Seeing with new eyes

Field research and self-analysis in a clinic for treatment of eating disorders

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As a part of ethnographic data collection for my PhD, I carried out one-year's participant observation in an eating disorders clinic in Madrid. I took part in all the therapeutic activities offered in this clinic from lunch to dinner time every weekday during this period. It was an intense and shocking experience, both from a personal and an academic point of view. In this article I will explore my search for a balance between being immersed in a therapeutic setting and maintaining a consistent anthropological approach. This contribution will hopefully be of value not only in its own right but also as an account of personal struggles in the field that may be helpful to others in similar situations.

[reflexive anthropology, emotions, ethnographic research, eating disorder, treatment, Spain]

> *Here you will see what eating disorders are really about, not like in your books.*
> The psychiatrist of the clinic, first day

For almost one year I participated in the therapeutic activities of a clinic for eating disorders in Madrid, collecting ethnographic data for my PhD dissertation. During this, my first major fieldwork experience, I had to deal with many unexpected challenges that are part of the life of a practicing anthropologist; the result was a revelatory experience both from a personal and an academic point of view. This article aims to explore the connections between these two fields of ethnographic experience through an 'observation of participation' (Tedlock 1991) trying to reflect on and critically engage with my own participation within the field. I will focus in particular on my 'disturbing encounter' with the reality under study, attempting to integrate the discomfort I experienced as a fundamental tool in my research.

The 'reflexive turn' and the consideration of the researcher as a cultural agent in the production of knowledge during the ethnographic encounter (Clifford 1986: 13; Marcus 1989: 200) opens the way for including what can be a difficult exercise for an anthropologist, namely problematizing his/her own life in order to increase "awareness of what generally remains hidden in fieldwork productions" (McLean & Leibing 2007: 1) something which I consider should be one of anthropology's fundamental tasks. Practicing from this perspective makes the ethnographic ambition of being immersed in the context of study an intimate process of learning and transformation, involving the anthropologist in a 'totalizing experience' (Okely 1992: 3). These considerations reveal the artificiality of separating the researcher's biography from ethnography, something which has already been addressed by several authors (Bruner 1993; Fabian 2000; Parker & Van der Geest 2010) and which has inspired works overcoming the dualistic approach that separates the 'objective' and 'subjective' realms of knowledge.

This objective requires the ethnographer to maintain a reflexive attitude, not only in the theorization prior to fieldwork, but also when carrying out fieldwork (Guber 2004: 83). Although this is true of all qualitative research, there are issues that involve the ethnographer in more intense reflexive work, for example, when faced with what are sometimes referred to as "sensitive topics" (Dickson-Swift et al. 2006; Watts 2008). In this type of research, encounters in the field can have a significant impact on the researcher, particularly when the setting is inhospitable or dangerous.

An important example of reflection on how to manage in these settings is *In Search of Respect: Selling Crack in El Barrio*, an ethnography about crack sellers in Harlem, New York, in the mid-1980s (Bourgois 2010). The author explores the daily struggles he faced in approaching his informants in a setting which was dangerous for both informants and researcher. The book is a reflection on the trafficking and use of crack as well as a diary of everyday research practice. The very title of the book contains this dual dimension of reflection: it refers to the informants, their use of the sale of crack as a strategy in their search for respect in a context of racial segregation and poverty, and at the same time, it refers to the personal struggle of the author and his efforts to gain the trust of his informants.

Other examples come from studies that directly examine the violence seen in the field, reflecting on the methodological difficulties of dealing with violence while carrying out fieldwork and in the writing of the ethnography. In *Charred Lullabies* (Daniel 1996), the author's personal encounter with suffering and the impossibility of recounting it, leads him to question the methodology of anthropology as an adequate tool, focusing on the difficulty of translating the experience of violence without minimizing it. In addition, his confrontation with this stubborn context transformed his perception of his role as an ethnographer. It made him more aware of the need to produce an account that recognised the risks for his informants in sharing their stories with him.

Along the same lines, in her study *Life and Words*, Veena Das (2007) explores the possibilities of finding a voice that considers this violence. Her interest is not in the description of violence, but rather in explaining what happened based on her experience. Thus part of the author's reflections derive from her very personal experience of unanticipated exposure to violence, while using her own story as a reflective thread.

