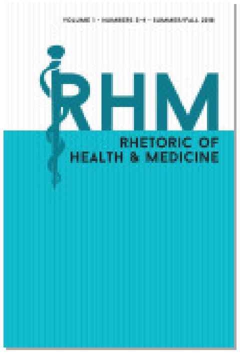
A Dialogue on Possibilities for Embodied Methodologies in the Rhetoric of Health & Medicine

Cathryn Molloy, Cristy Beemer, Jeffrey Bennett, Ann Green, Jenell Johnson, Molly Kessler, Maria Novotny, Bryna Siegel-Finer



Rhetoric of Health & Medicine, Volume 1, Numbers 3-4, Summer/Fall 2018, pp. 349-371 (Article)

Published by University Press of Florida

Rhetoric of Health & Medicine
Vol. 1, Nos. 3-4, pp. 349–371
doi: 10.5744/rhm.2018.1017

A Dialogue on Possibilities for Embodied Methodologies in the Rhetoric of Health & Medicine

Cathryn Molloy (dialogue coordinator), Cristy Beemer, Jeffrey Bennett, Ann Green, Jenell Johnson, Molly Kessler, Maria Novotny, and Bryna Siegel-Finer

Drawing on our experiences with qualitative research involving health and medical topics to which we have a personal connection, this dialogue asks scholars in RHM to consider key methodological issues in embodied research by exploring: the choice to take up inquiries with which we have personal connections; the ethics of representation within these projects; and determining if, how, when, and to what degree we should reveal these connections in the research write-ups themselves. Our conversation is characterized by a "heuristic orientation"—defined as intuitive, creative, and generative. We conclude by offering a heuristic tool for researchers to use as they make crucial decisions in embodied research in RHM.

KEYWORDS: research methods, methodology, diagnosis, disclosure, heuristic, personal

---

Introduction

Performance studies scholar Ben Spatz (2017) explained that "no proposal for embodied research in the social sciences, humanities, or performing arts takes seriously the idea that areas and disciplines of embodied practice might constitute substantive epistemic fields in their own right" (p. 1). Thus, Spatz highlighted the need for individual fields of study to explicitly take up questions of embodied research methodologies within their own purviews. The primary question that drives discussions on embodied research methods, argued Spatz, is, "What can bodies do?" (p. 5). While rhetoric of health and medicine (RHM) researchers engage with this question obliquely and to varying degrees, there is a need for more explicit scholarship addressing embodied research methodologies in the field.

That is, while many scholars do reveal their personal connections to their RHM scholarship and, therefore, add important insight into the autobiographical dimensions of their work, few present a clear methodological stance. Some writers do gesture to methodological engagement or even enactment of embodied scholarship, but these moves are somewhat distinct from explicit and candid discussions of behind-the-scenes methodological decision-making (Beemer, 2016; Besler, 2015; Green, 2018; Hausman, 2003; Hensley-Owens, 2015; Johnson & Quinlan, 2017). Thus, RHM scholars would do well to take an explicit methodological stance on researchers' personal exigencies and how they ought to be embedded (or not) into the research process and write-ups that follow. Following Lisa Melonçon (2018), this focus on bodies—physical bodies—is precisely how we operationalize embodied research as we put forth a preliminary heuristic framework for a methodological stance on embodied research explicitly for RHM. We do so by first offering a dialogue on the topic—one that helped us to clarify what we might contribute to this important methodological area with and for RHM researchers. Importantly, this dialogue is meant as a starting point. Expanding methodological inroads for personal health and medical topics in RHM is, thus, still necessary—particularly as these explicit statements on methodologies might enhance rigor.

Our Goals for RHM

In the inaugural Winter/Spring 2018 issue of this journal, Laura Gonzales and Rachel Bloom-Pojar (2018) use their dialogue with medical interpreters to deliver several important implications, including the call to incorporate "participants' histories, stories, and lived experiences as essential to the success of RHM research" (p. 209), suggesting that the genre of the *Rhetoric of Health & Medicine* (*RHM*) dialogue offers space for collaborations that give way to important insight for the future of RHM scholarship.

Our dialogue begins with the question: What might an embodied methodology for RHM look like? As we mention above, we operationalize embodied research as research that leads with physical bodies, their exigencies and vulnerabilities. Embodied research calls attention to shifting identities that are born of everyday bodily realties—of the researcher and of the participants. Rather than offer a definitive response, we offer a conversation and a heuristic to prompt further efforts of making the researchers' own dispositions toward embodied research in RHM more explicit. An important part of this discussion, naturally, is helping researchers to determine whether it is advantageous for their research agendas to take up personal topics to begin with. Choosing to research a health and medical phenomenon with which one has a personal connection can lead to vulnerability and fatigue. Perhaps even more problematically, personal research topics can lead to a lack of objectivity as the writer can be too close to what she or he is examining. Indeed, some conditions are stigmatizing, some leave writers in precarious positions, most require humility, and nearly all dredge up a groundswell of emotion—a reality that is very clear in our own work (Johnson, 2018; Molloy, 2015). At the same time, writing and research that grow out of personal connections can stimulate interest and positive affect. Firsthand experience with a health and medical reality can lead to an intimate understanding of the identities, feelings, and experiences of others; it offers an insider's view.

