

Narratives of Somatizing and Non-somatizing Patients in a Primary Care Setting

VIRGINIA ELDERKIN-THOMPSON AND
ROXANE COHEN SILVER

University of California, Irvine, USA

HOWARD WAITZKIN

University of New Mexico, Albuquerque, USA

VIRGINIA ELDERKIN-THOMPSON is a Post-doctoral Scholar and ROXANNE COHEN SILVER is an Associate Professor and Faculty Chair in the School of Social Ecology at the University of California at Irvine.

HOWARD WAITZKIN is a Professor in the Department of Family and Community Medicine at the University of New Mexico, Albuquerque.

ACKNOWLEDGEMENTS. Portions of this research were presented at the American Psychological Society, San Francisco, June 1996, and the International Conference of Medical Communication, Oxford, UK, July 1996. This article is based upon the doctoral dissertation of Virginia Elderkin-Thompson submitted to the University of California, Irvine; dissertation committee co-chairs were Roxane Cohen Silver and Howard Waitzkin. We thank Gabriele Schwab and Chuansheng Chen, members of the committee, for their thoughtful comments and suggestions.

The research reported was supported by a National Institute of Mental Health Grant (1 RO1 MH 47536) to Howard Waitzkin and Roxane Cohen Silver, and a Chancellor's Fellowship, Regents of the University of California, Irvine, to Virginia Elderkin-Thompson. We would like to thank Jose Moreno, Silvia Gutierrez, Margaret Heredia, Peter Kaneshegi, and Yvette Villasenor for conducting the original data collection, and Fanay Loiselle and Rocio Rivadeneyra for assistance in data transcription and qualitative analysis.

ADDRESS. Correspondence should be directed to:

ROXANE COHEN SILVER, Department of Personality and Social Behavior, School of Social Ecology, University of California, Irvine, CA 92697-7085, USA. [Tel. +1 714 824 5574; fax +1 714 824 3002; email: rsilver@uci.edu]

Journal of Health Psychology
Copyright © 1998 SAGE Publications
London, Thousand Oaks and New Delhi,
[1359-1053(199807)3:3]
Vol 3(3) 407-428; 004550

Abstract

Somatizing patients, who comprise approximately 20 percent of the primary care population, often present physicians with recurrent but confusing combinations of symptoms without organic explanations. Illness narratives presented during initial medical encounters with primary care physicians were examined qualitatively to determine if the narrative structure, chronological development of symptoms and temporal frame differed between somatizing and non-somatizing patients. Following a structured interview to identify somatization tendency and co-morbidities of depression and post-traumatic stress disorder, 116 patients' encounters with primary care physicians were video-recorded and transcribed. Somatizers demonstrated a narrative structure that was similar to that of non-somatizing patients, but they used a thematic rather than a chronological development of symptoms and they did not convey a clear time frame. Somatizing patients with a co-morbid psychological condition focused on concrete physical sensations, were unable to provide contextual history or chronological organization, and did not develop a temporal frame. The narratives of somatizing and non-somatizing patients differed sufficiently to warrant further research for use as a clinical aid in the diagnosis of somatization.

Keywords

communication, illness story, narrative, primary care, somatization

DURING THE LAST half of the 20th century, medical practitioners have become increasingly aware that approximately 20 percent of their patients are somatizing, i.e. they are presenting physical symptoms for which psychological factors are suspected of having a role in the onset, exacerbation, or maintenance of the symptoms (American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders [DSM-IV]*, 1994; Katon, Ries, & Kleinman, 1984; Kroenke et al., 1994). Treatment for somatization remains largely outside the traditional medical model that focuses on symptoms as indicators of pathophysiology. A more recent approach, the biopsychosocial model of medicine, proposes that an individual's biological, psychological, and social systems are inter-related realms hierarchically nested one within the other (Engel, 1977; Lazare, Eisenthal, Frank, & Stoeckle, 1978; McWhinney, 1989; Mechanic, 1972). If one level becomes distressed, the distress can reverberate through other levels of an individual's physiological, psychological, or social functioning. In the biopsychosocial model, somatization is conceptualized as a disturbance that originates in emotional and psychological conflicts but which manifests in the physiological system as physical symptoms (Goldberg, Novack, & Gask, 1992; Kaplan, Lipkin, & Gordon, 1988). Recognizing the source of patients' symptoms requires that physicians' clinical skills be complemented with excellent communication skills sufficient to determine the source of, and to help patients develop insight into, their medical problems.

Numerous clinical and communication barriers work against the recognition of somatization. Clinicians must be cautious that the lack of positive test results for organic disease is not a result of patients having a pre-disease state, an unknown or unsuspected condition, a false-negative test result, or ambiguous symptoms that do not lend themselves to diagnostic protocols. Only when a patient has symptoms of depression and anxiety (common co-morbid disturbances of somatization) is recognition likely (Kirmayer, Robbins, Dworkind, & Yaffe, 1993). Unfortunately, when clinicians do suspect somatization, patients frequently have little insight into the cause of their symptoms and resist a suggestion of psychological etiology (Kaplan et al., 1988; Kirmayer & Robbins,

1991a, 1991b; Olfson, 1991; Smith, Monson, & Ray, 1986a). Patients who do not accept psychological causation may respond by using multiple care-givers and undergoing numerous inpatient services, thereby frustrating the physician's attempts to control the disorder and incurring high medical utilization costs as a consequence (Kaplan et al., 1988; Katon & Russo, 1989; Lin et al., 1991; Olfson, 1991; Smith, Monson, & Ray, 1986b). When somatizers do remain with one physician, they are more likely than other patients to be demanding of physicians' time yet non-compliant with treatment recommendations, a pattern that results in poor treatment outcomes (Kaplan et al., 1988; Kroenke, Lucas, Rosenberg, Scherokman, & Herbers, 1993; Lin et al., 1991).

Social, behavioral, neurobiological, and psychodynamic explanations have been offered for somatization behavior. Socially, some societies may tolerate somatic symptoms more readily than emotional or psychological ones, so individuals from those cultures can more safely express emotional conflicts through somatic outlets (Angel & Guarnaccia, 1989; Inclan, 1983; Nichter, 1981). Behaviorally, people may demonstrate illness behavior if they are reinforced by their environment for assuming the sick role (Kaplan et al., 1988; Parsons & Wakeley, 1991). Neurologically, impairments in the physiological functioning of the central nervous system may inhibit the expression of emotion, which may then be forced into a somatic idiom (Kaplan et al., 1988). Finally, the psychodynamic approach posits that somatization occurs as a result of underlying emotional conflict, where somatic sensations act as a defense mechanism for release of the conflicting emotions by channeling them into a somatic expression (Barsky & Klerman, 1983; Katon, Kleinman, & Rosen, 1982; Kellner, et al., 1985). The psychodynamic approach is the most widely accepted explanation, and supporting evidence comes from studies of blood pressure and skin conductance that have found repressed anger and over-control of emotional expression to be associated with somatic symptoms (Kellner, 1990; Pennebaker & Traue, 1993).

If somatic symptoms do arise from unresolved emotional conflicts, this suppression might be reflected in a general inhibition of affect during their communication with others.

Presumably this inhibition would also occur during interactions with physicians. In most interpersonal situations, the main channel of affective communication is the non-verbal one (Horowitz et al., 1993; Siegman & Feldstein, 1987). To explore the possibility that emotional suppression might be evident during somatizers' interaction with medical professionals, we quantitatively examined the non-verbal behavior of somatizing and non-somatizing patients in a primary care clinic (Elderkin-Thompson, 1996; Elderkin-Thompson, Silver, & Waitzkin, 1998). Results indicated that during medical encounters, somatizing patients were more emotionally distant and detached and were less affectively expressive and relaxed than non-somatizers. Specifically, patients who avoided eye contact by often staring at their hands or the floor and who appeared over-controlled and tense in terms of lower body and small muscle movements were significantly more likely to be classified as somatizers in a standardized diagnostic interview. This picture of the somatizing patient's non-verbal behavior contrasts with the clinical description of somatizers as patients who tend to describe their symptoms in 'colorful, exaggerated terms', who are prominently depressed or anxious, impulsive and frequently suicidal, and who often lead chaotic and complicated lives (American Psychiatric Association, 1994, p. 450). The over-controlled non-verbal behavior juxtaposed with the exaggerated, dramatic verbal presentation creates a picture of a person who may use words to compensate for his or her non-verbal affective deficit. The result would be a 'mixed message' in which the verbal and non-verbal messages would be dissimilar.

Despite clinical impressions of somatizing patients' narratives as flamboyant and colorful, no empirical studies have been done to support this description. In fact, analysis of patient narratives is relatively new to research in medical communication. Previous attempts to examine patients' narratives in medical interactions usually relied on quantitative analyses, such as Roter's Interactional Analysis (see Roter, Lipkin, & Korsgaard, 1991, for an example). Quantitative measures use broad categories to represent the meanings of the patients' or physicians' statements. However, this system is limited to an examination of the referential meaning of what is said during encounters; it is not able to

probe for underlying meanings because of the superficial nature of the categories. With somatizing patients, the surface meanings of the narrative may act as a disguise, or substitution, for underlying meanings that remain unarticulated because they are suppressed by clinical imperatives, self-presentational concerns, or lack of awareness (Kirmayer et al., 1993; Polkinghorne, 1991). The difficulty that physicians have identifying somatizers, and recent evidence that a large minority of non-somatizers also present unexplained symptoms in medical encounters (Kroenke et al., 1994), indicates a need for a more sensitive method of analysis that probes beyond the surface content of patients' illness stories. Clinical researchers are turning to qualitative approaches, such as literary analysis of the narrative produced during the encounter, for more sensitive and complex interpretations (Clark & Mishler, 1992; Frank, 1994; Gee, 1986; Mishler, 1984; Mishler, Clark, Ingelfinger, & Simon, 1989; Waitzkin, 1991).

