

Giving an Account of One's Pain in the Anthropological Interview

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Abstract In this paper, I analyze the illness stories narrated by a mother and her 13-year-old son as part of an ethnographic study of child chronic pain sufferers and their families. In examining some of the moral, relational and communicative challenges of giving an account of one's pain, I focus on what is left out of some accounts of illness and suffering and explore some possible reasons for these elisions. Drawing on recent work by Judith Butler ([Giving an Account of Oneself, 2005](#)), I investigate how the pragmatic context of interviews can introduce a form of symbolic violence to narrative accounts. Specifically, I use the term “genre of complaint” to highlight how anthropological research interviews in biomedical settings invoke certain typified forms of suffering that call for the rectification of perceived injustices. Interview narratives articulated in the genre of complaint privilege specific types of pain and suffering and cast others into the background. Giving an account of one's pain is thus a strategic and selective process, creating interruptions and silences as much as moments of clarity. Therefore, I argue that medical anthropologists ought to attend more closely to the institutional structures and relations that shape the production of illness narratives in interview encounters.

Keywords Chronic pain · Complaint · Illness narrative · Narrative positioning · Medical institutions

Introduction

In a provocative critique of the concept of illness narrative, Unni Wikan ([2000](#)) suggests that the Western academic literature artificially construes illness narratives

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as being about “my illness and me,” while the stories of sickness she hears in the field and at home revolve mainly around social relationships, and complexly intertwine with “the ongoing stories of their lives” (p. 218). Storytellers’ compelling concerns, Wikan argues, need not be confined to the illness. And, perhaps more radically, “An illness story need not be about illness at all, or illness may be only a part, and not the most salient part, of what the teller (or narrator) seeks to convey” (p. 230).

In this paper, I give serious consideration to the issue of what an illness narrative—or, rather, a pair of illness narratives—is “about.” Specifically, I analyze the illness stories narrated by a mother, Faith, and her 13-year-old son, Allan, who suffers from chronic migraines, to examine what is left out of some accounts of illness and suffering and explore some possible reasons for these elisions.¹ As I will show, a critical part of Faith’s story concerns the kind of mother she desires to be: a mother who responds in an ethical way to the injustices of her son’s long-lasting pain. In what follows, I draw on recent work by Judith Butler (2005) to investigate how the pragmatic context of storytelling interactions—in this case, the medical anthropological research interview—shapes narrative production in critical ways. My approach thus recognizes that narrators are constrained by their ideas about what can and should be told in a particular setting—what Shuman (2006, p. 150) calls “available narratives”—and that, as Ochs and Capps (2001, p. 252) acknowledge, “certain narratives remain untold.”

The Politics of Storytelling

Anthropologists and sociologists have produced abundant accounts of how illness sufferers mobilize narratives of personal experience as therapeutic resources and meaning-making agents (Capps and Ochs 1995; Frank 1995; Garro 2003; Good 1994; Hyden 1995; Kleinman 1988; Mattingly and Garro 2000; Shohet 2007). However, as Jackson (2002, p. 252) notes, “Stories belong to the in-between spaces of intersubjectivity.” And yet, apart from Mattingly’s (1998) persuasive theory of the narrative structure of everyday social action, relatively less scholarship has focused on the ways in which illness stories are lived and told in relationally constructed social worlds.

Illness narratives are often filtered through complex household dynamics that mediate their production. Reflecting on the collection of illness stories from people afflicted with seizure disorders in Turkey, Good (1994, p. 158) recalls, “In nearly all the narratives we heard, family politics was not only present as a subtext of many of the stories, but was also central to the pragmatics of their telling.” Stories told in such family settings emerge through interwoven multiparty conversations in which cultural values and communicative practices may serve to conceal certain aspects of subjective life (Throop 2008), and the right to tell one’s *own* troubles may be contested (Wilce 1995). One particularly dramatic example occurs among the Australian Aborigines of Darwin fringe camps, where giving an account of one’s

¹ Following Garro and Mattingly (2000), I use “stories” and “narrative” interchangeably in this article.

own suffering is not culturally sanctioned since malevolent spirits are believed to infiltrate the sick and render them unreliable narrators (Sansom 1982). Children may likewise be considered incompetent narrators of their own illness experience (see Tate and Meeuwesen 2001). However, among the few anthropologists who have closely examined parental stories about children's illness (cf. Bluebond-Langner 1996; Carpenter-Song 2008), little attention has been paid to the pragmatic context of their telling.

Narrative asymmetry provides a crucial window onto cultural processes concerned with power and agency in social relations. As Ochs and Capps (1996, p. 33) explain, "Silencing is part of the fabric of culture in that it is critical to socializing prevailing ideologies." Moreover, the narratives borne out of storytelling encounters evince the limits of narrative representation by pointing to the ways in which narratives may pragmatically interrupt, silence or otherwise distort certain aspects of human experience. As numerous studies have illustrated, illness narratives are rhetorical accounts that may be designed to elicit a particular interpretation of the condition (Charmaz 2002; Good 1994; Hyden 1995), restore the moral position of the teller (Frank 1995; Kleinman 1988; Riessman 1990; see also Ochs and Capps 2001) or provide a means to some other end (Brodwin 1992; Wikan 2000).

In medical anthropological research, institutional structures and clinical spaces provide one important backdrop for the production of illness stories. Yet the anthropological literature has only rarely considered how institutions influence the pragmatics of illness narratives. This fact is puzzling, considering the extent to which institutional policies and bureaucratic hurdles constrain access to research subjects. In one notable exception, Saris (1995) embeds an analysis of one man's account of living with schizophrenia within a subtle critique of medical anthropological praxis. Specifically, by suggesting that "narratives and silences configure, even entail, one another and that both are set up by specific institutional configurations" (p. 68), Saris bravely admits that anthropological research—itsself an institutional practice—may be susceptible to collusion in a sort of symbolic violence (Bourdieu 1991; see also Estroff 1995).²

Young (1995) likewise attends to the role of institutions—and institutional ideologies, in particular—in shaping illness narratives. Based on ethnographic fieldwork at a Veteran's Affairs hospital-based PTSD treatment institute, Young argues that narratives of traumatic experiences told in psychotherapeutic settings may reveal as much about patients' understandings of institutional expectations for recovery as they do about therapeutic efficacy. In other words, patients may learn to tell the kinds of stories (they think) their therapists want to hear (see also Hyden 1995; Kirmayer 2000).