Drawing on our experiences researching and writing from places of illness, caregiving, and the diagnostic and treatment processes, this dialogue shares fragments from an asynchronous conversation (conducted on a shared file stored in a private Google document) on this important methodological topic, including textually reproducing some productive tension in our conversations. These topics include:

- the choice to take up inquiries with which we have personal connections;
- the ethics of representation; and

- determining whether authors ought to reveal their personal relationships to the topics of their work and the degree and timing of such personal disclosures in their research write-ups.

All three of these categories, of course, are unified in a deep commitment to metacognition and to rhetorical appropriateness where researching personal health and medical topics are concerned. Moreover, issues of self-care pervade all three areas of conversation mapped in this dialogue.

Our conversation takes on a "heuristic orientation," which we define as intuitive, creative, and generative, and we offer a possible heuristic, question-posing tool for researchers to utilize as they attempt to make crucial decisions in research designs that take embodiment as a given. We also present possibilities for continuing conversations on this topic and for engaging meaningfully with its various themes—especially those that might exceed what we manage to cover in this short dialogue piece. Knowing full well that we are only a small cohort among many RHM scholars who take up personal health and medical topics in research and reference their methodological decision-making in some ways in their writing, we hope the ideas we present here are revisited, challenged, and meaningfully expanded as the field continues.

A Conversation among RHM Scholars Studying Topics of Personal Connection

This dialogue brings together eight scholars from various stages in their careers—some of whom knew each other prior to the conversation, and some of whom met for the purposes of this dialogue. We used our experiences with living through and researching cancer, type 1 diabetes, fibroids, anxiety/depression, inflammatory bowel disease/Crohn's, infertility, psychogenic symptoms/mental illnesses, and BRCA+ (positive breast cancer gene), to compose short, individual pieces of writing that we shared with each other in a Google drive folder. After we'd considered the thematic overlaps in our individual writings on embodied research, we used a single google drive document to write back-and-forth to each other on those specific issues. This dialogue, then, is arranged around those issues: 1) the choice to take up inquires with which we have a personal connection; 2) the ethics of representation within these projects; and 3) the decision-making processes for if, how and when we reveal these personal connections in the research write-ups that follow them.

ON THE CHOICE TO TAKE UP INQUIRIES WITH WHICH WE HAVE A PERSONAL CONNECTION

We've not always come willingly into researching personal issues and topics. Yet these personal matters dominate our lives in such a way as to make researching them feel variously natural and inevitable, albeit at times uncomfortably complex. Concealing the personal does not always fully erase it from our work, either. Rayna Rapp (1999) illustrated these complications well when she described "an escalating whirlwind of data that flows through [her] daily life, and the daily lives of [her] friends and family members" (p. 14). Rapp, thus, highlighted the complex nature of fieldwork and permeable boundaries that separate everyday life from research and writing. Rapp addressed the inevitability of everyday life infiltrating the research scene and vice versa. Jackie Stacey (1997), in *Teratologies,* though, explicitly attempted to "overcome some of the usual boundaries between academic and other forms of writing which have conventionally separated the personal from the intellectual" (p. 24). That is, Stacey actively resisted the illusion that personal and academic life are definitively separable. In these statements and their larger works, these authors usefully critique boundaries between the scholarly and personal that impact their research and experience.

Perhaps our positions on this topic are characterized by true ambivalence in the sense that we are drawn to and repelled by the idea of researching such personal things in equal measures. Thinking rhetorically, we feel certain that narratives and personal connections are compelling forms of evidence, yet we experience some of the narrative ambivalence Susan Sontag (1989) described in considering whether to include personal stories in her work: "I didn't think it would be useful—and I wanted to be useful—to tell yet one more story in the first person of how someone learned that she had cancer, wept, struggled, was comforted, suffered, took courage . . . though mine was also that story. A narrative, it seemed to me, would be less useful than an idea" (p. 101).

Indeed, personal narratives—engaging, interesting, necessary, even vital—are not always the most advantageous rhetorical choices among many. Still, we are swept up into these topics that dominate our own day-to-day lives; there is truth in these stories, and considering these personal-relational issues through rhetorical lenses feels somewhat inescapable. For many of us, embodied research is a natural fit for the other forms of health advocacy in which we are moved to participate. Rhetorical engagement with health and medical realities creates a vantage point through which new and potentially liberating knowledge is possible. In our conversation, we described our exigencies and decision-making about whether to research what we and our loved ones experience. (Cathryn)

Cristy: I started writing about breast cancer because I had no choice. I think many of us are swept into writing about these topics because we find ourselves or our loved ones dealing with a health issue, and the need to share what we learn is the exigence that drives our work. There is a strong desire to understand, to repair the divide between perception and experience. To somehow return to one's body through an understanding of the illness, and no doctor's explanation, no medical journal article chock full of jargon and statistical data, could help me understand what was happening to my body, to me.

Bryna: Isn't that how we all end up in RHM? I know it's a faulty assumption, but I do assume that anyone writing about health and medicine does it because they are experiencing it in some way. But I love how you describe that connection between perception and experience, Cristy—although I think that might be the opposite reason that I started researching BRCA+ rhetoric. I needed to somehow disconnect what I was experiencing from my own body. Turning it into scholarship, making it an academic enterprise—it helped me to do that a bit.

Cathryn: I similarly use research to separate myself from the emotional freight of seeing the unending suffering that these diagnoses brought to the lives of the people I love most because it otherwise became all-consuming. Symbolically recasting that energy into my research seemed like a somewhat healthier way of processing these sensations, so perhaps my initial exigencies were somewhat self-serving. Over time, I could see the potential for the work to be ennobling. Using scholarship as a space to build dignity became a more enduring reason to take up this work.

