11 Affective Processes and the Diagnosing of Chronic Fatigue

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> … I have always felt strong, and suddenly I do not have it in me, and cannot plan. I try to keep up just to do something, this is what I need somehow. I need to find a way to cope with this, acceptance. I cannot find the balance between [doing] too much and [doing] too little… I blame myself. I am angry with myself, but I also tell myself that others are in worse trouble… I think that sometimes I can… I am terrified to become too passive, I feel trapped …
> *(Trond)*

Imagine a life dominated by a constant sense of tiredness, feeling exhausted and overwhelmed; trying to make sense of an unpredictable and fluctuating, intense bodily sensation, while simultaneously experiencing how fatigue impacts your cognitive and physical capacities and your identity as well as depriving you of social and intellectual functions. Imagine further that the causes of this sensation of tiredness are not identified despite multiple medical examinations, tests and assessments.

Based on a study of people suffering from fatigue and hoping for help by taking part in a diagnostic assessment for conditions of chronic fatigue, we argue that the diagnostic process is enacted as a shared affective effort and that this effort is constituted and materialized in the relationality of the clinical encounter. With Manning we ask: "What if, instead of placing self-self interaction at the center of development, we were to posit relation as key to experience?" (Manning 2013: 2).

Several sociological and anthropological studies have scrutinized and elaborated the enactment of diagnoses and temporality in clinical settings and encounters (e.g., Büscher et al. 2010; Chew-Graham et al. 2010; Gardner et al. 2011; Gardner and Williams 2015; Mol 2002; Moser 2010; Smith-Morris 2015). These studies explore the making of a diagnosis in collaborative, relational practices of assessment as a material-semiotics approach to the assemblage of diagnostic processes. By contrast, Tessier (2018) presents an analysis of diagnosing dementia by drawing on early theories in psychiatry, particularly *Gefühlsdiagnose*. Tessier demonstrates how health professionals used their own feelings and reactions towards a patient as an instrumental effort to enable contact with the patient, making diagnostic work an assemblage of stabilized concepts built on sensory experiences of "affordances." Tessier concludes: "Medical expertise is still bound to a sensible experience of the world that is never given *a priori*" (Tessier 2018: 125). That is, stabilized biomedical knowledge and reasoning are combined with or perhaps guided by "feeling", by "our own affectivity" (cf. Minkowski, in Tessier 2018: 124) in a concrete and affective meeting with the patient.

This focus on affect is also taken up by Hadolt (2018) in a study of genetic counseling. He examines how a counseling situation is organized, stressing a specific style of affectivity that influences rationale, client-centeredness, and professional compassion. Hadolt argues that the counselor and counselee "connect and resonate with each other as experiencing and receptive bodies" (Hadolt 2018: 136). He employs the concept of "affective coordination" to analyze a process of shared and mutual attunement, whereby affect brings about affordances to which each person must respond. Collu (2019) likewise explores affect in psychotherapy sessions with a couple. Especially attentive to a crisis unfolding during a specific session, he elaborates how its affective moments move things (Stewart 2007), while "possessing" the couple and the therapists involved. He suggests that "we cannot understand therapeutic efficacy if we focus only on language and discourse" (Collu 2019: 290). Accordingly, we may benefit by asking what the impersonal and evanescent qualities of affect may offer to the analysis of therapeutic sessions or, in our case, diagnostic processes during the assessment of chronic fatigue (cf. Swallow and Hillman 2019).

The sparse anthropological literature which explores fatigue or tiredness does so through studies of chronic fatigue syndrome (CFS), cancer, or fibromyalgia (Hay 2010; Risør and Lillevoll 2021; Seppola-Edvardsen and Risør 2017) and tends to position the tired body in relation to, for example, illness narratives and diagnostic negotiations (Sachs 2016). Further, Ware's work on CFS (Ware 1992, 1999) demonstrates how life is lived in the context of specific cultural expectations that prompt a social course dominated by marginalization and social distance, while other scholars emphasize the embodiment of suffering (Addison 2013) and the legitimacy of a diagnosis and its medicalizing effects for possible CFS patients (Sachs 2001, 2016). Limited research has inquired how a diagnosis of CFS or related disorders such as medically unexplained symptoms (MUS) materializes (Chew-Graham et al. 2010; Hydén and Sachs 1998; Rasmussen 2017).