Literary analysis of a collection of diverse medical narratives differs from a literary analysis of narratives generated by a common experience, such as divorce (Riessman, 1989) or violence (Labov, 1972). In medical encounters, the narratives of somatizing patients may show disturbances, but they may be superficially obscured by the question-and-answer interaction typical of medical dialog and by the variety of clinical topics. Communicative patterns must manifest despite the diverse surface content that focuses on symptomatology and medical history-taking. Therefore, the methodology used must establish some structural or content criteria that can be applied uniformly and that would allow for differences in conversational topics among patients.

The goal of the present study was to examine whether somatizing patients' narratives differed qualitatively from those of non-somatizers and, if so, what the nature of that difference was. Specifically, we were interested in whether the presence of somatization disrupted a patient's narrative more than might be expected from other emotional or psychological conditions. Limited research does suggest that the narratives of somatizers would be likely to vary from those of non-somatizers. The hyperarousal of traumatized patients who suppress their emotions and the fragmentation of self-narratives of people

who are under stress (Butler et al., 1990; Gold & Wegner, 1995; Polkinghorne, 1991; van der Kolk, 1996) suggest that somatizing patients, who typically present to clinicians when they are experiencing stress (Miranda, Perez-Stable, Munoz, Hargreave, & Henke, 1991), may show subtle narrative disruptions. The exaggerated stereotype of the flamboyant and colorful somatoform symptom presentation may be based on extreme examples of patients with multiple emotional and physical disturbances, but it nonetheless indicates that clinicians have noticed that some patients suspected of somatization share patterns of speech that are noticeable beyond medical dialog. If patterns can be identified qualitatively that characterize somatizers with and without emotional co-morbidities, they might serve as clinical 'markers' of possible somatization. Timely identification of somatization would improve the clinician's ability to manage the behavior appropriately, enhance the chances of a positive health outcome, and reduce health care utilization (Abbey & Lipowski, 1987; Barsky, Wyshak, Latham, & Klerman, 1991; Fink, 1992; Shorter, Abbey, Gillies, Singh, & Lipowski, 1992; Smith et al., 1986b).

Method

Research participants

First-time patients were approached in an urban, outpatient primary care clinic associated with a university medical center for participation in a 6-month study of medical communication that piggy-backed onto a larger study of somatization. Of the 356 patients between the ages of 18 and 65 years who consented to being interviewed prior to their medical encounter for the larger study, 49 percent ($n = 175$) also agreed to being videotaped during their encounters. Sixty-six percent ($n = 116$) of the consenting patients provided complete interview information and were seen by physicians who had agreed to participate in the communication study. Seventy-five percent were English-speaking ($n = 87$), 52 percent were male ($n = 60$), and 75 percent were employed ($n = 87$). Ethnic distribution was 41 percent US-born non-Latino White ($n = 48$), 25 percent US-born Chicano ($n = 29$), and 34 percent Mexican or Central American immigrants ($n = 39$). Patients aver-

aged 37.2 years of age and had 10.5 years of education. Several had histories of psychological or mood disorders: 14 percent had been or were currently depressed ($n = 16$), 18 percent had previous or current post-traumatic stress disorder (PTSD) ($n = 21$), and 21 percent met criteria for somatization per the abridged construct ($n = 24$).

Clinicians were interns, residents or attending physicians from the university medical school who provided care in internal medicine at the clinic. Seventy percent of the clinic's physicians, six female and nine male, participated in the present study: six were Asian, five were non-Latino White, one was Middle Eastern, and three were Latino. Four physicians met with 64 percent of the patients; three other physicians saw another 10 percent of the patients. The remaining physicians saw between one and six patients each.

Instruments and measures

Composite International Diagnostic Interview The Composite International Diagnostic Interview (CIDI) is a structured interview developed by the World Health Organization to assess psychological and emotional disorders, such as depression or anxiety. It has been tested for reliability and validity in multiple cultures (Helzer, Spitznagel, & McEvoy, 1987; Robins, Helzer, Croughan, & Ratchliff, 1981; Robins et al., 1988; Rubio-Stipec et al., 1993; Spitznagel & Helzer, 1988; Wittchen et al., 1991). A reliability test by field trials in 17 different countries found no site differences in the proportion of unexplained symptoms in the somatization section between different sites and cultures (Rubio-Stipec et al., 1993). Currently, the CIDI represents the 'gold standard' for identifying somatization in clinical settings because it assesses the lifetime tendency to present clinically with symptoms that have no known organic etiology after appropriate medical investigation.

Somatization To determine somatization classification, a trained lay interviewer followed a flow chart to probe reports of 37 common symptoms found among primary care populations. If a symptom (1) could not be explained by illness, injury, medication, or drugs; (2)

prompted a physician's visit; (3) remained unexplained after appropriate medical evaluation; and (4) resulted in functional impairment, it was rated as 'somatoform'. Symptoms that only occurred during a panic attack were not included in the symptom count. Assuming that somatization is a dimensional construct, we adopted the abridged criteria of four lifetime unexplained symptoms for men and six for women, below-threshold levels (American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)*, 1987) that nevertheless retain predictive power (Escobar, Rubio-Stipec, Canino, & Karno, 1989). Previous research has found that patients who meet the abridged construct for somatization have a higher prevalence of psychiatric disorders, report more frequent use of medical services, and experience higher levels of disability than those who are below the somatization threshold, regardless of health status and demographic factors (Escobar et al., 1987, 1989; Robins & Regier, 1991). Furthermore, the criteria are sufficiently rigorous to minimize the likelihood of inappropriate classification of somatization for patients who might occasionally misunderstand the physician's diagnosis or experience unexplained symptoms. Hereafter, the term 'somatizer' refers to patients who meet the above standardized criteria for somatization.

Depression and PTSD were assessed because they are common emotional co-morbidities of somatization (Escobar, Swartz, Rubio-Stipec, & Manu, 1991; Holman, Silver, & Waitzkin, 1996; Robins & Regier, 1991). The depression subscale of the CIDI assesses patients' history, onset, and duration of depressive symptomatology sufficient for diagnosis of major depression and dysthymia per *DSM-III-R* nomenclature. A modified version of the PTSD subscale from the Diagnostic Interview Schedule (DIS) was used to assess traumatic experiences because no comparable section existed in the CIDI when the present study was designed and implemented. Patients who reported exposure to a potentially traumatic event(s), persistently re-experienced the event either cognitively or physiologically, avoided stimuli associated with the trauma, and experienced persistent numbing of emotions and increased arousal, met *DSM-III-R* criteria for PTSD.

Procedure

As part of the clinic intake procedure for all new patients, the reception staff collected demographic information (age, gender, marital status, ethnicity, and language). First-time patients were approached in private by bilingual/bicultural research assistants who invited them to participate in a study of health and patient experiences, answered their questions, and secured their written consent. Patients were assured that their participation would not affect their treatment at the clinic. Patients who agreed to be interviewed were subsequently invited to have their medical encounter videotaped in a way that maintained their privacy. No remuneration was offered as incentive for participation in the videotaped portion of the study, although patients received \$20 for the CIDI interview. Patients saw physicians in an examining room with a video camera mounted on one wall that was focused on chairs used by the patient and physician during discussions.¹

Transcribing of videotapes for facilitative analysis Transcripts of the medical encounter were prepared by trained bilingual research assistants or by professional transcribers who focused on presenting the flow of the interaction between patient and physician by preserving interruptions, speech hitches (i.e. stutters or hesitations in the flow of a person's speech), emphases, pace, overlapping speech, and pauses (Fisher, 1984; Fisher & Todd, 1983; Frankel, 1984; Street, Mulack, & Weimann, 1988; Waitzkin, 1991; West, 1984). Transcripts completed by one research assistant were verified by a second research assistant, who checked the transcript against the videotape for omissions or errors. Differences were resolved by discussion.

Narrative analysis

The qualitative analysis of patient narratives followed the three core steps recommended by Tesch (1990) and adapted for clinical settings (Miller & Crabtree, 1994): developing an organizing system; segmenting the data; and making connections. The organizing system was the examination of the narrative structure in patients' stories according to Labov and Waletzky's model (Labov, 1972; Labov & Waletzky, 1967). Labov and Waletzky identified six components that can form the core of a well-

developed narrative capable of transferring information succinctly. Their model contains an abstract, context, history or development of action, evaluation, resolution, and coda. In medical encounters, patients and physicians jointly create a narrative (Brody, 1994), with the patient contributing information that closely follows Labov and Waletzky's conception of an abstract, context, development, and possibly an attempted resolution or evaluation. The physician then adds his or her evaluation, resolution and coda, or return to present. For this analysis, only the patients' contributions to the narrative were examined and recorded on a structured form developed for this analysis, i.e. the abstract, context, historical development of symptoms, attempted resolution, and evaluation.

Not all narratives contain the above six components, and Labov and Waletzky (1967) did not suggest that they should. But in situations where succinctness and historical verisimilitude are valued—as in time-constrained medical encounters—the orderly presentation of the core components has spontaneously evolved as an efficient form of communication, and physicians prompt patients for information considered absent and necessary. Similar to 'scaffolding in a building' (Capps & Ochs, 1995, p. 39), Labov and Waletzky's structure of core components exposes the narrative resources that people have available for channeling or maintaining strong emotions, organizing their experiences, and modifying aspects of the narrative that they wish to emphasize or minimize.

A second structured form was used to assess the narrative content within the components for the presence of features that distinguish narratives from other forms of discourse: chronological sequence of events; a temporal frame with explicit boundaries; and evidence that the experiences being reported deviate from the norm (Bruner, 1987). Events in a narrative can be thematically organized, but scientific causality requires that one event must precede another to be seen as a cause. Consequently, physicians encourage, and patients usually report, a chronological development of symptoms.

