Abstract:
In this article medically unexplained physical symptoms are theoretically explored as inseparable from an illness behaviour, which can be observed in partnerships and in families. It is a central claim that different ways of somatization depend upon different narratives. Each narrative links individual dilemmas with an individual illness behaviour in a process of attachment. It is the argument here that an attachment to narratives blocks a liminal phase of transition. ‘Liminal’ and ‘liminality’ are concepts adapted from anthropology, and two different formulations are proposed: one for life-threatening sickness and one for somatization. Qualitative interviewing, narrative analysis and experiments in natural settings are methodological approaches, which are explored in an ongoing research project in Århus County, Denmark and in Yatinuvara AGA division in Sri Lanka.

Introduction
In this article three claims are to be explored theoretically (1) that medically unexplained physical symptoms are inseparable from an illness behaviour, which can be observed in partnerships, in families and in lifestyles, (2) that somatizing illness behaviour is inseparable from meaningful narratives of individuals and (3) that an attachment to narratives is causally implicated in soma-
tizing illness behaviour\(^1\). It is the hypothesis that different ways of somatization relates to different narratives, and each narrative links individual dilemmas with an individual illness behaviour in a process of attachment. Not only attachment as interpersonal interactions with others, which elicit care from others - including physicians (Stuart & Noyes, 1999), and attachment as object relations (Bowlby, 1969 A, 1969 B, 1969 C)\(^2\) - is implicated in somatizing illness behaviour – also an attachment to narratives, stories and other kind of linguistic material is implicated.

Illness behaviour is here conceived as the simultaneous realisation of three dimensions in their interrelationship and mutual influence: ‘structure’, ‘actor’ and ‘event’, and illness behaviour is also conceived as a sequential realisation in a process, where the experience of liminality trickers a behaviour, which begins with the first manifestation of malingancy. Liminality is a phase in an illness episode, and it is a theoretical claim here that an illness behaviour of an individual is in accordance with preferences of a lifestyle\(^3\). Today, agency within western, industrialized society is not a single, homogeneous lifestyle, but rather a complexity of lifestyles, since the industrial society has changed

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\(^1\) Forty years ago Mechanic (1961) proposed a concept of illness behaviour, which refers to the ways in which given symptoms may be differentially perceived, evaluated, and acted (or not acted) upon by different kinds of persons (p. 189), and following Talcott Parsons (Parsons, 1951) he took the “social role of the sick person” as a starting point. Still, today illness behaviour is often conceived as a sick role in society, but recent developments in anthropology challenge this conception.

\(^2\) Fifty years ago John Bowlby wrote a preface to a WHO report (Bowlby, 1951) about maternal care and mental health, which took him – and soon his group at the Tavistock Clinic and Tavistock Institute of Human Relations - into problems of attachment and loss. Bowlby conceived attachment as object relations, separation anxiety, mourning, defence, trauma and sensitive periods in early life, cf. (Vol 1: 1997 p. XV). Today, attachment theory does not use concepts of ethology, and observations of young children has been complemented with analysis of narratives of adult informants, who may object to what is said about them.

\(^3\) A lifestyle is found in the actual practice of individuals, and a lifestyle implies a certain aesthetic style and performance. Somatizers juggle with a split between internal \textit{needs} and external \textit{wants}, and preferences of a lifestyle is a way to express internal processes of the individual - i.e. internal \textit{needs}. Lifestyle preferences are also a displacement of external \textit{wants} directed toward the consumption of treatments, cures and therapies, and somatizers juggle personal needs with a social presentation of self. Decisions on a cure or a treatment are \textit{external} signals, which the social network must interpret and react upon, and partners, relatives, friends and colleagues may - or may not - legitimize the decision to choose a certain therapy as being the appropriate manner, ethics, personality, identity, social status and lifestyle of the person – cf. Andersen (1997).
into an affluent society with globalizing and postmodern tendencies\(^4\). Today an actor lives his or her life in a chosen lifestyle, and decisions on what to choose – and not to choose – are based on aesthetic and moral preferences. A somatizing illness behaviour of an individual is both internally and externally motivated. This split of double invested interests can be investigated by the integration of different interviewing techniques – such as qualitative interviewing, semi-structured interviews and scales – and by different models of narrative analysis – such as focus on partnerships, families or lifestyles as contexts of illness stories.