This paper builds on such work on the pragmatics of illness narratives by focusing specifically on accounting for pain in the medical anthropological interview. In arguing that we pay close attention to the interactional dynamics of the

² On this point, see Frank's (2004) excellent essay on the moral imperative of asking the right questions about pain. While Frank is focused on clinical settings and not research encounters, he highlights the relation among institutional practices, ethical responsibility and covert forms of violence.

interview encounter and its impact on the kinds of stories and accounts that researchers are told, I follow Briggs (1986, 2007) and others who have critically examined the ideological and epistemological assumptions underlying the interview as a dominant mode of knowledge production in qualitative inquiry.³ According to such critiques, social scientists have rather naively assumed that interviews afford a relatively unproblematic view of the inner world of the speaker. Atkinson and Silverman (1997, p. 316) view the illness narrative as a “vehicle for a neoromantic construction of the social actor,” in which ethical concerns for maintaining the integrity of the narrator’s authentic self displace considerations of verisimilitude and representation. The view put forth here is that, rather than taking interview data at face value, the denotational content of narrative discourse must be situated within its pragmatic framework, in which the moral character of the protagonist is always at stake. This suggests that even when telling stories of personal experience, the listener is critically implicated in the narrative unfolding of events and the moral stance that the narrator projects (Bakhtin 1981; Duranti and Brenneis 1986).

The Research Study

The interview narratives that I will turn to shortly were collected as part of a larger interdisciplinary study of children and adolescents suffering from chronic pain. Seventy-four children and adolescents participated in the study, which included oral history interviews, videotaped recordings of doctor–patient interactions and psychological questionnaires. The primary goal of the study was to examine anxiety and self-efficacy in children and adolescents with chronic pain, and to compare patients at three university-based tertiary-care pediatric services: pain, neurology and gastroenterology (see Clemente et al. 2008).

Prior to an initial appointment at one of these three clinics, research staff interviewed each child and one of his or her parents at the family’s home. This interview provided the occasion for the people I call Faith and Allan to tell the illness stories that I examine here. As a result, Allan’s upcoming neurology appointment was the primary condition for Faith’s and Allan’s interview encounters. Because the purpose of the oral history interviews was to create an oral history archive of childhood pain, the interviews elicited general biographical information as well as more specific details about the child’s pain experience and treatment history.

Following standard research conventions in Western medical settings, and in contrast to the situations described by Good (1994) and Wilce (1998), the research protocol for this study required that parents and children be interviewed separately. Two trained researchers interviewed Faith and Allan concurrently in separate rooms of their home, and each interview was videotaped. Since I became involved with this study after data collection was nearly complete, my own role was primarily limited to data analysis, and I did not interview Faith and Allan myself.

³ See Yanos and Hopper (2008) for a helpful review of Bourdieu’s work on this topic.

Illness History and Family Background

Allan suffered from incapacitating migraine headaches from the time he was 4 years old. At first, they were somewhat rare, but they increased in intensity and frequency over time. Faith explained:

And it's like over—from then till now, basically what's happened is, the frequency would increase and the duration would increase, until finally, they were, like, overlapping. They took over. I mean imagine like a wet paper towel, and you take a dropper with red food coloring and you put drop, drop, drop, drop, drop. The water spots start growing and growing until the spots start melting into each other, and that's sort of like his headaches over the years, until he's just got this headache that just—it's like his life is one big headache now. There is no start, there is no stop.

Faith estimated that the headaches began to come with increasing frequency when Allan was in third grade, and that they had started melting into each other about two and a half years before the interview.

Allan's symptoms—including pounding around his eyes, dizziness and extreme light sensitivity—bore the markers of classic migraine headaches. When he felt a headache coming on, Allan would often retreat to a makeshift living room fort constructed with blankets and chairs where he could play in complete darkness, much to the dismay of his mother, who preferred that he lie in bed.⁴ Faith's mother, all five of Faith's siblings and Faith herself all experienced occasional debilitating migraines, though none as frequently as Allan. Still, the hereditary link seemed clear to both Faith and Allan. Faith mused, “Yeah, I mean we must have a gene that's labeled migraine, my gosh.”

While Allan had tried a variety of medications, he tended to develop resistance to the drugs quite quickly, and they soon became ineffective. Before the interview, Allan had seen a neurologist for a short time, but the primary treatment he had received for his migraines had been from a pediatrician and emergency room visits. As Faith acknowledged, “One of the problems is that every time I switch jobs, we have a new insurance company. You start over at square one. So, you know, the most frustrating thing about this is that there has been no progress made.” After much wrangling with her insurance company, Faith had received a referral to see a new neurologist at a university hospital, which prompted Allan's enrollment in the present study.

The narrative account of Allan's migraines, in both Allan's and Faith's interviews, was interwoven with a more complex story of emotional pain and family suffering. In addition to migraines, both Allan and Faith have dealt with numerous other illness conditions. Allan was diagnosed with “failure to thrive” as an infant, and was still worrisomely thin at age 13; Faith, along with Allan's

⁴ In fact, Allan conducted a good portion of his interview from underneath a blanket, in order to shade his eyes from light. In reviewing the interview transcripts, I became curious about whether Allan retreated under the blanket when the conversation turned to particular topics that might have been difficult for him to talk about. However, I did not identify any such correlations between Allan's physical positioning and potentially sensitive conversational topics.

doctors, was unsure whether his thin frame might be a result or a cause of his headaches. Allan also had a number of developmental delays and learning disabilities, including ADHD, and received special education for reading and behavioral issues.⁵ As a result of these conditions, Allan had received psychiatric care since the third grade, and was taking Prozac and Concerta for his ADHD.

Faith, for her part, struggled with bipolar disorder, heart disease and migraines. Several months before the interview, she was hospitalized for heart troubles and had gallbladder surgery. According to Allan, “Well, she’s always been sick when I’m around her. I remember very few (days) of her working, and she’s usually sleeping or watching TV or going to the doctor’s appointment, something like that.” Because of Faith’s overwhelming health problems, both Allan and his 16-year-old sister had been sent to live with relatives for a time. Although Allan’s difficult behavior and complicated health situation became too much of a burden on Faith’s brother’s household, Faith’s daughter was still living with a cousin and her husband and three children at the time of our study.