CFS is a debilitating multifaceted disorder, characterized by fatigue, muscular and joint pain, extreme exhaustion after exercise and long recovery time, sore throat, flu-like symptoms, unrefreshing sleep, cognitive impairments, and sensitivity to sound, smell, and taste, however, not all patients experience all symptoms. CFS constitutes a profound challenge for those affected and for health professionals. Patients are often offered a variety of assessments, sometimes based on interdisciplinary, biopsychosocial approaches, followed by advice on activity regulation, psycho-education, and classes teaching coping and daily management strategies.

The diagnostic processes are, however, often surrounded by uncertainty, despite a presumed "aura of factuality" (Geertz 1993) of biomedical knowledge. Epistemic uncertainty becomes especially prominent when the classification of diseases is contested due to a misalignment between symptoms and established disease models; in other words, when the indexical aspect of the biomedical sign is denied (Staiano-Ross 2012). This is precisely the case for patients suffering from chronic fatigue where diagnostic assessment rests on a disorder with no clear etiology in the borderlands of disease classification.

In this study, we explore how the interplay between a patient, health professionals, diagnostic criteria, advice on regulated activity, emotion and affective interaction shape and enact the diagnostic assessment. In our analysis, we integrate how organizational routines, neoliberal health ideologies, gender and social circumstances work as a wider context for such an assessment, inducing an ambiguous complexity of concerns and matters-at-stake involving all parties.

Affect, affective atmosphere, and attunement

Anthropologists have increasingly attended to affect and affectivity which encompass ordinary activities (Stewart 2007). This affective turn reacts to textualism and cultural theory (Stewart 2007; White 2017). It emphasizes what slips and evades, what is maybe ineffable (Brown and Tucker 2010) or non-representational (Thrift 2008) but nevertheless significant because it moves and drives processes forward. Particularly related to a critique of dyadic encounters, this affective turn posits that intensities and potentialities emanate from atmospheres and non-individualized relationality rather than from subjective agency (Anderson 2009; Massumi 2002). Accordingly, affect is embodied and instills agency not in individuals but rather in and through relational experiences.

Attending to affect has helped anthropologists to examine the senses and sensations and the materialities of lives that are lived through body and mind (Stewart 2017). This focus rests on an ontology that, as Manning (2013) argues, is based not on a fixed notion of self, subject, or agency, but rather on the relation as the prominent analytical unit. Thus, the clinical encounter can be understood as a performance of mutual responses and resonances in the actual moment of a clinical process, accounting for emotions, sensing, adapting, mirroring, and sharing of knowledge as well as intersubjective experience. The social also encompasses moods, atmospheres, and rhythms that come from places where language stops or is insufficient (Knudsen and Stage 2016). Overall, bodies have the capacity to affect other bodies and to be affected by them (Anderson 2006). Attention to affect and its potentiality may illuminate change and movement in specific encounters.

Differences between affect and emotion are often debated (e.g. Swallow and Hillman 2019) and may be difficult to distinguish. However, following Massumi (2002), different logics and orders pertain to emotion and affect. An emotion holds subjective content, a qualified, owned, and recognized intensity. Affect is not part of a determined regime; it is not prescribed; it is prior to but potentially able to become something. Other researchers link affect and emotion (e.g. Ahmed 2004; Wetherell 2012), arguing that affective practices entangle emotional, bodily, social, and material figurations, and combine affect with meaning-making and the discursive. We acknowledge this understanding; however, we wish to remain close to the notion of affect as a felt intensity that is primarily experienced bodily. The intensities noted in this study were embodied and shared and also affected the first author and prompted her to try to understand their potentiality and their movement. Without abandoning discursive matters, cultural mechanisms, and templates that mediate clinical encounters and which are part of the assemblage of a diagnostic process, we attempt to choose another—bodily—scale of attention (Hastrup 2013) in order to grasp intensity and affective moments.