By ‘narrative’ is meant a relation to experience. A narrative functions not only as a form of talk, it also serves as an aesthetic and moral form underlying behaviour – for a similar definition see Mattingly (1998, p. 3). This broad definition does not sort out, what is to count as narrative and non-narrative discourse, and ‘narrative’, ‘story’ and ‘linguistic material’ are not defined *per se*, because it would be misleading to the point, that narratives are not some kind of text, but rather some kind of performance or a social act – i.e. a story about someone does something to him or her. Stories in a liminal situation may take on special therapeutic powers, and certain kinds of stories may have their special place as an integral part of a healing process\(^5\). Processes of attachment or detachment are intimately connected with narratives and with experience.

Problems in the cultural world of a somatizer are interconnected with medically unexplained physical symptoms, and in this article I propose that not only styles of communication and styles of attachment (Bartholomew & Horo-

\(^4\) According to Gerhard Schulze’s study in Nürnberg in 1985 – see: Schulze (1992) - there is no longer the kind of polarization, which was the case before, between the scene of conventional, allopathic medicine and alternative, complementary medicine. Today polarization and intolerance is within the mind of the individual, and polarization goes in various directions, since aversion is directed toward various cultural distinctions by chance. The subjectivity of a postmodern person is primarily concerned about the need to choose, what he or she wants, and it is now a necessity that the individual decides, what he or she wants *not* to choose, since the society is affluent and offers an infinit number of choices. A somatizer, who responds to tendencies of postmodernism, chooses to relate himself or herself to a therapeutic scene, which offers a bodily experience, which satisfies his or her internal need. The consumption of treatments, therapies and health seeking activities relates the individual to a scene, which adjust the practice of many people. They share the experience of a cure, and they signify the therapeutic scene by their consumption – cf. Andersen (1997).

\(^5\) Stories told by family doctors in the liminal situation of persistent somatization are especially powerful, and stories may go both ways – i.e. be healing or “pathological”. Waitzkin & Magana (1997), Herman (1992) and Mollica (1988) argue persuasively that a process of narrative building is the cornerstone of treatment for varying manifestations of trauma-induced suffering.
Black boxes in somatization and the concept of culture in anthropology

It is not only individual narratives of trauma as explored by Waitzkin & Magana (1997), which is a black box in somatization, also the internalization of narratives in partnerships, in families and in lifestyles is. The unmediated causal linkages of culture and individual behaviour is a theoretical “black box”. This “box” is explored, however, by recent debates in anthropology concerning the concept of culture. Waitzkin and Magana have offered “the beginnings of a theory” (op. cit. p. 818-819), which explains the mediation of culture and somatization, and which exposes the importance of narratives of somatizers at an individual level.

6 Fink (1997, p. 61-62)

7 Waitzkin &. Magana (1997) addresses a theoretical black box in our understanding of somatization and answer the following question: “how does culture mediate severe stress to produce symptoms that cannot be explained by the presence of physical illness?”, p. 811. They argue that extreme stress (torture, rape, witnessing deaths of relatives, forced migration, etc) is processed psychologically as an incoherent narrative of events too awful to hold in consciousness. Culture is claimed to pattern the psychologic and somatic expression of a “terrible” narrative, and they argue that “the coherence versus incoherence of narratives regarding prior severe trauma has much to do with somatization and its treatment” (p. 816). According to Waitzkin and Magana the narrative structure and its coherence versus incoherence provides a link between trauma, culture, and somatization in many patients whose physical symptoms cannot be explained by physical disease. How specific symptoms present themselves depend according to Waitzkin and Magana partly on how culture patterns their expression. But, not all individuals within a given culture react to traumatic stress in the same way. Some individuals may react to severe stress with less psychologic disturbance, or less somatic symptomatology than others. According to Waitzkin and Magana, a culture influences the pattern by which individuals process their narratives of severe trauma. So, the variability depends according to Waitzkin and
A large number of anthropologists argue persuasively that older descriptions of cultures overemphasized\(^8\) the stability, harmony, isolation, and uniformity of non-European peoples and two sets of ideas about culture in anthropology can be distinguished: an older set of ideas which equates 'a culture' with 'a people' which can be delineated with a boundary and a checklist of characteristics; and a new meaning of 'culture', as not a 'thing' but a political process of contestation over the power to define key concepts, including that of 'culture' itself. Today the concept of culture in anthropology is conceived as a non-substance - as a fluid process of becoming. From all sides of anthropology a call is being issued for a more dynamic, process oriented theoretical interpretation of culture and identity (Friedman & Lash, 1992), and the reciprocal indexation of culture and individual behaviour has become questionable. Modern anthropology exposes the way cultural adaptation is processed at the individual level.