Faith’s financial struggles as a single mother and her painful marital history further compounded the family’s health burden. Faith had worked for many years as a teacher, but it had become more difficult as her children got older. She explained, “Allan is not the kind of kid that I can just put in day care. He has a lot of problems, and it does not work out.” After giving up teaching, she tried working part-time, but she lost her insurance and the medical bills were devastating. Later, Allan’s health problems and her own prevented her from working at all. She asked, “What employer is going to have me work for them if 3 days a week I have to leave work to pick up my son from school because he has a headache?”

When Faith was pregnant with Allan, her husband lost his job and suffered what Faith describes as a paranoid breakdown. According to Faith, “His hate list got very long and got more and more irrational. As it got more and more irrational, I remember thinking to myself, I can’t talk him out of this.” The breaking point came when one day Faith, out of sheer exhaustion, decided to go to bed early. When she awoke the next morning, her husband had somewhat inexplicably erased all of her computer files and locked her out of the computer. Faith told him he had 2 weeks to pack up and leave. Since then, his functioning had waxed and waned; he occasionally found jobs but sometimes lived on the streets. Faith explained, “I think he needed antipsychotic medication. I think that—I don’t think he’s actually psychotic, but I think he’s right there on the borderline.”

Throughout his childhood, Allan’s father faded in and out of his life, and at the time of the interview, Allan had made a decision not to speak to his father anymore. He explained:

I chose to do the right thing, the thing that I should have done long ago, which I almost did a while ago, but then he came back. Then he left me again. Then he came back. Then he left me again. Then he finally came back, he left me again, and I’m just not going to see him until he gets help.

⁵ The neurologist who saw Allan after the interview indicated that Allan exhibited symptoms of Asperger’s syndrome, a diagnosis that Faith resisted at first, but finally accepted.

Discussing his father made Allan extremely uncomfortable. As he put it, “He’s a ghost to me. That’s how bad it is. He’s nothing. He’s dead, let’s put it that way.” When asked if he hoped that his mother and father might get back together, he said, “Yeah, I’ve always dreamed about that. Let’s change the subject please.” When the interviewer commented that some of these experiences sounded rather stressful, Allan replied, “Yeah, they are. All my antidepressants are because of my stress.”

Allan spoke of other life stresses, too. When asked about his worries, migraines were not his paramount concern. Central for Allan were the gangs at his school, the way he was teased about the appearance of his teeth and his lack of friends. He spoke of a “stalker” who had already been arrested a couple of times, and said, “I’m trying to talk my mom into letting me buy a BB gun. Anyways, she should have a gun in the house because this is a really bad area. There’s a lot of bad people in this area.” It was only after the interviewer explicitly asked, “Do you ever worry about the headaches?” that Allan acknowledged, “Yeah. I worry that it’s gonna—like, I always worry about going to sleep.... Usually when I wake up from sleeping it’s actually a lot worse.”

The move to his aunt and uncle’s house had been particularly difficult for Allan, since his aunt and uncle denied his pain and believed he was simply trying to avoid school. As a result, they had stopped his medications, and his symptoms had slowly worsened. Furthermore, Allan indicated that his uncle mistreated him and criticized his mother. He confessed:

My uncle—child abuse. He doesn’t think it’s child abuse or anything, but my mom told him and everything, and I showed him a little Boy Scout punch. Like, you punch your child—you could slap the child, but you can’t have an enclosed fist. You can’t do this or this. Otherwise, it’s considered child abuse. So when he stopped abusing, he did other things. He’d say bad things about my mom. So basically, that place was torture. It’s either one pain or another pain.

Allan’s statement, “It’s either one pain or another pain,” is admittedly ambiguous, and my information about this uncle is somewhat limited. Nevertheless, in what follows, I want to use this rather provocative claim as an entrée into a deeper exploration of the social and relational dynamics surrounding pain, suffering and narrative modes of communication. I hope to illustrate how and why migraines came to occupy a central role in Faith’s narrative of suffering, even amidst other equally harrowing forms of family distress.

Scenes of Address

Why does Faith foreground Allan’s headaches as the primary source of his suffering? In one respect, the answer is quite obvious. After all, her son’s upcoming neurology appointment had occasioned the family’s enrollment in a research study concerning chronic pain in children. Given this pathway to the interview, Faith might have (correctly) assumed that the researchers were mostly interested in learning about her son’s migraines.

On another level, however, Faith's narrative reveals a more sophisticated aim concerning the pragmatic functions of language. According to this line of thought, narrators position themselves with respect to their interlocutors to portray themselves in a particular way (Linde 1993; Ochs and Capps 1996; Wortham 2000). In doing so, they not only represent events in the world (a referential function), but also *perform* a set of social relations and *persuade* people to view the world from a particular moral stance. Mattingly (1998, p. 5), drawing on Austin (1962), calls this the perlocutionary force of narrative (see also Garro and Mattingly 2000, p. 11). From this perspective, an underlying objective of Faith's narrative is to portray herself in a favorable light: as a caring mother struggling through a prolonged quest to find appropriate health care for her son. And crucially, the type of narrative that Faith constructs within this setting is a narrative of hope, embodied with the full potential for Allan's neurology clinic appointment to bear a restitutive ending.

To understand this sort of narrative framing, I draw inspiration from Judith Butler's (2005) recent work, *Giving an Account of Oneself*.⁶ In this extended essay, Butler argues that ethical responsibility must be grounded in the dyadic encounter. For Butler, telling a story about oneself is not the same as giving an account of oneself, since giving an account "accepts the presumption that the self has a causal relation to the suffering of others" (p. 12). Giving an account is thus inherently a moral enterprise, imbued with the narrative dimensions of sequentality, persuasion and authorial point of view. Butler further specifies that an account of oneself always emerges within a scene of address, and that this relational dimension of speech structures all narrative accounts.⁷ Importantly, this scene of address also serves to interrupt the sense that this account of myself is mine alone. Butler explains, "If it is an account of myself, and it is an accounting *to* someone, then I am compelled to give the account away, to send it off, to be dispossessed of it at the very moment that I establish it as *my* account" (p. 36).⁸

How exactly does this scene of address impinge on giving an account of oneself? Butler (2005) argues that the "I" cannot give a full account of itself within this structure of address because it can never fully explain that which is prior to its own emergence as a subject. My narrative, therefore, begins *in media res*, "when many things have already taken place to make me and my story possible in language" (p. 39). Her larger project is then devoted to a demonstration of why this sort of theory of subject formation, which begins with an acknowledgment of the opacity of my own self to myself, does not, as some might otherwise suggest, undermine the possibility of ethical responsibility.

