“From some place deep in you.”

On personal connections between researcher and research in mental health

Margreet Peutz

This article explores the issue of situating oneself in one’s research. As a part-time, mature student with a professional background in psychiatry, I started my doctoral research with a Dutch self-help group for psychosis. The project evolved over a ten year period. In that time my life was punctuated by significant life events of family illness, disability and loss. Consequently, my research narrative became intricately interwoven with my own life story. The research called for self-reflexivity, not just on theoretical grounds because of my commitment to a self-reflexive research attitude, but also because of reverberating personal experiences. This article considers the interconnections between my research and my life experiences. I argue that reverberating personal experiences inform one’s ability of achieving resonance with one’s research subjects and significantly affect one’s research.

[ethnography, self-reflexivity, chronic illness, psychosis, self-help]

Doing research

Is there any research where the person of the researcher is not affecting or not affected by the research process? Even in the study of inanimate objects or of theoretical mathematical problems, the scientist’s background and interests influence directions that thinking can take and determine the course of the research in many ways, quite separate from a possible rigorous application of scientific methods. Historians and philosophers of science now acknowledge that all science, even natural science, is socially situated, and thus, contrary to previous beliefs, value-laden (Haraway 1988: 576; Hesse 1980: 172-173).

The social situatedness of science is perhaps more readily accepted in the social sciences. This insight has been particularly championed by feminist social scientists who suggest that different social groups develop different forms of knowledge (Harding 1993: 54-56; Edwards & Ribbens 1998: 6-10; Haraway 1988: 590). If “all knowledge attempts are socially situated” (Harding 1993: 56), the person of the researcher matters: she has a presence, she is embodied and visible throughout the research process. This particular subjectivity needs to be acknowledged and understood rather than erased (Code 1993). Self-reflexivity, therefore, should not be considered merely as a problem-solving strategy, as in preventing bias, but as a valuable resource in the research process (Harding 1993: 73). Exploring the connections between the research (the project's topic, the participants, the location, the social context, its evolution over time) and the researcher (personal and intellectual biography) brings the person of the researcher into the project, and in doing so, more clearly positions the new knowledge.

In Martha Nussbaum's view, the quality of one's work depends on this personal connection. When asked in an interview how she decided on which subjects to study, she said: "If the work is going to be good it has to come from some place deep in you" (Nussbaum 2006). My own journey of exploration in the course of my research turned out to be bound up with me as a person in a deep way. It was closely connected with what had particular meaning to me, emanating from sensitive personal experiences.

My doctoral research involved the ethnographic study of a Dutch self-help group for psychosis. I originally trained and worked as a psychiatrist and concurrently studied anthropology. My research project evolved over a ten year period. However, during this period I experienced significant life events in relation to the serious illness of my husband, which interrupted the research. These experiences eventually led to an even closer interweaving of my research narrative and my own life story. In this article I examine the importance of this interweaving to both my research and myself.

The person of the researcher

Why was I interested in self-help? I had long been drawn to understanding how individuals who experience serious mental illness find support outside of the psychiatric system with respect to living with and surviving their difficulties. I realised that this interest was in fact rooted in personal experiences as a child, when I was confronted with my own vulnerability and powerlessness due to illness. From the age of eight I started to suffer from frequent knee cap dislocations, which caused painful falls as my knees would suddenly and unexpectedly give way. However, at the age of fifteen an operation corrected the problem. In the process I was introduced to the world of the hospital and of medical science. Here I experienced powerlessness aggravated by not being listened to as a (child) patient, and disappointment as the (para)medics could not answer questions that loomed large for me, such as: "How do I learn to walk again?" After major operations on both knees simultaneously and having been immobilised in plaster for two months, this was not obvious. "Just try", was the answer. The professionals' knowledge did not seem to include more elementary processes of recovery. However, I discovered that my fellow-patients possessed a fund of experiential knowledge of how to go about it, what to expect, what was painful and what not, and how not to get discouraged. This, alongside laughter and adolescent gossip, provided immense emotional support.