Today an anthropological approach to somatization will pursue, what is in the “black box”, and assert that the conceptual and methodological approaches of narrative analysis can help to clarify the “black box”s content and explore, how a culture influences the partnership, family and lifestyle of an individual somatizer. It is an epistemological and methodological task then to demonstrate, how “the box” contains a set of narratives, which is processed psychologically in ways that depend upon the specific context – i.e. localised narratives, which depend upon a particular style of a partnership, a family or a lifestyle.

The literature of cultural psychiatry\(^9\) and of historical psychiatry\(^10\) recognizes the importance of culture. It is shown, how 'culture' pattern somatization in characteristically different ways; yet these studies generally do not examine the narratives in the interplay of culture and individual behaviour to

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yield somatization as a characteristic response, as opposed to other forms of psychopathology, and psychiatry does not explain how the development of medically unexplained physical symptoms occurs in some individuals and not in others, or why some styles of attachment dispose to somatization differently across cultures. Despite major advances in cultural psychiatry, the concrete processes by which somatization is mediated by cultural differences, remain puzzling, and the causal linkages remain uncertain. In psychiatry a theoretical “black box” still exists in the understanding of somatizing illness behaviour, and the mechanisms by which culture mediate or produce somatoform symptoms, as opposed to more overt psychological disturbance, remain poorly understood.

One reason is that the emphasis on prevalence and epidemiology\(^\text{11}\), on classification\(^\text{12}\), on diagnostic and statistical manuals of mental disorders\(^\text{13}\), on diagnosis and etiology\(^\text{14}\), on comorbidity\(^\text{15}\), on amplification of bodily sensations\(^\text{16}\) and on the specific treatment methods\(^\text{17}\) has not enhanced an understanding of the precise cultural interconnections among sociocultural conditions, physical symptoms and healing at the individual level of a patient, who lives his or her life in a family context and in a lifestyle. Another reason is that the importance of individual narratives and stories told about illness behaviour has not been fully recognized.

**Liminality and somatization**

In anthropology ‘liminality’ is primarily a sequential phase of a ritual\(^\text{18}\), whereas liminality in a medical context is a major category of the experience of illness.

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\(^{12}\) Murphy (1990), Ford (1983).


\(^{16}\) Barsky (1979), (1992), Barsky, Goodson, Lane & Cleary (1988).


\(^{18}\) Anthropologists and ethnographers studying Sinhalese healing rituals in Sri Lanka claim that a liminal phase exposes liminality as a phenomenon, when the demons are celebrated during the
Liminality was first used in anthropology by Arnold van Gennep in 1909 in his study of rites of passage. According to Van Gennep rituals were marked by a process of passing through three major phases of transformation. During a period of separation from the rest of the society, the person was prepared by purification (rite de sepération). This phase of separation was followed by a phase of transition, which was marked by a transition rite (rite de marge), when the initiate had left his or her former state, but had not yet entered the new one. In the third phase, the stage of aggregation the initiate was accepted to full membership of the new status by another rite (rite d’agrégation). The second stage of the transition was termed liminal by Van Gennep.