To segment the data, the senior author and a research assistant independently analyzed the narrative structure (Crabtree & Miller, 1992a) of the first 15 videotaped encounters in the order that patients entered the study. The researchers

then came to an agreement as to the presence or absence of the expected components in the narrative structure. Tapes were replayed and transcripts reviewed as often as necessary to reach agreement. From this initial assessment, two tentative categories were created: narratives that presented the expected structural components and those that did not. The order in which the components appeared was not noteworthy in itself as evaluation or contextual commentary may be woven throughout the narrative (Labov, 1972). However, absence of a component and confusion or ambiguity within a component were noted.

CIDI diagnosis of somatization was then introduced to determine if the initial classification was successful in separating somatizers from non-somatizers (Miles & Huberman, 1984; Miller & Crabtree, 1994; Strauss & Corbin, 1990). Misclassified patients were re-examined. The features expected of medical narratives, i.e. temporal organization, deviation from the norm, and temporal frame, were introduced in order to refine the classification of patients (Crabtree & Miller, 1992b; Huberman & Miles, 1994; Miller & Crabtree, 1994). When elements of 'caseness' for somatizers and non-somatizers were agreed upon by the researchers, diagnoses of depression and PTSD were introduced to determine if they might account for the categories developed. The presence of depression and PTSD alone did not appear related to the absence of narrative components or degeneration of narrative content, so the analysis continued for the rest of the patients.

For the second round of data analysis, the videotaped narratives of the remaining somatizing patients ($n = 21$) and one-third of the remaining non-somatizing patients ($n = 31$) were selected for analysis. Patients were again evaluated for narrative structure and content in the order in which they entered the study. After narrative analysis, the diagnoses of somatization, depression, and PTSD were introduced. Results corroborated the definitions of categories developed with the analysis of the first round of video recordings (Strauss & Corbin, 1990). The senior author was aware of some of the somatization diagnoses of patients during the analysis, but the research assistant was blind to somatization diagnoses. Both researcher and research assistant were blind to depression and

PTSD until they were introduced into the analysis.

Validity Throughout the data collection, the individuals who performed the narrative analysis had no contact with research participants in order to minimize the likelihood of becoming biased by interpersonal impressions of the patients. To control overweighting some cases during analysis, all encounters were systematically examined in the order in which patients entered the study. Triangulation was defined as convergence among the research team as well as convergence among theories (Huberman & Miles, 1994), so researchers made decisions independently regarding each patient, and then they conferred to develop a consensual evaluation of each patient. When disagreements arose, videotapes were replayed to verify observations until all members of the research team agreed.

An internist acted as a clinical consultant during the analysis to identify extreme examples, to determine the clinical relevance of questionable statements, and to minimize researcher reactivity.

Narrative presentation The common method of presenting several excerpts from numerous cases to demonstrate a general theme or perception was not considered appropriate for this research. This method would separate the content from its context within the structural organization of the narrative and would minimize opportunity to demonstrate the internal structure spontaneously chosen by patients. Furthermore, the use of quotations from multiple cases tends to support the analyst's interpretative commentary, which can be vulnerable to researcher bias (Edwards, 1997, p. 280). To minimize this authorial voice and to avoid decontextualizing the extracts, we decided to use longer extracts from fewer narratives, presented in detail, to typify the organization or theme at issue (Clark & Mishler, 1992; Gee, 1986; Mishler et al., 1989; Riessman, 1989). The latter method of selection would also enable a detailed comparison between the structure and development of somatizing and non-somatizing patients' narratives. Accordingly, three encounters were selected by consensus to represent typical patients classified as non-somatizers,

somatizers, and somatizers with emotional comorbidity. In order to focus on the organization and meaning of the patients' narratives, physicians' comments have been deleted in the passages to follow. Despite the general deletion, occasionally it was necessary to include in parentheses the gist of physicians' questions to help the reader make transitions between topics. Data reduction involves choices that may shape the narratives' final structure and format (Mishler, 1991; Waitzkin, 1991), but an effort was made to preserve the thematic and structural integrity of the patient's story without unduly burdening the reader.

Results

Narrative analysis

The first transcript is from the medical encounter of a non-somatizing patient who generally developed a temporally ordered narrative with the expected component structure. Next, the narratives of a somatizing patient and a patient classified as a somatizer with co-morbid PTSD are presented. These transcripts exemplify the deterioration in narrative quality that appears to be associated with progressively more serious levels of emotional disturbance.

Patient 1: non-somatizing patient without psychiatric co-morbidity

This 53-year-old Chicano woman considered herself to be in good health, but she had recently experienced chest pains. One year ago she had presented at an emergency room with a similar episode of chest pain that had been diagnosed as muscle strain. She was concerned about a possible diagnostic error and sought a second opinion when the chest pains returned. Her symptoms were classified as unexplained, but she was not classified as a somatizer by the CIDI and her narrative was typical of those of non-somatizers.

The patient began with an abstract that stated the primary problem and what she hoped to accomplish in her visit. She quickly followed her abstract with a narrative sequence of her developing symptoms. (See Appendix for interpretation of transcription symbols.)

Abstract

1. Okay—I'm having a lot of che:st problems.

2. ::n' I've been: u:m: having ^headaches a lot
3. but th' thing that's really: m:aking me u:h (...) nervous
4. is this chest. And I haven't ha:d any:: uh: .hhh what is it
5. they're always ta:lk:ing about a heart checkup, an:' uh:
6. * uh: clor? cholestero:l testi::ng
7. >And basically I was wondrin' if I could< have some of that done.

Development of symptoms

8. Hhuhh It's very sharp and it's very sho:rt
9. (...) It's like sho:rt,=
10. like jis::tiyhknow real short, an' 'en goes awa::y,
11. Just a few minutes and that's just >one after another.<

Orientation

12. We:ll, u- I had it um * Mondee it seemed like mu uh-
13. (what) was it now,

Development of symptoms

14. Yeah. It came in i' came in ^hard. <But see what happens with me,
15. hh it comes in, and then >all of a sudden goes< and I thought-

Evaluation

16. Becu:z I cooked. so much on Tu-
17. Monday: (...) I thought maybe it was heartburn. So Monday night

Development of symptoms

18. I went (n-) to bed, (...) and I was rilly chilled,
19. an' my an' my chest hurt. a lot.
20. Then Tu:esday I got up agai:n: and my chest still hurt.

Evaluation

21. That's when I started callin' (name) (an) see- what
22. kin'a benefits. Can I come in. and then they-

Orientation

23. (...) 'bout a year ago? I went to (name) ((with a similar pain)).
24. Yeah, it's the same thing. They- they they hooked me up to
25. the heart machine, and they said yeah, (...) you- your- heart's- runnin'.

26. You know they didn't check on cholestero::l,
27. they didn't check cu- uh blood, they didn't check urine.
28. They didn't check any'u the others so I thought ...

The development of the symptoms is the core of a medical narrative, and is roughly analogous to the equivalent of a plot. This patient introduced a concrete definition of the pain as brief, sharp, and recurring every few minutes, followed by another cycle of pain and respite (lines 8–11). After identifying the short temporal cycle of pain and remission, she located the repeating cycles within a larger time frame of Monday to Tuesday morning that enclosed the recent episode of pain. These two temporal frames were then rolled into an even larger one that reached backward 1 year and included her first episode of chest pain (lines 23–24). Thus, two time frames were presented, and each one contained chronological information that was subsumed by the largest time frame of 1 year. By establishing a clear beginning and ending of each time frame, she also conveyed the impression that each represented a deviation from her usual experience.

The final time frame was bounded by two episodes that she evaluated as similar. When multiple events occur, the narrator must use some technique—linguistic or structural—to connote the relationship between them. By classifying the symptoms as similar, she began to develop a meaningful relationship between the beginning and ending events of her narrative and to identify the temporal stretch of time as qualitatively different from the surrounding time. She did not try to overstate the significance of the similarity as she reported what her diagnosis had been at the time and why she was skeptical of its accuracy now, i.e. she was not aware of confirming laboratory tests. She substantiated the request made in her abstract for the routine laboratory tests associated with cardiovascular disease.

In addition to the meaning gained by classifying an event with other similar events, it is even more useful—and logically abstract—to identify how an event is dissimilar from other events. This patient mentioned that, initially, she had considered indigestion as the cause of her

pain. After explaining that that theory did not appear appropriate because the symptoms had not dissipated overnight, she moved to considering cardiovascular disease and the necessity of a medical evaluation. She also noted that the pain began when she was cooking, a routine task that did not imply any unusual stress, and oriented the physician to the context of the recent symptoms.

The woman had quickly created a small illness narrative with the expected components. She articulated an abstract and followed it with the context of the recent episode and its historical precedent. The evaluation of symptoms demonstrated abstract reasoning as to what the symptoms might be and what they probably were not, and she shared her deductions with the physician. The key component, the development of symptoms, was presented smoothly. A sequence of concrete sensations—pain and remission—denoted the deviation. She organized a chronological development of symptoms over three orienting time frames with a clear beginning and ending event, and she related the symptoms meaningfully to each other.

As she and the physician began to examine the symptoms more closely, she elaborated on the context of the previous symptoms.

Context

29. I remember I had had the pa:in. befo:re
(...) An' I was workin' with a do:ctor.
30. An' I was picking up a baby. A lot.
31. never checked but she thought it was— the
pain was
32. due to exercising certain muscles,

She continued by explaining why that explanation did not fit the current episode.

Context

34. Yeah, I babysit. ((for work))
35. hhh No:,,((I'm not picking up babies))
no:t really 'cause ugh the babies
36. I'm picking up are (.) basically four year
old and a three year's so—
37. they're (.) walking.
38. <But my kids seen that I— that thing on
TV,
39. that adds ten years to your life if you go to
gym?
40. So my kids bought me a gym pass hh.