To concretize affectivity, we draw on the notions of affective atmosphere and affective attunement. Anderson states that perhaps “the use of atmosphere in everyday speech and aesthetic discourse provides the best approximation of the concept of affect” (Anderson 2009: 78). Like affect, atmosphere denotes an intensity, but it draws attention to something shared, something overflowing in space and time, without belonging to a specific body but still being embodied. The atmosphere of a situation is undetermined because it is not fixed, yet it is there and affects the situation.

Further, by drawing on affective attunement, we may understand how bodies react to cues or atmospheres, either creating sameness or distinction depending on the bodies’ dispositions (Knudsen and Stage 2016). Manning, paraphrasing Stern (1985), notes: “Affective attunement is key to interpersonal becoming. Affective attunement is another mode of immanent relation where the relation radically precedes the purported unity of the self. Attunement is a merging-with of vitality affects across experiences toward emergent events” (Manning 2013: 7). We aim to show how patients and health professionals attune to each other in this way, resonate and create or transform emerging affordances or matters, giving way to potentiality and movement.

Lastly, hope anticipates the indeterminate that has not-yet-become and dispositions of hopefulness may move suffering bodies (Anderson 2006), creating specific hopes. Hence, potential is central (Massumi 2002) and speaks to the intensity of hope. Taussig et al. (2013) explore potentiality as something that can be imagined and talked about but does not (yet and never may) exist. It may denote something about to manifest itself when comparing what "is not and what might never be" (Mattingly 2010: 3). In this sense, there is a close affinity between affect, hope, and potentiality; i.e. hope as an ability to affect and be affected by the world (Anderson 2006: 747).

The study

This study is based on fieldwork in a Norwegian university hospital clinic specialized in diagnosing chronic fatigue. Participants in the study were patients who had been referred from primary care to a specialist fatigue clinic for CFS assessment. All the patients had a long-standing history of fatigue as a dominant health complaint, and all had experienced several examinations and tests in primary care as well as in hospital departments in order to ascertain mechanisms or reasons for their symptoms. On being referred to the specialist clinic, the patients primarily expressed nervousness ("How would it go?") but they were also relieved, hopeful, and excited to possibly be at an endpoint of their diagnostic trajectory, being seen by CFS specialists. Their long history of complaints and various symptoms had severely impacted their professional life, their social life, and personal identity. Some expressed a desire for a CFS diagnosis, others merely clarification and support. Personal endeavors, ambitions, hopes, and concerns were at stake and patients sought support to enable a more manageable life. This was the case for both Anna and Trond whose clinical encounters we analyze below.

To carry out the study, the first author collaborated with a specialist team at a university hospital, consisting of a physician, a psychologist, and an occupational therapist, occasionally substituted by a physiotherapist. By coincidence, all the professionals on the team were women. During spring 2017, the first author conducted fieldwork at the clinic where the team is based and followed twelve patients during three consultations, one with each health professional. The team assessed two or three patients each week, and patients spent an hour, sometimes longer, with each health professional, depending on the conversation and the problems discussed. Consultations were spread over two days and would eventually result in a diagnostic decision—a CFS diagnosis, an alternative fatigue diagnosis, or no diagnosis at all. Further, the final fourth session with all health professionals was also observed. Here, the professionals first discussed their individual conclusions and arrived at a joint diagnostic decision and then summoned the patient to explain their decision and offer advice. The verb "to summon" is deliberately chosen to describe the tension, nervousness, and atmosphere of anticipation associated with a verdict. Patient participants, waiting for this consultation had, for example, slept badly the night before, were exhausted, sweating and finally bursting into tears as both Anna and Trond did. The following analysis draws predominantly, but not exclusively, on this final session.

Fieldwork with the intention of analyzing a relational setting and grasping how patients and health professionals sense each other, and how they adapt, mirror, resonate, and respond to each other is not a straightforward task. A methodology that seeks to identify affective processes requires an understanding of what affect is and how it might be traced (Knudsen and Stage 2015; Staunæs and Pors 2021). Affect may be best studied if linked to a specific situation and to the bodies involved in that situation, including the researcher-body. To this end, the first author—by using her own body—noted the intensities of statements, reactions to these, responses in words and body, non-verbal language and expressions, moods, the intensity of voices or lack thereof, and the affects which were expressed verbally. Even though we allow for affect to be expressed through articulations of meaning (Wetherell 2012), in the following we primarily trace affective attunement and atmosphere through embodied fieldwork, for example by attending to more-than-representational layers of experience, sensory work, and bodily sensations, and how these intertwine with biomedical agendas, the materiality of the setting and resulting atmospheres (Knudsen and Stage 2015: 16).

