged more correct and true than assessments arrived at through conscious reasoning (Kahneman 2011). As such, bodily experiences of shame and anxiety cannot easily be cognitively argued away. While affect may escape conscious awareness it would, however, be a mistake to ignore the manner in which the affective entwines with the discursive. Separating affect from discourse may, furthermore, inhibit attempts to understand the complex ways in which the social entwines with the emotional and the bodily in the constitution of, for example, experiences of health-related stigma. I will now turn to the importance of affect in understanding medical encounters and the reproduction of inequality in medical interactions.

Affect in medical encounters

Social meanings that ‘stick’ to identities (Ahmed 2004a, 2004b) are important in the medical sphere also because assumptions that ‘stick’ can generate affect that facilitates as well as hampers access to medical resources. The entwining of identities, stereotypes and affect in medicine and health can capture the reproduction of both deep-seated inequality and of unacknowledged privilege.

Assumptions pertaining to identities intertwine with norms and expectations related to behaviour, affect and emotion, also in the realms of health and illness. People inscribed with differing identities are, for example, assumed to cope with pain in varying manners, to exhibit hysteria to differing degrees, or to be more reliable in their accounts of illness (Ussher 2011; Mik-Meyer 2011; Barr 2008; Coyle 1999; Lupton 2012; Roberts 2011). What is deemed appropriate affect in medical situations is gendered with different expectations existing, for example, in regards to the

emotional labour performed by male and female medical workers (Wharton 2009; Hochschild 2003; Kittay 1999) but also by male and female patients (Mik-Meyer 2011; Lupton 2012). Social class is, simultaneously, important in defining what constitutes normal and valuable emotionality. '[I]ntrospectiveness and reflexivity' that characterize middle-class emotional cultures (Illouz 2008:150) are, for example, normalized today.

While expectations in relation to affect in illness entwine with social identities, these identities also exist in the context of the strengthening of neoliberal values over selfhood. Emotionality that is understood as appropriate centres on displays of self-responsibility, emotional coping and acceptance, even the embracing of adversity (Illouz 2008; Ehrenreich 2010). Values such as these capture the importance of choice, autonomy and self-responsibility in the governance of today's neoliberal subjects (Rose 1999; O'Grady 2005). While different biomedical professions across cultures vary in their manner of dealing with emotions that surface in regards to affliction (Jutel 2012; Lupton 2012), making most of a difficult situation, following doctor's orders and smiling in the face of hardship (Ehrenreich 2010) constitute idealised emotional responses to ill health, particularly in the West.

The often implicit entwining of affect with stereotypes related to social identities is present also in the doctor-patient relationship. Studies in medical sociology have long highlighted that medical professionals' relationships with patients are shaped by assumptions pertaining to race and social class (van Ryn and Burke 2000; Coyle 1999; Lupton 2012; Barr 2008; Shim 2010; Roberts 2011). Physicians' presumptions of, for example, a patient's capacity of adhering to a treatment regime and

understanding medical information reflect broader social and cultural stereotypes (van Ryn and Burke 2000; Barr 2008; Mik-Mayer 2011) as well as a patient's possession of what Shim (2010) terms 'cultural health capital.'

Shim's (2010) concept of 'cultural health capital' provides a starting point for reflecting on the entwining of affect with identities in the context of health and medicine. Following Bourdieu (1984), cultural capital refers to class-based skills and competencies that align 'with the standards of dominant institutions' and that can, furthermore, 'be used to produce meaningful situational advantages' (Calarco 2011:863). Cultural health capital encompasses a 'repertoire of cultural skills, verbal and nonverbal competencies, and interactional styles that can influence health care interactions' (Shim 2010:2). What tends to constitute cultural health capital today include 'linguistic facility, a proactive attitude toward accumulating knowledge, the ability to understand and use biomedical information, and an instrumental approach to disease management.' (Shim 2010:2). There is, as such, a connection between cultural health capital and economic as well as educational privilege (Shim 2010). Cultural health capital entwines with classed dispositions and resources, as well as captures the broader neoliberal ethos of self-responsibility. Cultural health capital and its capacity to foster advantages when navigating biomedical institutions also fortify the privileged position of biomedical knowledge in defining ill health. Simultaneously with upholding the power of the biomedical expert, cultural health capital positions a patient in possession of cultural health capital as an ally in the production of health.