Healing contexts stand out as settings where numerous sensitive topics emerge. The ethnographer is very often challenged by the encounter with individuals struggling with suffering, trying to make sense of their lives and possibly questioning the order of things (Good 2006: 189). The studies gathered by Van der Geest and Finkler (2004a) in 'Hospital ethnography', their special issue of *Social Science and Medicine*, provide an excellent analysis of the specificity of the hospital setting and discuss the methodological and ethical complexities of doing fieldwork in hospitals. The contributions emphasize the significance of reflexivity for the ethnographer in overcoming the apparent and "deceptive familiarity" (p. 1996) of the hospital setting, showing the importance of the ethnographer's intellectual effort to make a profound *epistemological break* (Bourdieu 1975: 347) with that familiarity. In fact, hospitals appear as institutions where the core values and beliefs of a culture come into view and a process of "reflection on and reinforcement of dominant social and cultural processes in a given society" (Van der Geest & Finkler 2004b: 1996) takes place. Being a part of those dynamics may therefore be especially challenging for a researcher who adopts a critical theoretical position toward medical discourse.

Just as in these studies, the participant observation I carried out took place in a therapeutic setting; the encounter with fieldwork was therefore a challenging experience, both raising theoretical issues and providing emotionally difficult situations to deal with. The ethnographic experience seriously challenged my academic and personal abilities, especially in relation to two important aspects I had greatly underestimated in my preparation for the field: the impact of participating in emotionally and cognitively difficult situations and the consequences of my intimate and personal involvement in psychological therapies. I will use these difficulties as seeds to reflect on how this encounter led me to understand what eating disorders were really about – as the psychiatrist told me the first day – and also taught me what working as an anthropologist really means.

The setting

The reflections that I will present are based on my fieldwork experience in a clinic for the treatment of eating disorders in Madrid. The participant observation this involved was part of the data collection for my doctoral thesis, research exploring the relationship between medical intervention and the shaping of the experience of illness in the case of eating disorders. My interest was especially focused on analysing the interactions between medical personnel and patients in the therapeutic setting.

The location for my fieldwork was a private clinic in Madrid that treats patients with eating disorders without limitations on age, sex or co-morbidity with other illnesses. Patients participate in group therapy on an outpatient basis (from 2pm to 9pm, Monday through Friday); the program consists of eating disorder rehabilitation, based on three daily meals in the clinic's therapeutic dining room, and patients' participation in cognitive-behavioural therapy sessions.

Group therapy includes different professionals: psychiatrists, psychologists, psychotherapists and nurses. The group of patients changes often due to frequent patient turnover in the clinic. However, there is a clear profile of patients; they are predominantly women, between the ages of 17 and 30 with complex and long clinical histories.[1]

The choice of location for my fieldwork was in part determined by the difficulties in finding a medical team willing to permit an anthropologist without training in healthcare to participate in its activities. Of all the private and public facilities I contacted, only this clinic accepted my participation, in exchange for collaborating in marginal tasks in the hospital. The tasks were primarily related to providing support and monitoring, such as accompanying a patient to the bathroom, being with patients during meals and updating files on patients' body weight and body mass. In the process of negotiating my presence in the clinic, the role I saw for myself was altered, as I accepted a greater degree of participation than I had initially foreseen. Given the lack of meaningful alternatives, I accepted and tried to limit the consequences this deeper involvement would have on the construction of my role in the context of the clinic.

I did my fieldwork and 'collaborated' with the medical team for one year, participating in all of the therapeutic activities carried out in the clinic every day. Just like the therapists, I did not wear a coat and I had access to all areas of the clinic. I participated in the different therapy groups, therapeutic meals and recreational activities, always observing the interactions between doctors and patients, as well as the internal group dynamics among the healthcare professionals and among the patients. I also participated in meetings with the medical team, parents and the parents' support group. In addition, I carried out semi-structured interviews with all of the patients and the medical team.

Learning how to be/feel in the field: The conquest of my space at the clinic

> *Feeling and emotions, in my view, are like reverberating loops. They hold information in an active form, so that it doesn't go away, and yet does not pre-empt everything else.*
> Roy Goodwin D'Andrade 1981: 191

Where my fieldwork first confronted me with unexpected challenges was in dealing with my feelings. During my stay at the clinic I had to cope with the constant impact of my emotions on the course of my ethnographic research and had to face both the personal and professional consequences of this.

After negotiating my presence at the clinic, I began my immersion in hospital life with the main goal of finding my own place amongst those participating in the therapeutic activities. Due to the way the clinic worked, doctors' and patients' roles were not as clearly demarcated as I had expected them to be. Patients were involved in many different activities at the clinic – they ate three meals a day, had group therapy and participated in leisure activities and study. These required the therapists to approach them alternately as either health professionals, monitors while eating or confidantes, depending on what was needed. This made for a context of 'diluted roles', which greatly complicated the task of making the specificity of my position clear and comprehensible.