The CFS landscape in Norway

CFS is a disorder that has increasingly been diagnosed in Norway during the last few years. How many people are diagnosed is uncertain since registration is unreliable and contradictory. An estimated 10.000-20.000 individuals currently have this diagnosis and the media mention a five-fold increase between 2008 and 2015, especially among young people and adult women. The increasing number instigates debates about the impact of societal strains on people. It also spurs academic and clinical debates about diagnostic borderlands. On the one hand, the expansion of disease boundaries increasingly specifies more and more bodily states as diseases and, on the other hand, this introduces continuous contestation and ambiguity related to illness experiences, exposing what is outside the borders of disease (Rosenberg 2006). Several patient associations, medical societies, and lay media vigorously take part in debates about both diagnostics and recovery strategies.

To meet the growing demand for assessment and treatment of possible CFS, specialist teams were established in several Norwegian hospitals from 2013 onwards. The national guideline on assessment, diagnostics, and care (Helsedirektoratet 2015) constitutes the backbone of the work of these teams. Assessment includes physical and psychological examination, history taking, and differential diagnoses (based on, for example, blood tests, diagnostic imaging, and the use of depression and anxiety scales). The Norwegian guidelines base the diagnosis of CFS on the Canada consensus criteria (Carruthers et al. 2003; Helsedirektoratet 2015), which are considered to be conclusive for a diagnostic decision. These criteria measure and operationalize levels of fatigue by assessing whether a patient has a 50 percent reduced activity level, compared to self-reported previous activity levels. This supposedly objective measurement is decisive for a diagnosis, being the principal criterion to sustain or dismiss the overall symptom presentation.

Norwegian guidelines further provide advice to patients on how to regulate their everyday activities, for example, through adjusting and balancing activity according to individual capacity. Accordingly, talk about activity was the most important focal point of the observed consultations, defining the agenda of the encounter, i.e., talking about activity levels "before" and "after" in order to determine reduced capacity and establish details on general activity to advise on regimens suitable to a patient's situation. The term "activity" thus references a specific assessment criterion integral to "activity levels", but also everyday activities, and care, revealing tensions and discrepancies in perspectives.

Being active is a cultural and social norm for all patients. Due to physical constraints and fatigue activity, "doing" is connected to what has been and what is longed for. For the patient, activity is embodied, practically embedded, and inscribed with despair, anticipation, and hope (Adams et al. 2009). All participants deeply regret what they no longer can do, while also trying to explain that they are still active, in their own way and on their own terms, thus embracing hopefulness as well as a prevailing notion of agency (Laidlaw 2010). In the medical context, the notion of activity is closely related to productivity, agency, and competence, and activity levels constitute a biomedical diagnostic criterion. This transformation of activity into a supposedly objective measure of activity level detaches activity from its subjective meaning. Thus, the perceptions of activity generate moments of hope and intensity for all parties, however in different ways.

The case of Anna: Resonance through hope, fear and passion

Anna, in her mid-thirties, is a single mother of two children. The first author meets Anna in the waiting room at the university clinic, where other patients wait too. We sit next to each other while Anna awaits her first consultation with the occupational therapist (OT). The first author asks her some questions about her situation, how long she has waited to be referred, where she lives, whether she has children, and related questions about these kinds of topics. Anna makes the first author feel a bit hesitant about asking, not inviting much to the conversation, just answering politely. But when talking about her children, Anna happily shows pictures of them playing football. We continue talking more about them and my children as well. While waiting, Anna wears her overcoat—dark, somewhat out of shape—which she also keeps on during consultations.

