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# Interweaving personal biography and academic work

## Studying infertility among ‘others’ and ‘at home’

Trudie Gerrits

*In this article I reflect on how in the last two decades my personal biography – having been confronted with the problem of not getting pregnant when I wanted to and having been able to overcome this problem by means of IVF – and my academic biography have been interwoven. While I acknowledge and show the impact of my personal biography on my academic work (and vice versa), at the same time I contend that its impact should not be overstated. This is related to a number of factors, including the invisibility of my condition, which gave me the freedom to disclose or not disclose it; the fact that I chose not to exchange in-depth experiences with my informants; and the openness of informants to share their experiences. I argue that, based on the different positioning of myself and my informants in two studies (varying in context and temporality), a comparable physical condition does not necessarily have to be experienced as a shared, similar or same experience or situation, either by the informants or by the anthropologist. In both study situations I considered myself rather a ‘partial insider’, even though I once was – physically speaking – a ‘full insider’. At the same time I argue that the implications of similar circumstances for other social scientists, having different histories and experiences, may be quite different. Therefore, I emphasize the importance of a full disclosure of researchers’ relevant biographical experiences, to increase both the credibility and the value of the ethnographic texts anthropologists produce.*

*[infertility, IVF, reproductive technology, anthropology, personal biography, Mozambique, Africa, Netherlands]*

### Introduction

In 1993 I conducted a study on infertility and childlessness in Mozambique; in 1994 I became a mother of twins by means of in-vitro-fertilization (IVF); and in 2008 I defended my PhD-thesis, which is a hospital ethnography about a Dutch fertility clinic. Clearly, important themes in my academic and my personal life are narrowly related and have mutually affected each other.

McLean and Leibling, in their thought-provoking article that served as a ‘teaser’ for the symposium leading to this special issue, distinguish three ways in which ethnography and autobiography may be related in current day (medical) anthropology: “(1) through exploring the influence of personal life on ethnographic research; (2) through exploring the influence of anthropology and ethnographic research on personal life; and (3) through the use of ethnography as self-exploration” (McLean & Leibling 2011: 1). In this article I will explore the first two relationships.

In the first part of this article I present a chronological overview of my personal biography – both having been confronted with the problem of not getting pregnant when I wanted to *and* having been able to overcome this problem by means of IVF – and my academic work in the area of infertility and reproductive technologies. I will elaborate on the connection between my personal biography and my choice of research topics and consider how my academic involvement with the research topics has affected my personal biography, respectively. In the second part of the article I reflect on how my personal experiences have affected actual fieldwork practices, my interactions with participants and knowledge production.

Throughout the article I will point to differences between studying ‘others’ with comparable experiences in a faraway country like Mozambique, and investigating the same topic ‘at home’. In addition, I consider my different positioning in the two studies, in the sense that during the first study I belonged to the group that ‘suffered’ from a problem, while during the second study I had ‘overcome’ the problem.

By reflecting on the mutual impact of my personal and academic life I intend to contribute to the on-going debate about the relationship between ‘ethnography and self’ and the importance of reflexivity in anthropological knowledge production. Below I introduce the main themes: personal biography and choice of research topic, impact of anthropology on the scholar’s personal biography and personal experiences affecting fieldwork interactions and knowledge production.

### ***Personal biography and choice of research topic***

Social science literature provides us with several examples showing the close connection between the personal biography of researchers and the choice of their research topic, which is particularly striking in the area of ‘failed reproduction’. Well known researchers, including for example Gay Becker (2000), Arthur Greil (1991), Marcia Inhorn (1994), Gail Landsman (2005), Linda Layne (1996, 2003), Rayna Rapp (1999), Johanne Sundby (1999), Charis Thompson (2005) and Frank van Balen (1991) have all been very explicit about the linkage between their personal experience with some form of ‘failed reproduction’ and their academic interest in the area. They had various reasons for choosing the topic: the realization that hardly anything had been published about the topic when they wanted to learn more about it; their disagreement with the way the topic was represented in the literature or with the fact that literature did not provide insights from the perspective of the people involved; the wish to make a contribution to the political or public debate about the issue, or to provide health professionals with the patients’ perspective. Some of these researchers have been ex-

PLICIT about their initial reason to start studying this topic and also reflect extensively on their personal experiences in their academic work. Linda Layne is one of the most outspoken examples of this. When she saw herself confronted with the taboos and uneasiness of people regarding her own miscarriages, she “realized that the tools of anthropology might help illuminate the cultural confusion surrounding pregnancy loss” (Layne 2003: 3). Since then, she has devoted a large part of her academic work to the study of miscarriages in the USA. For other scholars, personal experience seems to have been mainly a starting point of their academic interest, but is not explicitly elaborated in their publications.

In the chronological overview of my own personal and academic involvement with infertility and assisted reproductive technologies that follows this introduction, I show that I did not seek to conduct my first study on infertility in Mozambique because of my own experiences; yet, I certainly felt challenged and intrigued by it when it came my way. In addition, I show that my *continuing* academic involvement with the topic of infertility and reproductive technologies is certainly related to my personal biography and experiences with reproductive technologies. Nevertheless, I recognize that my further involvement with the topic also results from some specific circumstances, and can only be understood in the context of wider (structural) developments at different decisive moments (such as the slowly increasing interest in infertility in developing countries, resulting from the International Conference on Population and Development, ICPD, in 1994 in Cairo).