Cristy: That's really fascinating, Bryna and Cathryn. I felt my disease was inescapable, but I felt so alienated from my body. A cancer was growing inside me, and I was completely unaware, betrayed. So, I needed to reconnect and make sense. I can completely understand how the opposite could be true, too—the experience can be all-consuming, and one can need to "disconnect" through research, as Bryna says.

Molly: I think disconnecting through research is a really interesting idea, Christy and Bryna, and it really resonates with what I felt (and feel) about my work on IBD and related conditions. I've always described my choice to conceal my Crohn's in my academic work as a move to have my research taken seriously and not written off as too anecdotal, too personal. But, I'm realizing, as we're talking through these ideas about being both researcher and patient, that part of my rhetorical move to conceal was a very real effort to separate myself from my disease. Not speaking about my own Crohn's in my research definitely became both a methodological choice and personal protest.

Bryna: I conceal myself, too. It seems inappropriate to always be focusing on "me, me, me," to disclose my health issues in my scholarship. But at the same time, it does feel a bit like lying to not disclose my own status . . . to readers and to myself.

Jenell: Yes, the question of "appropriate" is interesting. Appropriate to scholarship, but also in the sense of *appropriation*. What happens when you're driven to study something because of someone else's experience? I was initially attracted to critical studies of health due to a family member's experience with psychiatric treatment. I've never written about that because it felt inappropriate while he was living. But there's no question that it's served as an open question that I keep trying to answer for myself through my work.

Ann: Implicit in the conversational thread above is gender as well. As women who write about bodies, our work is already suspect. As Audre Lorde and Adrienne Rich wrote early on, our politics of location is key to what we bring to the work. When we try to hide our personal connection to a topic, we're trying to "pass" as that objective scholarly voice that still is valuable in academic settings and reads white, male, straight, cisgender. Whether we're putting on that objective scholarly voice or not, what we're doing is telling a story about healthcare, and that is also a valuable way of knowing.

Maria: I suppose that my decision to disclose my personal relationship with infertility has to do with that idea of appropriation, Jenell. I draw frequently on cultural and feminist rhetorics as useful methodological frames to inform my RHM work. For me, infertility is not just a medical or health issue. As Ann suggests, it is also always embedded within gendered, sociocultural constructs. As such, I tend to examine infertility from an intersectional methodological perspective. By bringing in cultural and feminist rhetorical perspectives to my RHM work, I find it difficult to not be upfront about my own positionality in terms of infertility. By not disclosing, I feel as if I am not practicing this intersectional methodology.

Jeff: I think frequently about these ideas related to appropriation and standpoint, in part because of diabetes' strange classificatory system. I was diagnosed with type 1 diabetes shortly after defending my doctoral dissertation. The ways people narrated and made the condition intelligible was perplexing, if not dizzying. Everyone seems to know someone who lives (or lived) with some form of diabetes (type 1, type 2, LADA, MODY), and I became keenly aware of how those discursive forces imposed themselves on my body—even when the kind of diabetes being engaged was not the one I lived with. In this way, diabetes is common, but also oddly non-normative in its public materialization. Perversely, however, this imposition has made me productively conscious about the ways I chart the lives of people living with diabetes and the varying ways our bodies are constituted.

Cathryn Molloy (2015) called on other qualitative researchers to "consider how intellectually recasting personal exigencies and affective landscapes give way to and productively complicate formal qualitative projects" (p. 471). Similarly, Laura Ellingson (2017) asserted that "researchers begin with the body. Although some researchers are unconscious of it (or even deny it), embodiment is an integral part of all research processes" (p. 1). In our experiences, researching health and medical topics that are deeply personal can be incredibly rewarding and even healing, but the decision to research such experiences is also difficult and fraught. Indeed, handling the permeable boundary between everyday life and research with ethical and methodological care is a real concern, and tending to bodily needs and the embodied toll of research are important considerations.

Our dialogue about this important consideration makes it clear that some researchers are able to leverage the decision to linger with their bodily experiences, while others are able to use the space of a research project to productively dissociate from bodily discomforts. There are many possibilities between these two positions, of course. Regardless of where a researcher is on such a continuum, issues of appropriation and intersectionality loom large in this methodological landscape. (Cathryn)

ON THE ETHICS OF REPRESENTATION

Like Kristin Bivens (2018), our concerns with the ethics of representation are often more rigorous than the IRB boards we look to for advice on ethical treatment of human subjects, and we take the ethical burdens of representing our own and others' experiences very seriously. That is, the IRB board, while useful as a starting point, is limited to institutional ethics; embodied research must consider what Lisa Melonçon[1] calls "embodied ethics"—an ethical stance that considers, among other things, the relationship of the embodied experience to the research in ways that exceed institutional ethics. There are, of course, major ethical implications to this type of research that exceed the purview of most IRB frameworks.