Victor Turner (Turner, 1967, 1969) elaborated on the term liminal, and he particularly applied liminality to ritual, drama and performance (Turner, 1979, 1982, 1987), which he explored as public liminality, defined as a space between and betwixt the normal, day to day cultural and social life – a particular space, which serves to reverse individual roles or social status. In ‘The Ritual Process’ (1969) the space of liminality is termed ‘anti-structure’ – cf. the subtitle: ‘Structure and Anti-Structure’.

Miles Little, Christopher Jordens, Kim Paul, Kathleen Montgomery and Bertil Philipson (1998) from the University of Sydney argue that all cancer patients enter and experience liminality as a process, which begins with the first manifestations of their malignancy. An initial acute phase of liminality is marked by disorientation, a sense of loss and of loss of control, and a sense of uncertainty. According to Miles Little and his research group an adaptive, enduring phase of suspended liminality supervenes, in which each patient constructs and reconstructs meaning for their experience by means of a narrative. This phase persists, probably for the rest of the cancer patient’s life (p. 1484). According to the research group the experience of liminality is grounded in the body of a patient – a body, which houses both the disease and the self, and the group wants to capture the subjective experience of illness by using narratives in a way, which grounds medical understanding of illness in the central fact of its embodiment (p. 1486). The group emphasises that an illness narrative expresses

“night watch” (mādayama), cf. Vogt (1999), Andersen (1995), Kapferer, 1997, 1983, 1979, Andersen, G, S. (1993), Obeyesekere, 1972, 1967. Sinhalese healing rituals, like the Suniya-ma, the Kohomba-Kankariya, the Mal Baliya and the Mahasona rituals, are aesthetic – and from a narrative perspective very effective – manifestations of liminality and narrativity. It is, however, outside the scope of this article to demonstrate and describe, how illness behaviour is narrated and performed during a healing ritual, how stories are co-authored and how new stories become public during a ritual transformation of a suffering human body, which, during the course of the ritual, is separated from – and reincorporated into – the family and the village community.

bodily experiences, and narratives provide an understanding of the subjective experience of illness through the rich descriptions, they impart, and the wealth of detail that emerges.

Within so-called narrative and patient based medicine\textsuperscript{20} - and within qualitative medical research in the works of L. C. Hyden, A. W. Frank, C. Mattingly, I. Robinson, C. K. Riessman, E. G. Mishler and others\textsuperscript{21} - there have been a surge of interest in narrative accounts of illness and in methods of narrative and thematic analysis. The theoretical interest in ‘liminality’ complements this interest and takes it even further, since it drives an understanding of illness behaviour towards an experience of an embodied suffering agent of an illness episode. The experience of liminality drives the method of analysis towards a pre-verbal linguistic material\textsuperscript{22}.

Liminality is a heterogenous process of social and cultural conditioning, which is a reversal of an everyday life without physical symptoms and medical complaints - it is thus a phenomenon, which is different from ordinary, homogenous life. Following Victor Turner, somatization is anti-structure, and persistent somatization can be defined as a phase of embodied suffering of an individual, which cannot be transformed into a stage of aggregation, because the new status, position or situation of the individual – i.e. being ‘not not-healthy’ - is not accepted by the individual him/herself, by a partner or by the network of family, friends, colleagues etc.

In serious illness episodes and in persistent or chronic illness the liminal is not conceptualised as a second phase of a demarcated tripartite process – i.e. as the phase before an aggregation into the fabric of society. People, who experience chronic or life threatening illness, like cancer, do not pass through the three phases: ‘separation’, ‘liminal’ and ‘reincorporation’.