### ***Impact of anthropology on the scholar's personal biography***

Academic involvement with a certain theme or perspective may affect anthropologists' – and other scholars' – biographies when confronted with it in their personal life. Social science literature provides us with a number of insightful examples of this (see e.g. Blume 2006; Gottlieb 1995; Layne 2003). Stuart Blume, a scholar in Science and Technology Studies, for example, gives an impressive account of how his academic critical perspective on medical technology influenced the way he and his partner considered the use of medical technology (the cochlear implant) for their deaf children (Blume 2006). Another example is provided by the anthropologist Alma Gottlieb, who spent some years among the Beng in Ivory Coast conducting ethnographic research about childbirth and related issues. Gottlieb reports on her opposition to the medicalization of pregnancies and deliveries in the USA and her refusal to use medical technology during her own delivery, claiming that these critical attitudes had – at least partly – been inspired by her observations of ‘natural’ pregnancies and deliveries among the Beng (Gottlieb 1995). In this article I reflect on how both my fieldwork among infertile women in Mozambique and my involvement in critical academic debates on reproductive technologies have affected my personal biography (to some extent), including how I experienced my infertility and my considerations about the use of reproductive technologies. In contrast to the above cited authors, my academic involvement did not make me refrain from using medical technology to overcome my problem.

## *Personal experiences affecting fieldwork interactions and knowledge production*

By now it is widely acknowledged that personal experiences of social scientists may influence the manner they conduct their study and may have implications for knowledge production (see e.g. the 2007 special issue of *Medische Antropologie* on Inter-subjectivity). It has become good practice among qualitative researchers to adopt a critical attitude towards their data, “to be reflexive and identify – honestly – some of the social, practical and biographical contingencies that helped to produce the data” (Brewer 2000: 5). By doing so, instead of denying or trying to eliminate the effects of these contingencies, researchers add credibility to their analysis, and increase faith in its reliability and validity (see e.g. Hammersley & Atkinson 1983: 17; Green & Thorogood 2004: 191). What difference does it make when the researcher has gone through comparable experiences as the research participants? For the sake of clarity I distinguish two issues.

The first issue concerns the way researchers *handle* their comparable condition with their research participants and how this affects the interaction and rapport building. When the shared condition or experience is visible from the outside – for example, when the shared condition is a visible physical disability – participants immediately come to know this when they first meet the researcher (cf. Mogendorff 2007). However, when the shared condition or experience is invisible, it is up to the researcher whether or not s/he discloses it. Disclosing or not disclosing may be expected to have an impact on the interactions between the anthropologist and the research participants, though this depends on how this characteristic is being employed during their interactions. While in both studies I shared an important feature with my study participants, it was not visible from the outside. Therefore, I could choose whether to hide my experiences or disclose them to research participants; as I will demonstrate later in this article, I managed this differently in both studies and for different reasons, which in turn had different implications for the rapport and interactions with my informants.

The second issue concerns the way comparable experiences affect researchers' *involvement* in the study, and subsequently how they make sense of what they see and hear. Anthropologists, in particular those working in the field of health, have argued that the mere sharing of a comparable condition or experience – independent of its disclosure to study participants – may affect the researchers' comprehension of their informants' stories. Some anthropologists have mentioned that because they lived through similar, emotionally laden experiences as their study informants, they were better prepared to understand their concerns, not only personally but also intellectually; some of them even claim that the sharing of a similar experience is a prerequisite to empathically understand a particular study topic (Katz-Rosaldo 1989; Rothman 1986). Other researchers, however, while underlining the particular vantage point of researchers who share or have shared the experiences they study, and recognizing that this may enhance their empathic understanding, do not see this as the *only* way to gain empathy and valuable insights (The 1999).<sup>1</sup> The sociologist Nijhof (2001) has emphasized, after having been seriously ill himself, that he started to give attention

to events and concepts that he previously had disregarded (Van der Geest 2007).<sup>2</sup> Ria Reis (1998), based on insights she gained from an interview with the mother of a handicapped child with whom she shared some comparable experiences, raises the question whether researchers who had not had similar experiences as their informants would interpret the informant's narration in a similar manner as researchers who had shared similar experiences, a question she finds hard to answer.<sup>3</sup>

Anthropologists have also emphasized the importance of actually exchanging experiences as part of ethnographic research. Sjaak van der Geest, for instance, sees mutually exchanging (comparable) experiences as the best means anthropologists have to achieve experience-near anthropology, to come close to people's emic point of view. Though, at the same time he contends that we can never assume that "the same experience produces the same experience" (Van der Geest 2007: 9). In a similar vein, Van Dongen reminds us that, apart from sharing a similar experience, other characteristics such as social class, education, upbringing and personal life course (and one can easily think of other features as well), can make people – even if they belong to the same society or have similar experiences – experience similar events very differently (Van Dongen 1996: 343).

To add to this debate, in the last part of this article I will reflect on how my personal involvement with infertility and reproductive technologies has affected – to the extent that I am aware of – the manner I conducted the studies, my interactions with the study participants and subsequent knowledge production.

## **My personal and academic involvement with infertility: A chronological overview**

### *My personal confrontation with infertility*

It was somewhere in 1987 when my partner and I decided that we would like to have a child – at that time we were living in Mozambique. To our surprise, our attempts were not immediately successful; at the same time though, we were not really concerned about it, as we simply thought 'our time would come'. Infertility, or even its treatment, was something we had hardly heard of or thought about, although the first successful IVF treatment in the Netherlands had taken place in 1983, two years before we went to Mozambique. Briefly we once spoke about our problem with a befriended Dutch doctor working in Mozambique, but at that time we did not think at all of pursuing any diagnosis or treatment. However, when returning to the Netherlands in 1990 still childless, we decided to seek medical assistance. We underwent infertility examinations and found out that we belonged to the category of 'unexplained infertility'. Given our age (early to mid-thirties) and the period that we had been trying to get pregnant 'by ourselves' (almost five years at that point), we were advised to start treatment immediately. After having done a series of unsuccessful intra-uterine-inseminations (IUIs), at a certain moment we saw ourselves confronted with the option of pursuing IVF.