This how-did-you-do-it question has remained with me throughout my medical studies and gained a new lease on life when embarking on my training in psychiatry. Psychiatric training amounted to a process of socialization into a new language, the language of medicine, and of psychiatry (Hunter 1991; Barrett 1996).[1] However, I remained uneasy with psychiatric language, and the theories and understandings it conveyed, as they appeared to be badly tailored to connect with the experience of sufferers. In particular, the concept of the unintelligibility of psychosis hinders attempts at dialogue between mental health workers and patients. A number of authors have exposed the inadequacy of medical language to allow the expression or incorporation of personal meanings of illness and distress. Elliot Mishler, in his work on medical interviews, speaks of a battle between the 'voice of medicine' and the 'voice of the life world', showing how the voice of medicine typically tends to dominate, suppressing patients' attempts to make sense of their problems within the contexts of their own life worlds (1984: 190). Medical understanding, diagnosis and treatment were therefore experienced as far removed from personal understandings and experience of illness. This rang true to me as I had experienced it, if only in a minor way, as a child.

Psychiatric language and concepts imposed on people suffering from mental disorder also serve to objectify them and define them as persons. Rob Barrett argued that through the accumulation of various professional practices that have dealt with the issue of psychosis over the years, the person with schizophrenia has come to be defined as a marginal and anomalous category of person (1996: 17, 254). The participants of my study, most of who had been hospitalised during a psychotic breakdown in the past, had all been at the receiving end of this objectification process. The discomfort with being an object of observation, and feeling objectified, was clearly voiced by one of the members of the self-help group. He said he did not want the group to "become a research group" instead of a self-help group, which my presence during the meetings was signifying to him. This discomfort seemed to be more strongly related to my note-taking, which identified me with the power-wielding doctor or the objectifying scientist (Foucault 1995: 192).[2] It became clear that when I did not take notes in the meeting, I was included more in the conversations and addressed personally more often.

While my familiarity with the experience of psychosis through my practice as a psychiatrist may have amounted to the acquisition of an insider's perspective (Hayano 1979: 100), my familiarity with professional perspectives on mental illness, together with my lack of personal experience of psychosis, could equally position me as an outsider. In addition, I was a researcher and the research process itself creates, if not maintains, a self/other divide, situating the researcher and the researched as members of separate and distinct social groups (Abu-Lughod 1991: 140). However, in reality the divide between self and other is never absolute and pointing out the connections and linkages of the studied group with oneself and with other groups across the stated boundaries makes this visible and helps to avoid objectification of this social group (Abu-Lughod 1991: 148). During the fieldwork I have attempted to avoid objectification by actively sharing personal experiences with the group and later by reflecting on my personal connections with the group.

One easily overlooked connection was that I shared nationality and cultural background with the members of the group.[3] My status of insider from the point of view of nationality and culture was reinforced in a particular instance when it turned out that I was connected to a particular participant by locality. She was born in the same year as I and grew up in the same hamlet, which prompted us to wonder: Did we go to the same kindergarten? It created an immediate bond, despite our diverse life trajectories since childhood.

Migration has been a feature of my life. I grew up in the Netherlands, studied medicine in Belgium, trained as a psychiatrist in the U.K, worked as a psychiatrist in Canada, returned to the U.K to work and study. Finally, the fieldwork of this research project was conducted in the country of my birth, the Netherlands, where I now live and work. For many professionals in the current globalized world, geographical and cultural displacement is closely associated with education and a professional career (Reed-Danahay 1997a: 124). The phenomenon of displacement, of moving through and between different cultural contexts, has made me a figure never "completely at home", as Deborah Reed-Danahay describes; however, this very experience allows one to "transcend everyday conceptions of selfhood and social life" (Reed-Danahay 1997b: 4). In other words, it promotes self-reflexivity. Nigel Rapport and Joanna Overing consider self-reflection a universal part of human consciousness, but particularly brought out by displacement and continual change (2000: 18-28). I discovered migration had caused me to feel more out-of-place, but also more at ease in strange environments, less concerned with conventions and perhaps more open-minded and self-reflexive.

As a psychiatrist, I was clearly an outsider to the group I was studying, yet, I believe my childhood experiences, my Dutch roots as well as my self-reflexive approach helped me to continually cross over presumed self/other boundaries and avoid objectification of the members of the group.

The fieldwork

For my fieldwork I returned to live in the Netherlands for one year, with my husband and three small children, in the area where I was born and had grown up. However, I had been away for over twenty years and while memory fooled me in thinking it all still looked the same, society had changed. Through some helpful contacts I was put in touch with a self-help group of people who have had experiences with psychosis, that eventually agreed to take part in my study. The group was based in a large town in the Netherlands and the group members met in a building which housed Public Health Services, patient advocacy organizations, and a wider self-help organization.