41. A:nd they paying my dues.<And I have
been going to the gym.>
42. So I doin' a workout, three times a
week.<Would that—?>

Evaluation

43. No I do:n't.((get pain after exercising))
44. <That's what was so surprising.

She did not present her symptom as unexplained because she appeared to have accepted the previous diagnosis of a strained muscle. However, when the physician mentioned that he thought the most likely explanation was, again, a strained muscle, she considered his suggestion. In a stream-of-consciousness passage, she told a narrative sequence of how she came to have a health club membership and might be straining herself while exercising (lines 38–42). She candidly asked, 'Would that—?' She denied pain after exercising but thought it 'surprising' that a strained muscle did not hurt after strenuous exercise. She continued thinking aloud, briefly reviewing her symptoms and when they occurred to determine if the exercising might be responsible. Even though gradually she came to accept the physician's suggestion of a strained muscle, he acknowledged her hesitation in his diagnostic recommendation for an EKG, to which she responded positively.

Treatment negotiation

45. Oh, good. ((that you're ordering an
EKG)) Uh [huh,
46. Y'know how they: they uh: * they do
a:uh: ** the lab test
47. on bloo:d an' urine or any'a 'at do 'em **
Can I get that?
48. O:h good, that's what I wanna do. I wanna
have uri:ne,
49. I an' blood, an' make sure that every-
thing's fine.

In this coda the conversation returned, full circle, to the patient's opening comments regarding what she wanted from the encounter, i.e. assurance that she was still healthy. The physician and patient negotiated what she wanted done and what he felt to be reasonable given her lack of convincing symptoms. Her test results were subsequently found to be negative as the clinician had suspected they would be, yet her concern appeared well-taken by him.

Patient 2: somatizing patient without psychiatric co-morbidity

The next patient, a 20-year-old somatizer, reported lower back pain that was interfering with his work as a jet ski mechanic. He presented with an apparent physiological problem, but his presentation became complicated almost immediately by narrative deficits that were found to be associated with somatizing patients.

This patient's introductory comments were less precise and orderly than the non-somatizing patient's. He offered his primary problem, as she did, but his opening statement regarding the nature of his symptoms was vague. He was neither able to develop a clear sequence of chronological events representing the development of his symptoms, nor able to create a temporal frame around his symptoms. He used the expected components, but they were abbreviated and lacked congruency.

Abstract

1. <Uhm::m ** for quite a while (..) I've had * ah:: <some ba:ck pains,
2. jis:st sor:ta an' I can't sh:ake an' I need to >get somethin' done about it

Evaluation

3. *** I've had uh >
4. my back feels almost like its outta place,

Development of symptoms

5. >It's right here it's always right here< ((pointing to lower back))

Evaluation

6. My back feels like its outta place 'n once in while after a long day
7. It's pinchin' a:h (.) ah:: nerve or something'

Development of symptoms

8. I get a lotta numbness in my foot- my leg * lotta throbbin' pain

Orientation

9. an' I get a lot at work 'cause I work as a jet ski mechanic an:: ah-
10. so I do a lot of heavy liftin' n'- too
11. ((*Dr: Where do you work:?.))
12. As a jet ski mechanic nn' if I lift something'
13. (2) after liftin' all da:y
14. * by the end of the day

Development of symptoms

14. and I'm jist- I walk (..) >I walk totally like this< ((hunched over))
15. an' I can sh:: (..) - I can't git strai:ghten' up
16. and the pain goes through down ta my leg and
17. throbbin' (..) real throbbin' (..) in (.) my right leg and jist-
18. ((*Dr: So the pain kinda extends down to your right leg?))
19. Ya, it goes up here and I feel alotta down here-and my fo:ot goes nu:mb-

Evaluation

19. I mean it feels like almost somethin's being pinched in the back ((Dr. * Ok, all the way down to your foot.))

Development of symptoms

20. Um hmm (..) and then like in some instances- uh-
21. depending on how I move- a:h my foot'll be nu:mb like a lot

Orientation

22. 'cause I'm on my feet alot during the day so-

Development of symptoms

23. I get- I get allot a ex:cruciating pain in- like in here ((pointing to back))
24. from my back and ah::
25. ((*Dr: Anything make the pain better.))

Orientation

25. I:m ** I try to take some aspirin- I don't know if it helps so much.
26. I usually don't take 'em 'til the afternoon.
27. A:h (..) I take (..) maybe (..) 3 or 4 a day. ((*Dr: Ok, and that's not really helping you.))

Context

28. Uhm mm, yeh, I work right now- I work all day
29. and I get home- leave aroun' 6:30.
30. I- I drive to my house about a half an hour drive to my house
31. I jist**jist wanna scream 'n yell- it hurts so bad sometimes.

The man followed his abstract with an evalu-

ation of his pain as a pinched nerve or the more serious suspicion that something was 'outta place', which he mentioned twice, creating an emphasis. The mentioning of his evaluation so early in the narrative rather than leading to it with the development of symptoms served a somewhat different purpose than might occur in other settings: it suggested that he was distressed about the possibility of a serious problem and was seeking reassurance or confirmation (Brody, 1994).

The most marked differences between this narrative and that of the non-somatizer lay in the disorganization of the narrative components and in the absence of a chronological development of symptoms. All of the expected components were there, but the patient's story shifted quickly among components and he repeatedly interjected commentary about his pain. The doctor's comments are included in this passage in parentheses preceded by an asterisk to show that the shifting topics are not attributable to the physician's control of the dialog. Most of the physician's comments are reflective as he tried to confirm what the patient was saying.

The lack of chronological development of symptoms is equally evident. The patient reported numbness, pain, and throbbing, but he did not explain their development over a narrative sequence of events or establish a relationship among them. For example, in lines 14 to 18, he listed his symptoms in the following order: (1) walking hunched over; (2) being unable to straighten up; (3) feeling pain going down his leg; and (4) having numbness in his foot. Intuitively, one suspects that the sequence of events began with pain going down his leg. As the condition worsened, he had difficulty straightening up, so he began walking hunched over. At some point he became aware of the numbness. The patient began this sequence with a statement implying a painful condition that was causing functional impairment. Instead of developing a sequence of events chronologically, he presented a topic of distress supported by randomly ordered physical symptoms, the equivalent of a thematic organization. This passage mirrors his introductory passage in which his distress appeared primary and the symptoms were supporting evidence.

This patient appeared to fear a serious condition. He mentioned taking aspirin for the pain, but he was not able to explain what happened after he took the aspirin. Instead, he described how he took it. The physician followed on his equivocation with a direct question as to whether the aspirin helped relieve the pain (after line 27), a request that nominated the topic as important and worthy of further dialog. The patient ignored the physician's inquiry, but justified his rejection (cf. Clark & Mishler, 1992) with a dramatic recital of his pain when driving home (lines 29–31). In the delivery, the man's soft voice and subdued mannerisms softened the impact of his words, yet throughout this passage he focused verbally on conveying his emotional frustration.

Rhetorically, he moved closer to descriptive prose than narrative development. The intensity of the symptoms was conveyed sensually: 'real throbbin'', 'lotta numbness', and 'excruciating pain'. His frustration culminated daily in a desire to 'scream 'n yell' on his way home. In the first 25 lines of speech, he repeated the word 'pain' five times, 'numbness' three, and 'throbbing' three. To emphasize the descriptions, he used the historical present through most of his narrative rather than the more common past tense. The historical present takes a past, completed action and recreates it as a vivid, ongoing experience, e.g. 'My back feels outta place' rather than 'My back felt as if something was outta place' (cf. Wolfson, 1978).

This patient used another verb construction that conveyed a static condition as opposed to a transitory state. Descriptions of transitory actions or events are stated with progressive verbs, e.g. 'I am feeling pain' or 'he is running a temperature' (Schiffrin, 1981). This patient used the non-progressive form, e.g. 'I get numbness' or 'I walk hunched over', a modality associated with habitual activities or occurrences (Schiffrin, 1981). The combination created an effect of a continual, ongoing condition rather than a deviation from the norm. He further increased the constancy of the problem by not indicating a beginning event in his narrative. The passages intended to develop the onset and worsening of symptoms instead described a stable condition of limitation and pain.

When the patient tried to tie his symptoms to his work environment, he failed to develop a

clear relationship between context and pain (lines 21–24). He tied the numbness in his foot to being on his feet ‘alot’. However, he had offered earlier that the lifting he did at work was probably the cause of the back pain. The lack of congruence between his activities and the consequent symptoms again suggests a thematic rather than temporal organization. Throughout the man’s narrative, the explicit topic of discussion remained his request for relief from back pain, yet the larger issue of his distress appeared to be the theme that connected his comments.

Similar to the non-somatizing patient, this man mentioned previous medical care for his pain.

Orientation

33. –I went to the doctor about four months ago.
34. Up in the city, I live in I had X-rays done on my back.
35. It didn’ show anythin’.

Symptom description

36. It was– I’ve had it but it’s been real severe this last month=

Orientation

37. Then they took X-rays.
38. It didn’t show anything.
39. An’ that’s the main reason why I went in for it ‘cause I’ve had back pains
40. since I was a little kid and stuff–
41. but that was more like upper back problems.

The prior medical visit occurred 4 months ago when X-rays were taken but they were negative. Whatever the earlier diagnosis may have been, there was no indication that the man accepted it as accurate for that time or for the present. He switched abruptly to his present condition with an ambiguous ‘I’ve had it . . .’ without clarifying what he meant by ‘it’, i.e. he might have been referring to the feeling of dislocation mentioned initially or to his chronic pain. In a spontaneous comment, he remarked that the problem extended back into his childhood but ‘that was more like upper back problems’. These remarks suggested that he had upper back problems as a child, but it was lower back pain that prompted the medical evaluation four months ago as well as the present encounter. Nonetheless, the patient stated that the reason he sought medical

care was for his chronic back pain since childhood (lines 39–40). The juxtaposition of the symptoms four months ago, the current symptom, and the childhood symptom created a semantic grouping by structure, yet linguistically he was ambiguous as to how the three events related to one another. He also eliminated any temporal frame around his symptoms.