⁶ Here, Butler (2005, p. 21) expands her traditional poststructuralist framework to make "eclectic use" of various philosophers and critical theorists, including Adorno, Foucault, Laplanche, Levinas, Nietzsche and Hegel. She draws heavily on psychoanalytic theory and Levinasian perspectives, while acknowledging that these approaches are not always compatible.

⁷ As Butler explains, the notion of the scene of address presupposes an addressee, but whether or not this addressee actually receives the account is inconsequential for the dyadic structuring of the account. Similarly, Burke (1950) suggests that we can be our own addressees insofar as we use persuasive tactics to convince ourselves of particular matters. In this case we have "what Mead would call an 'I' addressing its 'me'" (p. 38).

⁸ This idea also resonates with the concept of "audience as co-author" developed by Duranti and Brenneis (1986).

Without adhering to the specific details of Butler's thought-provoking argument about the relationship between ethics, responsibility and subjectivity, which lies beyond the scope of this paper, what is particularly compelling for my purposes here is her treatment of language within the scene of address. Drawing on work by Emmanuel Levinas, Butler argues for close analytic attention to both the propositional content of narrative and the rhetorical scene in which it is deployed. For Levinas (1998, p. 32), "Language, in its expressive function, addresses and invokes the other."⁹ Therefore, Levinas asserts an important distinction between *saying* and the *said*:

Is language meaningful only in its *said*, in its propositions in the indicative, everywhere at least latent, in the theoretical content of affirmed or virtual judgments, in pure communication of information—in its *said*, in all that can be written? Is it not meaningful in the sociality of *saying* [*dire*], in responsibility with regard to the other person who commands the questions and answers of the saying, and through the 'non-presence' or the 'appresentation' of the interlocutor, which thus contrasts strongly with the presence of things according to the underlying simultaneity of the given universe? (p. 164)

While Butler's view of language as social action is well rehearsed in linguistic anthropology (cf. Agha 2006; Duranti 1997, pp. 214–244), she departs from other narrative theorists with her suggestion that the rhetorical dimensions of the interlocutory scene are irreducible to the pragmatic function of narrative. As Butler puts it, the structure of address is not a feature of narrative—it is an *interruption* of narrative. Butler describes this paradoxical nature of the scene of address as follows:

And as I make a sequence and link one event with another, offering motivations to illuminate the bridge, making patterns clear, identifying certain events or moments of recognition as pivotal, even marking certain recurring patterns as fundamental, I do not merely communicate something about my past, though that is doubtless part of what I do. I also enact the self I am trying to describe; the narrative 'I' is reconstituted at every moment it is invoked in the narrative itself. That invocation is, paradoxically, a performative and non-narrative act, even as it functions as the fulcrum for narrative itself. I am, in other words, doing something with that 'I'—elaborating and positioning it in relation to a real or imagined audience—which is something other than telling a story about it, even though 'telling' remains part of what I do. (Butler 2005, p. 66)

For Butler, all of this is to say that there is a violence—as a sort of disruption or distortion—inherent to the interlocutory scene. Furthermore, she challenges the

⁹ Here, I find a striking parallel between Levinas' view of addressivity and that of Russian literary theorist Mikhail Bakhtin. Of course, for Levinas, the fundamental relation to the other is nonreciprocal, while Bakhtin's orientation is dialogical. Nevertheless, Bakhtin's and Levinas' views of responsibility and addressivity are remarkably similar. According to Bakhtin scholar Michael Holquist (2002, p. 3), for Bakhtin, "The world addresses us and we are alive and human to the degree that we are answerable, i.e., to the degree that we can respond to addressivity. We are responsible in the sense that we are *compelled* to respond, we cannot choose but give the world an answer." This compulsion to respond resonates with Levinas' (1985) view of responsibility as "what is incumbent on me exclusively, and what, *humanly*, I cannot refuse" (p. 101), the "essential, primary, and fundamental structure of subjectivity" (p. 95).

notion—widely held in psychoanalytic theory (cf. Schafer 1976)—that narrative reconstruction of a coherent life story is the ultimate therapeutic (analytic) goal. Instead, for Butler (2005, p. 52), “Conditions of hyper-mastery, however, are no more salutary than conditions of radical fragmentation.”¹⁰

Narrative Ethics

One of the primary reasons I use Butler (2005) to explore Faith’s account of Allan’s pain is because of the way she makes ethical relations essential to understanding the narrative address and the rhetorical effects brought to bear on the interlocutory scene.¹¹ Butler borrows the notion of “giving an account of oneself” from Nietzsche’s (1969) *On the Genealogy of Morals*. For Nietzsche, we are only forced to give an account of our actions within a system of justice. Accountability thus follows accusation, and is deeply embedded in moral and legal frameworks. While Butler ultimately illustrates why this juridical stance toward ethical responsibility is unsatisfactory, since it fails to account for the structure of address through which any self-accounting takes place, the Nietzschean backdrop is useful for thinking about Faith’s interactional positioning within the interview encounter. In what follows, I would like to suggest that medical institutions, like legal ones, can serve as key instruments of justice. In this sense, the research interview, insofar as it indexes a crucial clinical tie, might also be viewed within a retributive framework. As I will show, these dynamics have important consequences on the ways in which Faith addresses her interlocutor and narrates an ethics of care.

Accounting for Maternal Responsibility

Very early on in her interview, Faith is faced with an important dilemma: how to account for the fact that her children, for a time, had been living apart from her. One of her interviewer’s first questions concerns who lives in the house and how long they have lived there. Faith replies that she had been there a year and a few months, but that Allan had only been there for six and a half months. At the outset, therefore, there is a discrepancy. When asked where Allan had lived previously, Faith says:

He spent the school year previous to this at my brother’s house. I had just become overwhelmed with things and was developing depression and some heart problems, so my two children went to live with relatives. At the end of the school year, my brother just said, you know, “He is too much for me and my family.”

¹⁰ While space constraints restrict me from providing a full account of this part of her argument, it should be noted that Butler does not deny the therapeutic utility of narrative, particularly vis-à-vis certain traumatic conditions. Nevertheless, she suggests, “It does not follow that, if a life needs some narrative structure, then all of life must be rendered in narrative form” (Butler 2005, p. 52). For anthropological critiques along similar lines, see Desjarlais (1992), Kirmayer (2000) and Young (1995).