My fieldwork with the group consisted of attending a number of introductory meetings, joining the group's regular weekly meetings as a participant observer and conducting individual interviews with the group members. In the group meetings I did not use a tape recorder, but took notes. As I referred to above, the disruptive effects of my note-taking was commented on. However, the uneasiness around my presence existed only initially. I shared my findings with the group from the beginning, which triggered conversations through which we got to know each other better. Even though I wasn't asked for my story routinely, I was often personally addressed and I experienced the emotional flow in the meetings as part of the group. This became even stronger as I was getting to know the stories of most of the members who were attending the meetings more intimately through the interviews that they were giving. And as time went on, talking about salient events in my life when asked about it on the sidelines, the group also became familiar with my own personal story. By then, although still being an outsider in many ways, I no longer feared that my professional background could be a hindrance to my presence in the group. The connection to me as a person had been made.

I conducted interviews with those members who were willing to engage with me in a conversation about their experiences of psychosis and about their membership in the self-help group. The interviews were aimed at eliciting personal experience narratives related to illness and participation in the group, although participants did not limit their stories to these. My overarching concern throughout the interviews was to reach a shared understanding. This meant not just listening, but actively engaging in a conversation. Marianne Paget describes the in-depth (research) interview as a jointly produced discourse, a dialectical process whereby what is said influences the next utterance or question, and since the aim of the interviewer is to understand subjective experience, the direction or content of the interview is strongly influenced by what is still puzzling the interviewer as the conversation evolves (1983: 78). Paget described knowledge of subjective experience as created in in-depth interviewing as "achieving a resolution of puzzlement" (1983: 88). Throughout my interviews, I paid heed to my puzzlements. Eventually, I was hoping to experience, as Hans-Georg Gadamer put it, "a fusion of horizons" (1989: 306).[4] This potential coalescing of visions, I envisaged, would result from reaching this shared understanding and would engender a new way of seeing things.

However, I learned that in the course of the interviews I could not reach this understanding consistently, particularly when the experience narratives were leading me into the world of psychosis. Hence I could not always expel my puzzlement. Gadamer suggested the primordial way of understanding others is through language (1989: 378), but language sometimes failed. For example, in one particular interview the participant explained to me how her experience of psychosis had been the beginning of becoming 'conscious', which provided her with an understanding of the cosmos. She employed a whole range of images referring to issues such as reincarnation, extracorporeal experiences, possession (by bad souls), telepathy and many other parapsychological phenomena. Her psychosis, she had subsequently realized, was in reality the phenomenon of souls, residing in another dimension than the material world, making contacts with her. She felt that her ideas were confirmed by the theories and practices in the alternative medicine circuit, such as reflexology, Universal Energy, and aura-photography, and supported by revelatory writers, particularly Jozef Rulof (2012), a Dutch spiritualist author who claimed to be a medium for souls in the world beyond, the Masters of the Light. While I knew something about spiritualist ideas and paranormal phenomena, understood their importance in many cultures as a result of my anthropological knowledge, and thus could understand why she might be drawn to these ideas, I could still not understand her subjective experience on the basis of the explanations she was offering and the conversation that followed. As spiritualist understandings feature less in my life, I could not relate it to myself. Not being able to relate her experience to my own, I felt I had to look beyond the words and the meaning of the narrative and suspend understanding through language.

I tried to understand instead what was achieved by the process of accounting these experiences in relation to me (in the interviews), or to the group (in their meetings). I could then see that her understandings of her psychotic experiences were very important to her. She had contacted me herself, when hearing about my research through the information leaflets, being very keen to give an interview. Also, this keenness to share this knowledge and its benefits as she had experienced them, had extended to the self-help group, which had been an important reason for her to join. Furthermore, by aligning herself with alternative medicine as well as by pointing out that her view was recognised and shared by other sufferers, including some members of the group, she was offering me proof of her sanity, perhaps as part of her fight against being disregarded by society. Thus, I could begin to understand her as a person and in a social sense. This understanding depended on relational, interactional, and non-verbal ways of knowing people. My experience of her warm personality and manner towards me, my awareness of some of her sensitivities that could be deduced from her stories speaking of her dismay at not being taken seriously or heard, my awareness of the context in which she was attempting to survive, all contributed to my coming to an understanding of her and perhaps with her in the interview. On such occasions, knowing other people was no longer contingent on the cognitive process of reaching a shared understanding through language. However, it was possible to make a connection on an interpersonal, relational level.