We are highly sensitive to the fact that our work can and will alter the lives of those we wish to represent—including ourselves, but especially other people. We cannot go into these inquiries without great care, and not all of these stories are really ours to tell. We, therefore, take pains to engage meaningfully with the questions of identification that accompany this work. We actively calibrate our ethos and our persona. We embrace the nonlinear, impressionistic, and unreliable nature of memory. We are very aware of the privileged positions our personal experiences have given us and the heavy responsibilities that come with them. This isn't just "spilling your guts." (Cathryn)

In our own words:

Jenell: As someone deeply committed to the disability studies ethos of "nothing about us without us," it is important to me to bring the voices of people who are affected by what I study into the

---

[1] This term comes from Melonçon's work-in-progress titled "Affective Investment in Research Practice" and is used with permission.

text in some way. This was especially important to me while writing *American Lobotomy*. I had originally meant the book to be a kind of voices-from-below history, but I was constrained by privacy regulations when it came time to actually include those voices in the text. Even so, I hoped to underscore for my readers the basic humanity of people who had been enfreaked (Hevey, 1992) by popular culture, and took great pains to bring the voices I could access into the text where I could.

Maria: "Nothing about us without us" rings true to me, too, and probably in a lot of medical and healthcare situations. When I write about infertility, I find myself thinking about the many friends and colleagues that I have in this community. I realize that while many of them may not have read or even, perhaps, know about the pieces of scholarship that I publish about rhetorics of infertility, that I—as a "scholar-patient-advocate"—have an ethical responsibility for how this community is represented in my work. For example, some interdisciplinary scholarship on infertility has described female patients as "willing to do anything to get pregnant," while men are frequently described as "passive" and only wanting "to fix" the situation for their wives (see Lee, 2017). I think how we represent communities, particularly communities with illnesses or facing health disparities, matters. I think RHM—as a *rhetoric* field examining health and medical communities, their practices, the discourses used—is uniquely positioned to develop ethical practices of how we write, present, and talk about our research participants.

Cristy: I was already a member of the online breast cancer support community when I decided to write about it. I was concerned that my community would question my motives or feel betrayed by me. The Institutional Review Board said that their words were public and, thus, exempt from the need for permission. Still, it bothered me that the people who wrote those posts intended for them to be shared with other members of the breast cancer community—not the academic community. I believed that I owed more to my community. I adapted my methods to slightly alter screennames and protect writers' anonymity even further than the avatars and screennames already in use. As a member of the community, I know that those screennames have value. They may seem like words already publicly shared and, therefore, fair game. However, those screennames have living, breathing people behind them. These people have friends and share the most intimate details of their embodied experiences as patients with one another. I couldn't risk causing them any harm. I knew that I didn't understand that until I was a part of that community.

Ann: Cristy, did you ever contact anyone individually to ask her permission to use her voice? Did you announce your project to the breast cancer support group in any way? I feel like these are naïve questions on my part. After my mother broke her first hip, her surgeon taped her x-ray to the window to show us the break. The x-ray came home with us after the hospital stay, and I wanted to show my "Hospital Stories" class her hip. I also wanted to share her repaired abdominal aortic aneurysm. My sisters were opposed to these things, so I didn't do them. I regret that—not sharing—in some ways. What better way to a make a point that a patient is a person than to show my mom's x-rays?

Jeff: This idea of ethically communicating to students about those living with a variety of conditions is compelling, especially insofar as students so frequently contribute to these conversations from their own life experiences. The particular details of one's life experiences may feel far removed from the minutia of another's, but teaching often highlights where commonalities and differences rest in public dialogues about the body. Addressing the complexities of illness and pain and disability (among others) involves constructing more narrative variations about embodiment, and classroom discussions often underscore how rich these variations can be. Such narrative critiques can relay new ways of being and interrupt staid medical suppositions while also drawing attention to the ways vernacular publics produce articulations whose interpretations of the body fluctuate dramatically. These logics, of course, are also at play in research.

Ann: When I write about my mother's decline and think about how language works—the medical rhetoric that isolates each part of her body and each disease rather than considering her as a whole person—I try to ground what I write in my particular body. As her biological daughter, I owe her not only a truth to her experience, but a recognition of the connection between our two bodies. I have inherited, as she tells me, not only her stubbornness, but her fibroids and tilted uterus, the genetic tendency to melanoma, and a myriad other things large and small that genetics and environment create space for.

Molly: This is all very interesting. It is tricky to determine if and when to talk about these health and medical realities; it's tough to know when to bring them into research in particular. When I began this line of research, I always thought it would be easier *not* to tell people about my Crohn's. That way, I wouldn't have to deal with being judged for having a digestive disease, nor would I have to deal with having my findings constantly questioned. However, I've realized that hiding my IBD has, ironically, been an unintended invite for stigma and judgment. Let me give a few examples: colleagues have scoffed at studying IBD and ostomies as "disgusting," they have made "poop jokes" in response to article drafts or conference proposals, and one even went as far as to close a review with: "Why would someone want to write about shit?" I can assure colleagues, both through my own experience and through my research, that living with and communicating about IBD goes far beyond dealing with feces, but why should I have to? These are some of the complexities of researching about bodies as/in a body.

Ann: Molly, it's so funny that you bring this up. As Mom has become more demented, incontinence has become more of an issue. Obvious, I know. And I know that lots of people have had bad experiences with their aging parents and incontinence. But this conversation makes me really want to write something about shit. Shit happens. Adult diapers are called "depends" or "tranquility" or "dignity" or "reassure." When writing about bodies, we have to talk about shit. We have to talk about the language of excrement and the words for the things that are so private that we don't want to disclose them—even to a gastroenterologist. But how does one cross this boundary while remaining committed to the dignity of the patient?

Molly: It certainly can and should be part of our job to think about the ways medical professionals think and act toward all forms of patient embodiment—our physical conditions and experiences, and the traumas that come with both of those. But I also think our attention equally needs to extend to other areas, like public domains and even within our own field as we review and think about each other's work. There really needs to be an effort for empathy and sensitivity. After all, we are studying and writing about *people's lives*. As we all know, this is delicate and difficult work, both for us and for those we represent in our writing.