I propose two different formulations of liminality in the context of medicine: one for life-threatening sickness, which follows Miles Little's conception of liminality, and one for medically unexplained physical symptoms. Both are


\textsuperscript{22} Riessman (1993) uses the terms ‘prelinguistic realm of experience’ (p. 8-9) and ‘prenarrative’ (p. 4). The definition of the later: “it does not develop or progress in time, and it does not reveal the storyteller’s feelings or interpretation of events” (p. 4) comes close to my use of the term ‘pre-verbal linguistic material’, which follows the definition of ‘prelinguistic realms’ in the sense that it is an experience, which makes no distinction between “my bodily perception” and the “objects I am conscious of” (p. 9). ‘Pre-verbal’ simply means that the nature of the experience is linguistic and would be verbalised, but is held back, until the storyteller reveals his or her feelings.
blocked processes of transformation, and liminality has become a structure in life. Both see medical complaints and physical symptoms as a phase of liminality to pass through before a re-integration into a normal way of life; but differences arise from the nature of the physical symptoms themselves, from the state that people enter into, when they are given a diagnosis of a serious sickness, particularly a diagnosis of cancer and from the narratives produced. In both ways of formulating ‘liminality’ the movement through the three phases has not succeeded, and the movement has been blocked in a liminal situation, which may persist for a duration of time and eventually become chronic.

Cancer patients, along with other chronic patients and those who have survived serious threats to life, enter a phase, in which adaptive mechanisms are repeatedly formulated and reformulated. A diagnosis of cancer precipitates a sense of urgency both in the patient and in all those around the patient, and many struggle with the fact that the nature of their experience is impossible to communicate in words to those, who have not undergone a similar experience. Sometimes language collapses in the face of the recollection of the incommunicable, but a narrative is then constructed to give meaning to the challenging and changing biographical, physical and existential phenomena in which illness and sickness evolve in the locus of the body.

Somatization as a persistent phase of embodied suffering is on the contrary not related to a diagnosis of a serious sickness. Liminality is then the experience of a space between and betwixt the normal way of life, and somatizing illness behaviour is a state, which is different from the normal way of life, which was a life before without physical symptoms and medical complaints. Liminality is thus a phase of transition, which has not yet been returned to the situation before. Somatization is ‘not-returning’ to a life before an event – i. e. a situation, which was devoid of physical symptoms and somatic complaints. The movement of transformation has been blocked, and the link between physical symptoms of the suffering body and life events of an individual has been blocked, and the somatizer finds it impossible to communicate such a link.

Making the Link

In persistent somatization linguistic materials has not been vitalized by the meaning of a narrative, which links somatic problems to life events, and it is beyond the willpower of the individual somatizer to articulate this preverbal linguistic material, which embeds the physical symptom.

In Linda Gask’s ‘retribution’ model (Gask, 1995) which describes a practical model for the detection, acknowledgement, and management of functional somatic symptoms, which can be learned and managed in primary care, ‘making the link’ is the third stage – after ‘feeling understood’ (stage one) and ‘broadening the agenda’ (stage two), and she suggests some strategies in making the link in primary care settings. Involving the patient’s family in the consultation is one of them, where spouses, parents, and adult children may attend to provide ‘support’ for the patient and demand that ‘something is done’. A
joint session in which the agenda is broadened, and links are made, can be especially therapeutic effective in primary care.

Susan H. McDaniel suggests nine treatment strategies for relational therapy, which assist in treating somatizing patients within a family context. One of them is ‘Link the somatic and the psychological’. It is McDaniels position that somatoform symptoms can be reframed as signals from the body or the mind that something is wrong, either physically, psychosocially, or both. The patient and family can be encouraged to speculate, what the significance might be of the particular symptoms the patient is experiencing.

**Personality disorders and somatization**

Persistent somatization may be a manifestation of personality disorders - the most common being passive-dependent, histrionic, sensitive-aggressive and borderline personality disorders. Studies examining the full range of personality disorders have found nonspecific increases in patients with somatoform disorders, but the literature is unclear, as to whether personality disorders pre-dispose patients to the development of somatizing illness behaviour, or whether maladaptive personality traits develop as a result of patients’ attempts to deal with physical symptoms and chronic illness.

According to the first theoretical scheme somatizing illness behaviour evolves from strategies developed in childhood to cope with family conflict. During childhood, these strategies may be adaptive, but when they persist into adulthood, they become “pathological”. So, patterns of behaviours arising from childhood experiences may be reinforced by attachment to a partner, to family members or to the whole family system, and attachment is then a process, which evokes responses from others that give a sense of security.

