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Beyond the “Fetishism of Words”: Considerations on the Use of the Interview to Gather Chronic Illness Narratives

Nathan Miczo

The author explores the technique of interviewing chronic illness patients to obtain narratives of their illness experiences. It is argued that the perspective that interview responses are accurate reflections of experience (the “fetishism of words”) hampers the understanding of patient voice and agency. Discussions of chronic illness and narrative are followed by an examination of the interview based on the work of Charles L. Briggs. The author then uses the concepts of self-presentation and social support to examine what interviewers and interviewees contribute to the coconstructed discourse that is produced by the interview and addresses the question of how these concepts contribute to the beneficial outcomes of constructing narratives. The author offers specific suggestions for future research.

Keywords: *chronic illness; narratives; qualitative interviewing; self-presentation; social support*

In a recently published keynote address, Margarete Sandelowski (2002) argued that theoretical development in qualitative health research was being hampered by a naive view of the chief methodological tool of such research, the qualitative interview. She stated that qualitative researchers are “in danger of taking what people say in interviews at face value as revealing *what is behind the face* and thus are in danger of being taken in” (p. 106, italics in original). What they are being taken in by is the belief that the interview “reveals authentic experience” (p. 105), and thus they presume that what is said by a respondent can be treated unproblematically as a direct expression of the true, or private, self. In contrast to the “fetishism of numbers” (treating statistical abstractions as real entities to be acted on) that characterizes quantitative research, qualitative researchers might be characterized as suffering from a “fetishism of words,” the treatment of words as real entities that stand for the experiences they represent. My purpose in this article is to slip behind the face, as it were, and to examine the interview as a communicative event. For example, establishing rapport is seen as a key factor in conducting a successful interview. But providing rapport is also a relational message that tells interviewees what is

AUTHOR’S NOTE: An earlier version of this article was presented to the Interpersonal Communication Division, National Communication Association convention, Atlanta, GA, November, 2001. The author wishes to thank Mark Nichter and Susan Philips for the original impetus to this article; Lisa Miczo for editing and commentary on earlier drafts; and Janice M. Morse and two anonymous reviewers for their suggestions on the original manuscript.

QUALITATIVE HEALTH RESEARCH, Vol. 13 No. 4, April 2003 469-490
DOI: 10.1177/1049732302250756
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permissible and/or expected. The consequence of failing to appreciate such metacommunicative factors is that power issues in the interview are masked and patient voice is actually distorted to serve the requirements of academia. As a result, knowledge and understanding of patients' communicative responses to illness does not advance.

In this article, I use the case of chronic illness and the practice of collecting patient narratives to explore issues surrounding the interview as a communicative event. Chronic illness is treated as an exemplar of the type of situation that is particularly amenable to qualitative treatment. That is, chronic illness is uncertain and open-ended, allowing for multiple interpretations, including patient voice; it is often met with intense emotional responses at various points, suggesting the appropriateness of a confessional mode of discourse (Atkinson & Silverman, 1997); and it typically poses a threat to valued identities, prompting the need to construct accounts and justifications. Accordingly, I begin by providing some context for the illness interview with brief discussions of chronic illness and narrative. I then proceed to an analysis of the interview, relying heavily on the work of Charles L. Briggs (1986). The concepts of self-presentation and social support are then used to provide a greater understanding of what is going on in the interview. The article closes with my suggestions for future research based on the application of the concepts.

At the outset, three caveats should be mentioned. First, although chronic illness is an ideal illustration for many of the points raised in this essay, I do not mean to restrict my argument to chronic illness. Much of what is said should apply to other conditions, such as bereavement, abuse, unemployment, or accidents, with many points being applicable to any interview situation. Second, given the scope of the article, I have drawn on research selectively. I would be the first to admit that it is problematic to ignore potentially contrary evidence, or even to fail to seek it in the first place, and many might take issue with some of the assumptions and strategies I outline as prototypical of the interview. However, this topic would require a book-length treatment to truly do it justice, and, thus, generalizations have been made. Third, many chronic illness patients suffer profoundly from their condition, physically, emotionally, socially, and spiritually (Kleinman, 1988). By examining issues such as self-presentation, I do not intend to minimize or trivialize that suffering and pain. Rather, my position here is that restoring voice and agency to patients' demands that we consider what they are doing, and what they desire from that doing, when they agree to sit down and talk about their illness experiences.

CHRONIC ILLNESS AND PATIENT WORK

A working definition of chronic illness ought to begin with a consideration of health more generally. Research on "lay definitions of health" consistently reveals a multi-dimensional variable, with three aspects emphasized. First, health is an embodied state reflecting the person's experience of his/her body and the feeling states associated with that body (Colantonio, 1988; Telles & Pollack, 1981). Second, health is a resource that allows one to engage in desired activities (Frankish, Milligan, & Reid, 1998; Saltonstall, 1993). Third, health is a positively valued social attribute that influences one's identity and "fitness" (Backett, 1992; Miczo, 1998). If these dimensions are considered as continuums rather than dichotomies, then illness, when opposed to health, becomes a difference in degree rather than kind. That is to say, ill-

ness is a disruption of normal body states and functioning, and/or an alteration in the experience of one's body; it depletes and diminishes resources, including such things as energy levels, finances, and social ties; and it deprives one of status and esteem, rendering questions about one's fitness problematic. What defines an illness or condition as chronic is that it is characterized by its open-ended nature; because there is no "cure," the disruption, depletion, and diminishment of illness often become extreme in their effects. Although the list of chronic and/or disabling conditions can be quite lengthy (cf. Lyons, Sullivan, Ritvo, & Coyne, 1995, p. 7), for the purpose of this article, a chronic illness or condition is defined as a condition with an uncertain probability of course, cure, and/or recovery. Issues of whether the condition is progressive or associated with a pattern of acute episodes are of secondary importance in this instance. Emphasis is placed on the uncertainty inherent in chronicity.