Cathryn: I couldn't agree more, Molly. There is no excuse to insult someone's work based on the idea that it is "disgusting." I once wrote in an application for a small grant at my institution that I wanted to engage in work that could end stigma against those with mental illnesses. The application was rejected, and the woman in charge told me it was because the committee couldn't understand the problem. I cited sociological research that explains that many people do not want to be in community with those with mental health diagnoses; they don't, for example, want to live near them, work with them, or have them marry into their families. She told me bluntly that she doesn't want those things, either. This interchange affected me in a visceral way, and my own reaction came as a surprise. I thought a lot about the far-reaching consequences of this kind of intractable stigma. I don't want my work to draw attention to family members or their diagnoses for that reason.

Ann: This is heartbreaking. I am so sorry that this happened. It really speaks to the need to tell more stories about mental illness and other diseases that are often hidden or invisible.

A complicating methodological factor in embodied research is that our bodies, of course, live and move with other human and nonhuman bodies. When we purport to add to generalizable knowledge on a specific condition or set of conditions, we must contend with the heavy ethical burden that comes with presuming to know the bodies whose everyday lives are affected by them. Equally pressing is the need to take the private health data of others very seriously. While we wish for our work to have an ameliorative effect on the stigmas that follow certain diagnoses, we cannot control how our representations of health and medical realties are taken up by readers. Thus, considering the ethics of representation as a key component of embodied research methodologies in RHM would seem appropriate. (Cathryn)

ON DETERMINING WHETHER TO DISCLOSE AND THE DEGREE AND TIMING OF DISCLOSURES

Of course, researching topics with which one has a personal connection does not always mean that this information is a heavy presence in the research write-ups. Indeed, there is a continuum where most health and medical research projects involving personal exigencies fit between full disclosure, heavy narration, and complete omission of the personal connection. We, therefore, find decisions about whether to disclose, the degree of disclosure, and the timing of disclosure to be especially rhetorically sensitive, and we aren't always fully confident in our choices. Indeed, sometimes we feel quite stuck in "lose-lose" situations around the question of disclosure. As our conversation on the ethics of representation makes clear, sometimes sharing these stories is risky; we can't be sure if we'll be met with compassion and understanding or whether we (and our competencies) might, instead, be judged. At the same time, omitting personal connections to research topics brings its own set of risks, including inadvertently inviting critique and stigma from audiences who fail to appreciate our personal investments in them. Moreover, there are limits to the confessional mode that are hard to ignore, and there is a great deal of linguistic baggage to the idea of "coming out." Where (and if) to "out" ourselves is in a constant state of negotiation and renegotiation when we engage in these projects. There is a humility in telling our stories, and there is deep care in telling others' stories. (Cathryn)

In our own words:

Cristy: I wanted my audience to know that I didn't go to this community as a morbidly curious outsider, and I can be trusted with their words. Self-disclosure was important to me. Writing about my methodological choices was inseparable from writing about me. Did you feel this responsibility, too?

Jeff: I appreciate your position, Cristy. I'll add that, as a queer scholar, I'm well aware of the limits of the confessional and the trappings of "coming out" as a rhetoric. But coming out is not a uniform process. Different forms of diabetes will incite variable incarnations of the coming out narrative. In this way, context is everything. Those with type 2 diabetes often find kinship with rote scripts about choice, excess, and personal responsibility that continue to be used against LGBT people. People with type 1, conversely, are often met with familiar rhetorics about genetics and narrow conceptions of agency and identity. As with queerness, there are often risks to coming out as "crip," and there are also limitations to rendering diabetes to the private sphere. Diabetes is often clouded in shame, and rarely articulated to pride, and this reality has certainly affected our ability to organize, lobby, and demand resources.

Ann: I appreciate your position here, Jeff. I often have to ask myself, "Who am I in this body?" Meditating on my position in this particular body is the place I begin when I think about the ethics of representation. Cisgender, white, straight, ordinary. Fibroids and a bumpy thyroid (technically a "goiter") that need to be checked to make sure they are benign (and they have been). Breasts that radiologists call "extremely dense" for mammograms. Regular ultrasounds. Periodic needle biopsies of various parts. Tests covered by good insurance that is a benefit of the increasingly rare tenured job. Rare complications with a bill that are straightened out, but an amazing number of tests for a healthy almost fifty-year old person. These are things I want to disclose as they are deeply present in my researching and writing experiences.

Jenell: Interesting. For me, disclosure is performative—it does what it says—and so the question that we must always ask ourselves is, "What do I want this to do?" Some people with visible illnesses or disabilities do not have the privilege of choice. Considering the discrimination that comes with illness and disability (particularly when it comes to employment or access to health insurance), some in precarious positions may not want to shoulder the considerable risk that comes with being "out" as ill or disabled. Some simply may not wish to turn the volume on our parts up that much. We are always in our research one way or another—the question is a matter of degree. It's a little bit like mixing a record. As writers, we have the power to adjust the volume of our own parts in relation to the others in different ways.