The search for my place started with an intense exploration of the 'patients' world'. In order to lay the foundations for both a professional and personal relationship with them I began by reading all the information available on each patient at the clinic[2] and participating in group therapies, where patients would share illness trajectories and current difficulties. This period was characterized by a passionate immersion in the patients' painful and traumatic experiences. This certainly increased my understanding of their situation but also exposed me to their suffering. Unlike many scholars engaged in medical anthropology, I had no professional training in the management of emotional pain and discomfort. Although this may have methodological advantages, it generated deep uncertainty about how to handle my emotions as they emerged in the practical life of the clinic. The therapists warned me about the risk of getting too involved but I clung to a certain 'myth of empathy' (not uncharacteristic of our discipline). In retrospect I let patients' stories and feelings overwhelm me and faced the consequences by relying solely on my personal resources.

This emotional intimacy with patients also intensified the impact of my immersion within the clinic's dynamics of immediate intervention. The activity at the hospital was always characterized by a highly pragmatic attitude (towards this direct intervention) that, to a certain extent, involved me in those dynamics. I was constantly aware of the potential impact that my actions (or non-actions) had on the lives of other human beings, and the appropriateness or inappropriateness of my behaviour within a logic of healing, not one of doing research. In particular, having to deal with remarkably complicated situations (such as patients' attempts to harm themselves, anxiety crises, running away from the clinic, etc.) would catapult me – despite my best intentions-, into a state of 'urgency' that demanded more than just observation and note taking.

In addition to this common atmosphere at the clinic, I had to deal with the hidden demands of patients specifically seeking my support. Defining my role at the clinic was clearly a difficult task not just for me, but also for the patients. At the clinic, they had never had this ambiguous figure between them and the doctors. Perceiving me as close to them and having no other reference than the therapeutic one, they just automatically thought of me as a possible care giver and sought that kind of support from me. I sometimes failed in my role by responding to those demands (basically giving very general advice, encouraging them, etc.), trying to do something that I was not equipped to do, keeping them and myself confused about my position and role.

My empathetic approach, along with the impact of the clinical dimension of intervention on the one side and the demands of the patients on the other, puzzled me and made me feel like a stranger to my own research project. I often had to stop and try to escape from that context and remind myself of the initial goals of my study. I intuitively thought that my emotions were the key to solving this situation, so I turned my reflections in that direction. By doing so I came to understand that I was being seduced by the pressure for practical involvement not just because of empathy and altruism (which served a purpose during this whole process) but as a consequence of a certain kind of strategy, an unconscious one, in reaction to so much suffering.

Inspired by these considerations I undertook an intimate personal exercise – one might say a spiritual one – to train myself in a sort of emotional dissociation. Not from the patients – this would have been impossible considering my personality and level of involvement, as well as detrimental to my research – but from the possibility of doing something for them in a therapeutic way. Even though it had been clear to me since the very beginning that I was not a doctor, I felt a tremendous conflict within myself, with the limitation of my possibilities as an anthropologist immersed within a therapeutic field. When elaborating a theoretical approach, anthropologists assume they can talk about or discuss anything as long as a complex account is produced in the final text. Once in the field, however, all those tools that seemed so powerful in terms of enhancing the understanding of social phenomena, just turn out to allow the researcher to stay in what struck me as a very small and quiet place: the silent contemplation of the ward.

Unexpectedly, that 'silent contemplation' turned out to be a unique condition at the clinic. 'Verbalization' was regarded as an important stage in the healing process and patients were highly encouraged to tell stories about their illness. Moreover, therapists were always expected to make a comment or give advice in response to patients' demands. Therefore, 'silent places' were almost absent or left out of the healing logic applied at the hospital. I became conscious that trying to make that small place mine was, at the same time, a step further in learning how to be an anthropologist and in creating my own place in the field.

In attempting to occupy that silent space, I tried to practice the type of listening based on the 'oblivion of oneself', described by Bourdieu (1999: 7) as a "welcoming disposition, which leads one to make the respondent's problems one's own, the capacity to take that person and understand them just as they are in their distinctive necessity."[3] I tried to become that space where they could talk and feel free while I would simply listen and do nothing else. When I did intervene in their discourse or answer some of their questions, it was always based on my personal experience and a willingness to share my stories with them. Practicing this type of deep listening I learned to explore their worlds with more serenity, supported by the feeling that I was also giving them something back. I think the patients and I finally started to build 'our own interaction', a micro-space that somehow developed outside of the therapeutic dynamics, although it did take place within clinic boundaries. I cannot imagine the possibility of reaching this position without the first moment of total surrender to the patients' stories and loss of my position, as well as without certain experiences of pain, rage and powerlessness. However, many times I have wondered if this is by necessity the path an ethnographer dealing with human suffering has to follow.