At the end of his encounter, the clinician said that the examination showed no neurological involvement and that he might have a strained muscle. The man accepted the diagnosis with a markedly changed characterization of his symptoms.

Evaluation

42. A little bit ((*pulling sensation*))– ‘n sometimes when I lay on the floor–
43. I mean– I could tell there’s somethin’ wrong
44. ‘cause it feels like one side is higher than the other.
45. I don’ seem to be laying flat at that point–
46. as soon as I get home I have to–
47. like lay flat on my back to try and stretch my back out if I can.
48. Um, ya: ‘til I get back up– I got to lift–
49. walk *** it’s just lately, after I get done working, it’s just so that–
50. this one’s really bad ‘cause the muscles have been tighn’ up.

His rhetoric became less dramatic and his sentence organization more fragmented, but he continued to present his problem. On the other hand, the physician had found no evidence of restricted movement or dulling of sensation that would indicate an organic problem commensurate with the man’s reported symptoms. Although the patient initially appeared to acquiesce to the physician’s evaluation when he recharacterized his problem as ‘somethin’ wrong’ (line 43), he continued to describe his difficulty as if he was still trying to convince the physician of a more severe problem. The encounter began to conclude with no acknowledgement by the physician of the intensity of pain and frustration that the patient was reporting and no indication that the patient accepted the physician’s analysis as accounting for his experience. The patient’s resistance to the physician’s evaluation surfaced in his last comment about ‘this one’s really bad’ (line 50), which

indicated that this episode was one of many and that the physician's diagnosis of an isolated episode of strain was not congruent with the patient's evaluation of a more severe and chronic problem. Thus, the physician's and patient's evaluations remained dissimilar and the encounter concluded without a mutually accepted resolution.

Patient 3: somatizing patient with co-morbid PTSD

The most marked qualitative deviations in narrative structure and content occurred when somatization was co-morbid with depression or PTSD (as assessed by the CIDI). The next patient, a somatizer with a diagnosis of PTSD, was a 34-year-old Spanish-speaking woman who complained of multiple pseudoneurological problems on the left side of her face, shoulder, and arm. She had facial numbness and pain, lip paralysis, watering of her left eye, facial and eye burning, and numbness down her left arm—symptoms she reported that she had never before experienced. The burning in her left cheek appeared to alternate with numbness and sharp pain. She reported that her lip paralysis made it difficult for her to swallow. Three months ago, she had experienced difficulty swallowing because of a pain in her throat, but she did not mention other accompanying symptoms.

Her physician spoke fluent Spanish, removing a potential language barrier. The transcript reported here is a translation of the original Spanish, so all transcription symbols are approximations of verbal inflections and pauses.

Introduction

1. Hi ((softly))

Development of symptoms

2. It's this. My who:le face fell asleep ((motioning over left cheek))
3. ^and my mouth goes crooked ((covers mouth with fingers))
4. (...) and my eyes (...) this one—
5. >this one waters and it pulses every now and then<.
6. ^And all this hurts me right now ((stroking left shoulder down to breast)),
7. this part hurts ((pinches forehead between fingers)).
8. ((Patient keeps hand, when free, in front of mouth))

Orientation

9. =No ((I've never experienced it before)).
10. ^Since Wednesday it began,

Development of symptoms

11. and >daily I would feel pain right here, very strong ((motions over left cheek))
12. ^ (...)and in the evening a burning of my eyes ((points to left cheek))
13. * and yesterday Thursday ** uh:: I started a: feeling pain
14. (...)right here ((stroking left cheek))
15. And I remember that right here * all of this— * just like this.
16. ((stroking left side of face from side of nose to ear))
17. ^My ear, no ((burning)).
18. ^No, just this part right here, ((probes under jaw with fingers))
19. < (...) all this > ((rubbing face))—
20. ^And burning in my eyes (...) PAIN right here (**)
21. and when I shut my— my eyes they watered alot (...) on Wednesday
22. (.) and then Thursday I felt all this part asleep ((stroking cheek))
23. (...)and I noticed that when I put my fingers on my lips,
24. ((holding fingers to lips))
25. they wouldn't respond. ((holding fingers in front of lips))
26. My tongue feels scalded, or rather I feel it like this—
27. Like when one burns himself, that's how I feel it (word) and—
28. At night, and then it started more, and right now.
29. * I feel my mouth like this ((points))
30. It's going toward this side. ((rubs left shoulder area))

This patient was not able to construct a narrative. Her symptoms tumbled out without order or sequence, but connected by her topic of pain and confusion. There was no abstract, context, or evaluation as she focused exclusively on her physical sensations, which she appeared to perceive as a plethora of simultaneous phenomena that occurred without warning or pattern.

In response to the physician's question as to when the symptoms began, the woman tried to explain how the pain started on Wednesday.

However, she could not differentiate between the symptoms on Wednesday and Thursday. At one point she mentioned that the pain started on Thursday, but later commented that the numbness began on Thursday. Unlike patient 2 who took his symptom back into childhood, this patient reported that the symptoms appeared recently and suddenly, yet she reported no precipitating event. Again, similar to patient 2, this woman used the present tense although it is not the historical present. She appeared to be experiencing at least some of the symptoms as she was talking. In the majority of verb constructions she used a non-progressive modality, as did patient 2, implying habitual activities or occurrences ('My tongue feels scalded'). Her few attempts to establish a beginning point to her narrative were rendered meaningless by her confusion and by the static but salient nature of her distress.

She conveyed the same confusion with her syntax as she did with time. Her sentences were simple clauses, sometimes spoken individually and sometimes run together with conjunctions. Many of the simple sentences were only three or four words long, e.g. 'my mouth goes crooked'. Rarely did she use subordination to develop relationships among the symptoms. She relied on juxtaposition—a technique found with patient 2—as a substitute for the absence of an articulated logical link between the symptoms.

Similar to patient 2, this patient used descriptive behavior, verbal and non-verbal, rather than narrative sequences. She repeated sensual words: the word 'feel' was used six times in the above passage. Occasionally, she used only phrases accompanied by hand movements to indicate what she meant. Use of the hands to cover or stroke one's body is an indicator of fear and may be an unconscious attempt to protect oneself (Horowitz et al., 1993). Patient 2 used metaphorical references within a limited narrative structure to indicate his emotional pain, but this patient's narrative structure was so fragmented that she was incapable of constructing a multileveled, cohesive narrative. She appeared unable to distance herself mentally from her body's sensations in order to create a temporally ordered causal chain of experiences or to draw conclusions as to the significance of her symptoms. Instead, her speech resonated with confusion and anguish.

She recounted an earlier episode of difficulty swallowing:

Orientation

31. It's barely been one, two, or three months (words)

Development of symptoms

31. ^I had an immense pain (words) different from what I felt here ((inaudible))

32. ^I had an immense pain in my throat.

33. ^A pain different from what I felt right here, but inside.

34. But it's like it wouldn't let my food pass

35. and it wouldn't let my saliva go down.

Evaluation

51. It bothered me a lot.

The patient was unable to identify when the previous episode of pain occurred. She thought it was one month ago, but immediately listed 'two, three months', suggesting that common time frames were indistinct or lacked distinguishing reference points for her. She vividly portrayed her experience of pain, however. A phrase using an extreme modifier—'an immense pain'—was mentioned twice, and she continued on the topic of pain in the next clause, creating a list of repetitions to increase the significance of the condition. Only her first statement (line 31) meets the criteria for a narrative clause. The next line was repetitive, the next descriptive, and the final sentences used the verb 'would' indicating a general rather than specific situation.

Paradoxically, her blurring of the time frame and use of an indefinite verb construction implied a habitual or enduring activity, yet she characterized the previous sensations as 'different' from the current ones. Thus she blurred the timing of the events into each other at the same time as she insisted that they were separate. In addition, she did not see the second episode as a more serious version of the first. To do so would have required that she establish some abstract concept of each episode so that points of similarity could be matched. This narrative was marked by an absence of abstractions, including any ability to group physical sensations based on similarity or dissimilarity. Furthermore, both episodes remained 'decontextualized', i.e. they occurred without articulated contexts of home or workplace or social situation, expected elements in an orientation.

Unlike patients 1 and 2, this woman accepted her symptoms with fragile stoicism. Her emotional distress was manifesting in a more diffuse group of symptoms than with patient 2, suggesting less ability on her part to categorize her physical sensations. Everything was equally distressing, but she had few cognitive resources left for contemplating their meaning or devising home remedies. For instance, patient 2 mentioned taking aspirin and stretching out on the floor to help his back. It was notable that this woman did not report any agentive action: she endured the symptoms until she 'gave' the problem to the physician. During the encounter, she often stroked her face and shoulder, as if comforting herself. In the CIDI interview, she reported that she was a rape victim and had intrusive memories, nightmares and flashbacks of the event, although her memory was blank for some part of it.

This patient was so soft-spoken that transcription was difficult. She sat tensely at the front of her chair, never moving her legs or torso but using her hands and arms to gesture. Her choice of words, though, was dramatic. The burning in her eyes created 'PAIN', her tongue felt 'scalded' or like when 'one burns himself', and she had 'an immense pain in her throat'. The choice of superlatives and the use of inhibited body language formed a communicative paradox that differed substantially from what would be expected from a stereotypic flamboyant and impulsive patient.

The physician diagnosed a viral infection of a cranial nerve as causing the facial paralysis. The symptoms down her chest and arm were not addressed. The patient listened to the explanation but was unable to fit the diagnosis to her illness.

Treatment negotiation

52. It goes crooked
53. And it's going to fix my mouth?
54. On this side? ((taking eye patch))
55. How long?
56. Right now my brain hurts a lot and this right here
57. And they say—
58. What's the discussion about?
- ((Physician and patient walk out))
59. And the pills, what are they for?
60. My lips don't have any force.