Much cultural health capital is interactional in character (Shim 2010). Doctors' assessments of a patient's capacity to comprehend and comply intersect with an on-

going, and often non-conscious, affective evaluation of individual patients, and of social identities. The meaning that ‘sticks’ (Ahmed 2004s, 2004b) to certain people or issues thus resounds also through medical landscapes, silently shaping communication, diagnosis and treatment. While cultural health capital (Shim 2010) can be practically useful to patients possessing this form of cultural capital, ultimately, ‘cultural capital contributes to the accumulation and exercise of power and the maintenance of inequality.’ (Shim 2010:2). In areas such as health and illness, the cultural capital that provides access to further advice and treatment reproduces privilege in the form of physical health and longevity.

Cultural health capital (Shim 2010) captures social inequality also on a further, more affective level. Cultural health capital can be seen as important in generating patient experiences of worth. The possession of cultural health capital – or the alignment of one’s classed interactive style with what is valued within biomedical institutions – can translate to experiences of legitimacy and affirmation. Cultural health capital that often embodies an affinity of classed interactive styles (Shim 2010) and a congruence of class identities between doctors and patients can give rise to experiences of recognition. Recognition, in turn, facilitates feelings of self-assurance, self-respect and self-worth (Honneth 2001). While affect that is generated through experiences of recognition – for instance, feelings of validity and worth – may escape the biomedical framework for understanding disease, these same emotions can feature prominently in patient experiences of illness, and in patient responses to medical advice. The positive affect that relates to recognition can alleviate emotional challenges associated with ill health. Experiences of acceptance premised on the possession of cultural health capital can mediate the lack of legitimacy associated with, for example, the absence of

diagnosis. Importantly, however, recognition ‘is partly conditional upon behaviour and achievements, and these depend on access to valued goods and practices’ (Sayer 2005:960). Cultural health capital (Shim 2010) entwines with affective experiences of worth and acceptance that, simultaneously, reproduce deep-seated inequality. Affect in medical encounters springs in relation to social assumptions. This affect suffuses the doctor-patient relationship and it can, furthermore, generate benefits such as access to treatment, advice, worth and validity. That class-based cultural competencies subtly facilitate access to resources for health can also serve to generate further affective experience: feelings such as shame and guilt among the privileged, and anger among the excluded.

Embodied affect

So far, I have argued that affective experience, also in affliction, entwines with discourse and socially generated meaning. I have also outlined the affective relevance of social perceptions of identities, and the significance of forms of capital such as ‘cultural health capital’ (Shim 2010) in the generation of affect that can shape medical encounters and patient access to not only treatment but also worth. I now want to extend these examples of the entwining of affect with discourse and social meaning to develop further understanding into *how* affect saturates affliction. In order to do this, it is important to focus on the body and on the manner in which affect makes itself present as embodied feeling.

The body has been argued to constitute ‘the unproblematic medium through which I experience life’ (Leder and Krucoff 2008:322)ⁱⁱ. However, one’s relationship with the

body changes in the face of ill health. Ill bodies deal with, for example, pain and irritation, and lost control and function. The bodily discomfort that often characterises ill health encompasses ontological significance; feeling in the body brought on by illness can make the body *present*: ‘bodies, at the most general level, become most conscious of themselves when they encounter ‘resistance’ or ‘difficulties’ of various kinds’ (Williams and Bendelow 1998:159). The experience of the ill body often captures changes in physiological functioning, but it also entails important affective dimensions. The affect in affliction is embodied beyond biomedical understandings of the physiological roots of disease. Affective experience – feelings of, for example, shame, anxiety, embarrassment and expectation – dwell in the body and can, moreover, feature prominently in the lived experience of illness.

To make further sense of bodily affect that often accompanies affliction, I turn to affective neuroscience. Literature into affect that is associated with neuroscientist Antonio Damasio conceptualises affect in terms of bodily feedback loops that emergent situations can call upon (Cromby 2007a, 2007b; Wetherell 2012). Damasio, as Wetherell (2012:30) notes, ‘formulates affect as the impress of alterations rippling through the body, registered as differences from average states’. In Damasio’s (1994) assessment, events and encounters can revisit and rehearse prior affective experience, shading situations with their specific emotional hue. Upon encountering a relevant – conscious or non-conscious – stimulus, earlier affective experience can be rehearsed in the body. Through what Damasio (1994) names ‘somatic markers’, body states associated with past experience ‘can get momentarily reconstituted in feedback loops between brain and body.’ (Cromby 2007a:101). The body, furthermore, can respond as if an actual stimuli is appearing even when a physiological response relating to an

event results from internal rather than external stimulus (Wetherell 2012:35). A similar idea is outlined also by Kahneman (2011) in his discussion into ‘associative activation’. Upon encountering a relevant stimulus, the body responds ‘in an attenuated replica of a reaction to the real thing’ (Kahneman 2011:51). That emerging events can call on ‘somatic markers’ or rehearse existing associations, ultimately, captures the interdependency of cognition and affect (Damasio 1994, 1999) as well as the complex and continual entwining of prior experience and social meaning with affect, cognition and embodiment (Kahneman 2011).