¹¹ Here, Butler is building on a rich tradition in moral philosophy positing that one’s sense of “the good” is inextricably tied to grasping one’s life as an unfolding story (cf., e.g., Aristotle 1953; MacIntyre 1984; Ricoeur 1992; Taylor 1992).

A few minutes later, Faith elaborates on a hospitalization that prompted her children's removal from her care. She explains, "I was away on a religious retreat and my heart acted up, and a nurse at the retreat took me into the ER. My family finally stepped in and they said, 'Listen. You know, we can't have you—if you die....'" At this point, the family decided that Allan and his sister would go to live with other family members. Faith's daughter was still living with a married cousin at the time of the interview.

Thus, before Faith even begins to talk about Allan's pain, she frames his headaches within a larger story of her own suffering. By portraying her hospitalization as a dramatic turning point that prompted her family to intervene on her behalf, Faith depicts herself as playing a relatively passive role in the events leading up to her relinquishment of caregiving responsibilities. These points become crucial when we learn, later, that living with his uncle had important consequences for Allan's medical care. Moreover, insofar as narratives of pain and suffering may be "re- (or pre-)cast as morally valenced and meaningful lived experiences" (Throop 2008, p. 276), Faith's account can be seen to bestow a moral worth that renders her an appropriate advocate for her son.

When asked to review Allan's previous pain treatment, Faith reports that a neurologist had begun to help Allan, but that her brother's failure to follow through on the treatment regimen counteracted these efforts. She reflects on this development in the following way:

I think probably, eventually [the neurologist] would have helped my son. However, that was ended when I had my—when I was taken to the hospital. Then my son went to live with my brother. My brother didn't believe in my son's headaches, and he took him off of Neurontin and everything.

In his own interview, Allan reported that his headaches got worse when his aunt and uncle stopped giving him his medication. By the time he returned to his mother's house, he said, "It was like in the eights a lot. Then like right now it gets into tens a lot more often."¹² It is clear, then, that Allan's move had repercussions for his pain management.¹³

Faith's interactional positioning within the interview encounter reveals her strategic awareness of the ways in which she is implicated in the failure of Allan's medical care. Consider her statement: "When I had my—when I was taken to the hospital." This deft reformulation reveals a shift in agency from an active to a passive voice, within which Faith's metapragmatic verb choice (cf. Silverstein 1976; Wortham 2000, p. 172) creates a sense of powerlessness that mitigates her responsibility for Allan's worsening health. Faith thus asserts a subtle moral claim about her maternal identity, and the way in which the interviewer should interpret her prior actions.

¹² The numbers refer to the 1–10 scale that Allan used to rate his pain episodes.

¹³ When Faith regained custody of Allan, her insurance changed and she could not return to the same physician. She initiated the complex referral process once again, and the appointment that she ultimately secured prompted her enrollment in our study.

To compensate for conceivable moral failings, Faith highlights her maternal responsibility at various points throughout the interview, emphasizing the difficulties of raising Allan on her own. In discussing her unstable employment history, she says, “It’s been a real trial to try to do right by my son as a single parent, to pay the bills and to be a good mother to him as well. That has just been very overwhelming.” This comment is striking both for its representation of single motherhood as a “trial,” which indexically invokes notions of judgment and justice, and for its apparent disregard for Faith’s daughter, for whom Faith’s maternal failings are less clearly articulated (and less relevant) in the context of this interview. Insofar as accounting for one’s actions is entrenched in the context of judgment, Faith is already on “trial” within this interview; here she metapragmatically positions herself as someone who has been somewhat unfairly oppressed by such juridical frameworks. Such observations resonate with the claims of scholars such as Frank (1995) and Kleinman (1988), who have argued that illness narratives work to restore the moral positioning of sufferers. From their perspective, giving an account of one’s pain is not only a moral but also a political project.

In the extract below, Faith draws on tropes of maternal sacrifice to portray herself as prioritizing Allan’s care over her own personal needs.

Interviewer: You do so much caregiving for Allan. Who’s been taking care of you through this?

Faith: Well, that’s the thing. I wish somebody was. I get very lonely. It’s like Lisa, that’s my friend from junior high that I was telling you about, she goes, “Faith, you need to be married. You are so designed to be married. You’re just like a square peg in a round hole, or whatever, trying to be single.” And it’s the truth. It’s the truth. I wish that I had somebody else. You know, but it would take a very special person to be a father to Allan. And I’m very picky. I’m not going to bring the wrong kind of person in my home. I know so many people that get married again, and it is just a disaster for their kids, and I just think that they are so selfish. While I would love to find someone, and there have been people that I’ve considered—two really came close. But my child comes first.

Here, the interviewer’s question provides a powerful framing device that projects an empathic stance toward Faith’s account. Faith in turn asserts a powerful moral claim: although her health constraints might limit the material support she can offer, she is not the sort of mother who would place her relationship needs above the emotional care of her children. In this respect, she makes clear, “My child comes first.” If we read Faith’s account of her separation from Allan through this stance toward remarriage, we may interpret her maternal care in a more positive light. In important ways, then, this account of Faith’s romantic life makes a pragmatic bid for a favorable judgment of her mothering.

Faith’s moral accounting practices extend beyond the domain of motherhood, however. As the interview unfolds, Faith not only positions herself as a caring—albeit struggling—single mother, but also as a good Christian. She notes that she was on a retreat with her church at the point at which she was hospitalized and gave

up care of Allan, and highlights the supportive role of her church in coping with these misfortunes. In this way, Faith draws her religious practice into her account of pain and suffering. As she explains:

I have a God that I know is with me in my suffering and is with Allan with his suffering, that when we cry, He cries. When Lazarus died, Jesus wept. It's not like he doesn't know what we're going through. Whatever we're going through, he went through worse. This is not a God that's removed. This is Emmanuel, God with us. It's sort of like people say, Well, where was God when she was raped? Well, He was there being raped. That's the kind of God that I have.