As the patient struggled to integrate the physician's diagnosis and treatment plan with her symptoms, her comments continued to be disorganized and lacking inflection. Accepting and enacting a treatment regimen requires a cognitive assumption about a relationship among the symptoms and an abstract conceptualization of how the treatment regimen will remedy the problem. This woman's thinking was restricted to her concrete sensations, thereby precluding abstract reflection and assimilation. Because the physician and patient were not able to construct a narrative jointly that told this patient's complete illness story, the narrative remained fragmented to the end.

Discussion

Somatizing patients represent some of the most difficult patients that health care professionals encounter, and their treatments are among the most costly. We sought to examine qualitatively the narratives of somatizing and non-somatizing patients to determine if the underlying emotional conflict that has been assumed to be associated with somatization might systematically modulate the global structure of somatizing patients' narratives in clinically observable ways. A second objective was to determine if the presence of a co-morbid psychiatric condition noticeably increased any narrative disturbance that might be associated with somatization. Both objectives were designed to highlight possible behavioral manifestations that could be used as diagnostic aids for somatization tendencies. In fact, narrative differences did emerge that allowed for an identification of somatizing patients who presented with somatoform symptoms sufficient to meet Escobar and colleagues' (1991) abridged construct. When the patient also had a psychiatric co-morbidity, the narrative differences became more salient and disruptive.

In the non-somatizing population, patients use the components expected in the Labov and Waletzky (1967) narrative model to develop a succinct but clear story of their illnesses. They present the abstract, orienting information, development of symptoms, and attempted resolution. Sometimes they offer an evaluation, but usually the evaluations derive from unsuccessful attempts at resolution. The development of symptoms is presented with chronological

sequencing within a temporal frame that has beginning and ending events. The symptoms represent deviations from the norm that the temporal frame encompasses and separates from non-symptomatic time frames. Patients readily explain relevant contextual or historical details to justify their initial description of the problem or to orient the physician.

Somatizing patients differ from non-somatizing ones in both the narrative structure and rhetorical features of their illness stories. They use the components of abstract, orientation, development of symptoms, and evaluation, but the components are not congruent with each other or well-developed internally. Each component receives a few sentences, which are frequently disjointed, and the components are not organized in a straightforward manner, although the organization is not random. Patients do convey their physical distress. For instance, functional impairment is likely to be as salient in the abstract as presentation of symptoms, thus introducing a complex narrative that has both an explicit theme, i.e. the symptoms, and an implicit theme, i.e. their functional limitations. Physicians tend to focus on developing the story associated with the explicit theme, and the extent to which patients are willing to relinquish the implicit theme may determine whether or not they can reach agreement during the treatment negotiation phase of the encounter. Orientations are less specific, and somatizing patients are likely to introduce ambiguities into their medical history. As the story emerges, somatizing patients frequently mention long struggles with their problem in an attempt to turn the physician's attention to their implicit theme. Comments about prior diagnoses or ineffective treatments are often unclear or disparaging, although patients may be reluctant to clarify why the previous care was unproductive.

For somatizing patients, the degree of similarity between the episode presented and a previous one is usually ambiguous because the orienting information and temporal boundaries are unclear. Presumably the symptoms are not experienced by the patient as associated with any one time frame or context. The patients are unlikely to elaborate sufficiently in any of the components to remove the ambiguity or to articulate relationships between them. Events are often mentioned in juxtaposition, as if

mentioning them within one sequence of speaking turns is sufficient to infer their connectedness. Consequently, somatizing patients' narratives take on a thematic organization rather than the chronological organization preferred by physicians for causal analysis.

A serendipitous finding in the present study was the use among somatizers of verb constructions that imply static conditions rather than transitory ones. For example, a non-somatizing patient might mention that his headache got worse when he drank coffee, but a somatizing patient might say that he 'gets headaches', suggesting a consistent phenomenon as opposed to an emerging symptom. Other researchers have reported the higher functional impairment among somatizing patients compared to non-somatizing ones, even after controlling for severity of condition (Escobar et al., 1987; Katon et al., 1984; Lipowski, 1988a, 1988b). Somatizers appear to perceive their symptoms or illnesses as a constant threat to their functioning, and this concern becomes apparent in their narratives in linguistically subtle and complex ways.

Somatizers with co-morbid psychiatric disorders manifested more striking disturbances in their ability to narrate the symptom development than those seen among patients with somatization only. Patient 3, who had co-morbid PTSD, appeared so overwhelmed by her symptoms that she could not present a structured narrative. Instead, she reported a diffuse collection of symptoms without chronological development, and the temporal frame was limited to the immediate present. She was also more overt in resisting or rejecting the physician's evaluation of her situation or suggested treatment regimen than was the somatizer without a psychiatric comorbidity. On the other hand, she was similar to the somatizing patient without psychiatric comorbidity in that when the physician asked questions about past events, she was unable or hesitant to categorize clearly how a past episode related to the current episode. Both patients also had difficulty developing coherent time frames that differentiated the period of symptoms from the period of time without symptoms.

Somatizers with co-morbid emotional problems also used concrete language. When used with clarity, concrete language evokes vivid imagery associated with abstract ideas. How-

ever, the concrete language of these patients was not used with clarity or specificity, and it did not lead to obvious abstract conclusions. This language was used to increase the vividness of the patient's experience, but the physical descriptions did not coalesce into symptom clusters that were clinically interpretable. Moreover, the unwillingness among these patients to accept emotional explanations for their symptoms further constrained abstract interpretation.

According to Pennebaker (1995), fragmentary concrete references to somatic sensations represent an intermediate step in the translation of our large multidimensional non-verbal system, of which both emotion and somatic activity are components, into our symbolic verbal code. Pennebaker (1995) defines an emotion schema as a cluster of components within the non-verbal system that 'include motoric activity, facial and vocal expression, and somatic activity' (p. 101). A person experiencing a strong emotion, for example rage, could theoretically refuse to acknowledge the emotion by focusing on the somatic components of that emotion schema. The somatic component might stay agitated as long as the emotion remained active and forceful. If the emotion was not acknowledged, the person would use language to 'name' the somatic sensation, thus transforming the rage into a symptom experience. The somatic activity occurs, then, not in a predictable developmental sequence as would be expected with organic pathology, but in flashes of intense emotion that travel circuitously through somatic expression to finally take form in language.

Thus, the triggers of these symptoms would be beyond the immediate awareness of the patient and without reference to immediate contexts (Pennebaker, 1995), which would explain the consistent narrative disruptions during the development of symptoms and contextual material. Once this pattern of emotional expression is developed, it would become—as Bruner (1987) suggests—a way of telling capable of 'guiding the life narrative up to the present (and) directing it into the future' (p. 31). The present study indicates that the effort required to suppress intense emotion would be likely to be associated with the extent of narrative fragmentation. For example, somatization alone allowed some narrative structuring, but somatization with co-morbid emotional con-

ditions limited the patient to reporting of concrete sensations without narrative structure. However, all somatizers—with and without co-morbidities—could still be considered as metaphorically locked, to some degree, in the intermediate step between their multidimensional non-verbal schema and their symbolic verbal code. This constraint appears to limit the resources that the patients have to draw upon to construct their narratives.

Additionally, this conceptualization of the link between emotional experience and narratives among somatizing patients contributes to an explanation of the non-verbal inhibition observed among somatizing patients (Elderkin-Thompson et al., 1998). Non-verbal behavior is the main channel for emotional expression, and somatizing patients have been found to inhibit their motoric, facial, and vocal behavior. This inhibition suggests that their emotional expression might be forced through another idiom. According to Pennebaker (1995), it would be forced into a somatic one. On the other hand, this study found that verbal behavior was forced to convey both explicit historical narrative and an implicit affective message. Somatizers have strong emotions that they wish to communicate, but the non-verbal inhibition limits them to semantics for conveying that message. Consequently, the voice may be soft with limited inflection and few accompanying gestures, but the lexical choices tend toward strong and dramatic words conveyed with numerous rhetorical techniques that further increase their impact. Thus, somatizers appear to rechannel emotion through both somatic and verbal channels, but the expected non-verbal channel is highly limited. The result is a discordant narrative in which the lexical choices fit neither the severity of the physical abnormality nor the patient's manner of speech. This discordance between non-verbal behavior and semantics becomes particularly salient in a situation in which a clinician is trying to understand a verbal narrative to identify causal inferences and to gauge the severity of physical abnormality.

Despite the usefulness of our qualitative analysis, several limitations must be noted. This study was conducted at a public health clinic in a large Californian urban area, and other geographically or ethnically diverse samples might not show the same differences. The range of

educational achievement in our sample was broad but the average was 10 years of schooling, so other socio-economic samples should be examined. Moreover, many of the encounters in this sample lasted 20 to 30 minutes, but in the current managed care environment, routine encounters are likely to be shorter. The somatizing-non-somatizing differences we identified might not be as clear in encounters where the physician must work under such time constraints.

This study was interested in developing structural patterns of narratives for somatizers and non-somatizers. Narrative methodology is particularly suited for formating generalizations and comparisons (Edwards, in press), but it has other limitations. It cannot explore the interaction of the encounter, how somatizers negotiate the meaning of their symptoms, or how they respond to physicians' turns at talk, research questions better addressed by conversational analysis. The interactional focus of conversational analysis could probe into the explicit and implicit messages that somatizers appear to be trying to convey (Potter, 1996). Furthermore, it could document which types of messages are accepted by clinicians and which are subtly rejected. Particularly useful would be a combined qualitative and quantitative approach that examines the verbal and non-verbal interaction, and how that dynamic is associated with clinicians' responses (Edwards, 1997). Two other questions for future researchers are salient: (1) does the degree of verbal disturbance increase with increasing levels of somatoform symptomatology? and (2) does the narrative fragmentation observed in the clinical setting extend into other contexts of the patients' lives?