During the consultation with the OT, Anna is met with eager questions about her everyday activities, her daily rhythms, and her resources; all very concrete, routine questions for the OT. Anna answers quite briefly, giving the impression of being very exhausted, sad, and dejected. She remains wrapped in her thick coat, sits with her hands clenched and hardly moves when talking. When answering there is a tone of sorrow and a heaviness to her voice and bodily presence—at least this is how she affects the first author and how she interprets the mood of the scene. Anna adds information about her lived life, past and present troubles and efforts, feelings of regret and grief because she was unable to keep the job she enjoyed, can no longer undertake outdoor activities with her children, and no longer has any social life. Anna emphasizes that her main concern is to be a good mother to her children.

The OT seems affected by Anna's narrative and the emergent mood. She tunes into Anna's history, makes eye contact with her, nods, and shows openness in her body language by leaning towards her. Eventually, the OT moves on to her routine advice about activity regulation for managing daily tasks, while also trying to inspire Anna to be in charge of her life. Talking about the need for and control of activity highlights a paradox in the affective atmosphere—the co-existence of tragedy and exhaustion with clinical empowerment. Anna's response to this atmosphere is to keep emphasizing what she manages to do despite debilitating pain and fatigue in addition to managing the effects of domestic violence. This paradoxical pattern repeats itself during Anna's later consultations with the other health professionals. All the health professionals are moved by her; they have, we would say, empathetically attuned to her hardship which fills the room with both words and sensations.

Before Anna meets the three professionals in the final consultation, the professionals discuss their assessment, their clinical as well as person-oriented impressions and conclusions, and how they may help her:

Psychologist: She pushes herself, pulls herself together. She wants them [her children] to feel good, it is as if she needs to perform, and it is probably an important priority in many ways, pushes herself when they are at home, and thinks that they should notice as little as possible that she is ill, does not want to pull them into her illness.

> *OT:* She pushes herself and I get the impression that it's not because she suddenly has a lot of energy, but she says anyway that she functions better when she has the kids. Since when she does not have them, she just lies down. I think that is

> perhaps not typically CFS, but I don't know really, because you can mobilize a lot if something is important enough.
>
> *Physician:* But she is maybe not that good at doing things for herself then ...
>
> *OT:* No, there are few things like that ...
>
> *Psychologist:* She also does not do anything with the kids that she used to do. Her life was about hiking, trips, and out-door life for a large part and she does not do that now.

This conversation jumps from summing up Anna's history with violent or game-addicted husbands to emphasizing how she has tried to cope amidst periods of depression and making ends meet to give her children the best conditions, even attempting to arrange for them to see their father. While talking, the professionals are clearly touched and moved by Anna's history, but they also assess her hardship professionally to reach a conclusion—is it CFS or not according to the criteria?

When the health professionals summon Anna to present their conclusion, they explain their rationale about a possible diagnosis, while acknowledging and feeling sympathetic about her struggles and efforts. Anna seems quite tense. In the waiting room, she confided her fear that the health professionals might report her to the child welfare authorities. At the start of this final consultation, she answers very briefly and while she does receive a CFS diagnosis, she hardly reacts. The OT asks: "What do you think about that?" Anna answers: "I don't know, I .... what is the prognosis from now on? Is there anything that will make me well?"

This brief exchange provides the cue for the rest of the consultation. The OT, physician, and psychologist grasp the opportunity to passionately offer Anna different types of help which Anna responds to positively but also hesitantly, because she might not have the energy, as she says. Importantly, Anna's cue contains hope, for herself and her children; a hope projected into the future imagining recovery. The resulting hopeful atmosphere in the room seems to affect everybody. The health professionals talk energetically, they perceive a chance to help and make a difference; they bodily show relief. A "collective condition" of hope and future seems to be established (Anderson 2006). Especially the OT shines when there is an opening to give detailed advice on energy management, which Anna promises to think about. Anna herself appears increasingly comfortable, relaxes bodily, and slightly laughs for the first time when she says to the OT, in response to very detailed activity advice: "One would think you were in my head!" This makes everybody laugh. The intensity in the room is characterized by a shared optimistic tone: advice is given, courses on coping are recommended and Anna accepts and nods. Eventually, the psychologist says: "[...] I have been surprised many times by how big constraints people have in their lives and what people experience, but also […] how capable and coping people are, and how much they manage to become good parents anyway, yes, I have to say this, and I just want to say to you … much suffering and much coping […].”