Apart from my involvement with the self-help group, I extended my explorations beyond this particular group to include other self-help initiatives and user-led projects in the area of mental health, and also to the Dutch statutory mental health services abidingly present in the background. It included research in another Dutch city of similar size to the home town of the self-help group, and with comparable mental health service provisions and a number of user-led initiatives, which on exploration provided enlightening conversations. It afforded me momentary peeks into the worlds of people struggling with mental illness, most of whom were connected in loose networks that were relatively hidden from the uninitiated. These worlds were clearly spilling over into the worlds of the homeless and other more marginal social groups in Dutch society. These explorations took me through the back streets of the city I had grown up in, yet showed me a side of the city I did not know existed. Knowledge of the past and of what was going on at the time in this realm was held within conversations and relationships. Here nothing was on record. My own explorations of this world were similarly unsystematic. The result was a kaleidoscopic outlook on a mass of information. Following in some way the lead of my informants in my explorations, I no longer went from A to B, but strayed in all directions, for example paying equal attention to daily concerns as to the supernatural. I returned to England with a different mind-set. I was definitely no longer thinking in terms of linear processes, but more in spirals, loops, side-tracks and randomly located clusters of activity.

Interruptions

Returning to the U.K. after fieldwork a calamitous event in my personal life intervened. Paul, my husband, suffered a serious stroke, which left him in a coma. All normal daily activities in my life ceased. Even though the destructive event did not affect my own body or mind as it did Paul's, it utterly disrupted my life. My days were divided between the hospital and home, caring for our three children, then five, seven and nine years in age. All else was suspended, my personal concerns, my research, and my recently acquired appointment as Consultant Psychiatrist, which would normally have come into effect barely a week after my husband's stroke. As Gay Becker encountered among many people who experienced unexpected disruptions to life, following Paul's stroke I found myself living in limbo (1997: 119).

Once Paul survived the acute stages of his stroke, the arduous journey of his rehabilitation began. Eventually he regained the ability to walk, albeit never effortlessly. He did not recover his ability to swallow and chew and it became clear that he would remain dependent on liquid food for the rest of his life. He also did not manage to speak with ease and communication presented a challenge to him and all around him. For various reasons, both practical and emotional, I decided to move back to the Netherlands with Paul and the family as soon as Paul could be discharged home. Ten months after his stroke we arrived in the Netherlands, coming home to a country I once knew, but where everything had changed.

Two years had passed since Paul's stroke before I could even think about returning to work and to my research. The return to part-time work as a psychiatrist was a priority in order to support the family financially. However, since work took up all available time and energy alongside the full-time task of looking after Paul and our young family, it was a struggle to get a grasp on my research again. The abrupt change in my life, including the move to the Netherlands, and the ongoing demands on my time, had interrupted my research and it had caused my academic work to be relegated to a small corner in my life and mind.

It is hard to put a time on how long I continued living in this liminal period where my former identity and activities seemed to be suspended.[5] Initially I was not consciously aware of that situation as my days were filled with essential tasks all geared to keeping the household afloat. The emotional toll on my life was severe and even though I reflected on this often in my personal diary or while talking with friends, I could not step out of the hold it had on me. In his auto-ethnographical account, *The Body Silent,* Robert Murphy (1990) described his becoming disabled due to a progressive neurological condition, which resulted in his becoming paraplegic. He wrote about the effects of his dependency on his partner, who became his carer. Like her, I had similarly become a captive of my husband's predicament (1990: 199). His dependency on me was complete and my life revolved around fitting in everything around his needs. I tried to minimize the impact of all of this on the children, providing as near to normal a home environment as possible, which again increased demands on me. It was the resulting social isolation, combined with the loss of a confidant due to Paul's seriously reduced communication capacity, that weighed the heaviest. I had made several attempts at escaping the captivity of my situation, mainly by developing work related interests, but none of these reduced the burden. I felt I had lost track of myself in the maelstrom of events. Only after suffering a spell of physical ill health myself, and only with the help of others, was I able to redress the balance and refocus on what was important to pursue in my life. A Gordian knot was cut by letting go of my involvement in psychiatric practice, resigning my job and setting about finishing my research.