Much in the same way that Faith describes God as being with her in her suffering, she relays her attunement to Allan's ongoing pain experience. It is particularly difficult for Faith to watch Allan suffer because she herself has experienced the debilitation of migraine headaches. In describing Allan's troubles at school, she says:

But I sure remember how they're like, and the last thing in the world I want to be doing is reading a book, or trying to do a math problem. You know, so I can only—I'm being tough with him because I have to be. There's a part of me that just feels so bad that I'm sending him to school at all. And I don't want to say anymore because I'll start crying. [*Faith laughs.*]

Here, as Faith reflects on Allan's difficulties in school, and links his struggle to her own experience with migraines, her eyes tear and she begins to get choked up. Faith thus embodies the sense of hopelessness she feels in the face of her son's suffering.¹⁴ Absent from this account of Allan's school performance is any discussion of his learning disabilities and special educational services, which Allan receives—and likely will continue to receive—independently of his migraines. Despite the multiple struggles and sources of suffering the family has endured, throughout her narrative, Faith positions Allan's migraines as her biggest concern. She explains,

My son is in therapy. I also receive therapy. First because I'm on antidepressants. I'll be on antidepressants for the rest of my life. That's just me. You know, I mean, I've been on antidepressants since I was eighteen. So that's just me. Right now, I'm more concerned about my son. The biggest stressor right now in my life is his migraines.

¹⁴ Although it is beyond the scope of this paper, it is worth mentioning that Faith's tearing up here is only one of many signs of the intersubjective nature of Faith's and Allan's suffering. It is clear from this example that Allan's migraines are extremely painful for Faith. When the interviewer asks her what it is like to sit in the waiting room with a child in pain, Faith responds, "I don't even want to talk about it. I mean, you just want to cry, you just want to cry." To a certain extent, then, it is important to consider the limits and possibilities of shared pain. (For more on this topic, see Das (1997, 1998), Scarry (1985) and Wittgenstein (1953)). In much the same way that Allan's headaches began to bleed into one another like drops of food coloring on a wet paper towel, Faith's and Allan's pain seem to have become increasingly less distinguishable. Along these same lines, when reading an early draft of this paper, Jason Throop pointed out several interesting narrative convergences in Faith's and Allan's accounts of suffering. Faith was raped and Allan was abused. Faith's father died, while Allan's father endured a social death. Faith and Allan both experience migraines, and both take antidepressants. These parallels represent yet another way in which the pain of mother and son are symbolically intertwined.

Narrative Interruptions

At several points in her interview, Faith alludes to unspeakable troubles, especially those pertaining to her status as single mother. This topic is particularly painful for Faith, as we can see from her initial reference to her estranged husband.

Interviewer: How long have you been a single parent? Tell me about that.

Faith: You know, I love my own husband, and I have to say that the years of our marriage were probably the happiest of my life, but he's kind of emotionally fragile. And as long as we didn't have children, he could cope. Can we pause?

Interviewer: We sure can.

Here, Faith's request for a break suggests her emotional discomfort with this topic of conversation. When the interview resumes, the next 10 min is devoted to Faith's account of her husband's decline in mental health and eventual departure. After telling this story eloquently, Faith refers to troubles that elude her narrative framing.

Interviewer: How old were your children at the time he left?

Faith: My daughter was three and my son was one.

Interviewer: So you've been a single mom handling all of this on your own ever since.

Faith: For about 13 years.

Interviewer: No wonder you feel overwhelmed.

Faith: Yeah, that's a long time. And a lot of stuff has happened. A lot of stuff has happened. A lot of stuff has gone down. I mean, I had to go through my father's arrest and then having him released because he didn't do it. I had to go through. I was raped. My father passed away. We've moved several times. There was just—there are things that I would rather not talk about.

Interviewer: Sure.

Faith's account of her family's suffering thereby reveals—and conceals—troubling absences and erasures. In the same way that Allan avoids talk about his father, Faith carefully glosses over other social difficulties: an arrest, a rape, a death and other unnameable traumas.

By positioning Allan's migraines as "the biggest stressor right now in my life," Faith mitigates the role of other intertwining sources of pain. To be sure, many details of the family's social troubles—particularly concerning Faith's husband—do emerge in the interview; the social context of Allan's suffering is not silenced entirely. And yet, these accounts are punctuated with "things that I would rather not talk about" from Faith and "Let's change the subject please" from Allan. Between one pain and another, as Allan says, the migraine takes center stage.¹⁵

¹⁵ Of course, Faith's reference to "things I would rather not talk about" performs a specific pragmatic function. Faith might have easily chosen not to mention these distressing events at all. Instead, she alludes to these troubles in order to portray herself as one who has suffered in profound ways.

In the following statement, for example, Faith blames her inability to work on Allan's migraines: "Not only can I not do the things that I want to do, I can't do the things I need to do. What employer is going to have me work for them if 3 days a week I have to leave work to pick up my son from school because he has a headache?" What this assessment overlooks, however, is the significant extent to which Faith's own health problems have interfered with her daily functioning. As Allan puts it, "She always has a migraine or something. She's always tired or—like, if she goes to the store, she just will have to lie down because she's all out of breath, body aches all over, just from going to the store, usually."

In giving an account of one's pain, it seems that significant sources of suffering are strategically left out. To consider how Butler's view of interruption can illuminate my analysis of Faith's narrative of family suffering, I now turn to a deeper exploration of the interview encounter and the interlocutory scene it creates. Below, I outline the pragmatic contours of this scene of address by describing the medical anthropological research interview as a particular form of complaint that produces typified accounts.

Genres of Complaint

Although Faith was assured that the researchers from our study were not affiliated with the clinic or its staff, it is important to situate her interview narrative within the context of waiting for health-care services, since she was interviewed prior to, and on account of, Allan's upcoming neurology appointment. In this interview setting, the desire for medical relief figures prominently into the conditions of address. Accordingly, Faith's hopes and expectations for medical care shape her narrative in important ways.

While medical anthropologists often go to great lengths to emphasize confidentiality and distance themselves from the clinical domain, it is doubtful that research participants accept such disassociations at face value. After all, in most cases, and certainly here, the interview itself is wholly contingent on a patient's relationship with a particular institution. As a result, the interview forms a curious sort of extension of the medical encounter in which patients may treat physicians—or the medical establishment more broadly—as indirect addressees.¹⁶

Along these lines, Kugelmann (1999) found that his research respondents, 14 adult residents of an inpatient pain management program, seized the interview as an opportunity to voice a call to rectify their longtime suffering. Drawing on Levinas' distinction between *saying* and the *said*, Kugelmann suggests that his interlocutors were not merely reporting their experiences, but drawing him into a scene of address that forced him to bear witness to their suffering. The illness narratives that Kugelmann collected were thus articulated in the genre of complaint, fully imbued

¹⁶ Since I started work on this paper, I have begun dissertation fieldwork in a clinic for children and adolescents suffering from chronic pain. Because families typically meet me for an initial interview prior to meeting any of the clinical staff, I have found that parents will occasionally project implicit expectations that I will relay the extent of their child's suffering—and the extensive measures they have taken to relieve it—to their (as yet unknown) health care providers.

with the expectation for justice. According to Kugelmann, the language of these narratives resembled legal proceedings, which recalls, I might add, Nietzsche's sense of giving an account of oneself. In some cases, the stakes of these accounts were quite high, since the institutional requirements of health insurance and worker's compensation mandated that patients "prove" their pain before reimbursement. However, Kugelmann (1999, p. 1673) notes, "While a few were literally plaintiffs in a legal sense, all were plaintiffs in existential terms."