Anna reacts with humility expressing that “one has to learn”, and right after as a final outburst, she vehemently says while crying: “Thanks for the help, you don’t know how grateful I am … you will get paid in heaven [all health professionals start laughing].”

Anna came to the clinic with hope and fear. She hoped for help, not necessarily a CFS diagnosis, but help to be able to live a life with her children the way she feels they deserve. She also feared that coming would have consequences for her role as mother, and this fear, the first author realized just before the last consultation, was perhaps just as intense as her hope. Fear might have made her extra conscious about stressing her competencies. However, she also needed to balance her fear by staying with her main issue: hope to receive help. Before Anna was summoned for the final consultation, the health professionals did discuss the children’s welfare but decided that they did not see reasons for making a report. Overall, the consultations built up an atmosphere of mutual resonance, where the health professionals met Anna’s concerns and hope, where they were led by feelings of empathy for a struggling mother, and possibly shared life experiences, just as much as by diagnostic criteria. Affected and gendered bodies moved the diagnostic process, making it fluid and contingent.

The case of Trond: Transformation of hope

Trond, in his mid-40s, is a man who likes to talk, also with the first author in the waiting room, apparently unconcerned about other patients overhearing the conversation. A big, bearded man, he resembled a bear who is down on his knees because of his many health complaints. He eagerly expresses his hope for help to be able to recover to some extent, not only hoping for a CFS diagnosis.

Trond’s story as told to the first author and the health professionals, one by one, centers on several issues: being tormented by poor concentration, poor memory, and exhaustion while also trying to recover mentally and physically from the effects of malpractice when having had cancer. He tells his story in quite an overwhelming way, taking up more time in each consultation than the other patients. Also, Trond actively engages in weekly support groups for cancer patients and exercises twice a week. He says he gains a lot from helping others, but he is tormented by the things he no longer can accomplish, having been used to a very active life. He experiences his lost abilities as a personal failure.

In the final session during which the health professionals discuss Trond’s case, the first author sits as usual next to the table where the professionals have assembled. Trond has not yet been summoned. Everyone hesitates, fiddles with their papers, and chats with each other, waiting for the physician to give her assessment first, as usual. The physician has the role of the medical expert who can make the authoritative distinction of whether a patient meets the diagnostic criteria or not. She is also the one who tends to bring up activity levels as the decisive criterion in accordance with the Canada criteria. Anticipation affects us all: What will happen? What does each person bring to the final session on this patient, who—everyone had expressed previously, judging from their individual consultations with him—was rather perplexing and overbearing?

The physician eventually begins, noting first that Trond's poor experience of cancer treatment dominated her consultation with him: "It's not a case that's quite closed, so it's kind of still lying there, that's how I see him. It's like it's still lying there muttering, everything about it, so it's like he doesn't really move on, sort of." Responding to the physician's introduction, the OT and the psychologist modify this and emphasize that having experienced cancer malpractice is not an exclusion criterion *per se*. The physician agrees but also repeats her statement, then notes that the blood test results "looked nice." She then quickly begins to talk about activity levels. She finds that Trond has less than a 50 percent reduction in activity level, so the criteria are not met. The psychologist is surprised and disagrees. All three discuss back and forth how they may interpret what Trond has told them about his activities, i.e., how many percentage reductions may be assigned. There is suspense in the room. Particularly the psychologist becomes insecure, hesitates, tries to find her notes, and initially defends Trond—until her voice loses power.

The physician continues to argue that Trond presents with less than 50 percent activity reduction. By listing his many different current activities and his varying exhaustion levels after each effort, she reiterates that these do not fulfill the Canada criteria. The OT declares that Trond is not a classical CFS patient and somewhat supports the physician, while the psychologist still contests this. Though the OT initially mediates, she then argues with the physician that Trond's previous cancer and his long history of poor treatment may explain his fatigue. The psychologist then turns to Trond's very high score on the self-reported anxiety scale and while all three agree that he does not appear to display clinical anxiety, they consider possible trauma or a diagnosis of posttraumatic stress disorder (PTSD). This turn from activity levels to a topic that allows the psychologist to show her expertise seems to lower the intensity of disagreement and the clinicians now seem united, eager to reach a consensus. The physician summarizes their views:

> I think that his fatigue may be excluded by the cancer. You may think that his great strain is due to this, in relation to his maltreatment, and that he has huge exhaustion, and then, in a way, as we discussed yesterday, he does not, in a way, fulfill the Canada criteria concerning loss of function. But he does have a considerable loss of function anyway, so ...