Social life is shaped to a considerable degree by roles, which provide sets of behavioral expectations for what is appropriate and effective (Thoits, 1983) as well as ways of integrating and giving meaning to experiences. Insofar as the chronically ill body is surrounded by uncertainty, it is brought under control and made safe by being hedged about with expectations and modes of work. As with any role, then, the patient role defines the work that ill persons must engage in to be considered competent and to have their experiences validated. Corbin and Strauss (1985) describe the "work of illness" under the rubric of identity work, consisting of three types: illness trajectory work, everyday life work, and biographical work. Illness trajectory work concerns activities focused on the management and regulation of the illness experience. Patients must learn how to obtain needed and desired information while navigating medical bureaucracies. They must learn how to manage treatment regimens, diet regimens, exercise regimens, and medication regimens. They must learn to adapt to changes in body functioning and alterations in mobility, as well as to pain and fatigue. Also included here is emotion work, "the work required [by patients] to regulate their emotions, to protect themselves and their families against excessive depression or anxiety, and to prepare themselves for the fearful events that were anticipated in the course of the illness" (Thorne, 1993, pp. 43-44). Emotion work is included here because these emotions often arise as a function of the illness itself. In sum, becoming chronically ill involves one in a variety of activities, whose performance plays a large part in defining what it means to be chronically ill.

Everyday life work concerns the pursuit of pre-illness goals, goals formulated during the course of the illness, and the maintenance of close relationships (Jeon & Madjar, 1998; Kaufman, 1988; Larson, 1998). Of particular interest here is what might be termed "interactional work." A great deal of research attests to the strains and difficulties in interactions between the healthy and the chronically ill. According to Hebl, Tickle, and Heatherton (2000), these "awkward moments" in normal-stigmatized interaction arise from both sides. Healthy individuals might be uncomfortable because they do not know what to say, or fear saying the wrong thing. They might avoid interaction because they fear physical or social contagion. They might also engage in interpersonal rejection if the ill person is experiencing depression (Coyne, 1976; Vaerum & McCabe, 2001). Patients, on the other hand, might anxiously fear rejection from partners, or fear being evaluated and treated as a disease rather than as a person. Perhaps partly as a result of these factors, patients can overinterpret others' behaviors in a critical or negative fashion. These strained

interactions can take on a superficial appearance. In a study by Peters-Golden (1982), healthy individuals perceived their role as that of encourager, believing that if they made an effort to appear cheerful and optimistic, then patients should reciprocate with positivity of their own. The recipient breast cancer patients, on the other hand, often resented this forced cheerfulness as a barrier that prevented them from talking about their true feelings and experiences. In addition, patients reported being "babied" and made to feel incompetent in performing everyday tasks, whereas the ability to perform such tasks was taken as a hallmark of "good health." Thus, interactions between the healthy and the chronically ill are often marked by anxiety and avoidance; when they do occur, the patient often experiences infantilization and invalidation. This suggests that the patient role is a low-status one, lacking the status shields that validate and protect the self-esteem and social position of the well person (Freund, 1990).

Biographical work involves making sense of and finding meaning in the event that has befallen one (Bury, 1982; Charmaz, 1983; Mathieson & Stam, 1995). This type of work rests on ideas about self and temporality. The biography of the self consists of recollections of the past and imaginings of the future, both of which can become reference points for present understandings. Self-conceptions and temporal constructions interact and influence one another continually. Insofar as chronic illness influences present experiences and understandings, it can touch the entire biography. One aspect of the biography, then, involves the changed relationship of the ill person to his/her body. The disruption and alteration of body functioning can lead the patient to experience the body as a betrayer that can no longer be trusted. In addition to its impact on embodied states, illness can initiate an intense scrutiny of the past. To address the questions, "Why me? Why now?," individuals may reinterpret past events as potential causative agents. Also, plans and goals that had been projected into the future might be deemed no longer attainable. If that is the case, it logically follows that one must review present options, recasting plans and goals, or abdicating them altogether. Because chronic illness often disrupts the temporal experience of the self, biographical work is an important part of reasserting a socially valued and valuable self into the social category of time.

With respect to the "works of illness" described above, two points must be addressed. The first is that these three types of work exert reciprocal influences on one another. Corbin and Strauss (1985) described the difficulties in achieving equilibrium, or a state of relative balance: "Even under the most routine conditions of illness and everyday life, but even more so during critical periods of the illness, there is a tug-of-war between the requisites of trajectory management and those of everyday life and biography" (p. 233). During acute phases, illness trajectory work can dominate the patient's life. Time spent on illness management, however, comes at the expense of attention to one's social network and close relationships, contributing to feelings of loneliness and isolation (Lyons & Meade, 1995). These feelings can result in negative emotional states that further strain interactional work. On the other hand, having close others who are supportive can facilitate a smoother passage through the illness trajectory.

The second point is that much of what we know about the works of illness has been obtained through patients' recollections. That is, whereas biographical work clearly involves the translation of experiences of self and temporality into words, it is often the case that patients are asked to translate their experiences of trajectory

work and everyday life work into words as well. This is not to deny the voluminous research on the actual communication patterns of, for example, doctors and patients (Ong, De Haes, Hoos, & Lammes, 1995; Thompson, 1994), or between "normals" and the stigmatized (Heatherton, Kleck, Hebl, & Hull, 2000). However, this research has only an indirect bearing on how the identity work of chronically ill patients is actually conducted in their day-to-day lives. This is because these patients who are asked to recount their experiences are often not the same ones who participate in interaction studies. Thus, in talking about their illness trajectories or everyday life work, patients are doing something other than engaging in that work itself. They are telling stories about those "work" experiences. The next section elaborates on this proposition by examining the narrative concept more closely.

NARRATIVE APPROACHES

The human propensity to construct narratives is a cultural universal (Fisher, 1984; Scalise Sugiyama, 1996). Definitions of narratives, or accounts, abound: "Generally, narratives are understood as stories that include a temporal ordering of events and an effort to make something of those events" (Sandelowski, 1991, p. 162); "They are meanings organized into a 'story' and thus represent more than collections of disparate attributions" (Harvey, Agonstinelli, & Weber, 1989, p. 40); "narration allows the storyteller to construct himself or herself, social others, and social events in meaningful ways" (Singer, Scott, Wilson, Easton, & Weeks, 2001, p. 593). These definitions share the idea that narratives are stories organized to allow the individual to make sense of, or impose order on, a set of related experiences. Put succinctly, narrative is motivated biographical work. That is, although all people carry around with them their biography, those biographies are not always organized into a coherent story. The question that naturally arises is, "What conditions might motivate individuals to construct stories out of their biographies?" One such condition is the experience of a traumatic event (Williams, 1984). If it is true that individuals seek to make sense of themselves and their environments (Giddens, 1991; Strauss, 1959; Swann, 1996), then any occurrence that threatens established meanings can prompt a narrative response. It must be borne in mind, however, that stories are told to audiences. A second condition that might motivate storytelling, then, is the prompting of an interaction partner. In other words, people tell stories because someone asked them to tell a story.