Interweaving of stories

When I returned to my research in earnest, I discovered that my horizon, in Gadamer's sense, had changed. The arduous task of supporting my partner, who was struck down by a destructive attack on his brain, mind and personality, and fighting for appropriate treatment, care and respect, afforded me a glimpse of a side of modern society that nobody wants to admit exists: the tendency to write off damaged individuals. Call it stigma. However, what I learned about it was not the academic view, which I had already become familiar with through, amongst others, the work of Erving Goffman (*Stigma*, 1963), but the insider's view: the pain, the frustration and anger involved in being discounted and relegated to the margins. This, in addition to the sheer amount of tasks that filled the day, gave me an experience of social isolation that I hadn't experienced before. With rage I responded to a health professional judging me as being over-involved and unable to get on with my own life. This gave me a new insight into the psychiatric concept of 'expressed emotion' (Falloon 1988). Expressed emotion refers to the amount of emotion displayed by relatives or carers towards a patient, with high levels believed to be negatively influencing outcome of the illness. In my experience as a carer, the rather limited analysis by mental health professionals of the emotions at play in situations of families attempting to care for their mentally disabled or brain injured family members, doesn't pay attention to the social complexity of the situation. The idea that one should teach a person to relate to a suffering family member in a different way avoiding strongly expressed emotion is terribly inadequate and insulting. Families generally are the last to abandon an injured individual, which is confirmed practically by all biographical accounts of people suffering from mental illness.

My understanding of loss, marginalisation and isolation is one of having gained some insight, through personal experience, into the force behind these notions. In his well-known '*Grief and a Headhunter's Rage*' Renato Rosaldo wrote "how life experiences both enable and inhibit particular kinds of insight" (1993: 19). As an anthropologist he conducted fieldwork among the Ilongot in the Philippines, who were known to go out headhunting following the loss of a family member through death. They explained that headhunting was a way of coping with the anger and rage felt in their grief. When throwing away the severed head, they could throw away their anger. However, it was only after Rosaldo personally experienced rage in the context of his own devastating loss of his long-term partner in a fatal accident, that he felt he really understood the Ilongot in this respect. He is careful to point out that at the time of his fieldwork, he did grapple with the Ilongot explanation of their practice of headhunting on an intellectual level, but it was only later, being bereaved himself, that he understood the force of the Ilongot words, referring to both the affective intensity of their words and their significant consequences (Rosaldo 1993: 20).

Having made contact again with the self-help group after more than four years, I explained how my personal circumstances had delayed the completion of my project. From their comments and non-verbal responses I knew they understood. Crucial to that understanding was, that it was a mutual understanding based on our respective personal experiences of suffering and social struggle that generally accompany serious illness. Due to these important shared understandings, my connection with the group had grown significantly. The lives of the group members, of course, had also continued and changed, and our reunion was a strange meeting infused by both comforting familiarity and understanding and the shock of newness and change.

In the final phase of my project, analysing the data and writing about my findings, I had regained a certain private space for reflection, which I had lost in the depths of my captivity by my circumstances earlier. My research focused on subjective experience, more specifically on personal experience narratives, and I applied a narrative analysis to my research material (Riessman 1993; Mishler 1986; Wood & Kroger 2000). The outcome of my analysis was that the self-help group could be considered a safe space in which reflection was promoted and in which members' efforts to understand and manage psychosis was supported through a number of narrative processes.[6] I found that the group promoted recovery in a truly communal way and that the group members had created amongst themselves what I termed an ethical space, characterised by complete openness to the experience of the other and by mutual care and concern.

Finding resonance

Unni Wikan speaks of the tasks of the anthropologist as achieving resonance with the people he or she is trying to understand, which involves both feeling and thinking and "going beyond the words" to engage with the other's compelling concerns, and subsequently creating resonance between the reader and the ethnographic text (1990, 1992). Ruth Behar wrote about the response she received from a reader of her book *Translated Woman* (1993), in which she included her own life history and personal experiences, particularly her personal struggles. Because of giving her own story and relating it to the story of the protagonist of her ethnography, she had made the book whole for her readers (Behar 1996: 15).[7] It is this reciprocity that also patients demand from their doctors or therapists, but do not receive. It is this connecting at the level of experience that can make a story whole, and that can enable horizons to fuse.