These considerations suggest a critical need to reflect on the role that empathy plays in our discipline, especially within medical anthropology, not only regarding the advantages and drawbacks of applying empathy as a research tool, but also by exploring the possible consequences this may have for the researcher committed to a close relationship with informants (Fainzang 2007). I believe that empathy is too often accepted as an absolute value in qualitative research; questions about the protection of the well-being of the observer and the importance of keeping the emotional involvement of the researcher within certain limits are almost ignored. Accepting that getting emotionally close to the patients may improve research quality, what are the real risks involved when the observer attempts to 'grasp the native's point of view', come what may, in a psychiatric ward? How can we protect ourselves from our emotional involvement without losing the specific contributions that the anthropological perspective brings to the understanding of human behaviour?

Moreover, the emotional discomfort I evoke here demands a wider sensitivity toward dynamics that not only appeal to personal motivations and reasons, but also respond to social, political, and cultural patterns. This is necessary especially if we assume – as I do – the essentially social roots of emotions (Rosaldo 1984) and the importance of considering the 'emotional space' as a space of intersubjectivity (Jenkins 2004; Csordas 2007). This would commit anthropologists to not only a reflection *through* emotions – that is, using emotions as a tool of knowledge (Davies & Spencer 2010) – but also to a reflection *on* emotions *themselves;* in other words, trying to give an account of the structural conditions that permit us to feel the way we feel. In this light, my discomfort appears not only as a result of the struggle for empowerment in an 'unfamiliar setting' (Lorimer 2010: 100) but also as due, in part, to a certain hierarchy of knowledge that took place in the hospital setting. The unusual 'encounter' of different discourses about the body and the illness experience condensed in my figure, implicating my immediate emotional reaction. Probably my discomfort did not merely emerge within myself, but it was also an expression of the discomforts of a whole discipline, a way of 'being in the world' that does not fit in a hospital setting. I have barely explored this topic, but it surely opens important spaces for future research that feel urgent, especially considering the key role that anxiety and discomfort played in the development of my fieldwork experience.

Challenged in my own logic: The real encounter with mental illness

> *No contact with savage Indian Tribes has ever daunted me more than the morning I spent with an old lady swathed in woollies, who compared herself to a rotten herring encased in a block of ice: she appeared intact, she said, but was threatened with disintegration, if her protective envelope should happen to melt.*
>
> Claude Lévi-Strauss 1974: 20

The other important personal challenge during my experience at the hospital came from an area that, as I pointed out before, I had not anticipated during my preparation for the field: coexistence with people suffering from mental instability. During my fieldwork I shared situations of daily life with the patients in which they often applied a logic different from my own, placing me in situations which were difficult to understand. I will describe how this coexistence with 'another logic' led me to question the coherence of my theoretical work and revealed the consequences of the application of its analytical tools in my fieldwork.

Eating disorders are classified as mental disorders because of the important role that psychological factors play in the development of these behavioural abnormalities. Scientific literature indicates that their high co-morbidity with severe depression and other mental disorders such as personality, obsessive-compulsive and mood disorders (Swinbourne & Touyz 2007) usually leads to especially complex clinical histories.

The group of patients with whom I worked fully reflected these profiles. Of the 22 patients that participated in treatment, half (11) also suffered from obsessive-compulsive disorders and seven had been diagnosed with depression ('severe' depression in five of these cases). In addition, the majority (16) had come to the hospital after abandoning other treatments due to their failure. This further complicated the severity of their diagnosis. As a result, the patients made up a group with important mental disorders. Therefore, during my fieldwork I was exposed to numerous behaviours that were the result of these disorders and I was unable to face them with serenity. I am referring to both behaviours which clearly broke with the rational logic that we are familiar with, as well as with others that were at the ambiguous borderline between the 'correct' and the 'incorrect' from a social rather than a pathological perspective.