Molly: Discrimination is also a real concern for me, Jenell. In fact, receiving insensitive, unkind or hostile comments has not exactly encouraged me to go out of my way to report that I am one of the patients that other scholars have poked fun at or been repulsed by, and I think it's important to remember: even if I don't disclose, my work is introducing IBD to reviewers and readers who may otherwise go their entire lives being unaware of the realities of these conditions. My writing and research—whether I admit my patient status or not—are acts of care and acts of advocacy. Your point, Jenell, about adjusting the volume on how and to what extent we share our various identities is really important. Neither disclosing nor concealing are easy choices, but we can't ever really turn off our patient status or our investment in our projects—concealing is an explicit choice, but having Crohn's is key to who I am, how I see the world, and how I write. I can definitely turn down the volume, but I can't shut off the record, if that makes sense. I am the body doing the research and the writing no matter what.

Maria: Molly, I feel your sentiment about receiving insensitive, or even hostile comments, when trying to put forward scholarship that is both personal and intellectual. It hurts; you feel it in your body. I think this affectual consequence is the result of the reality that there is a lot of "coming out," as Jeff put it, when your research is personal, and without doubt, it can be fatiguing. Because of the fatigue of wearing an identity in RHM work, I think there is a space to consider how our methodologies support moments of self-care. RHM work lives on and through multiple bodies, including our own bodies. A question I have for other RHM scholars, then, is: What does care look like for all bodies involved in our work (our participants, our readers, and even ourselves)?

Jenell: Oh, yes, Maria! Fatiguing. Very exhausting. And exhausting in interesting ways. As we know, the process of publication is very long, which lends a weird temporality to disclosure in published writing. I reveal my experiences with infertility in *Graphic Reproduction*, which was published this year. However, the comic was written two years ago, and I wrote it about a year after I had come to terms with ending treatment. But for readers, it's immediate; it *just happened* for them. So, for the last couple of months, I've been fielding questions like, "How are you doing?" I'm confused until I remember that the reason they're asking about my well-being is because they *just* read about my experiences from six years ago. It's exhausting to relive something you've put behind you.

Cathryn: Wow, well said, Jenell! Let's add this to the many consequences of lag time in academic publishing?

Ann: I would say so! Also, there is a part of "coming out" that is always a process. It's not a single moment. I have mentioned depression in other pieces I have published, but it has not been in the bulk of my writing, which has often included reflections on race and class. At this cultural moment, though, I am thinking about how to integrate depression into my writing, in part because of my social location as tenured professor. I am "safe." I can choose when and where I publish from this position of privilege and make depression—an invisible illness—visible. Oddly enough, because students' depression and anxiety is more visible now, I think it's easier to write about my own depression. Twenty years ago, it was easier to disclose a working-class background than to disclose a mental health issue. I worry that our ability to disclose is undercut by precarity.

Cathryn: Maybe the precarity is necessary. Researching misdiagnoses of symptoms that were supposedly "in the person's head," but turned out to be treatable medical diseases, necessitates a bit of self-disclosure during participant recruitment and data collection. The participants I speak with naturally want to know if I "have something," if I have what they have, and if I've ever been misdiagnosed myself. To withhold this information from them would seem unfair, and to do so in the research write-ups that follow this study will be similarly unjust.

Bryna: I can definitely see that. As an insider in my own research area, I always have to take a step back and question my research. Do I have evidence to support this claim that isn't only my personal experience? Do I know this information from my data, or is it from my experience? I have to resist the urge to be the corroboration for my data and ensure that it corroborates itself. Of course, being an insider makes this kind of research emotional, as well. It is sad to read about people who are experiencing what I have experienced or worse.

Ann: Yes.

We find value in the explicit discussion of personal connections to research topics and have seen similar work emerging in RHM, such as Maria Novotny's (2015) multi-authored essay that traces the methodological practice of rhetorically listening to one's body as a valid site of knowledge-making, Jenell Johnson's (2018) graphic edited volume, *Graphic Reproduction*, in which she reveals her personal experiences with reproductive healthcare. Still, other scholars have valid reasons for leaving personal connections to their research out of the research write-ups that follow their inquiries, such as Molly Kessler's (2016) essay on wearable technologies for those with inflammatory bowel disease (IBD), where a discussion of her own illness experiences might have distracted from the primary focus on public discourses surrounding ostomy pouches. Similarly, in Jeff Bennett's (2014) essay on the "Born this Way" blog and in Bryna Siegel-Finer's (2016) essay on BRCA+ bloggers, a prolonged personal discussion of their relationship to the topics of their research might have distracted from the blog participants they wished to highlight. As rhetoricians, we find that the decision to disclose a personal connection to research in RHM is heavily dependent on context. That is, instead of advancing a hard-and-fast stance, such as the mandate that researchers disclose personal connections to their work, we'd advocate for each writer taking careful stock of the rhetorical aim of the project, the new knowledge the research might advance, and how the admission of a personal connection might be carefully calibrated to these elements. (Cathryn)

Conclusion

Personal experiences can add a powerful dimension to research, and research that grows out of corporeal realities has the potential to help us to trust our bodies again after life-altering diagnoses. As well, recasting painful bodily experiences into our research agendas can offer productive ways to process the visceral and temporal dimensions of health and medical realties. We believe our own experiences researching and writing from personal health and medical realties have made us more careful and thoughtful writers and scholars. For example, Bryna's work with BRCA+ grows out of a life-altering set of prophylactic surgeries that, along with considerable pain and suffering, plunged her into premature menopause and permanently altered the composition of her body. These experiences with extreme pain and irreversible bodily change make her hyperaware of participants' complex subjectivities.