### *Academic and personal encounters with reproductive technologies*

In the same year I had started to study medical anthropology at the University of Amsterdam, while also working as an assistant in some research projects, including one on 'Gender, Reproductive Health and Population Policy'. I got involved in studies and debates on gender and reproductive health, dealing with notions such as reproductive rights, users' perspectives, quality of care, and (feminist) critiques on the medicalization of women's bodies and on medical technology. At that time, part of the (more radical) critical feminists positioned themselves strongly against the use of IVF. I attended meetings in which female scholars occasionally questioned whether "women had nothing else to do than think of getting pregnant and bearing children." My confrontation with these sorts of comments was not easy; and though I did not agree with them, I also did not have the 'courage' to express a different voice. Yet, at the same time, the feminist and health activist discourse had certainly become part of my/our considerations about starting or not starting IVF treatment. We – my partner and I – asked ourselves whether we really wanted to use all medical-technical options available; we raised ethical questions about the 'makability (*maakbaarheid*) of life'; and we discussed our concerns about possible long term side-effects of hormonal treatment for me and a potential child. We struggled with these questions; even though we strongly wanted to have a child, we could also imagine having 'a good life' without children. After a tough period of thinking and deliberation, we decided to place ourselves on the IVF-waiting list and to try one IVF treatment. Nonetheless, we were still alert and critical, and we explicitly said that we would not automatically go for a second IVF cycle, in the case that the first one was not successful. Rather we planned to consciously decide which step we would take next in order to avoid becoming obsessed with our wish for a child and IVF treatments.

Fortunately, we did not need to consider a second IVF cycle, as in 1994 the first IVF treatment made us the happy parents of healthy twins. Thus, in the end my participation in the critical academic discourse on reproductive technologies had not really affected my personal life path as it had not made me defer from IVF treatment and thus from motherhood. Still, the critical discourse became very much part of my/our own considerations and turned me into a more conscious and critical user of reproductive technologies.

### *Studying the experience of infertility among women in Mozambique*

In the meantime, more or less at the same moment as we were placed on the IVF waiting list (1993), I had started to prepare a study proposal on infertility in Mozambique. A friend of mine – involved in health research in Mozambique and knowing that I was looking for a research topic in the area of reproductive health for my master's thesis – suggested that I do a study on this topic. She had come across an epidemiological study proposal on the risk of sexual transmitted diseases among infertile women in Montepuez, Mozambique (Samucidine et al. 1999), in which the authors observed the importance of gaining more insight into sociocultural aspects of infertility and

fertility seeking behaviour (also including extra-marital sexual contacts) among Mozambican ethnic groups. My friend, who was aware that I was undergoing infertility treatments myself,<sup>4</sup> kindly added that this research topic might not be appealing to me as it might come too close to my own experience. To the contrary, I immediately felt challenged by the idea of studying the experience of infertility in a different cultural context. In the end her suggestion led me to conduct my fieldwork and to write my master's thesis on social and cultural aspects of infertility among the Macua in Mozambique, which in turn was my first academic work on infertility. I thus did not seek the topic because of my own situation, but my situation may have enhanced – consciously and unconsciously – my interest and eagerness to study it, when it was suggested to me.

### ***Studying the 'Other' with a comparable condition: Feeling privileged***

Above I have revealed how my academic involvement with the critical discourse about the medicalization of infertility and the use of assisted reproductive technologies influenced me personally, as it turned me into a more critical and conscious user of these technologies. Being confronted with the situation of the infertile women in Mozambique was another professional experience that has affected my personal biography, yet, in a totally different way, which I describe below.

The women among whom I conducted my first infertility study belonged to the Macua, a matrilineal ethnic group in the north of Mozambique, mainly peasants living in a rural area in the district of Montepuez. Thus, to a large extent the study participants were 'others' to me. The study was community based; I was assisted by two local women – both named Maria<sup>5</sup> – who were highly respected in their community and of enormous value in finding and approaching infertile women (which was not difficult at all – women were eager to talk about their fertility problems) and making them feel at ease, next to translating for me (from Portuguese to Macua and vice versa). When speaking with the women about their infertility and involuntary childlessness we were told heart-breaking stories about their feelings of grief, pain and jealousy towards other women. These experiences were in some parts comparable to what one may expect to hear from infertile women in Western countries. Yet, women also expressed their anxiety about being childless in old age (Who will take care of me when I am old?) and their concerns about being buried without having children (Who will mourn for me?) and without someone to fulfil the required ceremonies (Who will remember me?) – concerns that are less likely to be expressed by infertile women (and men) in Western countries (cf. Inhorn & Van Balen 2002). The Macua infertile women also complained about being excluded from societal events and conversations, all kinds of rituals and gatherings that had to do with pregnancies, deliveries, name-giving ceremonies and so on, and how bad they felt about this exclusion. Even while these infertile Macua women were living in a *matrilineal* society in the north of Mozambique, in which they were not physically, or otherwise, maltreated by their husbands and in-laws because of their inability to produce children for the lineage of the men<sup>6</sup> – as often happens in *patrilineal* societies, such as the ones in the south of



Mozambique, for example (Mariano 2004) – they were seen as incomplete women and they suffered enormously from this.