During my fieldwork, for example, I was the 'object' of many attempts at manipulation on the part of certain patients; in effect, they took advantage of my presence, trying to use me to achieve their objectives: finding out information that I had access to, gaining a little bit more freedom when I was monitoring them, obtaining certain privileges, etc. In addition, in many cases they blatantly lied to me, for example telling me they had been given permission to do something when it was not true, taking advantage of my lower status in comparison with the therapists. Both the manipulations and the lies were explained by the patients and the medical team as 'part of the game' and accepted as intrinsic to the patients' pathology. However, I experienced these actions as attacks on our relationships and experienced them with anger, dissatisfaction and anxiety, once again failing to control the contamination between my personal and professional roles.

In addition to this discomfort, I was challenged by witnessing the most striking behaviour that would be difficult to understand as anything other than irrational. These were primarily obsessive behaviours such as manias related to meals, expressions of absurd thoughts regarding the body, weight and eating, insistent observations, constant repetitions of the same questions, etc. In addition, I witnessed crises of anxiety, panic attacks, self-harm and attempts to escape from the clinic. The logic of rational behaviour was violated by these acts, and my experience and understanding of them led to significant intellectual and emotional exhaustion; particularly considering that my theoretical approach was based on a proposal to move beyond the explanatory dichotomies of rational/irrational and healthy/ill in the exploration of these behaviours. The continual suspension of the rational logic required by this approach generated an uncertainty that was difficult to live within the daily life of the hospital; exhausted by this effort I made certain decisions to protect my emotional integrity and composure in the field.

First, I decided to break free of the expectations of reciprocity that I had originally had with regard to the patients, adopting a certain distance and redirecting my relationship with them toward its real nature. I had to make it clear that we were, so to speak, epistemological partners, not friends. Secondly, I decided to clearly delineate a line separating the rational from the irrational and the healthy from the ill within the context of the clinic, so that I could safely situate myself in the field.

This personal strategy allowed me, in part, to regain a certain emotional stability and to distance myself from the feelings of anxiety, discomfort and even rejection engendered by the patients. But at the same time, resorting to these measures generated questions regarding the research process. The hospital was confronting me with the practical limitations of pursuing my theoretical mandate, as I had escaped from the emotional difficulties of my fieldwork by returning to those dichotomies which my theoretical approach was explicitly critiquing. Was I then lacking a critical commitment? Was my proposed interpretation incorrect?

In answering these questions, I deepened my understanding of the work of the anthropologist, and the complexity inherent in healthcare settings when proposing a critical approach. The discomfort I experienced and how I managed it illuminated the challenge posed by the 'duality' of ethnographic work: of being both engaged in the production of an analytical approach while experiencing the event being studied. During ethnographic research two different ways (theory and practice) of addressing the object of study are pursued (Bourdieu 2001) which must fit together and reciprocally support each other. My anguish and exhaustion were symptoms of the experience of crossing the boundary between the two approaches that normally define the ethnographic experience.

The task of reconciling theory and practice becomes an even greater challenge in a hospital setting. Medical discourse and the hospital setting are 'factories' in that they produce and reproduce the basic structures of thought which we use to think about and act in the world, particularly in therapeutic settings, where healing is predominantly articulated through the reestablishment of the fundamental differences between healthy and ill. Trying to understand the experience of illness beyond this dichotomy implies constantly moving on an uncertain and in some cases dangerous terrain. In my fieldwork experience, evidence appeared of how these structures of dichotomous thinking are incorporated within us; their questioning entails not only a critical-theoretical approach, but also the experience of dismantling our cognitive structures in a constant questioning of our own thoughts.

I believe the use of these dichotomous categories was necessary for me to feel safe in the daily life of the clinic and did not invalidate the initial objectives of my research, as they were only a resource for survival, not for interpretation. Beyond this individual solution, the confrontation with these issues raised questions about the discipline of anthropology and the possibility of carrying out fieldwork consistent with one's theoretical position. Assuming that it is possible to theoretically 'think' illnesses and the treatment enterprise beyond the biomedical dichotomies, is it possible to also experience them from the same place? How can we fit the experience of such a practical challenge to our basic thought structures into our critical paradigm of knowledge?

How my past knocked at my door in the middle of my fieldwork

> *In this type of work, it is good for the ethnographer sometimes to put aside camera, note book and pencil and to join in himself in what is going on.*
> Bronislaw Malinowski 1922: 16

The most stimulating but also challenging personal 'surprise' I had to deal with during my fieldwork was what I call 'reflex therapy', which took me on an intense inner journey before I was able to return to the field.