This method of conceptualizing narratives rests on two assumptions. First, it is assumed that the truth value of narratives depends on the subjective experiences and interpretations of the storyteller rather than truth in an objective sense. This emphasis on the experiences of the individual as constituting social reality is consistent with a phenomenological approach: "At the core of phenomenological analysis is a deep respect for the uniqueness of human experience" (Thibodeau & MacRae, 1997, p. 71). All stories and, by implication, perhaps, all experiences, are not constructed equally, however. Fisher (1984) proposed that audiences evaluate stories against the criteria of narrative probability (the guidelines for what constitutes a coherent story) and narrative fidelity (the assessment of whether the story "rings true" with other stories the audience knows to be true). This suggests that the uniqueness of narrated human experience is bounded by the storyteller's and audience's

awareness and shared understanding of conventions and subject matter. One will not be able to escape cultural modes of relating and ideologies in consideration of narrative.

Second, it is assumed that constructing a narrative, particularly in the wake of a traumatic experience, is beneficial to the individual (Borkan, Quirk, & Sullivan, 1991). Smyth, True, and Souto (2001) offered an explanation for this improvement outcome. They argued that following a traumatic experience, thoughts and feelings are not integrated, "possibly resulting in memory being stored as sensory perceptions, obsessional ruminations, or behavioral reenactments" (p. 162). The process of creating a narrative integrates these thoughts and feelings, allowing memories about the event to be managed more efficiently and leading to reduced distress about the event. Other models of the account-making process (i.e., Harvey, Barnes, Carlson, & Haig, 1995; Harvey, Weber, & Orbuch, 1990) stress the end product of the account as identity change or a sense of completion or acceptance.

The pervasiveness of human narrative activity suggests that it is functional for both storyteller and audience. Although Fisher (1984) suggested that the key to narrative success is suggestion and fostering identification, others have focused on how storytellers manipulate information to serve their own interests (LaRossa, 1995; Scalise Sugiyama, 1996). LaRossa posited that the meaning of stories resides in their ability to make distinctions: "Stories allow people to lump themselves with some individuals, and split themselves from others—to create islands of meaning generally known as 'selves' and 'others' " (p. 555). Scalise Sugiyama argued that individuals who have information that others lack might be sought out as storytellers. Narrators, then, "may acquire social benefits (such as increased status) through the possession of special knowledge" (p. 417). On the other hand, the benefit to listeners is information acquisition (Scalise Sugiyama, 2001). Listeners can obtain information about their social environment without "undertaking the risks and costs of firsthand experience" (pp. 223-224). The emphasis on status and information control suggests that storytelling is not innocuous: Stories have moral and political implications.

Chronic illness narratives are stories about conditions with an uncertain probability of course, cure, and/or recovery. It has been suggested that these storytellers are motivated by the need to reorganize understandings in the wake of the disruptions of illness and/or by the promptings of audience members. Narrators can acquire social status by virtue of their possession of special knowledge and their ability to manipulate information, whereas audience members can acquire information that is potentially relevant to them in their local social worlds. Given the interactive nature of storytelling, it is possible that the beneficial effects of crafting narratives reside, at least in part, in the increase in social status that accrues to the narrator. This might be especially the case with chronic illness, where the patient role lacks other types of status shields. This success, however, is contingent on whether the story "rings true" with the audience. Stories will ring true to the extent that they conform to expectations, which are shaped by the situation in which the story is delivered, the social roles of storyteller and audience, and shared understandings regarding the structure and content of stories. One particular situation with a bearing on the chronic illness narrative is the social science interview.

THE INTERVIEW IN SOCIAL SCIENCE

The interview is, perhaps, the most commonly used methodological tool in social science research (Atkinson & Silverman, 1997; Briggs, 1986; Sandelowski, 2002). It is certainly one of the "easiest" to learn, at least compared to advanced statistical techniques. It is useful for acquiring fairly large amounts of data in a short period of time. This apparent ease and efficiency, however, can contribute to the lack of reflection on the social-cultural underpinnings of the interview. It seems very natural to us to collect information in the question-answer format. It is a method inculcated in schools, where students sit passively absorbing information, with the frequent admonishment to "ask questions if you don't understand something." It reflects a Cartesian dualism, where the disembodied mind is asked to provide information, usually about the habits and preferences of the silenced body. It also accords with a culture of efficiency, where obtaining desired information via observation would simply be too time consuming. It is precisely in those areas that seem natural, that we must be most vigilant regarding ideological influences on our own behavior.

Briggs (1986) has provided an insightful analysis of the interview. He begins by defining the interview as a face-to-face interaction, which involves a researcher posing questions to a respondent in a research context (pp. 6-7). Although the definition is straightforward, the interview as a communicative event is far more complex and much more under-studied. Briggs highlights three overlooked aspects of the interview. First, whereas the social activity that drives the interview is talk, this is often talk about activities, actions, and conversations that occur, or have occurred, in another place and time. Understanding this metacommunication requires a great deal of competence in the linguistic repertoires of the speech community under study; it cannot be assumed that interviewers understand all the repertoires that respondents might draw on, even if they come from the same culture as their respondents. Second, for the interview to be conducted successfully, participants must agree, at least implicitly, to abide by certain communicative norms. The effect of these norms is to move "the roles that each normally occupy in life into the background and structures the encounter with respect to the roles of interviewer and interviewee. Attention is concentrated on the topics introduced by the researcher's questions" (pp. 2-3). The problem with this is that it deflects attention away from the interview as a speech event in its own right. Third, respondents might resist the communicative norms imposed by the interview. This might be especially the case if the norms of the interview are inappropriate relative to other communicative norms of the speech community (e.g., who has the right to ask questions of whom in the community?). If interviewers are not well-versed in the necessary communicative repertoires and are not focused on the interview as a speech event, they might overlook critical instances in which the interviewee is "breaking frame" and doing something with the event outside the definition provided by the researcher.