We hope this dialogue serves to create a more open space for rhetoricians of health and medicine to calibrate their identifies as variously entangled with their work—in whatever capacity—as we explore research areas and share methods/ologies and findings. Embodied methodologies' focus on the bodily experiences of researchers and participants shifts and expands ethics in significant ways and encourages researchers to consider how the personal does or does not impact the scholarly question. Moreover, strategic decisions on disclosure impact the actual research practice of embodied methodologies.

Table 1. Heuristic tool for working with personal health and medical topics in RHM research

Part I: Why am I choosing a personal health and medical topic for formal inquiry?
(*explore your exigencies in a 10-minute, uninterrupted freewriting exercise*)

Part II: Who am I helping by writing about this?

- *Am I helping rhetoricians?*
- *Am I helping people with the same condition?*
- *Am I helping medical practitioners?*
- *Am I helping myself?*

Part III: Whether, how, when and to what degree do I reveal the personal?

- *Why am I revealing the personal story behind this work?*
- *To what extent should I reveal the personal?*
- *Where in my write-up would the personal advance my rhetorical aim?*
- *What are the risks of revealing my own or my loved one's personal connections to this topic?*
- *What are the rewards of revealing my own or my loved one's personal connections to this topic?*
- *How can I build trust and credibility?*
    - *With my participants?*
    - *With my readers?*

Part IV: Representation

- *Do my representations of self and others take intersectional realities into account?*
- *Does this research project risk appropriating the experiences of others?*
    - *If so, how might I minimize this risk?*
- *Have I done my due diligence in securing informed consent from anyone whose reality I am representing in my work?*
- *How might I continually seek out opportunities to represent my participants in ways they'd value?*
- *How does the presence of my physical body alter the research scene?*

Part V: Self-care

- *How might I build opportunities for self-care into this research process?*
- *How is my physical body affected by this work?*
- *How is my emotional wellbeing affected by this research?*
- *How are my loved ones physically or emotionally affected by this work?*

We hope our field continues to search for ways to address, reflect on, and report on the many identities, experiences, and life positions that make us able to do the most committed, productive, and ameliorative work possible. Engaging with these important issues draws attention to the necessarily embodied nature of research. We urge those working in RHM to take methodological care and to be explicit in their methodological decision-making.

As we mention above, our experiences suggest the appropriateness of adopting a heuristic orientation when considering embodied methodologies in RHM. Janice Lauer (2003) described heuristic as in opposition to hermeneutic (p. 3). Heuristic thinking is a more "flexible way of proceeding in creative activities than formal deduction or formulaic steps and a more effective way than trial and error . . . heuristic strategies work in tandem with intuition, prompt conscious activity, and guide the creative act but never determine the outcome" (p. 8). Heuristic inquiry is "exploratory, serendipitous, and discovery-oriented; it is "intuitive, introspective, and reflexive; experiential, embodied, and holistic; existential and humanistic; culturally embedded and emancipatory; relational, authentic, and participatory; imaginative and creative; nonlinear, fluid and flexible" (Sultan, 2018, p. 3). Given these characteristics, our dialogue suggests that heuristic inquiry might be a promising methodological terrain for RHM scholars to take up as well, and to that end, we offer above a model of one possible heuristic to help guide our collective work. In this spirit, table 1 offers some questions that we'd include in an inventional tool for those considering RHM projects that align with embodied experiences or exigencies.

Readers: the questions a researcher interested in an embodied methodology in RHM might ask are nearly endless, so we invite you to adapt, use, and share this heuristic tool, and we also want you to think with us, to think of these questions, alongside our themes, as provocations for future conversations. What resonated? What did we miss? What did we get wrong? What do we need to know from your experiences and observations?

Cathryn Molloy is an associate professor in James Madison University's School of Writing, Rhetoric and Technical Communication where she serves as director of undergraduate studies. Her RHM work, which explores issues of rhetorical ethos in health and medical contexts, has appeared in *Rhetoric Society Quarterly*, *Rhetoric Review*, and *Qualitative Inquiry*.

Cristy Beemer is associate professor of English and coordinator of the professional and technical writing program at the University of New Hampshire. Her work has appeared in *Rhetoric Review*, *Pedagogy*, *Praxis*, and the collection *Performing Feminism and Administration in Rhetoric and Composition Studies*.

Jeffrey Bennett is an associate professor of Communication Studies at Vanderbilt University. His second book, *Managing Diabetes: The Cultural Politics of Disease*, is forthcoming from NYU Press in spring 2019. He is also the author of *Banning Queer Blood: Rhetorics of Citizenship, Contagion, and Resistance*.

Ann E. Green is a professor of English at Saint Joseph's University where she teaches "Hospital Stories," a service-learning course in narrative medicine. She received the 2017 Outstanding Leader in Experiential Education Award from NSEE. Ann has published in *The Intima*, *CCC*, *The Huffington Post*, and The LARB Blog.

Jenell Johnson is Mellon-Morgridge Professor of the Humanities and associate professor of Rhetoric, Politics, and Culture at the University of Wisconsin-Madison. She is the author of *American Lobotomy: A Rhetorical History*, editor of *Graphic Reproduction: A Comics Anthology*, and co-editor of *Biocitizenship and The Neuroscientific Turn*.

Molly M. Kessler is assistant professor of Writing Studies at the University of Minnesota-Twin Cities. Her research areas include rhetoric of health and medicine, technical communication, and disability studies. Most recently, her research has focused on patients' lived experiences within the context of digestive diseases and the gut microbiome.