However, while Damasio’s understanding of ‘the fundamental unity of mind and body’ (Cromby 2007b:156) is appealing, there are problems to Damasio’s approach. Damasio’s view of the ‘affective automaticity’ of the body (Papoulias and Callard 2010:41) builds on the idea that ‘humans are primed to respond strongly to particular contexts, and our emotional responses are triggered by perceptions in the here and now of ‘meanings’ that have been laid down by evolution.’ (Wetherell 2012:38). However, ‘emotion is not an automatic (mechanical) fully formed response to stimulus’ (Burkitt 2014:85). Rather, affect emerges in context and in relation to other people: ‘people frequently explicitly look to the situation and to others around them to decide whether it is excitement, anger or fear they could be feeling.’ (Wetherell 2012:41; see also Burkitt 2014; Cromby 2007b). Despite these problems, there is potential in neuroscientific formulations to help make sense of affect in affliction.

The affect generated in relation to encounters that rehearse existing associative connections is inescapably physiological as it is embodied in the haptic, kinaesthetic

or vestibular reactions akin to the responses generated in relation to an earlier affective event (Cromby 2007a:101-2; Wetherell 2012; Damasio 1994; Kahneman 2011). The physicality of affect, together with the potential for past affective experience to resound through the body long after the original event, is also important for further understanding the illness experience. The affective experience of affliction can remain not only in conscious memory but also as a *memory inscribed in the body*. Even non-related events and encounters can, furthermore, draw upon and revive past bodily responses. The affective echoes of illness that remain in the lives of those once afflicted are thus more than conscious. The affect associated with illness dwells in, and reverberates through, bodily systems. When the memory of ill health – an association connected with an illness experience – is called upon, the body reacts and an embodied affective experience emerges. The affect unfolding can, furthermore, ‘be induced in a nonconscious manner and thus appear to the conscious self as seemingly unmotivated.’ (Damasio 1999:48). A long past affliction can, as such, revisit us on the level of embodied feeling without a trigger that can easily be identified. However, rather than something automatic, this process is shaped in relation to complex individual, social and cultural meaning (Burkitt 2014).

In the context of ill health, the associations called upon can, for example, involve the experience of exclusion of one’s affliction from the confines of the biomedical discourse. A missing diagnosis, while practical as well as related to feelings of worth and legitimacy (Nettleton 2006) is also entwined with the generation of embodied affect, also long past the original experience. This affect surfaces in the body but it also relates to all that diagnosis can encompass: certainty, restitution, or stigma (Jutel 2011). Health-related stigma that is socially generated can also enable affective

associations to develop in individual bodies. Shame engendered in relation to stigma can remain inscribed in the body. This shame echoes through bodily systems in a manner that often escapes conscious thought. The capacity of affect to remain elusive to conscious reflection makes recognising social categories that underlie feelings such as shame particularly challenging. It is, as such, tempting to conceptualize affect as existing outside discourse. The manner in which associations can generate physiological as well as emotional responses, furthermore, marks the affective experience with considerable depth and truthfulness (Kahneman 2011). Affect saturating the body lends the experience additional weight and reality.

The unfolding of affective experience in relation to socially-generated associations can also reverberate through the doctor-patient relationship. A patient possessing the ‘cognitive, attitudinal, and behavioral resources’ (Shim 2010:2) that constitute cultural health capital may, as Shim notes, ‘inspire more earnest efforts by their clinicians to give them additional information, resources, and skills.’ (Shim 2010:8). Social meaning continually imbues affect that, in turn, shapes medical encounters. Subtle affective judgements made on the basis of perceived patient character can be powerful in reproducing inequality. Simultaneously, patients’ views of providers are shaded by affect capturing histories of, for example, exclusion and marginalization.