To understand how and why this might occur, it is necessary to understand the distinction between the referential and indexical functions of language. *Referential* refers to the content of what is said and "rests ultimately on a perceived correspondence between the 'content' of expressions and some state of affairs in the 'real world' " (p. 42). *Indexical* is "dependent on some feature(s) of the context in which the expression is uttered" (p. 42). Indexical meanings are often conveyed nonverbally,

indicated through variations in vocalics, gestures, facial expressions, even changes of posture, although they can be signaled verbally as well. Briggs (1986) argues that the interview is highly indexical "because the meaning of responses is contingent on the questions that precede them, previous question-answer pairs, the social situation, the relationship between the interviewer and interviewee, and a host of other factors" (p. 42). In other words, the discourse produced by the interview is coconstructed (Jacoby & Ochs, 1995). Yet, researchers often analyze the transaction at the level of its referential content alone. That is, respondents' replies are treated as if they were stand-alone, independent utterances that accurately mirror a subjectively experienced state of affairs (see Sandelowski, 2002). Within this conceptualization, the role of the researcher is often considered with respect to doing what is necessary to establish rapport or keep the conversation going, rather than as a coconstructor of the final discourse.

For us to appreciate the chronic illness narrative as a coconstructed product of the interview, it would be efficacious to consider some of the factors influencing the shape and form of this type of speech event. One of those factors concerns the institutional-structural requirements that allow the interview to take place. Most studies exhibit a selection bias in the form of inclusion/exclusion criteria. To participate, patients must, at a minimum, possess the lucidity and physical ability to talk about their experiences. Beyond that, they must also consent to be participants in the interview process. Thus, before the first question has been asked, the final product has been shaped by the practical and institutional requirements of conducting scientific research. In addition to the issues of ability and willingness, there is the issue of multiple contacts over time. Phenomenological research is often guided by a grounded theory methodology (Strauss & Corbin, 1998), whereby patients are interviewed in a semi- or unstructured format (cf. Hallsdórsdóttir & Hamrin, 1996; Nelson, 1996; Thibodeau & MacRae, 1997; Utley, 1999, for examples out of the cancer narratives literature). However, to validate emerging categories and check for meaning, researchers sometimes follow up initial interviews with additional ones in which patients are asked to clarify and elaborate on earlier statements: "Areas needing clarification or elaboration were noted and addressed in subsequent interviews" (p. 1520). The necessity for this type of follow-up suggests that initial responses can, at times, be disjointed and/or hard to follow. Even when only single interviews are used, however, multiple contacts are implicated in the ethical standards of informed consent. That is, ethically, researchers are required to inform patients of what they are getting into. For example, Nelson (1996) used an unstructured format that avoided leading or suggestive questions. However, during the initial telephone contact, patients were "informed that they would be asked to describe uncertainty experiences from the time of diagnosis and treatment until the present" (p. 61). The extent to which the requirements of informed consent influence the preinterview cognitive activity of patients is an empirical question. The point being made here is that it cannot be assumed that the influence is nil. Yet, this is precisely the assumption made when the referential function is foregrounded, and data collection begins when patients begin to answer the first interview question.

The issues raised above point to how structural requirements of the interview setting have the potential to affect the final product of the interview itself. According to Briggs's (1986) analysis, we also need to explore the metacommunicative norms of the interview if we are to fully understand how patients are using the

"medium of language" (Duranti, 1994) for description and manipulation. Several norms center on the issue of content. The first concerns cultural norms about how stories are formulated. In this culture, we often expect stories to have a beginning, a middle, and an end (Sandelowski, 1991). This can influence the manner in which interviewers construct the format and order of questions, which will affect the content and appearance of responses. For example, using the quote from Nelson (1996), above, it is likely that, in preparing for the interview, patients would begin with the "time of diagnosis and treatment" trying to recall events from that period forward. Certainly, the structural requirement of answering questions in the order they are asked will force a temporal appearance on the narrative. Given the temporal assumptions of storytelling, then, it is little wonder that time is often an important element in narratives.

A second content norm concerns the focus on the experiential. Atkinson and Silverman (1997) have noted that the interview has pervaded modern society, in particular, however, the interview that "rests on a confessional mode of discourse and has as its goal the revelation of private experience" (p. 310). This conceptualization of interviewing privileges the private self and raises up personal experience as a criterion of truth and authenticity. The confession, or revelation, of the self, however, is experience writ large. On daytime talk shows, in sound bytes, interviewees are usually people who have something dramatic to say. It is unlikely that patients would not be influenced by cultural ideas about the self when presented with questions about their own experiences. Thus, although interview questions might be "about" anything, they are often about patients' experiences: with diagnosis (often a dramatic "turning point"), with medical personnel (often frustrating and unsatisfactory), with close others (often characterized by isolation and loneliness), and with regimens (often time consuming, painful, and/or impractical). Themes from the "works of illness" are represented here, laden with strong emotion, such that the audience itself cannot remain neutral. The chronic illness narrative, as revealed in the interview, is a glimpse into something intensely personal and deeply profound. As Atkinson and Silverman have stated, the interview "furnishes the viewer/reader/hearer with the promise of privileged—however fleeting—glimpses into the private domain of the speaker" (pp. 314-315). This observation accords with the argument put forth by Scalise Sugiyama (1996, 2001) about the storyteller as the possessor of special knowledge.

A third content norm concerns the idea of transcendence, or transformation. Recall that one of the assumptions of narrative is that constructing a narrative is beneficial to the teller. Writing about grief, Harvey, Barnes, et al. (1995) state, "We assume that a diligent process of account making regarding the loss and confiding parts of the account to close others are essential to an individual's arriving at the point of completion and acceptance" (pp. 216-217), where the sense of completion involves "emphasis on the possible growth in personal strength and potential for contribution to others that may be associated with dealing with major losses" (p. 216). This assumption of growth, transformation, or transcendence is mirrored in themes revealed in patients' narratives (e.g., "redefinition" in Hallsdórsdóttir & Hamrin, 1996; "gaining understanding" in Nelson, 1996; "self-transcendence" in Pelusi, 1997; "cancer as transforming" in Utley, 1999). The fundamental core of this theme is that chronic illness has had a beneficial impact on the patient's life, even to the point where some patients claim that "they would not have missed this experience

[of redefinition] because of it" (Hallsdórsdóttir & Hamrin, 1996, p. 33). Other aspects of this narrative include any of the following: experiencing a greater appreciation for relationships and for the little things in life, getting in touch with one's spiritual side, realizing what is really important in life, desiring to assist others, and "overcoming" a too great attachment to material wealth and possessions (see Ezzy, 2000, p. 614, for an example of the latter). A new self, then, is born out of the trials and tribulations of the illness experience. This idea of a distinction drawn between the old self caught up in the bustle of modern life and a new self, who realizes what is truly important, accords with Atkinson and Silverman's (1997) assertion that redemption and transformation are key motifs of confessional narratives (p. 313). This theme can also be read as part of Joseph Campbell's (1968) monomyth, where, following the overcoming of difficult trials, "the hero shall now begin the labor of bringing the runes of wisdom, the Golden Fleece, or his sleeping princess, back into the kingdom of humanity, where the boon may redound to the renewing of the community, the nation, the planet, or the ten thousand worlds" (p. 193). Metacommunicative norms regarding the appearance and content of stories are likely to influence both interviewer and interviewee, particularly when a common cultural heritage is involved. This is reflected in the way questions are structured and the way answers are given.