In a similar fashion, Faith, in her interview, makes a plea for justice. Although she spends some time reproaching the educators and family members who question the legitimacy of Allan's pain, a primary objective of Faith's account is to demonstrate Allan as deserving of medical care.¹⁷ To this end, she poetically articulates his profound suffering with the metaphoric imagery of a wet paper towel (see above, "Illness History and Family Background") and the poignant suggestion that Allan's pain "has stolen time":

What the pain has done has stolen time.... It has, what the pain has done is it has kept him from having fun with other children, because he doesn't have time to go out and make friends, because he can't even attend Scout meetings on a regular basis. What being in pain has done has kept him from being involved in religious education like before.

Thus, despite Allan's various mental and neurobehavioral difficulties, Faith blames the migraines for his social problems. She also protests the inadequacy of his prior medical treatment. For instance, she relays her dismay with a pediatrician's advice: "She said, 'You're doing the right thing. Continue to give him Tylenol.' I'm giving him Excedrin and she's telling me to give him Tylenol. I'm looking at her like she's nuts. Tylenol doesn't do squat for a migraine. What is she doing?" With respect to the neurologist whom Allan saw prior to his move, Faith's feelings are ambivalent at best: "I think that he probably could have helped Allan. It might have taken years. It was like the slow boat to China."

Faith also discusses some of her frustrations with her own medical care. She is particularly irate that her doctors failed to consider the role of her sleep in her migraines.

There's so many things—how many years did I have migraines and did I have headaches, and nobody, not one doctor ever thought that it might have something to do with my sleep patterns. It wasn't until I went in and had the sleep study done, and then just coincidentally, my headaches went away. But when I looked into it, I found out that one of the major symptoms of sleep apnea are frequent headaches. Well, then how come headache doctors don't know that? You know, it makes me angry. It makes me really angry. If I can find out this stuff, then how come a specialist doesn't know it? And that makes me angry. It makes me very angry. I am not a specialist. I am an ignorant

¹⁷ On the uncertain ontological status of pain, see Das (1998), Hilbert (1984), Jackson (1992, 2005), Scarry (1985), Trnka (2007) and Wittgenstein (1953).

amateur. I should not have to bring this up with the neurologist and that makes me angry.¹⁸

As a result of this experience, one of Faith's biggest hopes for Allan's upcoming neurology appointment is to have a sleep study scheduled. However, about his first neurologist, Allan says, "I couldn't talk to him about the sleep study, and—I couldn't talk to the man. He wouldn't let me get a word in edgewise." Likewise, Faith says, "I brought it up with [Allan's] psychiatrist, who just said, 'Uh-huh.'"

It is important to note that this type of complaining characterizes health-care encounters more broadly, and is not limited to interviews. When patients meet new providers, they recount past treatment, often highlighting areas where medicine has failed or otherwise left them unsatisfied. Moreover, because Faith and Allan have dealt with many different clinicians and several different insurance providers, we might assume that Faith has engaged in this type of "saying" repeatedly.

Building on Kugelmann's discussion of the genre of complaint, I use the term to highlight how anthropological research interviews in biomedical settings (and the broader class of clinical encounters in which they are embedded) invoke certain typified forms of suffering that call for the rectification of perceived injustices. However, while Kugelmann's use of genre is drawn from Burke (1954) and Bruner (1990), my use of this term here is also informed by Bakhtin's (1986, p. 60) notion of speech genres as "relatively stable types" of utterances that relate to specific spheres of language use. For Bakhtin, it is crucial that "each speech genre in each area of speech communication has its own typical conception of the addressee, and this defines it as a genre" (p. 95). Language choice is thus structured by the specific nature of the given context of address. This dialogic feature of genre-ed forms is critical to my understanding of the particular narrative turns that Faith's account takes. In this sense, my view of genres of complaint is also in line with Wilce (1998, p. 51), who suggests that "complaints must be recipient-designed if they are to succeed at referential specificity."

The medical anthropological research interview—as a particular genre of complaint shaped by the interaction of specific institutions, individuals, and conditions of address—produces a form of interruption that resonates with Butler's (2005) view of narrative. What Butler offers is a conceptual language for thinking through the distortions inherent to such interview accounts. According to Butler, the rhetorical scene of address constitutes an interruption of narrative as much as a feature of narrative itself.

The moment the story is addressed to someone, it assumes a rhetorical dimension that is not reducible to a narrative function. It presumes that

¹⁸ Faith's description of herself as an "ignorant amateur" forms a marked contrast to two previous statements regarding her high IQ. First, when asked whether she had described to any physicians her explanatory model of migraine pain—that the neurons had "gotten too much practice in hurting"—Faith replied, "Look. I have an IQ of 145, and all sorts of theories about everything, none of which anyone is going to listen to." Then, just before the extract quoted above occurred, in reference to the hoped-for sleep study, Faith said, "The other thing that I think should be explored—you know, I'm not stupid. I have a friggin' IQ of 145. I read extensively." The fact that Faith frames her intelligence and expertise in such strikingly different manners is a testament to her rhetorical ingenuity. See also Ochs and Capps (1996, p. 22) on "partial" selves.

someone, and it seeks to recruit and act upon that someone. Something is being done with language when the account that I give begins: it is invariably interlocutory, ghosted, laden, persuasive, and tactical. It may well seek to communicate a truth, but it can do this, if it can, only by exercising a relational dimension of language (p. 63).

By posing the scene of address as a source of interruption, I do not mean to suggest that Faith's story exists as an a priori narrative that is violated whenever it enters the social arena. Instead, I view interruption as part of the very fabric of social life, and hence, narrative itself. If Faith's life contains multiple narrative threads, as all lives do, by fashioning her story in the genre of complaint, Faith necessarily pulls on some of these threads while tucking others under. While many different social forces may tug and pull at narratives, the structural dynamics of the interview encounter invoke a more explicit form of interruption. Thus, in shifting from the mundane sorts of narrative frames encountered in everyday social life (cf. Mattingly 1998) to a more formal scene of address, Faith's life story is transformed into a stylized type of account. In the course of this process, a subtle violence is wrought.