Two theoretical schemes have attracted some attention in explaining the genesis of somatization, which in fact are merely two aspects of the same comprehensive theoretical model: according to the first, adverse childhood experiences contribute to the development of somatizing illness behaviour; according to the second, somatizing behavior is a manifestation of maladaptive interpersonal communication (Stuart & Noyes, 1999, op. cit).

The two schemes are complementary within the same model, since adverse childhood experiences have an impact on the attachment styles of persons, who later manifest somatizing illness behaviour, and a pattern of insecure attachment in childhood may later develop into maladaptive interpersonal beha-

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viours and traits of personality disorders. This maladaptive pattern may result in inflexible care seeking behaviours in interpersonal interactions that culminate in rejections by others – i.e. rejections by partners, spouses, family members, colleagues, friends, doctors, health care professionals etc., and this pattern of self-defeating interpersonal interactions creates a descending spiral in which the somatizer becomes “hateful” – cf. Groves (1978) - and produces hostility in others.

According to T. J. Craig and his group in the South London somatization study\(^{25}\) adult somatization is best modelled by an inadequate parental care followed by childhood illness. Craig and his group states that among somatizers childhood illness afforded an escape from neglect and abuse from a withdrawn or indifferent parent. Childhood experiences of badly needed attention set in motion a pattern of care-eliciting behaviour that is repeated later in life. Craig points to the link between early childhood environment and somatizing behaviour in adulthood, and according to A. J. Barsky and his group\(^{26}\) traumatic experience during childhood, such as sexual abuse and physical violence, seems to contribute to a somatizing illness behaviour.

**Attachment to Narratives**

Traditionally attachment is conceived as seeking care from others; but attachment to narratives of individuals, of families and of lifestyles is also a kind of attachment, which is causally implicated in somatizing illness behaviour. Attachment to narratives is seeking contact from others by internalizing a narrative, which then becomes meaningful to the individual. This definition accepts Gerhard Schulze’s historical analysis of social and cognitive transformations in the sense that internalisation of narratives is associated with a change of social reality (Schultze, 1992, part 3.3 and 5.7).

In primary care settings - and in the context of family therapy\(^{27}\) - it is a task to initiate a process of detachment and to transform the patient’s construction of a somatic complaint from an individual, intrapersonal view to an interpersonal, relational one. It is important to transform the narrative, since somatizing illness behaviour is embedded and maintained in the “stories” the patient tells, when describing his or her behaviour. The transformation involves the patient, the family doctor and relatives, who co-generate qualitative changes in the story. A successful consultation, from the narrative perspective, is one in which a transformation has taken place also in the partner/spouse’s or the family’s set of dominant stories about the illness behaviour of the patient, so as to

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\(^{25}\) Craig, Boardman, Mills, Jones & Drake, 1993.

\(^{26}\) Barsky, Wool, Bannett & Cleary (1994).

include new experiences, meanings, and interactions. This inclusion has the effect of a loosening of the thematic grip of the set of stories about the somatizing illness behaviour. The goal is to search for elements in the story that are amenable to challenge, redefinition, or alternative interpretation, so that a new definition of physical symptoms and somatic problems can emerge.

Following the literature on somatization in primary care settings it is the interaction between the family doctor and the patient that best facilitates the transformation process; but the partner and significant members of the family-network are also important co-authors of a “new story”. The multiple viewpoints of the patient, the doctor and family members allow the individual to reconstruct a new meaningful story, and reconstructing a “new story” also allows partners and family members to observe one another and to detach the meaning, which has been attached to the old problem. Reconstructing an “old story” in a new, detached way is a healing process itself.

Narratives of somatizing patients have to be distinguished into “true somatization” and “facultative somatization”, since the therapeutic approaches of the family doctor have to be different, because the social acts performed by somatizing patients are different.