A metacommunicative norm with more profound implications was outlined by Radley and Billig (1996). They argued that the health status of the researcher is rarely taken into account in the conduct of illness interviews. "In consequence, respondents with a medical diagnosis are nearly always in the position of speaking to people who are not only seen to be experts in these matters, but are also health-privileged in the interviewing relationship itself, by the very fact that the interview is taking place at all" (p. 225). An exception to this lack of reflexivity is provided by Backett (1992):

In all previous work I had always concentrated on the more psychological aspects of creating rapport and mutual respect in the fieldwork endeavour. I had tried to be open, friendly, non-intimidating and dressed in the style described by [comedian] Billy Connolly as "smart but casual." This time, however, I gradually realised that I was actually bothered about how *healthy* I would appear to be. At that stage I felt that it would in some way be insulting to people to ask them about their own health and health practices whilst not appearing outwardly to be particularly healthy myself. So, undoubtedly influenced by prevailing culturally determined lay health beliefs about appearing healthy, I resolved to lose some weight and take extra exercise before starting interviewing. Thus I hoped I would appear fit and healthy. (p. 259, italics in original).

I should point out that Backett's dilemma is a two-edged sword, especially in the case of chronic illness. The very attempt to not be insulting by appearing outwardly healthy oneself actually heightens the status differential between researcher and respondent. As Radley and Billig (1996) have pointed out, the researcher is engaging in his or her occupation through the very conduct of the interview. The moral implications of not being able to participate fully in the socially valued activity of work cannot be lost on the ill. If they are to assert themselves as still valued and valuable members of the moral order, then perhaps the most efficient means at their disposal is through the social activity of talk.

SELF-PRESENTATION AND THE ILLNESS INTERVIEW

Schlenker and Pontari (2000) define self-presentation as the goal-directed activity of controlling information about the self. Based on the writings of a number of researchers (Cupach & Metts, 1994; Goffman, 1959; Leary, 1996; Steele, 1988; Swann, 1996), several propositions can be put forth. People generally attempt to present a positive image of self in social interaction. Their attempts are constrained, however, by their ability to support the definition, including such things as appropriateness norms attached to specific roles and information about the actor possessed by the audience. Situational features can also influence self-presentation. For example, Tice, Butler, Muraven, and Stillwell (1995) found that individuals presented themselves in self-enhancing ways when interacting with a stranger but were more modest in interaction with a friend. Although self-presentational concerns are ever present in interaction, backgrounding them allows participants to pursue other goals. This results in a tendency to accept another's presentation unless given a reason to do otherwise. When the self is threatened, concern with presentation is likely to move to the foreground. Reestablishing a positive self requires the attention and support of other actors precisely because the self is a social construct.

Chronic illness is a situation fraught with self-presentation concerns. The diagnostic label itself is laden with stigma and negative connotations. There are also multiple aspects of a loss of status. Patients often report being reduced to their disease. The dependency entailed by the patient role renders it a lower-status role. Acute episodes and disease progression can leave the ill person unable to work or forced to work in a reduced capacity. This can result in a loss of both employment status and financial status through reduced income. Social status can also diminish with the shrinking of networks and loss of ties. Inherent in chronic illness are multiple threats to any attempt to project a valued and valuable definition of self.

Given these threats, it is little wonder that patients often report experiencing a host of psychological symptoms, including depression, anger, and anxiety. If anything, it seems almost illogical for patients to express anything positive about the illness experience. Yet, the theme of a positive aspect to the illness recurs in the literature. Furthermore, it is assumed that a transformed self is an important step in the process of acceptance and the reduction of psychological symptoms. Narrative plays an important role in this process. It might be that crafting an account integrates cognitions and emotions (Smyth et al., 2001). It is also possible that, as storyteller, the patient regains lost status, taking center stage, justifying his or her own actions (Riessman, 1990) or offering moral-political commentary on some state of affairs (Williams, 1984).

An alternative perspective is offered by Wilkinson and Kitzinger (2000) in their analysis of how patients use talk about "thinking positive" in conversations about illness. The authors point out that discussions about the relationship between positive thinking and "beating cancer" have become prominent in the popular press and media, and are consistent with the broader cultural notion of exerting one's will to control processes of the body and nature. Their analysis describes the many ways in which the concept of "positive thinking" can be used by patients, including the use of the phrase as a moral injunction: "that is, 'thinking positive' is presented as a moral obligation, as something you 'have' to do" (p. 806). In contrast, having and expressing negative feelings was permissible but not required. Furthermore, for

some of the women in the study, establishing themselves as people who engage in the requisite work of positivity allowed them to "speak about [their] pain, suffering, and distress without unsettling others or attracting censure" (p. 806). As such, expressions of positivity often occurred in close conjunction with expressions of negative feelings.

There is no doubt that the presentation of a positive self has almost normative force in this society. Goffman (1967) maintained that the face work necessary to maintain positive self-images was the foundation of social life as we know it. Negative emotions and negative self-conceptions are disruptive of the smooth flow of interaction; many people in this culture lack the skills and resources for dealing with raw negative emotions. There is, therefore, pressure toward "glossing over" negative events and experiences, and patients are aware of this pressure. Although they might resent it, patients report being aware that acceptance by both close others and medical professionals is often contingent on showing a positive front. Whereas forced positivity is unwelcome, it is possible to understand that patients themselves are going to want to choose to find ways to reestablish a positive self. With traditional avenues to "success" closed and patients finding themselves unable to support the definition entailed by those standards, they might choose to align themselves with alternative values (i.e., simple pleasures, the value of relationships, living in the present, spiritualism). These can be political statements, critiques of modern life. On the other hand, it must be understood that patients are conforming to the value attached to the positive image of self. The transformation theme does not represent a rejection of the value placed on positivity. One cannot disentangle the fact that patients who report the transformation experience find acceptance and closure at the same time that they once again become acceptable to other members of society.