Most of the group therapy at the clinic is aimed at getting patients to develop self-reflective work and discover the real roots of their illness. "One of the objectives of this therapy is to know what happens inside you," said the psychiatrist in one of the weekly therapy sessions. And another therapist said: "We are here to find out who we are." During these group therapy sessions, the patients are guided through an exploration of their stories and beliefs about the world in order to find the real causes of their illness. These are very intense sessions, fundamental and traumatic issues related to identity formation and the search for independence are presented and discussed.

As a result of the intense immersion in the 'habitus' of the clinic, exceptionally condensed in these kinds of therapies, I found myself completely involved in the dynamic of psychological self-analysis. As a consequence, my own past and my own weaknesses emerged and set the tone for my presence at the clinic, to an even greater extent than my actual research objectives. After reading Csordas I consider this moment as my 'revelation' in the field, my experience of the "transmutation of sensibilities" (2007: 109) between me and the intersubjective setting of the therapeutic context. Indeed, I often experienced my participation in these therapies as if I were a patient and not an external observer. On many occasions I would find myself reflecting on some important phase of my own adolescence or evaluating certain decisions I had made in the past. When the therapist would give some very general examples such as: "Because sometimes, when we are children and our parents say this … and we do this …" it was impossible not to turn inward, find that point in my story and try to see it under the new perspectives being offered by the therapists.

Predictably, the further I went into myself and my own personal story, the harder it was to return to the clinic setting and particularly to my supposed role. At the time, I was experiencing very contradictory feelings that greatly increased my frustration; on the one hand, I felt that the self-analysis I was carrying out was needed from a personal perspective but, on the other, I had a sense of failure as a researcher, of not knowing how to handle my personal problems and make fieldwork my priority. I finally decided to let my personal life infiltrate my fieldwork, abandoning myself to the course of 'reflex therapy'. Dealing with the sense of inadequacy due to my choice and finding a precarious balance between being lost in myself and being there at the clinic were the new challenges my fieldwork offered me.

This decision, however, turned out to be beneficial both me and my research. It gave me a great opportunity not only for self-improvement but also, to a certain extent, to do what the patients themselves were doing (or what the therapist asked them to do).

I shared a similar struggle as we tried to make sense out of our own stories, and in so doing I possibly got a little closer to their perspective.

On this journey 'within' I realized that my recent experiences were making me more sensitive to the therapy. One of my closest friends had recently been dealing with his pathological gambling; after initially supporting him in his recovery, I changed my perspective on his disorder and refused to continue helping him. Pathological gambling is considered to be a mental disorder, included in the fourth edition of the DSM. This means that the behaviour of individuals suffering from it (not just the gambling but also the actions they take to get money) are interpreted in the light of the pathological dynamic, which partly excuses them for what they do. For family and friends who have to deal with the consequences of such behaviours, understanding this point is a great challenge. In the case of my friend, I could not accept the idea of his illness and refused to accept his lack of responsibility for the choices he had made, making it impossible to maintain our friendship. The same interpretation about personal responsibilities applies to the case of eating disorder patients at the clinic; the therapies focused on releasing them from the guilty feelings they had about their behaviour, using the idea of pathology as an explanation for it. "It was not you, it was the disease," said one therapist when one of the patients, upon recalling her own lies and tricks, started to cry during a therapy session.

When, during these group therapy sessions, they would explain the behaviour of the patients' families, arguing that "they don't understand this disease," I was able to understand their motivations and feel their insecurities, remembering my own. In those moments I was one of those people blamed for not understanding the patients' problems as something out of their control. I then felt guilty for the way I had dealt with my friend's difficulties and had to look for new reasons for my past choices, facing ghosts that I thought had disappeared long ago. From my personal perspective, I became conscious of how these therapies underestimated the tremendous effort that the encounter with the patients' illnesses required on the part of patients' families. To get a broader perspective on this issue, I participated in the parents' support group carried out in the clinic, and I noticed that the direct approach with parents was quite different. The underestimation of the difficulties family members face that I had noticed before in therapy sessions was just an instrumental tool for treatment purposes, just part of a specific recovery strategy based on patients' needs and was not present in the parents' support group.

My personal experience made me more aware of the importance of relationships with 'others' (parents, partners, friends) and their management to the whole healing process. In addition, it led me to focus on certain specific uses of the 'disease concept' and its usefulness in dealing with mental disorders. On the personal side, the process of self-inquiry improved my reflective skills and helped liberate me from a sense of guilt about my own past. Once I reached that point in my personal exploration, the inner trips triggered by the therapy sessions became gradually less intense, and I learned to better manage the balance between my private concerns and the group context. The complete acceptance of my own 'shadow' (McLean & Leibing 2007) was fundamental in being able to return to the therapy sessions and listen to them 'from the outside'. In other words, letting the therapy get inside me turned out to be a good way of eventually being able to keep it out.