“Facultative somatization” is defined by Linda Gask as patients, who had somatized during an interview with the family doctor, but who are prepared to consider psychological factors as being relevant to their somatic symptoms “when interviewed by a sympathetic psychiatrist” (Gask, 1995, 393), and the point is that “facultative somatizers” are only partly fixated in a somatizing illness behaviour. Their narratives can be challenged and redefined by a sympathetic therapist, but this is not the case with ‘true somatizers’. In this case an attempt to transform the construction of a narrative and to co-author a new story is rejected by the patient, and from a narrative point of view the consultation is most probably doomed to be unsuccessful. When unprepared and unreflected the healing process of reconstructing a “new story” becomes an act of analytical violation by the family doctor. Unless “true somatizers” have become ‘objectors’, who are rendered able to object to the statements of the family doctor, they remain difficult patients in primary care.

A practical model for management of functional somatic symptoms in primary care should ideally reframe the perception of difficult patients by the family doctor and point out the paradox that the patient, who does not verbalise an objection to change, may in fact resist a process of detachment from an old problem. The model teaches the family doctors to make the distinction between “true” and “facultative” somatizers and to trust their intuition not to intrude and

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intervene into private zones of “true” somatizers. Verbal and non-verbal linguistic material from such zones are not a “story” to be reconstructed by a new meaning – merely an expression of suffering to listen to by a sympathetic human fellow. Reconstructing an old story and co-authoring a new story are narratives, which underlie a change of behaviour, but this kind of narratives should be distinguished from expressions of ‘true’ somatizers, who block out a change, and who resist an attempt to transgress the liminal situation, which has become chronic.

All patients have private zones, which should not be transgressed by anybody. Though facultative somatizers may interact freely and talk lively about their physical symptoms, somatic complaints and existential and emotional problems to their family doctors, they have also private zones, which are not approachable by the family doctor. Their utterances will freeze in such situations, and meaning will not be expressed in a story, which progresses in time, and which can be tapped from the mouth of the patient. In such situations meaning is not a discoursive statement, which can be transformed, reconstructed or co-authored at will

Somatizers as objectors

In ‘When Things strike back – a possible contribution of science studies’ Bruno Latour (2000) formulates the idea, that an ‘objector’ is produced by allowing the respondent to object. The respondent is allowed to object to the framing of a scientific project, to the meaning and purpose of an experiment etc. Objectors produce an objectivity, which does not refer to a special quality of the mind or an inner state of justice and fairness, but to the presence of objects, which have been rendered 'able' to object to what is told about them.

Somatizing patients are not produced as interesting objectors in the aforementioned literature on somatization. This problem is both ethical and methodological. The problem is partly due to the fact that the source of knowledge of somatizing patients among medical doctors is restricted by deficient linguistic material, which is produced by quantitative methods. Quantitative, statistical methods do not produce somatizers as objectors, who object to what is said about them. The paradox is that quantitative, epidemiological methods imitate the natural sciences, but avoid precisely those features that would render

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29 In my project I have interviewed a number of somatizing patients, who have previously been SCAN interviewed by a psychiatrist (Schedules for Clinical Assessment in Neuropsychiatry), and who have been selected for qualitative interviewing, because they have been classified as “facultative somatizers”, and I have found that “facultative somatizers” also have painful, private zones, which are expressed in a narrative style, which is found in the narratives of “true somatizers”.
their contact with somatizers really objective in the sense that they would be able to object to the setup of an epidemiological survey study or an experiment. In medical discourse patients are humans, who are devoid of a possibility to influence the result of an investigation, and who are kept unaware of what is manipulating their behaviour. While the patient is held by forces unbeknownst to him or her, only the doctor is ’in the know’, producing what is taken as solid knowledge, since it is untainted by the subjective reaction of the patient.

The reason why more precautions have to be taken in medical science with human subjects than with natural objects is not merely because humans should not be treated like 'mere things' – as a humanistic critique of methods of medical science will have it; but because humans too quickly comply with what medical doctors expect of them. If family doctors and medical scientists wanted their patients to be able to object to what is said about them, they would allow them to be disobedient and capable of raising their own questions in their own terms. Then, somatizers would start to behave in the hands of medical doctors as interestingly as natural objects do in the hands of natural scientists, and somatizing patients would be as interesting, valuable and important informants to the research process as natives have been to anthropologists in the ethnographic fieldwork situation.