Of course, whenever patients talk about "thinking positive" or of transformation, one must not overlook the fact that these statements are being made in a coconstructed interaction with a health-privileged other, especially an "expert in these matters." If patients can voice agreement with the proper moral imperatives and describe the ways in which they are living up to those rules of conduct, then they have reasserted, through the activity of talk, their competence and moral status. Their ability to do this successfully, however, can depend in part on having a receptive cointeractant to support them.

SOCIAL SUPPORT AND THE ILLNESS INTERVIEW

If we respect the belief that patients are active agents in the illness experience, then we must acknowledge their capacity to do things through talk over the course of an illness interview. One of those things is to take their experiences and construct them into a coherent story about the self, with a beginning, middle, and end. To the extent that these stories are political, we should not be surprised to find elements that affirm the social order, as well as those that question it. Another thing patients might be doing is crafting positive moral identities for themselves. This might be partly in response to the health-privileged status of the researcher. What is missing, and what is needed to complete the unification, is a consideration of the researcher as a coparticipant in the interview-as-interaction process.

It is probably safe to assume that most interviewers do, in fact, care about the patients and the stories they tell. Regardless of that assumption, however, the interviewer must meet the interactional requirement of establishing rapport if the interview is to proceed smoothly (Kleinman & Copp, 1993). Establishing rapport involves a host of verbal and nonverbal cues intended to make the interviewee feel comfortable and secure in disclosing intimate information about the self. From the interviewer's perspective, these behaviors might be deemed a necessary, and even intuitively obvious, means to foster identification and an open climate. From a metamethodological perspective, however, the behaviors that the interviewer is engaged in can be viewed as social support.

An interactional approach to social support (Albrecht, Burleson, & Goldsmith, 1994) locates the provision and acceptance of supportive behaviors in the transactions between people. Two definitions in line with this approach will be highlighted here. Shumaker and Brownell (1984) defined social support as "an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient" (p. 13, italics omitted). Using concept analysis, Hupcey (1998) defined support as "a well-intentioned action that is given willingly to a person with whom there is a personal relationship and that produces an immediate or delayed positive response in the recipient" (p. 313). There are both revealing similarities and differences between these definitions.

First, the definitions differ with respect to who can provide support. Shumaker and Brownell (1984) claimed that "prosocial acts" provided by a stranger, for example, qualify as support, whereas Hupcey (1998) asserted that there must be some kind of personal relationship between provider and recipient. The interviewer falls somewhere between these definitions: not quite complete stranger but not a friend. The ability of the researcher to establish rapport quickly will influence how the patient comes to feel about that person. Second, the definitions differ as to the outcome of support, whether it is sufficient to intend to increase well-being or whether there must actually be an increase in well-being. Collins and Feeney (2000) found that support seekers who received support evidenced immediate improvements in mood postinteraction. At other times, however, the benefits of support might be more long-term. The point itself seems best suited to a message perspective. That is, verbal and nonverbal actions that are consensually recognized by a culture as supportive should be systematically linked to particular outcomes (Goldsmith, 1992, 1994). Such an approach underscores the importance of focusing on the actual communication of social support.

Despite these differences, the definitions share some important characteristics. First, they both focus on the actual exchange of messages rather than relying exclusively on the perceptions of the parties. Second, they both define support as a positive, helpful act. In one way or another, illness interviews are intended to be helpful. There is an assumption, often implicit, that having patients tell their stories will result in improved psychological outcomes, including a reduction in feelings of stress and improvements in mood. Even where that is not the avowed goal of the project, researchers sometimes believe that understanding patient experiences will facilitate other aspects of patient care (e.g., nursing). Thus, the interviewer often adopts the interactional position that the interview is intended to benefit the patient.

Much has already been said about the importance of focusing on how social support is communicated. In the close relationship literature, three of the most widely used coding schemes are the Interactive Coping Behavior Coding System (Barbee & Cunningham, 1995), the Social Support Interaction Coding System (Bradbury & Pasch, 1994; Pasch & Bradbury, 1998), and the Social Support Behavior Code (Cutrona & Suhr, 1992). All three schemes include several items designed to assess the provision of emotional support. To reproduce a supportive interaction, an experimental approach is often used with couples in romantic relationships. One member is either exposed to a stressor or asked to talk about a personally distressing event or situation that is not a source of conflict in the relationship. The other partner is instructed to respond as he or she normally would in such a situation. They are videotaped for, typically, between 8 and 10 minutes, and the interactions are coded according to the scheme being used. Although there might be something artificial about these settings (Goldsmith, 1995), for present purposes, they might be no less artificial than the interview setting. The patient has agreed to talk about a stressful event, the interviewer is constrained to offering some types of support while refraining from others, and some sort of record of the interaction is being made. If the interview parallels the experimental approach, then perhaps the same sorts of emotional support codes might be fruitfully applied.

Based on comparisons among the items found in the three coding schemes listed above, I have distilled a set of eight conceptual categories falling under the heading of "emotional support." With respect to the support provider and support seeker, these categories can be defined as follows:

- *Reassurances.* Provider conveys that seeker is loved, cared for, or esteemed; stresses the importance of closeness and love in relationship with seeker; tells the seeker that he/she is a good person.
- *Encouragement.* Provider inspires seeker with hope and confidence; says positive things about the recipient or emphasizes the recipient's abilities.
- *Alleviate blame.* Provider assures the seeker that it was not his/her fault; alleviates seeker's feelings of guilt about the situation.
- *Confidentiality.* Provider promises to keep the seeker's problem in confidence; assures seeker of confidentiality.
- *Understanding.* Provider expresses understanding of the situation or discloses a personal situation that communicates understanding; makes empathic remarks such as "uh-huh," or "ooh"; gets angry along with seeker about problem's cause.
- *Sympathy.* Provider expresses shock/sorrow at hearing the problem; expresses sorrow or regret for the seeker's situation or distress.
- *Expression of feelings.* Provider asks how the seeker feels about the problem; asks why the seeker feels that way; encourages expression or clarification of feelings, as well as expression of emotional displays.
- *Validation.* Provider expresses agreement with the recipient's perspective on the situation; acknowledges seeker's beliefs, interpretations, and feelings.