Working on a new gaze

> *The real voyage of discovery consists not in seeking new landscapes,*
> *but in having new eyes.*
> Marcel Proust 1981: 260

In this article I have explored the production of knowledge in my encounter with the field, trying to illuminate the difficulties discovered in the process. The greatest challenge for me has been to incorporate the advances I made on a personal level into both how I do and think about anthropology.

The confrontation with these 'difficulties' has played an extremely important role in my engagement with a discipline which is essentially reflexive. Ghasarian (2008: 18) suggests –that "in reality the ethnographer knows, intimately, that his/her work is based to a great extent on personal and continuous adaptations to circumstances".[4] Continuous personal adaptations and ongoing reflection on them have appeared on my journey as the lodestar of the ethnographer's work. Finding a balance between the anthropological project of analysing the reality observed, and the personal project of analysing oneself, were revealed to me as fundamental to the practice of anthropology and the place where reflexivity is most needed. In this article I have tried to reconstruct my own search for this balance, using the confrontation with some 'shadows' from my own past as the reflexive and narrative thread.

My stay at the clinic provided me with a series of issues that are characteristic of ethnographic work, such as finding one's place in the field. I have described here the process of constructing a legitimate space and role within a structure in which the hierarchical relationship between different sorts of knowledge was clear and accepted. My path in the clinic thus reflected, in part, the uneasy relationship between three types of knowledge: medical, psychological and anthropological.

In my fieldwork experience I also found the use of a specific mechanism for managing discomfort; exposure to the dynamics of the therapies used in the clinic involved me in a process of self-analysis and a return to my own past. This brought me greater understanding of the struggle the patients went through to find the meaning behind their illnesses. I have tried to provide an account of the transformation I went through during my fieldwork, showing how my experience in the clinic was not the same at the end as it had been at the beginning.

Lastly, my experience in the field brought me closer to those who were ill. From an emotional perspective, this closeness to suffering and my inability to cope with it offered me certain reflections on emotions and the space they could occupy in our discipline, both as research tools and as objects for analysis. In addition, my encounter with these individuals and their behaviour led me to question my theoretical aspirations; my fear and the need to feel 'safe' led me not only to see, but also to feel, the differences between the role of the researcher compared to that of somebody more directly and practically involved in the therapeutic activities of the clinic.

If the first issue applies to all of ethnography, the second and third are specific to medical anthropology. The type of self-analysis that working closely with human suffering and its management may require can be particularly intense. Hospitals can potentially also be settings for the practice of self-analysis, an additional tool that can be integrated into the interpretive enterprise that anthropology pursues.

In conclusion, I have tried to highlight the value and importance of what fieldwork can provide us with, in particular those unexpected elements that we may at first not understand and which can cause us discomfort and uncertainty. Research leads us into areas which we are not always prepared for, or with which we may find it difficult to cope. I strongly believe that the uncertainties, contradictions and surprises offered by 'the field' are resources that anthropologists should draw upon to find fresh perspectives ('new eyes') and improve their understanding of the complexity of human experience.

Notes

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1 As the clinic is private and expensive, families usually turn to it only after the failure of other treatments. Thus patients often arrive with clinical histories that make the possibility of a cure highly problematic.

2 Patients are allowed access to this information by signing and accepting 'informed consent'.

3 In Spanish: "[...] un talante acogedor, que inclina a hacer propios los problemas del encuestado, la aptitud para tomarlo y comprenderlo *tal como es*, en su necesidad singular."

4 In Spanish: "En realidad el etnógrafo sabe, intímamente, que su trabajo se funda en gran medida en adaptaciones personales y continuas a las circustancias."

References

Bourdieu, P.
1999 Comprender. In: *La miseria del mundo*. Madrid: Editorial Akal, pp. 527-43.
2001 *El oficio del sociólogo. Presupuestos epistémicos*. Madrid: Siglo XXI.

Bourgois, P.
2010 *En busca de respeto. Vendiendo crack en Harlem*. Buenos Aires: Siglo Ventiuno Editors.

Bruner, E.
1993 Introduction: The ethnographic self and the personal self. In: P. Benson (ed.), *Anthropology and literature*. Urbana: University of Illinois Press, pp. 1-26.

Clifford, J.G. & G. Marcus (eds.)
1986 *Writing culture: The poetics and politics of ethnography.* Berkeley: University of California Press.