Being confronted with these sorts of stories intensified my awareness of how culture shapes meanings and experiences.<sup>7</sup> At that moment I was, ‘physically’ speaking, in a comparable situation – I also wanted to conceive, but did not manage – yet, the personal, social and material implications for them were much more serious than for me. Even while there had been moments in the Netherlands that I had felt really sad about not being able to conceive, and I had also felt a sort of envy whenever a sister or sister-in-law simply announced to be pregnant (again), I had not felt myself to be excluded or less complete as a woman. In no way had I felt obsessed by the wish for a child (at least that is how I remember it now). I was able to think of many other things to do in order to have a satisfying life, I did not expect my husband to leave me for this reason, and in regards to my old age, I realized that my financial situation would not depend on whether or not I had children.<sup>8</sup> Moreover, several of my friends and colleagues did not have children at that time either, and for some of them this was – and still is – a conscious choice. Thus, doing research among the ‘other’ in a comparable condition, but in a completely different setting, was in a way a cathartic experience. It made my own situation somewhat ‘trivial’, more bearable. Without any doubt, I realized, I would rather be an infertile Dutch than an infertile Macua woman.

This feeling was strengthened when I thought about the means they, the Macua women, had to overcome the problem. The women told me what they had undertaken since they became aware that they could not get pregnant when they wanted. All of them had endless stories about visits to various sorts of traditional healers in the hope for a cure for their infertility problem, and about the types of treatments they had undergone (varying from reading Koran texts or drinking herbal teas, to attending sessions to expel spirits). Some of them also spoke about their attempts to conceive with other men and others referred to their role as foster parents (although caring for the children of others was seen only as a partial solution to their problem). More or less of half of them had visited a biomedical health care setting, but they hardly became any wiser, as the formal health care in Mozambique did not have much to offer to people suffering from infertility, and certainly not at the district level. In fact, the ‘quest of conception’ – as Inhorn (1994) has called similar on-going searches for a cure by her Egyptian infertile study participants – had only made them poorer, but had not brought them closer to a solution of their problem. In general, the women in my study felt extremely uncertain about what was actually causing their infertility, and about what would be the best way forward. Some of them had vaguely heard about infertility treatments at higher echelons in the health care system, but those were not at all accessible to or affordable to them, among others because of the travel costs involved (the nearest provincial hospital was in Pemba at 200 km and the Central Hospital in Maputo at more than 2000 km from Montepuez).

This situation, again, was strongly in contrast with my own situation at that moment: I was on the waiting list for a high-tech fertility treatment in the Netherlands at an academic hospital, and treatment would be fully covered by public health insurances. Once more I realized how privileged I was being infertile in the Netherlands

and not in Mozambique. My study on infertility in Mozambique has thus definitely affected me personally, my state of mind and the way I experienced my infertility. It helped me to put my own situation into perspective while making me feel extremely well-off, compared with the ‘others’ whom I had studied. In addition, this research experience also made me strongly aware that doing anthropological research among ‘the other’ with a *comparable* experience (physically speaking) does not at all mean that the researcher actually shares *similar* experiences or would therefore necessarily be in a better position to understand the other. The context in which a condition/an illness experience takes place and personal characteristics to a large extent define its meaning (cf. Van Dongen 1996). This insight, of course, does not come as a surprise for a medical anthropologist, but I had never realized it to this extent.

### ***Further academic involvement with infertility in the global South***

In the beginning of the 1990s, infertility and childlessness had hardly received any attention in the global South; the birth of too many children and overpopulation, rather than the situation of infertile and childless people, were main concerns of most policy makers and researchers in this area. At the International Conference on Population and Development (ICPD), held in Cairo in 1994, prevention of infertility and appropriate treatment, where feasible, were – for the first time – included as basic components of reproductive health care in its Program of Action (UNFPA 1995). In fact, I think, this slowly growing attention to infertility in the global South has affected my professional career to a large extent (probably even more than my personal experiences with infertility and reproductive technologies), as it enabled me to present papers at international conferences, to be involved in the creation of a network of researchers in this area and to publish on infertility, infertility care and assisted reproductive technologies in Mozambique, Sub-Saharan Africa and resource-poor countries in general up to the present.<sup>9</sup>

### ***Conducting hospital ethnography in a Dutch fertility clinic***

Given my continuing academic involvement in the field of infertility in the 1990s, it was somehow obvious to continue doing research in the same field when thinking about a theme for my doctorate. Inspired by my colleagues Sjaak van der Geest and Els van Dongen, I was interested in doing ‘hospital ethnography’ (Van der Geest & Finkler 2004) as well as ‘medical anthropology at home’ (Van Dongen 1996). So I decided to conduct my Ph.D. study in a Dutch fertility clinic. Reflecting on the question whether my personal situation has affected my academic pathway, I realize that I cannot tell whether I would have chosen the same topic if I had not become pregnant myself. Maybe I would have found it too confronting; maybe I would have seen it as a challenge. What I can tell, though, is that at that time I was disturbed by the tendency of radical feminist critiques of a one-sided picture of reproductive technologies “as a conspiracy of male ‘techno patriarchs’ and the pharmaceutical industry against women, aimed at taking control of the female body and especially the childbearing

process.” In addition, the radical feminists associated these technologies with “the glorification of traditional motherhood” and depicted the women who were using these technologies as having ‘false consciousness’ or being ‘cultural dupes’ (critiques summarized in Inhorn & Van Balen 2002: 15, inverted commas in original). This way of picturing reproductive technologies and its users disturbed me because I did not recognize myself and my experiences in these descriptions. From my own experience and from wider reading in this area (e.g. Inhorn 2003; Lock & Kaufert 1998; Lupton 1997; Rapp 1999), I had learned that the processes surrounding the medicalization of reproduction were more complex and nuanced than these radical critiques wanted us to believe. This insight inspired me to phrase the objective for the second study as follows: I aimed to understand, in a nuanced way, how actual daily clinical practices in a Dutch infertility clinic affected the way men and women with fertility problems experienced and used IVF and other assisted reproductive technologies (ARTs).

Clearly, my personal and academic biographies are closely connected, though not in the linear and straightforward way people often assume, through comments like “you have undergone it yourself; *that is why* you are studying this topic.” I would rather say that my academic and personal life have mutually affected each other. How then has this impacted the conduct of the studies?