No one objects now; tensions seem resolved and positions renegotiated. All are now very empathetic towards Trond and his constraints and the discussion moves on to how his functional level may be improved and how to help him, for example, through regulating activity. Trond has "regulation potential", they all agree.

Trond is then asked to join the session. Before the physician starts explaining their conclusion to him, he tries to sum up, quite despairingly, how he has tried to address his exhaustion and cognitive problems:

> I don't remember everything, so that's what … forget quickly and then I try to remember what we've talked about and then, I probably would have remembered more I wanted to bring up, but, but I feel, you know that [sighs deeply] the things you showed me, I've tried in a way to do those things, you know, those things, sort of that I try to make something robust, that it will work somehow, and then in a way, I'm so afraid that then it'll be too much and I get worse; as I mentioned, I've really pushed myself, because it got a bit too much, right, and then you don't feel well […] I feel I cannot get out of this by myself.

Trond refers to mental and physical challenges, particularly his efforts to try to follow earlier advice. He is active but also desperately wants help. The health professionals, however, are eager to convey their diagnostic conclusion and actively discourage any further elaborations. When learning that he does not receive a CFS diagnosis, Trond neither objects nor comments directly; instead, he reiterates his long and complex story about his complaints while trying to justify his recovery efforts. When he mentions his previous assessment for trauma, everyone grasps the opportunity to discuss this. Eventually, the health professionals suggest a new referral for anxiety and PTSD assessment. Trond responds: "I think it's just super; I want to get to the bottom of this, I want to get my life back." Having settled this, the OT eagerly turns to detailed advice on activity regulation, which Trond quickly supplements with suggestions of his own, interspersed with worries about the malpractice. The OT continuously tries to get him to focus on his resources and positive experiences that he must try to activate. The session ends in an atmosphere of emotional weariness. Trond appears exhausted from trying to explain himself again and again. However, he also tunes into, somewhat submissively, the offers he gets. Ultimately, he is on the verge of crying as he thanks the team for its assessment and help.

Trond's encounter with the team was dominated by distinct intensities in the clinical interaction. In the first part of the session, the possible constitution of a diagnosis was what mattered. The Canada criteria, especially activity reduction and advice on activity regulation, became the central discursive practice that helped create the diagnosis, enacted by the different human agents through the paradoxical affective atmosphere that dominated the session. The intensity of that atmosphere brought out different viewpoints, responses, and resonances, as well as shared perceptions of dealing with an overbearing male patient. Eventually, the activity reduction criterion was used to dismiss the CFS diagnosis together with cancer as an exclusion criterion even though there was initial disagreement on this. Overall, the notion of activity, both biomedical and colloquial, demarcated the boundaries of the ill body and the recovering and healthy body, emphasizing the agentic and active body as the endpoint of clinical concerns.

Hope, in this case, we suggest, is strongly evoked by Trond by making hope specific and determinate (Anderson 2006). At the same time as Trond hoped for medical support, solutions, and help, he repeatedly performed his "recovery potential", hoping for recognition through a persistent narrative of competence versus shortcomings. This, however, had a contradictory effect on the health professionals who focused on his high activity level rather than on his suffering. The health professionals transformed Trond's hopes by enacting a personhood that needed help, not by jointly enacting a diagnosis. This transformation was driven simultaneously by Trond's despair and hopes and the intensity in the room that depended on, and was changed by, the notion of activity as a biomedical criterion. As such, the diagnostic process drew on gendered, intersubjective, and affective attunements as much as on specific clinical affordances.