Conclusion

In this sample of patients, somatizers displayed difficulty constructing their medical narratives. Apparently their efforts at controlling their strong emotions interfered with their ability to construct the concise, informative illness stories typically presented by patients. If physicians become sensitive to the behavioral manifestations of somatization, they can elicit the information needed to determine the probability of somatizing tendency among their patients. When

somatization is identified, physicians can initiate the psychological care that is needed by these patients along with their medical care, thereby reducing somatizers' repetitive demands on the health care system. Accompanying the improvement in treatment would be a reduction in the expensive over-utilization of health care services that occurs when the underlying somatization remains unrecognized.

Note

1. While the presence of a video camera may affect the communication between physicians and patients, there was no indication in the present study that the physicians or patients were reacting to the camera. Physicians' primary concern was with patients' acceptance and comfort and, when assured of this, they appeared to ignore the logistics of the study. Moreover, patients in this study did not appear to restrain their comments. A growing literature corroborates this impression that video recordings of encounters have little impact on physician-patient behavior (Pringle & Stewart-Evans, 1990; Redman, Dickinson, Cockburn, Hennrikus, & Sanson-Fisher, 1989; Wilson, 1991).

Appendix

Transcription conventions

001	Lines of speech are numbered sequentially from the first line of the transcript to the end.
D, P, Tra	D is doctor, P is patient, Tra is translator. Speaker is noted at the first line of an utterance and at overlap points.
Mary: I don' k[no:w if] it [you don't] see	Brackets indicate that the portions of utterances encased are simultaneous. The left-hand bracket marks the onset of simultaneity; the right-hand bracket indicates its resolution.
But-, tie-tierne	Cutting short of the immediately prior syllable.
CAPS or <u>underscoring</u> che:st problem	Both are used to represent heavier emphasis on words so marked. CAPS are reserved for an unusually strong emphasis.

Swat I said= =But you didn't	Indicates that no time elapsed between the words 'latched' by the marks. It can also mean that a next speaker starts at precisely the end of a current speaker's utterance.	We::ll now, I ca:n't do that	Indicates slight stretching or prolongation of word of less than 1 second. Applies to vowels.
(5)	Indicates the seconds between speaker turns. It may also indicate the duration of pauses internal to a speaker's turn.	I put—I mean that	Indicates a change of thought without completing original utterance.
***	Silences within speaker utterances and between speakers. Each asterisk represents one second. Long pauses are denoted by number of seconds in parentheses. These between speakers, i.e. a pre-utterance pause. Used for 1- to 3-second pauses.	?	Indicates rising intonation. A period marks sharply falling intonation; a question mark indicates rising intonation.
(a knob) or (word)	Indicates that something was heard, but the transcriber is not sure what it was.	(Name)	Replacement of proper nouns for confidentiality.
((softly))	Double parentheses enclose descriptions of action. They are not transcribed utterances, but refer to some quality of the whole sentence or a concurrent action.	References	
> <	Rapid speech between the delimiters.	Abbey, S. E., & Lipowski, Z. J. (1987). Comprehensive management of persistent somatization: An innovative inpatient program. <i>Psychotherapy and Psychosomatics</i> , 48, 110–115.	
< >	Slow, measured speech between delimiters.	American Psychiatric Association. (1987). <i>Diagnostic and statistical manual of mental disorders</i> (3rd ed.). Washington, DC: Author.	
o or ^	Softness, or decreased amplitude.	American Psychiatric Association. (1994). <i>Diagnostic and statistical manual of mental disorders</i> (4th ed.). Washington, DC: Author.	
I (x) I did	Indicates a hitch or stutter on the part of the speaker.	Angel, R., & Guarnaccia, P. J. (1989). Somatization among Hispanics. <i>Social Science and Medicine</i> , 28, 1229–1238.	
.hh	Inhalation of breath in sigh or chuckle.	Barsky, A., & Klerman, G. (1983). Overview: Hypochondriasis, bodily complaints, and somatic styles. <i>American Journal of Psychiatry</i> , 140, 273–282.	
hh.	Exhalation.	Barsky, A., Wyshak, G., Latham, K. S., & Klerman, G. L. (1991). Hypochondriacal patients, their physicians, and their medical care. <i>Journal of General Internal Medicine</i> , 6, 413–419.	
((words in italics))	Italicized comments in double parentheses indicate a topic previously introduced by the physician.	Brody, H. (1994). 'My story is broken: Can you help me fix it?' Medical ethics and the joint construction of narrative. <i>Literature and Medicine</i> , 13, 79–92.	
(.)	Denotes a pause of one-tenth of a second.	Bruner, J. (1987). Life as narrative. <i>Social Research</i> , 54, 11–32.	
uh uh, uh-huh	Back channel comments of agreement. Can also signal impatience for speaker to finish, although it usually indicates attention on the part of the listener.	Butler, R., Braff, D., Rausch, J., Jenkins, M., Sprock, J., & Geyer, M. (1990). Physiological evidence of exaggerated startle response in a subgroup of Vietnam veterans with combat-related PTSD. <i>American Journal of Psychiatry</i> , 147, 1308–1312.	
uhm-hmm		Capps, L., & Ochs, E. (1995). <i>Constructing panic: The discourse of agoraphobia</i> . Cambridge, MA: Harvard University Press.	
		Clark, J., & Mishler, E. (1992). Attending to patients' stories: Reframing the clinical task. <i>Sociology of Health and Illness</i> , 14, 344–371.	
		Crabtree, B., & Miller, W. (1992a). A template	

- approach to text analysis: Developing and using codebooks. In B. Crabtree & W. Miller (Eds.), *Doing qualitative research* (pp. 93–109). Newbury Park, CA: Sage.
- Crabtree, B., & Miller, W. (1992b). The analysis of narratives from a long interview. In M. Stewart, F. Tudiver, M. J. Bass, E. V. Dunn, & P. J. Norton (Eds.), *Tools for primary care research* (pp. 209–220). Newbury Park, CA: Sage.
- Dickinson, B. (1989). *Developing quality systems: A methodology using structured techniques*. New York: McGraw-Hill.
- Edwards, D. (1997). *Discourse and cognition*. London: Sage Publications.
- Edwards, D. (in press). Structure and function in the analysis of everyday narratives. *Journal of Narrative and Life History*.
- Elderkin-Thompson, V. D. (1996). Narrative and nonverbal communication of somatizing and nonsomatizing patients in a primary care setting. *Dissertation Abstracts International*, 57–10, 6568B. (University Microfilms No. DA9709926.)
- Elderkin-Thompson, V., Silver, R., & Waitzkin, H. (1998). *Nonverbal behavior of somatizing and nonsomatizing patients in a primary care setting*. Manuscript under review.
- Engel, G. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196, 129–136.
- Escobar, J., Golding, J., Hough, R., Karno, M., Burnam, M., & Wells, K. (1987). Somatization in the community: Relationship to disability and use of services. *American Journal of Public Health*, 77, 837–840.
- Escobar, J., Rubio-Stipec, M., Canino, G., & Karno, M. (1989). Somatic Symptom Index (SSI): A new and abridged somatization construct: Prevalence and epidemiological correlates in two large community samples. *Journal of Nervous and Mental Diseases*, 177, 140–146.
- Escobar, J., Swartz, M., Rubio-Stipec, M., & Manu, P. (1991). Medically unexplained symptoms: Distribution, risk factors and co-morbidity. In L. Kirmayer & J. Robbins (Eds.), *Current concepts of somatization: Research and clinical perspectives* (pp. 63–78). Washington, DC: American Psychiatric Press.
- Fink, P. (1992). The use of hospitalizations by persistent somatizing patients. *Psychological Medicine*, 22, 173–180.
- Fisher, S. (1984). Doctor–patient communication: A social and micro-political performance. *Sociology of Health and Illness*, 6, 1–29.
- Fisher, S., & Todd, A. (1983). *The social organization of doctor–patient communication*. Washington, DC: Center for Applied Linguistics.
- Frank, A. W. (1994). Reclaiming an orphan genre: The first-person narrative of illness. *Literature and Medicine*, 13, 1–21.
- Frankel, R. (1984). From sentence to sequence: Understanding the medical encounter through micro-interactive analysis. *Discourse Processes*, 7, 135–170.
- Gee, J. (1986). Units in the production of narrative discourse. *Discourse Processes*, 9, 391–422.
- Gold, D., & Wegner, D. (1995). Origins of ruminative thought: Trauma, incompleteness, nondisclosure, and suppression. *Journal of Applied Social Psychology*, 25(14), 1245–1261.
- Goldberg, R. J., Novack, D. H., & Gask, L. (1992). The recognition and management of somatization: What is needed in primary care training. *Psychosomatics*, 33, 55–61.
- Helzer, J., Spitznagel, E., & McEvoy, L. (1987). The predictive validation of lay diagnostic interview schedule diagnoses in the general population. *Archives of General Psychiatry*, 44, 1069–1077.
- Hodgman, C. (1995). Conversion and somatization in pediatrics. *Pediatrics in Review*, 16, 29–34.
- Holman, E., Silver, R., & Waitzkin, H. (1996). *Trauma, somatization and post-traumatic stress disorder in primary care patients*. Paper presented at the World Congress of Psychiatry, Madrid, August.
- Horowitz, M., Stinson, C., Curtis, D., Ewert, M., Redington, D., Singer, J., Bucci, W., Mergenthaler, E., Milbrath, C., & Hartley, D. (1993). Topics and signs: Defensive control of emotional expression. *Journal of Consulting and Clinical Psychology*, 61, 421–430.
- Huberman, A., & Miles, M. (1994). Data management and analysis methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 428–443). Thousand Oaks, CA: Sage.
- Inclan, J. (1983). Psychological symptomatology in second generation Puerto Rican women of three socioeconomic groups. *Journal of Community Psychology*, 11, 334–345.
- Kaplan, C., Lipkin, M. J., & Gordon, G. (1988). Somatization in primary care: Patients with unexplained and vexing medical complaints. *Journal of General Internal Medicine*, 3, 177–190.
- Katon, W., Kleinman, A., & Rosen, G. (1982). Depression and somatization: A review, part I. *American Journal of Medicine*, 72, 127–135.
- Katon, W., Ries, R., & Kleinman, A. (1984). The prevalence of somatization in primary care. *Comparative Psychiatry*, 25, 208–215.
- Katon, W., & Russo, J. (1989). Somatic symptoms and depression. *Journal of Family Practice*, 29, 65–69.
- Kellner, R. (1990). Somatization: Theories and