While using established ethnographic methods and narrative theory, it was personal experience, reverberations emanating from ‘some place deep in me’, which facilitated my engagement and understanding. My experiences with illness in childhood had prompted me to focus on the importance of individuals’ own resources and to be interested in self-help. In the early part of my research I discovered how the lives of individuals recovering from mental illness lacked linearity, in contrast to professional knowledge and common sense ideas of progressing through life through consecutive stages and roles. Their worlds and stories told of lives as experienced in the raw, less coherent and unpredictable. It led me to try and adopt a view that allowed space for the incoherent and the random, the unknowable and the unexpected. However, it was my own personal experience of loss and coping with the effects of my husband’s disability that gave me a first-hand experience of the unknowable, the unexpected and the absence of linearity in life. This was responsible for my discovery that a fusion of horizons, which I had believed to be impossible during my earlier fieldwork period, was possible if mediated by personal experience. The shared understanding one could reach consisted of an understanding of the force behind the shared experiences, as Rosaldo described (1993: 20). This connection was formed deep inside of me, beyond words.

My personal experience of supporting my husband during his illness also allowed me to see something in this group’s work that I might not have seen otherwise. I acquired a sense that the space of the self-help group was in fact an ethical space. The various characteristic elements of the group’s space, such as the diligent search for a shared language, the mutual concern displayed between members and the home-like atmosphere promoting reflection and generating a sense of belonging, attested to their ethical endeavour. The group members stayed in touch, continued to care, welcomed back anyone who experienced the need to return after a period of absence. They seemed intent never to abandon anybody. I realised that even when care becomes a burden, to withdraw is damaging. To abandon someone, particularly someone who has become so dependent on others, means to diminish oneself. It is in the realm of mutual dependency and care that the aspect of one’s self-worth which derives from one’s social connections becomes particularly evident. I have become aware, by being wrapped up in such a process myself, that recovery or rather continuing to live a meaningful life after serious illness is a social and an ethical endeavour. Responding to the appeal of the other not only precludes diminishing oneself; what’s more, it leads to a fuller understanding of our shared humanity, making each one of us more fully human. I learned that self-help groups are one way in which individuals respond to the appeal of the other in this fulfilling sense.

However, the creation of an ethical space requires time. Jos Kessels, in his book on the Socratic Dialogue as a method of inquiry, stressed the importance of taking sufficient time to allow for ‘new thinking’ to emerge (2006: 83). Given ample time, something new can enfold within the space of a conversation. When it resonates with or when it says something fundamental about how one views the world, one touches upon what Kessels termed the ‘poetic argument’ of a good (Socratic) conversation (2006: 13).

Unfortunately, time was what all group members said the professional health care workers never had, while time was precisely what the members felt they needed most. Clearly, what was required was time for *poesis*,[8] time to create or recreate, to tell or retell, and not just to represent experience but to open up perspectives unto possible worlds, "better, higher, more noble" than the ones experienced so far, to use Ricoeur's words (1981: 180). This creative dimension and its connection to something fundamental in life determine whether a conversation is a good one. It was unmistakably present in the group of my study.

Reverberating personal experiences created resonances for me with my research subjects and affected my research. The direction which my analysis took and the way in which I have written up the results were undeniably influenced by my life-changing experiences in relation to my husband's illness and disability. My understanding of what it means to lose so much and still attempt to lead a good life while recognising one's dependency on others has become an intricate part of my understanding of the lives of the people I have worked with in this project. Resonance, here, has critically informed the formulation of central parts of my thesis.

In its turn, the research I did and under the personal circumstances that I did it, had an impact on me as a person. Amanda Coffey argued in her book '*The Ethnographic Self*' that doing fieldwork is identity work (1999: 1). In my case, I have become more acutely aware of the vital need for time, for poetics and for an unreserved acknowledgement of our shared humanity. This awareness contributes to keeping alive an ethical space in which to truly meet others and for me this has become the key to making a difference in my professional life. It resonates with my own longstanding search for a joint space between doctors and patients entered into on a basis of reciprocity and mutual respect. Finding ways of incorporating these realisations into my work as a psychiatrist is guiding my current efforts of shaping my own psychiatric practice.