Concluding discussion

We have invited the reader into the affective attunements and atmospheres of clinical encounters, making a point of attending to affects, including hope, fear, passion, and despair, which move forward and drive the setting of diagnosis and care—a setting that is always in the making. In our analysis, intensities, affective attunements, and atmospheres determined the course of the consultations and played a decisive role in enacting the relational encounters and negotiating mutual roles and practices. We thus may say that affect was the "felt reality of a relation" (Massumi 2002: 16), embodying diagnostic work (Goodwin 2010).

Some scholars, inspired by post-humanist approaches, have proposed to shift analytical attention to relationality as the core unit of analysis (e.g. Barad 2003; Kazimierczak 2018; May 2007). Attending to relationality goes beyond attending to dyadic interaction. Rather, it calls attention to relations that are ontologically prior to an interaction between self-contained selves and opens up for experience in the making (Manning 2013). Relationality accounts for the mutuality and immediacy of different agents, inter-relational dynamics, and resonances of which affect is central, affect being essentially relational. Adding to an analysis of affect such as we have proposed here, we follow Kazimierzcak who suggests that we need to understand "how different agents come to be articulated, enacted and materialized in relations and practices, which make these distributions and configurations possible" (Kazimierczak 2017: 9). Inspired by this, we see a link between the concept of "relationality" with its emphasis on situational immediacy and affect which is present in the diagnostic processes presented.

Investigating how relationality and affect may drive and generate diagnostic procedures seems inherent to analyzing the contingency of clinical encounters. For Anna, hope and fear remained open to what might come and they worked as modalities which moved the health professionals into empathetic resonances. Accordingly, the professionals attuned their clinical decisions to Anna's gendered performance of hope, strength, and competence as a caring mother (Young 2005), while simultaneously drawing on their professional ethos and passion to support her. The emergent hopeful atmosphere was shared, hope being a form of affect, and moved the diagnostic decision.

Trond also expressed hope, together with a sense of despair. However, Trond projected hope into potentialities and possibilities by attempting to present a narrative of competencies, his "recovery potential", to comply with what he thought was expected from him; however, his apparent well-run life made it difficult for the health professionals to attune to him. In this way, we might say that Trond himself transformed his hopefulness: Through being excessively eager to perform competence he appeared to seek to reconcile different forms of masculinity in health (Courtenay 2000; Nissen 2017). In Trond's case, the intensity of hope and despair is overwhelming and calls on the professionals first to negotiate their shared position and then to contain Trond. The diagnostic process entails Trond's affectivity, together with enacting specific agency, masculinities, and personhood as much as the health professionals' enactment of care and professional ethos in their diagnostic endeavor. Yet, no clear and definitive diagnosis was enacted.

According to Brown and Tucker (2010: 3202), there is "a material arrangement of relations between bodies that allows for certain potentials to act." In the cases above, the CFS diagnosis was a potential diagnosis from the outset, with its potentiality governed by the affectivity generated by moments, movements, and interaction-in-the-making of the clinical encounters, the relations between the professionals (i.e. three women professionals) as well as the hierarchical relations between their professions. The diagnostic outcome is partly determined and accomplished through affect, but it is the process of constituting bodies and affecting bodies, including affecting gendered bodies, that counts and shapes the diagnostic assessment, moving bodies from "here" to "elsewhere." But bodies do not move on their own. Potentiality in the case of CFS draws on guidelines, the morality of self-management, and the politics of healthy activity which requires patients "to do something." The dynamics of power are immanent in affectivity and help us to understand how bodies and subjectivities are being affected and by what. However, potentiality is ambiguous and always open-ended; it must be studied both locally and socially. Looking for its outcome requires sensitivity to what moves in ordinary worlds as well as attention to discourses (Wetherell 2012). Our analysis focused on how tensions, intensities, bodies, and sensations made parties participate, act, react, and move in a clinical setting. Attending methodologically to affective attunement and atmospheres to dissolve the dyadic clinical encounter foregrounds that, just as a CFS diagnosis is contested among patients and health professionals outside the clinic, it is also fluid and worked on in a clinic environment through and in response to the affectivities at play (Tessier 2018). Affectivity clarifies that being "under diagnosis" (Martin 2007) and working out a diagnosis or treatment advice is an arrangement of affect, policies and practices, relations, and participation in these relations, rather than merely a discursive and linguistic performance.

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