## **The influence of personal life on the conduct of ethnographic research**

### ***A comparable condition: How does it affect interaction with study participants?***

The condition that I shared with my study participants was not visible from the outside, nor did I conduct the studies in my own community, where people could have known my family situation. Therefore, as mentioned before, I could choose whether to hide or disclose my personal condition and experiences. I managed this differently in both studies.

### ***Disclosure and fieldwork interactions in the Mozambique study***

In the study in Mozambique, I told my research assistants and some of the infertile women that I myself shared their condition. In most cases I only brought this up at the end of an interview with an infertile woman, in a – likely flawed – attempt to give the women some consolation or to show that I could understand what they were going through (although at that time I realized that our experiences differed to a large extent). In my master’s thesis I did not bring up my personal experiences in the main body of the text (only in the preface) as I had not truly used them as a means to get in contact with the women nor as a means to attain an experience-near anthropology through mutual sharing (cf. Van der Geest 2007: 18). My ethnographic interviews thus did not turn into ethnographic conversations, in which we mutually exchanged experiences. In hindsight I am inclined to say that one consideration *not* to share my own experiences and emotions with my informants was that I was afraid that my expe-

riences would have looked trivial compared to what they went through and therefore might have increased, instead of decreased, the distance among us.

However, my status as a childless woman – or even worse, in the lower-than childless category of a woman who had never delivered nor been pregnant – was an issue for deliberation during the fieldwork. When I asked permission to attend ceremonies related to pregnancy, delivery and name-giving and to interview the female ‘experts’ who were in charge of these ceremonies (*nankossi*), my research assistants doubted whether I could attend these ceremonies and talk with the experts about such topics since I had never conceived myself. A Macua woman with a similar status would not be allowed to listen to such conversations, not to mention attend the ceremonies. Yet, after deliberation with my assistants, the experts agreed that, as I was a visitor and did not really belong to their community, my position was different from a local infertile or childless woman (I did not fit into their categories). As a result, they did not mind sharing their information with me and allowed me to attend the ceremonies. I remember that it felt alienating when they were talking about me being or not being allowed to join the ceremony; in a way I felt a small portion of the exclusion the infertile Macua women had told me about.

What impact sharing my infertility status with part of the study participants had is hard to tell. It may indeed have had some impact on my relationship with some of them and on the stories that were told about me in the community, and subsequently it may have affected the openness of the women and the sort of stories they told me. Yet, I am inclined to say that such an impact has been minimal and should not be overstated. I rather emphasize the importance of my research assistants, the two Maria’s, who were very good in making the women feel at ease and creating an ambience of confidentiality. Moreover, my having a comparable condition may have turned me into an empathic researcher, though personally I think I can be empathic towards people ‘suffering’ from various sorts of conditions and experiences – such as having cancer, a heart disease, a miscarriage or an abortion – even if I have not experienced the condition myself (cf. The 1999).

### ***Disclosure and fieldwork interactions ‘at home’***

In my second study on infertility, ‘at home’, I handled my comparable condition more consciously. This study was hospital-based, in the Clinic for Reproductive Medicine of the Radboud University Medical Centre in Nijmegen, a town in the east of the Netherlands. All study participants were visiting this hospital and had access to high-tech fertility treatments,<sup>10</sup> almost fully covered by public health insurance. They belonged to various socioeconomic classes and they had different levels of education, from low to very high. Thus, in various ways, the men and women in the second study were much more like myself; some of them even spoke the same dialect as the one I grew up with as a child. As I was aware that the way I would introduce myself to people involved in the study, both clinic staff and the participating couples, might make a difference in how they would react to me, I deliberately decided beforehand that I would present myself just as a researcher, and not as an ‘experiential expert’.

Later on, if it felt appropriate, I could always tell them about my personal experience. The reason why I did not want to immediately share my own experience differed for health staff and couples.

When seeking permission to carry out the study from the heads of the department I did not introduce myself as an experiential expert either because I wanted to prevent anyone, including myself, from thinking that I had gotten permission mainly or solely because of my personal experience, and that I would be 'uncritical' of the technologies. Only after being granted the permission, when we were talking about practicalities related to the study and the head of the fertility clinic asked me what I actually knew about the daily practice of fertility treatments, I revealed that I had undergone an IVF treatment myself. In my contacts with the health staff and other personnel during the first months of the study, when getting to know each other and talking about professional and personal issues, I sometimes brought up my own experience with fertility treatments. This was never planned; it fully depended on the moment and the specific situation, and whether I felt it was appropriate or relevant to the conversation. At the end of the fieldwork period about half of the health staff knew I had undergone fertility treatments, and occasionally, after having shared my own experience, they or I sometimes referred to it in conversations.

With regard to the couples participating in the study, I was even more conscious of what I should tell them, and when. I had two major reasons not to introduce myself as an 'experiential expert', as someone who had been infertile and a user of ARTs herself. In the first place, as my own first IVF treatment had been successful, my story could have become one of those success stories that would give hope and inspire couples to start or continue IVF treatment; or conversely, my informants could find it more difficult to express their doubts about or arguments against treatment if they knew that I was a former user. Secondly, if they did not know that I had undergone IVF treatment, I thought it would be easier to ask them in detail about their treatment experiences, without their assuming that I would know what they meant (as I had gone through it myself) or asking me about my experiences and wishing to compare their experiences and opinions with mine. So, also in this study I did not opt to employ the method of sharing experiences as a means to come to a more experience-near anthropology (cf. Van der Geest 2007).