- research. *Journal of Nervous and Mental Diseases*, 176, 150–160.
- Kellner, R., Slocumb, J., Wiggins, R., Abbott, P., Winslow, W., & Pathak, D. (1985). Hostility, somatic symptoms and hypochondriacal fears and beliefs. *Journal of Nervous and Mental Diseases*, 173, 554–561.
- Kirmayer, L., & Robbins, J. M. (1991a). Functional somatic syndromes. In L. J. Kirmayer & J. M. Robbins (Eds.), *Current concepts of somatization: Research and clinical perspectives* (pp. 79–106). Washington, DC: American Psychiatric Press.
- Kirmayer, L., & Robbins, J. M. (1991b). Three forms of somatization in primary care: Prevalence, co-occurrence and sociodemographic characteristics. *Journal of Nervous and Mental Diseases*, 179, 644–655.
- Kirmayer, L., Robbins, J., Dworkind, M., & Yaffe, M. (1993). Somatization and the recognition of depression and anxiety in primary care. *American Journal of Psychiatry*, 150, 734–741.
- Kroenke, K., Lucas, C., Rosenberg, M. L., Scherokman, B., & Herbers, J. E. (1993). One-year outcome for patients with a chief complaint of dizziness. *Journal of General Internal Medicine*, 9, 684–689.
- Kroenke, K., Spitzer, R., Williams, J., Linzer, M., Hahn, S., deGruy, R., & Brody, D. (1994). Physical symptoms in primary care: Predictors of psychiatric disorders and functional impairment. *Archives of Family Medicine*, 3, 774–779.
- Labov, W. (1972). *Language in the inner city: Studies in the Black English vernacular*. Philadelphia: University of Pennsylvania Press.
- Labov, W., & Waletzky, J. (1967). Narrative analysis: Oral versions of personal experience. In J. Helm (Ed.), *Essays on the verbal and visual arts* (pp. 12–45). Seattle: University of Washington Press.
- Lazare, A., Eisenthal, S., Frank, A., & Stoeckle, J. D. (1978). Studies on a negotiated approach to patienthood. In E. B. Gallagher (Ed.), *The doctor-patient relationship in the changing health scene* (pp. 119–139). US Department of Health Education and Welfare. Washington, DC: Government Printing Office.
- Lin, E., Katon, W., Von Korff, M., Bush, T., Lipscomb, P., Russo, J., & Wagner, D. (1991). Frustrating patients: Physician and patient perspectives among distressed high users of medical services. *Journal of General Internal Medicine*, 6, 241–246.
- Lipowski, Z. (1988a). An inpatient programme for persistent somatizers. *Canadian Journal of Psychiatry*, 33, 275–277.
- Lipowski, Z. (1988b). Somatization: The concept and its clinical application. *American Journal of Psychiatry*, 145, 1358–1368.
- McWhinney, I. (1989). The need for a transformed clinical method. In M. Stewart and D. Roter (Eds.), *Communicating with medical patients* (pp. 25–40). Newbury Park, CA: Sage.
- Mechanic, D. (1972). Social and psychological factors affecting the presentation of bodily complaints. *New England Journal of Medicine*, 286, 1132–1139.
- Miles, M., & Huberman, A. (1984). *Qualitative data analysis: A sourcebook of new methods*. Beverly Hills, CA: Sage.
- Miller, W., & Crabtree, B. (1994). Clinical research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 340–352). Thousand Oaks, CA: Sage.
- Miranda, J., Perez-Stable, E., Munoz, R., Hargreave, W., & Henke, C. (1991). Somatization, psychiatric disorder, and stress in utilization of ambulatory medical services. *Health Psychology*, 10, 46–51.
- Mishler, E. G. (1984). *The discourse of medicine: Dialectics of medical interviews*. Norwood, NJ: Ablex.
- Mishler, E. G. (1991). Representing discourse: The rhetoric of transcription. *Journal of Narrative and Life History*, 1, 255–280.
- Mishler, E. G., Clark, J., Ingelfinger, J., & Simon, M. (1989). The language of attentive patient care: A comparison of two medical interviews. *Journal of General Internal Medicine*, 4, 325–335.
- Nichter, M. (1981). Idioms of distress: Alternatives in the expression of distress: A case study from south India. *Culture, Medicine and Psychiatry*, 5, 379–408.
- Olsson, M. (1991). Primary care patients who refuse specialized mental health services. *Archives of Internal Medicine*, 151, 129–132.
- Parsons, C., & Wakeley, P. (1991). Idioms of distress: Somatic responses to distress in everyday life. *Culture, Medicine and Psychiatry*, 15, 111–132.
- Pennebaker, J. (Ed.). (1995). *Emotion, disclosure and health*. Washington, DC: American Psychological Association.
- Pennebaker, J. W., & Traue, H. C. (1993). Inhibition and psychosomatic processes. In H. Traue & J. Pennebaker (Eds.), *Emotion, inhibition, and health* (pp. 10–31). Seattle: Hogrefe & Huber.
- Polkinghorne, D. (1991). Narrative and self-concept. *Journal of Narrative and Life History*, 1, 135–153.
- Potter, J. (1996). *Representing reality: Discourse, rhetoric and social construction*. London: Sage.
- Pringle, M., & Stewart-Evans, C. (1990). Does awareness of being video recorded affect doctors' consultation behavior? *British Journal of General Practice*, 40, 455–458.

- Redman, S., Dickinson, J. A., Cockburn, J., Hennrikus, D., & Sanson-Fisher, R. W. (1989). The assessment of reactivity in direct observations of doctor-patient interactions. *Psychology and Health*, 3, 17-25.
- Riessman, C. K. (1989). Life events, meaning and narrative: The case of infidelity and divorce. *Social Science and Medicine*, 29, 743-751.
- Robins, L., Helzer, J., Croughan, J., & Ratchliff, K. (1981). The National Institute of Mental Health Diagnostic Interview Schedule: Its history, characteristics, and validity. *Archives of General Psychiatry*, 38, 381-389.
- Robins, L., & Regier, D. (1991). *Psychiatric disorders in America: The epidemiological catchment area study*. New York: Free Press.
- Robins, L., Wing, J., Wittchen, H., Helzer, J., Basbor, T., Burke, J., Farmer, A., Jablenski, A., Pickens, R., Regier, D., Sartorius, N., & Towle, L. (1988). The Composite International Diagnostic Interview. *Archives of General Psychiatry*, 45, 1069-1077.
- Roter, D., Lipkin, M., & Korsgaard, A. (1991). Sex differences in patients' and physicians' communication during primary care medical visits. *Medical Care*, 29, 1083-1093.
- Rubio-Stipec, M., Canino, G., Robins, L., Wittchen, H., Sartorius, N., & Torres de Miranda, C. (1993). The somatization schedule of the Composite International Diagnostic Interview: The use of the probe flow chart in 17 different countries. *International Journal of Methods in Psychiatric Research*, 3, 129-136.
- Schiffrin, D. (1981). Tense variation in narrative. *Language*, 57, 45-62.
- Shorter, E., Abbey, S. E., Gillies, L. A., Singh, M., Lipowski, Z. J. (1992). Inpatient treatment of persistent somatization. *Psychosomatics*, 33, 295-301.
- Siegmán, A. W., & Feldstein, S. (Eds.). (1987). *Nonverbal behavior and communication*. Hillsdale, NJ: Erlbaum.
- Smith, G., Jr, Monson, R., & Ray, D. (1986a). Patients with multiple unexplained symptoms: Their characteristics, functional health, and health care utilization. *Archives of Internal Medicine*, 146, 69-72.
- Smith, G. R., Monson, R. A., & Ray, D. C. (1986b). Psychiatric consultation in somatization disorder: A randomized controlled study. *New England Journal of Medicine*, 314, 1407-1413.
- Spitznagel, E., & Helzer, J. (1988). The Diagnostic Interview Schedule: Its development, evolution, and use. *Archives of General Psychiatry*, 42, 725-728.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory, procedures and techniques*. Newbury Park, CA: Sage.
- Street, R., Mulack, A., & Weimann, J. (1988). Speech evaluation differences as a function of perspective (participant versus observer). *Human Communication Research*, 14, 333-363.
- Tesch, R. (1990). *Qualitative research: Analysis types and software tools*. New York: Falmer.
- van der Kolk, B. A. (Ed.). (1996). *Traumatic stress: The effects of overwhelming life experience on mind, body, and society*. New York: Guildford Press.
- Waitzkin, H. (1991). *The politics of medical encounters: How patients and doctors deal with social problems*. New Haven, CT: Yale University Press.
- West, C. (1984). *Routine complications: Troubles with talk between doctors and patients*. Bloomington: Indiana University Press.
- Wilson, A. (1991). Consultation length in general practice: A review. *British Journal of General Practice*, 4, 119-122.
- Wittchen, H., Robins, L., Cottler, L., Sartorius, N., Burke, J., & Regier, D. A. Participants in the Multicentre WHO/ADAMHA Field Trials. (1991). Cross-cultural feasibility, reliability and sources of variance of the Composite International Diagnostic Interview (CIDI). *British Journal of Psychiatry*, 159, 645-653.
- Wolfson, N. (1978). A feature of performed narrative: The conversational historical present. *Language in Society*, 7, 215-237.