What interests me here, and what Butler has helped me to explore, is the way in which institutional dynamics and expectations play a role in bringing certain narrative threads to the forefront. By invoking Butler's concept of interruption, I aim to highlight the ways in which genre-ed forms of complaint necessarily background certain modes of suffering and, in turn, how narratives alter the conditions of address and shape the interviewer's line of questioning. In this sense, narrative interruptions and silences are collaboratively produced. Following Butler (2005, p. 12), "The refusal to narrate remains a relation to narrative and to the scene of address."

For Faith, the structure of addressivity mandates a particular performance of self. Not only must she portray Allan as worthy of treatment, but also she must depict herself as morally accountable within her story of his pain, and as a morally viable advocate within the scene of address. To do this, she must downplay her responsibility for her role in his suffering. In this respect, the ethics of care looms large, since her failure to fulfill her maternal obligations, and Allan's subsequent move, had important ramifications for his health and well-being. Not only did Allan's temporary caregivers neglect a treatment regimen that by all accounts appeared to be working—if only as what Faith terms a "Band-Aid" due to its short-term, limiting relief—but also this living arrangement resulted in allegations of abuse, as suggested by Allan's cryptic reference to "one pain or another pain."

From Butler's (2005, p. 12) perspective, Faith's moral predicament is the defining feature of giving an account of oneself, which, as mentioned previously, "accepts the presumption that the self has a *causal relation* to the suffering of others" (emphasis added). Insofar as Faith had a causal role to play in Allan's suffering, her account of his pain, within the confines of address, is necessarily distorted. The dialogic nature of the research interview, as a genre of complaint, thus creates a "presentational self" (Wilce 1998, p. 33) within which certain historical events are strategically concealed. In this respect, the anthropological research interview resembles other types of health-care encounters, such as Faith's repeated efforts to justify particular treatment strategies to new insurance carriers.

In Faith's interview account, the events surrounding the time Allan spent living with her brother are minor interludes from the central drama, not even quite side-plots of their own. In contrast, the migraine forms a master trope in Faith's narrative of family distress. She says:

Because they prevent him from going to school, which is the number one most important thing. But they also prevent him from going to Scouts, to church, to birthday parties, to family get-togethers, like Thanksgiving dinners. You know, it just goes on and on and on. It's like he can't live a normal life.

And yet, this explanation disregards the fact that it is quite unlikely—given his significant developmental delays and behavioral problems—that Allan would have gone through childhood unmarked by difficulty, even without the migraines. In Faith's telling, bodily pain becomes a metonym for other forms of social and emotional distress (Das 1997; see also Darghouth et al. 2006; Nichter 1981).¹⁹ Between one pain and another, the migraine is far more easily narrated.

Conclusion

In this paper, I have argued that illness narratives, as told within the interview encounter, are necessarily fragmented, partial and rhetorical in nature. I began my analysis with a question that troubled me as I poured over the interview transcripts: Why did Faith foreground Allan's migraines as the primary source of her suffering, despite multiple other illnesses and family troubles? In crafting a response to this question, I have situated the anthropological research interview within a specific scene of address to examine some of the moral, relational and communicative challenges of giving an account of one's pain. Specifically, I have suggested that the medical anthropological research interview, as a particular genre of complaint, makes a claim for certain retributive ethical judgments and thus privileges certain types of accounts. I have argued that a sort of narrative interruption can occur when narrators choose to highlight "one pain or another pain." When interviews are mired in medical and juridical institutional structures, as is so often the case in medical anthropological inquiry, what is at stake with such narrative turns becomes all the more consequential.

Lest this view of illness narratives appear too critical, I want to make clear that I recognize the significant role that the literature associated with "narrative medicine" (cf. Charon 2006) has come to play in breaking the silence surrounding illness and suffering and giving people a voice in their health care. The tension Mishler (1984) articulates between the "voice of medicine" and the "voice of the lifeworld" is especially pertinent here, and has framed ongoing discussions concerning how to more effectively incorporate patients' own perspectives into medical encounters. That a shift in tide of this nature should emanate from within the field of biomedical practice—Rita Charon, the pioneer of narrative medicine, is a physician at Columbia University's Presbyterian Hospital—is all the more

¹⁹ In this case, bodily pain erases what it metonymically indexes. I thank Jim Wilce for pointing this out to me.

impressive, and the role of narrative in this endeavor cannot be underestimated. As Mattingly (2006, p. 568) notes, “An interest in narrative within the clinical world has been linked to a concern with ethics—with how to provide a more humane, a more ‘human-centered’ approach to health care.”

To be clear, then, I do not mean to suggest that attending to patients’ stories of illness and suffering is not a worthwhile pursuit, or to deny the appeal of narrative medicine. Rather, I have tried to highlight some of the ways in which narratives deployed in interview settings, while illuminating personal perspectives on pain and suffering, also cast a deep shadow. In this way, giving an account of one’s pain is a strategic and selective process, creating interruptions and silences as much as moments of clarity. Therefore, I have suggested that medical anthropologists, in eliciting illness narratives, ought to attend more closely to the institutional structures and relations on which the practical success of much of their research is predicated.

For Allan, eating alone at lunchtime, being teased about his appearance and being followed by a stalker were just as troubling as his chronic migraines, and occupied a central place in his telling, as what Wikan (2000) might term his “compelling concerns.” Although I have chosen here to concentrate on Faith’s account, a secondary aim of this paper is to highlight the contrast between how a mother and how a son portray a son’s suffering. In this case, the disjuncture between Faith’s and Allan’s compelling concerns raises questions about the methodological practice of interviewing only the patient or, in the case of a child, only his or her mother. My analysis illuminates the potential benefit of eliciting multiple perspectives in medical anthropological inquiry. Faith’s and Allan’s stories and the discrepancies between them point to the importance of analyzing what is left out when collecting and analyzing illness narratives, accounts and complaints. As Wikan (2000) and others have noted, stories leave us with many unanswered questions. And yet, as I have shown, close analytic attention to the interactional framework of interview encounter can provide us with many telling interpretive clues, which are worthy of our critical attention.

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