Healing affect

While affliction can be saturated with negative bodily affect, the generation of wellness is also often permeated by affect: by cautious hope that an affliction may be resolved, by joy in rediscovering bodily function, by trepidation that ill health may return. These affective experiences inhere in the body that can feel a surge of

embodied optimism and pleasure; a belief that things can get better resonates in the body that can, literally, feel lifted. The impact of positive affect can, furthermore, transcend simply *feeling* lifted as positive affect can result in changes in physiology, including the immune system (Segerstrom and Sephton 2010)ⁱⁱⁱ.

However, if the illness experience entails culturally and individually shaped negative affect resonating through in the body – in addition to the existence of a biomedically defined pathology – then a part of the process experienced as healing involves the emergence of different kind of bodily affect. Healing experience can be conceptualised as the rise of positive affect as something other than pain, loss or shame is inscribed in the body. The inscription of positive affect in the body is an important, albeit poorly understood, aspect of many health practices. Studies into health practices that give rise to healing despite limited evidence of scientific efficacy provide a tentative starting point for reflecting on experiences of healing outside the biomedical framework. For example, complementary and alternative medicines often lack evidence of scientific efficacy yet these practices have been found to engender healing, including feelings ranging ‘from increased bodily awareness to a sense of bodily mastery.’ (Baarts and Pedersen 2009:729).

Some of the healing accomplished in complementary and alternative medicines is generated through touch. Many clients of complementary health practitioners experience touch as particularly important and healing (Baarts and Pedersen 2010; Sointu 2012, 2013). The healing prowess of touch relates to the capacity of touch that is wanted and accepted to ‘reaffirm the connection between self and other that may

have been disrupted by the pain, incapacities, and disfigurements of illness' (Leder and Krucoff 2008:324). Touch that is experienced as healing can be understood as meaningful in its capacity to elicit positive bodily responses in two ways. First, healing touch can break associations that may have emerged in relation to, for example, pain or limitation. Second, touch can help to generate new associations that can remain inscribed in bodily systems. Thus, just as ill health can be seen to encompass the inscription of negative affect in the body, processes of healing can also mark bodily systems and result in the emergence of affect that is felt to indicate the elision of illness and the return of health.

Conclusion

While 'the belief that affect is independent of signification and meaning' unifies much theorizing into affect (Leys 2011:443), this paper has sought to underscore the significance of discourse in the generation of affect and to highlight the complex manner in which social meaning and emotion entwine in illness, medicine and healing. The affect saturating illness is constituted in relation to relevant discourses even if the illness experience cannot be reduced to these same discourses. Illness, health and healing all involve more than discursive meaning marking forms of affliction; paying attention to the discursive production of illness, while enormously important, cannot alone capture what it *feels like* to suffer from ill health. Simultaneously, discourse – for example, social ideas of stigma – suffuse affective experience. As a result, the full extent of living with a stigmatising condition cannot be grasped without paying attention to the entwining of the social with the bodily and the emotional.

Even though the biomedical discourse pays limited attention to affect emerging in experiences of illness, the biomedical discourse is deeply significant in the constitution of affect in affliction. Social meaning that is attached to conditions carries affective weight. As the prowess of diagnosis and health-related stigma indicates, social meaning saturates the very fabric of our being. Ultimately, the separation between the body and discourse limits our understanding of human experience. Affective neuroscience offers a tentative, even if problematic, avenue for conceptualising how previous experience as well as socially located meaning resound through bodily systems, shaping experiences of affliction, also long after biomedical health has been regained.

The entwining of affective experience with social meaning is important beyond analysing the illness experience. If we appreciate affect as capturing social meaning, social identities also matter in the generation of forms of affect. In the realms of health, illness and medicine, the veiled manner in which affect connects with stereotypes related to social identities acquires great importance; affective judgement can play a role in the subtle and often non-conscious reproduction of both privilege and disadvantage.

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ⁱ This is not to say that emotion is simply ignored in biomedical settings. Nursing professions are, for example, often charged with care of the patients' body and emotions (Lupton 2012; Stacey 1997).

ⁱⁱ The general invisibility of embodiment is, however, patterned according to social identities including class and gender. For example, according to Stacey, 'self-scrutiny and self-surveillance are practically 'second nature' to femininity' (Stacey 1997:196). The self-scrutiny associated with femininities extends also the body.

ⁱⁱⁱ While there are indications that positive affect may positively influence health, the study of positive affect and health is plagued by difficulty. For example, positive affect may mean different things across cultures (Cohen and Pressman 2006). It is, furthermore, difficult to assess whether it is positive affect or the lack of negative affect that improves health (Cohen and Pressman 2006:124).