Csordas, T.
2007 Transmutation of sensibilities: Empathy, intuition, revelation. In: A. McLean & A. Leibing (eds.), *The shadow side of fieldwork: Exploring the borders between ethnography and life*. Malden, MA: Blackwell Publishing, pp. 106-16.

D'Andrade, R.G.
1981 The cultural part of cognition. *Cognitive Science* 5: 179-95.

Daniel, E.V.
1996 *Charred lullabies: Chapters in an anthropology of violence*. Princeton: Princeton University Press.

Das, V.
2007 *Life and words. Violence and the descent into the ordinary*. Berkeley & Los Angeles: University of California Press.

Davies, J. & D. Spencer (eds.)
2010 *Emotions in the field. The psychology and anthropology of fieldwork experience*. Stanford: Stanford University Press.

Dickson-Swift, V. et al.
2006 Blurring boundaries in qualitative health research on sensitive topics. *Qualitative Health Research* 16 (6): 853-71.

Fabian, J.
2001 *Anthropology with an attitude: Critical essays*. Stanford: Stanford University Press.

Fainzang, S.
2007 Anthropology and medicine: Empathy, experience and knowledge. In: E. van Dongen & R. Kutalek (eds.), *Facing distress. Distance and proximity in times of illness*. Wien: Wiener Ethnomedizinische Reihe, Bd. 4, pp. 1-20.

Ghasarian, C.
2008 *De la etnografía a la antropología reflexiva: Nuevos campos, nuevas prácticas, nuevas apuestas*. Buenos Aires: Del Sol.

Good, B.
2006 *Narrare la malattia. Lo sguardo antropologico sul rapporto medico-paziente*. Torino: Einaudi Editor.

Guber, R.
2004 *El salvaje metropolitano. Reconstrucción del conocimiento social en el trabajo de campo*. Buenos Aires: Editoril Pàidos.

Jenkins, J. & R.G. Barrett (eds.)
2004 *Schizophrenia, culture, and subjectivity: The edge of experience*. Cambridge: Cambridge University Press.

Lévi-Strauss, C.
1974 *Tristes tropiques*. New York: Atheneum [1955].

Lorimer, F.
2010 Using emotion as a form of knowledge in a psychiatric fieldwork setting. In: J. Davies & D. Spencer (eds.), *Emotions in the field. The psychology and anthropology of fieldwork experience*. Stanford: Stanford University Press, pp. 98-126.
Malinowski, B.
1922 *Argonauts of the Western Pacific*. London: Routledge Press.
Marcus, G. & M. Fischer
1999 *Anthropology as cultural critique: An experimental moment in the human sciences*. Chicago: University of Chicago Press.
McLean, A. & A. Leibing
2007 "Learning how to value your shadow!" An introduction to the margin of fieldwork. In: A. McLean & A. Leibing (eds.), *The shadow side of fieldwork: Exploring the borders between ethnography and life*. Malden, MA: Blackwell Publishing, pp. 1-28.
Okely, J.
1992 Anthropology and ethnography: Participatory experience and embodied knowledge. In: J. Okely & E. Callaway (eds.), *Anthropology and autobiography*. London: Routledge Press, pp. 1-25.
Park, R. & S. van der Geest (eds.)
2010 *Doing and living medical anthropology: Personal reflections*. Diemen: AMB Publishers.
Proust, M.
1981 *Remembrance of things past* (Vol. 3). New York: Random House.
Rosaldo, M.
1984 Toward an anthropology of self and feeling. In: R.A. Shweder & R.A. LeVine (eds.), *Culture theory: Essays on mind, self, and emotion*. Cambridge: Cambridge University Press, pp. 137-57.
Swinbourne J. & S. Touyz
2007 The co-morbidity of eating disorders and anxiety disorders: A review. *European Eating Disorders Review* 15 (4): 253-74.
Tedlock, B.
1991 From participant observation to the observation of participation: The emergence of narrative ethnography. *Journal of Anthropological Research* 47 (1): 69-94.
Van der Geest, S. & K. Finkler (eds.)
2004a *Hospital ethnography*. Special issue *Social Science & Medicine* 59 (10): 1995-2182.
Van der Geest, S. & K. Finkler
2004b Hospital ethnography: Introduction. *Social Science & Medicine* 59 (10): 1995-2001.
Watts, J.H.
2008 Emotion, empathy and exit: Reflections on doing ethnographic qualitative research on sensitive topics. *Medical Sociology Online* 3 (2): 3-14.