Though I was firmly decided against introducing myself as an 'experiential expert', I also realized that, given the informal interviewing technique and frequent contacts with informants (I had lengthy interviews with them at home and regularly saw them at the clinic), it would not take long before some of them would start to question me about my own situation. And indeed, about half of the couples asked me if I myself had children: a few of them wondered in the very first interview, though most of them posed questions in a later stage of the study. I always replied that I had children, often adding that I had twins, and as twins in this context always raise 'suspicion', in general I said that I had my own treatment story as well. Only when couples asked me directly did I give more details about my treatment trajectory, but I never went into great detail about how I had experienced treatments or how I had made my decisions. When people heard that I had my own experience in the field, their first reaction was

often that it might explain my vast interest in the topic, or they commented that it might help me to understand what they went through. Sometimes they also referred to it when telling me about their own experiences, using expressions such as “You have gone through it yourself, so you know how it is.” When they made this latter remark, I sometimes responded that – as I had told them right from the beginning – people experience and decide upon things differently, depending on their particular background and situation, and that the study was specifically aimed at gaining insight into these different experiences and thoughts.

A conversation I had with one of the couples gave me insight into the possible implications of my sharing a bit of my own experience. I had followed this highly educated couple, Nienke and Jos, from their very first visit to the clinic. Both were very talkative and reflexive about their situation and, as they both explicitly said, they enjoyed the lengthy interviews with me. They saw these interviews as good occasions to “talk things through at length,” as Jos observed. In detail they reflected on pros and cons of fertility treatments, living a life without children and/or going for adoption, and on many other themes. Occasionally they made disapproving remarks about parents who placed their children – in their view – far too much in the centre of their lives. In the second interview they pondered at length about the question “how far do we want to go in treatments?” By then they had undergone some intra-uterine inseminations and were offered to do an IVF, about which they were hesitant. At the end of this interview, Nienke asked me if I had children myself. I answered that I had two children and added, without her having asked for it, that I had gone through IVF myself. I immediately felt uncomfortable having added this last remark, as I was afraid that it might inhibit them from freely expressing their doubts about further treatment. At the end of the next interview session I brought up this event, saying that I doubted whether it had been wise to share this experience with them, adding: “It is not that it is a secret, but in a way I am the success story. IVF can indeed lead to healthy children, but this is not the message that I want to pass on as a researcher, as I can understand your considerations and doubts very well.” Jos’s immediate reaction was that he had not felt inhibited at all to make critical remarks in this third interview session; and Nienke added:

Scientifically speaking you could question if you should have shared this with us. Yet, that you told me about it gave me a feeling like ‘we have given you a lot, and now you have returned this to us’. That felt [good]. ... You have gone a long way with us (*Jij was al een heel eind verder met ons*). It does not matter anymore. But I think if you had shared this with us from the beginning, then we would constantly have questioned ‘how did you do things?’

In a way, this conversation with Jos and Nienke reassured me in my decision not to introduce myself as an ‘expert patient’.

Some qualitative researchers who shared, or came to share, characteristics that were central to their research with their respondents have mentioned that their informants opened up or started to share different stories once they became aware of the

researcher's experiences (Krumeich 1994; Cassel 1987). I, however, did not get the impression that this was the case in the current study. Most of the study participants had been eager to share their stories, and were quite open and informative right from the beginning. In addition, in a way my encounters with the couples, though being frequent and taking place over a long period of time, were also limited as I did not fully take part in their daily lives, unlike many other anthropologists who live and work twenty-four hours a day with their informants (cf. Zaman 2005: 37). Moreover, though I had shared a similar experience in the past, I had overcome my fertility problem about ten years before I conducted the fieldwork. Couples might not even consider me to be one of them, even more so because at the moment of the fieldwork, I was older than most of them.

In other words, my explicit disclosure of my own experiences to roughly half of the study participants seemed to only have had a minimal effect on my interactions with them. However, I do not intend to say that my own experiences did not affect the study at all, or the way I carried out the study. This brings me to the question raised earlier: how does a comparable condition or experience affect the way the researcher is involved in the study and makes sense of what s/he sees and hears?

#### ***A comparable condition: Affecting the interpretation of research findings?***

The current section, in which I address the above question, refers only to the study I conducted in the Netherlands. From the start of this study I was aware that my personal biography might affect what I would hear and see, and how I would make sense of it and use it in my write-up, not only because I had undergone similar experiences *and* was a successful user of IVF, but also because the focus of my study was very much related to my disagreement with how processes of the medicalization of infertility and the use of reproductive technologies had been depicted by some scholars. Had the mere fact that I had been confronted with comparable treatment and comparable decisions as my research informants changed the way I listened to my informants' stories and experiences and how I had interpreted and presented their stories? In this section I will share a few thoughts about this, realizing that these reflections are far from comprehensive.

Given the fact that I had been a successful user of IVF treatment myself, one may question if and to what extent I would be willing and able to take a critical stance towards the medicalization of fertility problems and the use of ARTs. This question has been at the front of my mind throughout the research process, and I had discussed it many a time with my supervisors and other audiences. I am fully aware that my own well-considered 'submission' to IVF treatment (despite a period of ambivalence and reluctance) and the subsequent successful outcome made me in some way loyal to ARTs, and this indeed complicates my ability to take a critical position. Yet in all study phases I have attempted to approach the topic both critically and in a nuanced way, which has been reflected in the presentation and interpretation of the data in my Ph.D. thesis and other publications based on this study.