Finally, when examining my writing, can readers find resonance in it, as Wikan (1992) suggests is vital? Helen Watson wrote about an experience during her anthropological fieldwork amongst women in the slums of Cairo: "One day when I was making laborious research notes a woman said, 'Words from the heart are more alive than your scribblings. When we speak, our words burn. Do yours?'" (Watson 1992: 11). I believe an anthropologist's words in an academic text *can* burn, but they must be informed by personal experience and arise from the heart to achieve this. I have attempted to reflect on what connections, coming from 'some place deep in me' were at play in my doctoral work. I exposed and described these, hoping to reach the reader somewhere beyond words.

Notes

Margreet Peutz is a psychiatrist and social anthropologist, having obtained her doctoral degree at the University of Bristol, U.K. She is working in independent psychiatric practice in the Netherlands. E-mail: mmaa.peutz@gmail.com.

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1 Kathryn Hunter describes the medical case presentation as a ritualised form of story-telling, which all medical students need to master. It involves learning the language to report on symptoms and signs, medical history and physical examination and tests, leading to potential diagnoses, treatment options and prognoses (Hunter 1991: 7). The case presentation has developed into a conventional structure and language, central to the scientific medical tradition (Hunter 1991: 51).

2 The power of the doctor exercised by examining a patient, recording and writing up the case, is described by Foucault as a mode of subjectification: "The turning of real lives into writing is no longer a procedure of heroization; it functions as a procedure of objectification and subjectification", making the individual an object of power and an object of knowledge (1995: 192).

3 Thus this research can be described as auto-anthropology, being "anthropology carried out in the social context which produced it" (Strathern 1987: 17) or also 'anthropology at home'.

4 The concept of horizon is related to the concept of situation as in situated knowledge. Characteristic of being situated is that you are inside that situation and cannot have an objective knowledge of it. Any light you can throw on the situation you are in is never complete. Gadamer suggests that a situation represents a "standpoint that offers limited possibilities of vision". A horizon then refers to "the range of vision that includes everything that can be seen from a particular vantage point" (Gadamer 1989: 302). A doctor might be interested in discovering what his or her patient thinks, where the patient is coming from, but in so far as the conversation only serves to get to know the patient's horizon as such, without reflecting it back unto oneself, without coming to an agreement on the subjects discussed, the conversation does not lead to understanding. The latter requires a search for something that is valid and intelligible to both. Horizons change continually, and horizons fuse when people reach true understanding in a conversation – thus horizons can be extended. "To reach an understanding in a dialogue is not merely a matter of putting oneself forward and successfully asserting one's point of view, but being transformed into a communion in which we do not remain what we were" (Gadamer 1989: 379).

5 Victor Turner elaborated the notion of liminality in the context of important transitions in life. He refers to a liminal period to indicate a time in which people exist in-between two different social situations or states. While the transition is enacted, individuals are temporarily living in an indeterminate social space, where they are no longer who or what they were before and not yet who or what they will be after the transition. They are "betwixt and between" (Turner 1967: 93). The concept of liminality is also applicable to unexpected social transitions, such as in the case of serious illness. In this respect, Turner's qualification of the liminal period as a stage of reflection, where people are encouraged, to some extent forced, to think about life, themselves and their position in society, appears particularly relevant (1967: 105).

6 As this article focuses on the aspect of personal interconnections between researcher and research, I have limited myself to summarising my research findings and resulting thesis. For more detail I refer the reader to my dissertation (Peutz 2010).

7 Ruth Behar's self-disclosure in her ethnographic writing has been heavily criticised as being overly confessional and narcissistic (as described in McLean & Leibing 2011: 189) and

lacking adequate analysis (Frank 1995: 348). However, it is Behar's interest in pursuing and achieving reciprocity, the latter confirmed by the feedback from her readers, that I wish to emphasize here, whether or not Behar's analysis rang true to other academics. The value of self-disclosure is one of providing opportunities to the reader of positioning the offered insights within the perspective of the ethnographer's personal life experiences. The reader is invited to examine her own personal experiences and through that to connect (beyond words) to the subject matter of the text. Reciprocity is thereby extended to the reader, sometimes acted upon when readers write to the author to comment.

[8] Making, creating (Greek).

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