I would argue that several of these codes are consistent with the interactional requirements of the illness interview, whereas others might be "hidden" in transcripts that are never presented for scrutiny. *Confidentiality* is a prerequisite for conducting scientific research, and patients should have been informed of this before giving consent to participate. *Expression of feelings* is usually part of the purpose of the interview—asking patients how they felt about something that happened to them or asking for clarification of feelings. *Validation* is important because patients

can become reticent if they perceive that the interviewer openly disagrees or disapproves of them (Kleinman & Copp, 1993). *Understanding* and *sympathy* are both also important for maintaining an open communication climate that will encourage the patient to talk. The other three codes (*reassurances*, *encouragement*, *alleviate blame*) go beyond validation in conveying the message that the respondent is a good person, a competent person, a valuable person. For example, if a patient were to begin to cry during an emotional segment of talk, and the interviewer, no matter how genuine the concern, said something along the lines of "It's OK," or "It wasn't your fault," that interviewer is offering support. At certain times, in certain situations, to fail to offer such support would itself violate the interactional requirements of the interview. If that is the case, however, one must entertain the possibility that having a supportive audience is one of the means by which crafting narratives is beneficial to patients.

If interviewers are providing social support, and social support is beneficial, then interviewers are providing a benefit to respondents. This raises the question as to whether researchers should view themselves as therapists. Perhaps they should, if they have designed their study specifically to benefit respondents. However, the emotional consequences of social support are likely more unintended and indirect, insofar as the research is intended to produce data to answer scientific questions. Consistent with Scalise Sugiyama's (1996) work on narrative, there are status benefits that accrue to both parties; researchers acquire professional social capital through the information obtained, and respondents can acquire social capital and status of their own in providing information, whether in the form of projecting desired identities or the special attention that comes with being the subject of research. This is dependent on the researcher's being supportive, but also the interviewee being talkative and having something to say.

The question of researcher as therapist masks a more fundamental question about the obligations that exist between individuals involved in mutual helping relationships. The institutional position of research is that the interview is a data collection tool appropriate to certain types of research. Yet, the interview is also a communicative event between two human beings; it is a phenomenological experience for them both. The decision of researchers to highlight one aspect or the other is a luxury they possess by virtue of their higher-status position in the interview. That is, researchers have the ability to maintain, which can be a euphemism for "enforce," their definition of the interview as a data collection situation (or vice versa) because they are in a position of power. This is the communicative hegemony discussed by Briggs (1986, p. 121). Researchers can effectively minimize the question of whether obligations or expectations have been created to the extent that they maintain a definition of the interview as a data collection tool. Still, a question worthy of pursuit remains: What is the meaning of participation in the interview to those who have been interviewed?

SUMMARY

People have always told stories (accounts, narratives) for a variety of purposes, including to make sense of events, to impose order on them, and to impart lessons learned to others. As a condition hedged about with uncertainty, chronic illness fulfills many of those purposes. Within the institutions of social science, illness narra-

tives are typically obtained via the interview. As a communicative event, the interview is affected by issues of power and affiliation. Power issues undergird the interview because the tempo of the interview is set by the interviewer, who is also in the higher status position relative to the patient. When genuine rapport is established, a coconstructed discourse is produced, in which the content is affected by shared norms about the temporal ordering of stories, the confessional mode whereby the revelation of private experience is constructed around dramatic moments, and the monomythic theme of personal transformation in the overcoming of adversity.

Social scientists have usually adopted a psychological explanation for the assumed benefits of narrative construction, including a sense of completion, acceptance, or the integration of cognitions and emotions. One of my goals in this article has been to suggest that narratives as revealed in the illness interview might be beneficial for additional reasons. Telling stories allows the patient a forum to engage in socially valued activity, including teaching, informing, and generally displaying the possession of special knowledge. Viewed in this light, stories become an attempt to recreate status shields (Freund, 1990), elevating the status of the patient in the eyes of others, perhaps even, or especially, the health-privileged researcher. On the other hand, the interviewer is the quintessential socially supportive interaction partner. By expressing thoughts, feelings, criticisms, fears, and so forth, and finding a receptive audience who encourages and accepts them, patients are, indeed, likely to feel a sense of acceptance.

RESEARCH SUGGESTIONS

My purpose in this article is not to advocate the abandonment of the interview as a research technique; nor, in line with Briggs' (1986, p. 93) argument, is it to suggest that researchers should focus on the communicative elements of the interview to the exclusion of the research problem. However, I would suggest that greater insight into those problems could be gained if some researchers, at some point in time, would focus in on those communicative elements. Toward that end, several suggestions are presented below.

Compare narratives along gender, age, and status lines. Such comparisons might reveal important ways in which discourses of illness are gendered. Research cited by Scalise Sugiyama (1996, p. 410) describes how the stories of men tend to be self-aggrandizing, whereas those of women tend to be more self-effacing. If that is the case with illness narratives, one would expect men to make themselves the center of their narratives, but women might prefer to place themselves on the periphery. One way in which males might do this is by focusing on what they can do, justifying failures and emphasizing their ability to be active. Some evidence of this is provided by Bury (1988). Although using a small sample, he found married men using "sanctioning" whereas the women respondents did not. That is, men were more likely to talk about how their spouses prompted them to seek help. Bury interprets this in the following way: "It is not that the individual is necessarily stoical, simply that he or she is unwilling to take the responsibility for the decision alone" (p. 106). It must be kept in mind, however, that these men strategically chose to reveal this information, which also includes themes of being strong, resistant to pain yet amenable to reason,

of having wives who properly care for their husbands (despite illness), and of being good husbands adhering to their wives' wishes. If narratives do function to increase the status and fitness of storytellers, analyzing narratives along fitness-related lines might reveal clues about the multiple meanings of stories.

Compare narratives of the chronically ill and the healthy. It is an obvious point, but one that bears repeating occasionally: If we ask patients about illness, then we will get narratives about illness. However, given the opportunity, would patients prefer to downplay, or even ignore, the role of illness (a stigmatized condition) in their lives? The principles of self-presentation suggest that they would, but that they would be constrained by their ability to support such a presentation. Killoran, Schlitz, and Lewis (2002) interviewed metastatic cancer patients who had survived at least 20 years. The overriding theme among these individuals was one of minimization: "Most participants reported that their diagnosis was not a major event in their lives" (p. 211). Given this, transformation was not a major theme in the narratives. The authors concluded that the time that had passed since diagnosis permitted these people to claim a "return to normality." This claim was further bolstered by reference to core cultural values of self-reliance and self-control. This suggests that patients will attempt to pass themselves off (Goffman, 1963) as normal if given the opportunity, with length of survival one of the factors affecting that presentation. It would be ideal to have narratives from these same patients 10 or 15 years earlier in their illness trajectory. Of course, it must be borne in mind that, had they participated earlier and revealed narratives of transformation, their earlier participation may have functioned as a constraint on their later ability to present a return to normality.