Maria Novotny is assistant professor of English at the University of Wisconsin-Oshkosh, where she teaches writing and rhetoric courses. Her research examines intersections of health activism, community literacy, and cultural rhetorics. Much of her work centers on her community-engagement with a reproductive loss arts exhibit, The ART of Infertility.

Bryna Siegel Finer is associate professor and the Director of Liberal Studies English and Writing Across the Curriculum at Indiana University of Pennsylvania. Bryna's scholarly work can be found in *Rhetoric Review, Teaching English in the Two-Year College, Praxis, the Journal of Teaching Writing* and others. She is the co-editor of *Writing Program Architecture: Thirty Cases for Reference and Research.*

References

Beemer, Cristy. (2016). From the margins of healthcare: De-mythicizing cancer online. *Peitho*, *19*(1), 93–127.

Belser, Julia. (2016) Vital wheels: Disability, relationality, and the queer animacy of vibrant things. *Hypatia, 31*(1), 5–21.

Bennett, Jeffrey. (2014) Born this way: Queer vernacular and the politics of origins, communication and critical/cultural studies. *Communication and Critical/Cultural Studies, 11*(3), 211–230.

Bivens, Kristin. (2018). Rhetorically listening for microwithdrawals of consent in research practice. In Lisa Melonçon & J. Blake Scott (Eds.), *Methodologies for the rhetoric of health & medicine* (pp. 138–156). New York: Routledge.

Ellingson, Laura. (2017). *Embodiment in qualitative research.* New York: Routledge.

Frost, Erin, & Haas, Angela. (2017). Seeing and knowing the womb: A technofeminist reframing of fetal ultrasound toward a decolonization of our bodies. *Computers and Composition, 43*, 88–105.

Gonzales, Laura, & Bloom-Pojar, Rachel. (2018). A dialogue with medical interpreters about rhetoric, culture, and language. *Rhetoric of Health & Medicine*, *1*(1–2), 193–212.

Green, Ann E. (2018) The safest place to teach in America is a prison. Retrieved from https://blog.lareviewofbooks.org/essays/safest-place-teach-america-prison/

Haraway, Donna. (1988). Situated knowledges: The science question in feminism and the privilege of partial perspective. *Feminist Studies, 14*(3), 575–599.

Hausman, Bernice. (2003). *Mother's milk: Breastfeeding controversies in American culture.* New York: Routledge.

Hensley-Owens, Kim. (2015) *Writing childbirth: Women's rhetorical agency in labor and online.* Carbondale: Southern Illinois University Press.

Hevey, David. (1992). *The creatures time forgot: Photography and disability imagery.* New York: Taylor & Francis.

Johnson, Bethany, & Quinlan, Margaret. (2017). Insiders and outsiders and insider(s) again in the (in)fertility world. *Health Communication, 32*(3), 381–385.

Johnson, Jenell. (2018). *Graphic reproduction: A comics anthology.* University Park: Pennsylvania State University Press.

Kessler, Molly. (2016). Wearing an ostomy pouch and becoming an ostomate: A kairological approach to wearability. *Rhetoric Society Quarterly 46*(3), 236–250.

Lauer, Janice. (2003). *Invention in rhetoric and composition.* Anderson, SC: Parlor Press.

Lee, Mihan. (2017). Don't Give Up! A Cyber-ethnography and Discourse Analysis of an Online Infertility Patient Forum. *Culture, Medicine, and Psychiatry*, *41*(3), 341–367.

Melonçon, Lisa. (2018). Bringing the body back through performative phenomenology. In Lisa Melonçon & J. Blake Scott (Eds.), *Methodologies for the rhetoric of health & medicine* (pp. 96–111). New York, NY: Routledge.

Molloy, Cathryn. (2015) Getting by or getting in?: Grappling with access and affect in qualitative research projects involving vulnerable human subjects. *Qualitative Inquiry, 21*(5), 467–476.

Novotny, Maria, Johnson, Maureen, Levy, Daisy, & Manthey, Katie. (2015). Embodiment: Embodying feminist rhetorics. *Peitho 18*(1), 39–44.

O'Toole, Corbett. (2013). Disclosing our relationships to disabilities: An invitation for disability studies scholars. *Disability Studies Quarterly, 33*(2), n.p.

Price, Margaret. (2011). Mad at school: Rhetorics of mental disability and academic life. Ann Arbor: University of Michigan Press.

Pryal, Katie Rose. (2018, June 29). What happened to Katie's head? Retrieved from https://katieroseguestpryal.com/2018/06/29/what-happened-to-katies-head/

Rapp, Rayna. (2000). *Testing women, testing the fetus: The social impact of amniocentesis in America*. New York: Routledge.

Siegel-Finer, Bryna. (2016) The rhetoric of previving: Blogging the breast cancer gene. *Rhetoric Review*, *35*(2), 176–188.

Sontag, Susan. (1989). *AIDS and its metaphors.* New York: Farrar, Straus and Giroux.

Spatz, Ben. (2017). Embodied research: A methodology. *Liminalities: A Journal of Performance Studies, 13*(2), 1–31.

Stacey, Jackie. (1997). *Teratologies: A Cultural Study of Cancer.* New York: Routledge.

Sultan. Nevine. (2018). *Heuristic inquiry.* Thousand Oaks, CA: Sage.

Vinson, Jenna. (2018) Embodying the problem: The persuasive power of the teen mother. New Brunswick, NJ: Rutgers University Press.