Further, I find it worthwhile to consider the difference between hearing stories and experiences that I recognized and could easily relate to compared to those that were less recognizable or far removed from my own experiences and views. At times, during the fieldwork, when I was listening to the stories of the couples or observing them in the clinic, I could very well imagine what they wanted to tell me or what they experienced. I then ‘shared’ their emotions, I recognized the ambivalence some people expressed and I was reminded of events and conversations from the time when I had gone through fertility treatment myself. For example, I had experienced the bodily tension of attending a foetal ultrasound, the moment of truth at the end of an extended and often stressful period of IVF treatment. I remember the moment of my own pregnancy ultrasound and the meaning that it had for me. In my Ph.D. thesis I write about the tension couples experience when undergoing the pregnancy ultrasound:

An ultrasound confirming pregnancy is *the* moment that couples have been hoping for, for many years, and in particular have been working towards during the last few months. Visualizing medical technology shows them whether the foetus’ heart is beating and whether the size of the foetus conforms to standards. I cannot think of any other consultation hour at the Radboud fertility clinic in which the ambience is so full of tense expectation than in the consultation hours in which the foetal ultrasounds are made (Gerrits 2008: 261).

Would a researcher who had not lived through this his/herself notice, experience, interpret, and write about such an event in a similar way? I could come up with a number of other comparable situations and ask the same question. In these cases, to be sure that I was not making up a point or argument that reflected my own experience and emotions I double-checked my empirical data and looked for ‘deviant cases’ to make sure that a point or argument was not too subjectively driven and biased by my own experience (cf. Hesebeck 2012, who conducted a study among adolescents who live with the same congenital heart disease she has).<sup>11</sup> At the same time, I also agree with Hesebeck, who states that because she has experienced situations and bodily sensations that were very similar to what her informants told her, her own “embodied knowledge” enabled her to phrase some experiences of her participants and her interpretations thereof as confidently as she did (Hesebeck 2012). Thus, she felt she really understood what her informants shared with her. Following this remark, I cautiously suggest that having similar experiences may lead to a more grounded, embodied, interpretation and presentation of research findings.

However, I was, as expected, also confronted with many embodied experiences, emotions and viewpoints that I did not share or recognize at all (cf. Van Dongen 1996: 343). These included: women who said that they would rather not have been informed about potential risks or side-effects of hormonal treatments and the limited success rates of IVF, as they felt this was discouraging and frightening; women who appeared to be obsessed about having a child and felt that their dreams for the future would be fully destroyed if they did not succeed to conceive; or men and women who ‘glorified’ doctors and medical technology because they were performing miracles. Further,



physical experiences and emotional reactions resulting from hormonal and other treatments proved to be enormously divergent among my study participants, varying from women and men who were heavily affected to those who hardly noticed any negative impact at all. Part of these experiences also diverged strongly from my own experiences as I remembered them. In addition, as I personally had been in the fortunate situation that my first IVF treatment had been successful, I was never in the difficult position to decide on another IVF treatment and thus did not share this experience with my informants at all. Consequently, while I had been in a comparable condition and definitely shared comparable experiences, there was much dissimilarity – in many aspects – with many of my informants as well.

Overall, I was struck by the enormous divergence of the stories and experiences, even though I had set out the study precisely to gain insight into this diversity and the complexity of people's reactions to processes of medicalization. I felt intrigued by these different views and experiences and was eager to understand them from my informants' points of view, given their particular histories and their specific life circumstances. Though many times I was emotionally touched by my informants' stories, I did not experience it as personally confronting or painful to hear their stories; it did not emotionally unbalance me (cf. Hesebeck 2012). In retrospect I would say that I handled a large part of my data in a relatively limited 'caught up' way, probably not too differently from a researcher who had never experienced a comparable condition. This contrasts with what for example Hesebeck (this volume) writes. This observation raises the question of whether or not the fact that I had overcome my infertility problem at the time of my research (conducted almost ten years after my own treatment) had turned me into a partial outsider, even when I had once been a full insider. This is also the reason why I am hesitant to overstate the impact of my 'comparable condition' on my knowledge production, and on the interpretation and presentation of my data.

## **Concluding remarks**

In this article I have reflected on the mutual impact of my personal and academic biography. The fact that I shared a comparable condition with my research informants – having been infertile and having undergone an IVF treatment that resolved the problem – was the reason I chose to submit a paper to the Symposium and the Special Issue of this Journal on 'Ethnography and Self-Exploration'. Throughout the article I have pointed to the impact of this comparable condition and experiences on the choice of my study topics and the conduct of the studies (which I am not going to repeat here). Yet, at the same time I have made several remarks that question, and sometimes even deflate, the importance of this comparable condition.

I have argued that this is partly related to the invisibility of the 'comparable condition' at stake, which gave me the choice to reveal or not reveal it. In both studies – for different reasons – I only disclosed my comparable condition with some of my informants, and in both studies I did not exchange in-depth experiences with my

informants. My ethnographic interviews thus did not turn into ethnographic conversations, nor have I used mutual sharing as a means to reach experience-near anthropology (cf. Van der Geest 2007). For both studies I have suggested that my disclosure only had a limited impact on my interaction with my informants, as in both studies most of them were informative and open anyway. I have suggested that this had to do with several other factors, such as the eagerness of participants to extensively share their experiences. This suggests to me that the study touched on a relevant subject in their lives and that informants seemed to be pleased that someone wanted to listen to their stories. Regarding the study in Mozambique this certainly also had to do with the characteristics of my Mozambican research assistants, who were skilled at making the informants feel at ease. Concerning the study in the Netherlands, the fact that I followed couples over a longer period, that I saw them at the clinic and visited them several times in their homes, were all favourable for building rapport and opening up my informants. In addition, for some informants, my particular personal characteristics, such as my age, gender, region of origin, and the fact that I spoke the same dialect, may have contributed to these as well. In both studies these circumstances allowed me to collect quite rich data. These outcomes lead me to question Van der Geest's view that *exchanging* experiences provides for all circumstances and topics the ultimate means by which to collect experience-near data. Is this indeed always the "best we have"? (Van der Geest 2007: 13).