Pay more attention to discordant elements in patients' narratives. In one sense, research reports can be viewed as metanarratives, stories about stories, organized by theme. This practice will tend to smooth out the original discourse, glossing over the coconstructed nature of the interaction. An example of this can be found in Davies and Dodd (2002, p. 284). In an interview between one of the authors and a young woman (the study concerned how overweight women dealt with messages surrounding body size and weight control), an extended portion of the transcript is presented, with seven speaking turns of the interviewee included. The authors do discuss the woman's use of the phrase "you know," but it can also be seen that in three places she responds to the interviewer with the phrase "I guess" and, in one place, responds with the phrase, "Probably, haven't done as much thinking around that." The point being made here is that, by examining the actual discourse, one could question the authors' conclusion: "By engaging in a conversation rather than adopting a distanced and neutral kind of attitude, Kate's complex understandings of femininity and images of the feminine and her body were able to emerge" (p. 284). Rather, Kate is revealed to have rather vague understandings on several points of interest to the researcher. Furthermore, the sentence itself displays some mystification. After all, it was not Kate who was choosing between conversation and distance, it was the researcher. Thus, the sentence might be read, "By the researcher's engaging in a conversation, Kate's understandings of femininity and her body were coconstructed." A focus on the discordant elements would illuminate such coconstruction.

*Pay more attention to the motivations of patients.*¹ Under the naive view of the interview, researchers begin analysis when respondents begin answering the first question. Such a perspective ignores the fact that the first answer is going to depend on the motives that led that person to be in the role of interviewee in the first place. In many ways, the interview conforms to Snyder's (1992) examination of behavioral confirmation in the "getting to know you" acquaintance situation. The interviewer is cast in the higher-power position of information seeker, whereas the role of the interviewee "seems to be defined and constrained so as virtually to mandate taking cues from others and fitting one's presentation of self into the outlines laid down by one's interaction partner" (p. 78). The motivation of interviewees can often be simply to "get along" by facilitating social interaction. Some evidence of this is found in the Davies and Dodd (2002) excerpt cited above, where Kate's use of the phrase "I guess" can be read as lack of full agreement with the researcher's suggestions, yet also a failure to challenge those suggestions. However, Snyder has argued that respondents can, under certain circumstances, be motivated to disconfirm information seekers' impressions. This can be particularly the case when the respondent's identity has been threatened. Because illness is such a situation, we should not be surprised to find patients with an active agenda of their own. One such agenda might be the desire to help others, to share the wisdom and knowledge gleaned from the inherent difficulties of the illness trajectory. That such a motive is suggested as appropriate to patients is sometimes provided by researchers themselves. For example, in a study of epilepsy patients by Schneider and Conrad (1983), the following lines can be found in the anonymous letter passed on to potential interviewees: "We think the results of our research will be helpful to others who have epilepsy as well as those who do not" (p. 251). If patients are motivated by a desire to help others, one simply cannot examine their narrative responses as if they existed in a contextual vacuum. Such responses have been strategically crafted to have political and moral implications from the beginning.

Pay more attention to how patients vary their self-presentation according to the situation with which they are faced. One way to do this is through the use of videotaping (Briggs, 1986, pp. 99-100). This does not just mean placing the video camera over the shoulder of the interviewer with the lens pointed at the respondent. What is being called for is positioning the camera as a third party, so that the camera eye captures both interactants. Patterns of reciprocity, compensation, and mutual adaptation influence all interactions (Burgoon, Stern, & Dillman, 1995), and the interview is no exception. This would allow a true appreciation for how nonverbal communication is shaping the discourse. Beyond that, it is necessary to compare the interview as an interaction to interactions with a spouse, other family members, and with medical personnel. A comparison of the accounts provided in these different contexts would begin to shed light on some of the metacommunicative norms specific to the illness interview. Finally, although some ethical issues are raised by the suggestion, it would be insightful to vary interviewer behavior. To the extent that interviewers strive to be supportive, interviewer behavior is a constant in the interview equation. What would happen to the narrative if the interviewer were less supportive? Would the research interview begin to look more like the medical interview?

CONCLUSIONS

My purpose in writing this article has been to move qualitative researchers beyond the "fetishism of words." In closing, I should like to suggest why such a move is important. Two elements seem almost formulaic in the "typical" qualitative research report, even when not explicitly expressed: first, that objectivity is impossible, and, second, that qualitative approaches give voice to those who would otherwise be silent or to those who are silenced by objectivist philosophies and research practices.² In response to the first point, it seems that subjectivity is not possible either. As Atkinson and Silverman (1997) argued, the self that is constructed in narrative cannot be entirely subjective precisely because it is a social construction, suffused with shared cultural understandings, social criticisms, political commentaries, and narrative conventions cast in a language of sentiment. With respect to the second point, if the interview is coconstructed, then power and status issues cannot be ignored. Briggs (1986) described the practice of communicative hegemony, whereby researchers impose their cultural standards on respondents both in the way interviews are conducted and in the presentation of results. Although many researchers are genuinely concerned with patients and their suffering, the naive view of the interview reinforces perceptions of patients as low-status others who need the scientist's assistance and guidance to make their voices known. Thus, whereas qualitative researchers often accuse quantitative researchers of reproducing modes of domination and oppression, they themselves seem to be guilty of, at the very least, a more "enlightened" form of despotism. Many chronic illness patients are suffering, and are suffering profoundly, but giving them voice and agency means that we cannot ignore their ability to manipulate language through the selective telling of stories. Such tellings are, in fact, a crucial part of the struggle to contest medical meanings, to educate others of the effects of rejection and social isolation, or even to spit in the face of their own feelings of vulnerability. A true theory of patient agency will emerge only when researchers move beyond the "fetishism of words" to a greater appreciation of the complexity that is going on behind the face of patient experience.

NOTES

1. Perhaps a primary motivation question concerns respondents' understandings of who the researcher is in relation to other health personnel. Paterson and Scott-Findlay (2002) discuss the attempts of traumatic brain injury patients to present themselves as competent to the interviewers under the impression that the researchers were another type of health care professional. Although brain injury patients might be an extreme case for some issues, it is likely that patients without cognitive impairments may still possess the same misunderstandings.

2. Between self-selection biases among potential respondents, shared assumptions about positivity, respondents' need for acceptance by being good subjects, and the smoothing out of discrepant information, the extent to which the voice which is presented as the patients' is representative is unclear.

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