In the first study, my informants and I had in common our inability to conceive when we wanted to; in the second study we shared the infertility experience and access to ARTs to resolve the problem. In both studies the comparability of the condition was also relative. I have shown that in the study among the Macua women in Mozambique, 'physically' speaking we may have been in the same condition, as we all could not conceive when we wanted to; however, the meaning, implications and our means to resolve the problem were extremely different given our different sociocultural, economic and health care contexts. This underlines the value of a basic medical anthropological insight. The implications for my informants were much more severe. This, as I suggested, was one of the reasons that I felt uncomfortable exchanging experiences, fearing that my own experiences would be considered trivial, thereby possibly creating more distance instead of proximity.

In the study in the Netherlands, 'at home', the meaning and implications of infertility and the means to resolve the fertility problem were more comparable to my own situation, though varying extremely among the informants. Yet, as I conducted the study ten years after having resolved my own fertility problem, I no longer shared a comparable condition with my informants. This may have affected the way my informants regarded me: if they had learned about my own infertility history, they may not have seen me as 'one of them'. What I am convinced of, though, is that I still did remember, recognize and relate to some of my informants' embodied experiences, which facilitated my writing some observations and interpretations "with confidence" (cf. Hesenbeck 2012). On the other hand, that condition had also become part of my past, which created distance. Therefore, I have argued, as I overcome the fertility problem and became less emotionally involved, I have become a researcher who can

listen to stories of my informants in a less ‘caught up’ way, which is probably similar to a researcher who never experienced such a comparable condition. Thus, the different positioning of myself, the researcher, and my informants in the two studies – as related to context and temporality – demonstrates that a condition does not necessarily have to be experienced as shared or similar either by the informants or by the anthropologist. In both situations I rather considered myself a ‘partial insider’, even though I once was a ‘full insider’. As stated earlier, this is why I am hesitant to overstate the impact of my ‘comparable condition’ on my empathic listening, my knowledge production, and on the interpretation and presentation of my data.

The argument presented above is based on my personal experiences and my subjective recall and interpretations in the current moment of my life. For other social science researchers in similar circumstances, the implications of their experiences and their representations may be completely different. They may instead conclude that their own experiences had tremendously enhanced their empathic understanding of the phenomena under study, or that their experiences had an enduring and profound emotional impact on their later life, as well as profoundly affecting their relations with their informants and the representation of their findings. This Special Issue illustrates such diverse possibilities. Clearly, there is no blueprint for researchers of how to act under comparable conditions and shared experiences with informants and how to analyze the impact on their research.

Thus it is crucial for social scientists who regard themselves as the significant research instrument in their work to reveal “the social, practical and biographical contingencies that helped to produce the data” (Brewer 2000: 42-43). It is this sort of transparency about the anthropologist’s subjectivity and positionality that increases both the credibility and the value of the ethnographic texts we produce. This might be in the format of a ‘measured economy of disclosure’, as suggested by McLean & Leibing (2007). However, given the importance to the reader of really understanding the contents and quality of presented findings and insights, it might be better to go one step further. Therefore I plea for a ‘non-measured’ economy of disclosure – a full disclosure<sup>12</sup> of the researcher’s relevant biographical experiences and the implications for their conduct in the field and production of knowledge. This Special Issue has afforded me the rare opportunity to elaborately draw on my personal experiences to reflect on the important nexus between one’s personal biography and academic work.

## Notes

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- 1 The (1999), who herself did not share comparable experiences with her research participants, stressed that her (emotional) involvement with her study participants – cancer patients, their relatives, and clinic staff – helped her to gain a deeper insight into their experiences.
- 2 A striking example of this is Nijhof's insight into what he refers to as 'apparatus security': social scientists have often written critically about the 'technologisation' of medical care and blame doctors and nurses for giving more attention to machines than to their patients. Nijhof instead describes how he, as a seriously ill patient, experienced machines as bringing security and trust to him (Nijhof 2001; Van der Geest 2007: 17).
- 3 This brings us to complex intra-psycho processes of projection, transference and counter-transference affecting the interaction between anthropologists and their informants, processes that have not received a lot of attention in anthropology (Tankink & Vysma 2006). These processes can be expected to be of increased complexity when anthropologists share comparable experiences or conditions with their informants (see Hesebeck 2012).
- 4 Although this was – as far as I know – not the reason that she mentioned the topic to me.
- 5 I am very grateful for their support throughout the study.
- 6 Moreover, in this matrilineal society relatives of the women actively supported them in finding a solution for their fertility problem, out of concern with the women and because this was in the interest of their own lineage.
- 7 I had hardly been able to prepare myself for this, as at that time there was limited information available. When writing my study proposal in 1993 I only found four articles explicitly looking into sociocultural aspects of infertility and childlessness in Sub-Saharan Africa (David & Voas 1981; Ebin 1982; Mammo & Morgan 1986; Sangree 1987).
- 8 Of course – as one of the reviewers suggested – childless people in a rich country as the Netherlands may miss the care of children when being old, even when they don't need the financial support of their children. At that stage of my life, though, I was not concerned about this.
- 9 For example: Gerrits 1997, 1999, 2000, 2002; Gerrits & Hardon 2001; Gerrits et al. 1999; Van Balen et al. 2000; Gerrits & Van Balen 2001; Van Zandvoort et al. 2001; Gerrits & Shaw 2010).
- 10 Half of them had also visited alternative healers at one or another moment in order to resolve their infertility problem; a small part of them considered adoption, though only after first having exploited all available biomedical options; the issue of having extramarital relations in order to conceive was rarely discussed and never mentioned as a real option.
- 11 Hesebeck (this volume) mentions this in her article as well. When I read her observation in the paper she presented at the symposium, I realized I had done the same. I want to thank her for bringing up this insight.
- 12 This notion of 'full disclosure' rather than 'measured disclosure' was suggested by one of the anonymous reviewers.

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