Experiments as an extention of qualitative interviewing

How is somatizing illness behaviour and patterns of interaction in partnerships to be studied? I suggest a three steps procedure, which integrates scales\textsuperscript{30},

\textsuperscript{30} In my project in Århus County, Denmark and in Yatinuvara AGA division in Sri Lanka patients are screened using the eight-item version of the Symptom Check List (\textit{SCL-8}), the seven-item \textit{Whiteley} Index, the twelve-item Somatic Symptom Subscale of SCL (\textit{SCL-Som}) and four alcohol questions (\textit{CAGE}). Secondly a stratified sample of patients are diagnosed using the SCAN interview (\textit{Schedules for Clinical Assessment in Neuropsychiatry}) in Denmark and the following set of investigations are performed in Sri Lanka: (1) an assessment by the doctor treating the patient by way of a questionnaire, (2) a questionnaire by the partner of the
semi-structured interviews and qualitative interviews as well as observations and experiments, and I propose to organise experiments in natural settings as a way to extend the range of qualitative interviewing.

Interview data are not sufficient to describe and analyse somatization behaviour in natural settings — i.e. in everyday life, and observation of how a somatizer behaves in concrete situations is therefore a complementary step. In patient, (3) an examination of physical symptoms together with the patient (Physical Symptom Charts), (4) an ICD-10 diagnostic interview with a psychiatrist, (5) Response Form for CIDI-SF Major Depression Interview and (6) a sinhalese anxiety scale. In the project in Århus County in Denmark six trained psychiatrists have performed the SCAN interviews, and of in all 887 patients, who were selected for a SCAN interview, 714 patients concluded the interview. In Sri Lanka 11 patients were seen by a psychiatrist from Peradeniya Teaching Hospital, who came to the field. As a third step in the study twelve of the SCAN interviewed patients in Denmark were selected for a series of qualitative interviews by me, and in Sri Lanka I homevisited and interviewed three patients and their families. In all cases partners were interviewed (IPQ-partner). Three couples in Denmark and three couples in Sri Lanka were then as a fourth step taken into an experiment with an exercise of physical contact, which generates a linguistic material to be analysed.

Patients were asked to take part in qualitative interviewing concerning their illness narratives and life trajectory stories, and they were interviewed on personality disorders (SCID-II) and depression (Hamiltons Depression Rating Scale) — i.e. interviews, which follow a semi-structured interviewguide. Partners were asked to answer a questionnaire developed by Weinman, Petrie, Moss-Morris & Horne (1996), IPQ-partner: Illness Perception Questionnaire and four complementary questions (JØA 1-4). The four complementary questions take the inquiry into a dimension, which requires the partner to decide on a five point Lickert scale, whether the partner believes, he or she has an impact on the condition of the illness.

The study of somatization and illness behaviour in Aarhus county in Denmark was duplicated in Yatinuvara AGA division (near Kandy) in Sri Lanka — i.e. the scales, structured interviews, method of qualitative interviewing, narrative analysis and the experiment were repeated in Sri Lanka - in order to test the sensitivity and cultural specificity of the research design. The design of the experiment proved to be robust and sensitive to cultural differences.

Somatizers and their partners were instructed to share their experiences of the above mentioned exercise in the experiment. They were instructed to relate their experiences themselves on a tape-recording and were asked to produce a linguistic material to be analysed by the researcher. The six couples were instructed to share their experiences of giving and receiving a partner’s touch on a number of points on the body, which in a flow contacts the medically unexplained physical symptoms of the body and raises consciousness about the physical symptoms.
practice interviews and observations alternate. But, observation brings with it its own problems, since routines determine the actions in everyday settings. Only rarely can one spontaneously observe how an individual acts and interacts in the family system and decides to follow the preferences of a chosen lifestyle. Another problem is that a somatization behaviour becomes what an agent of somatization sees with, but seldom what he or she sees. Illness behaviour is implicit and incorporated. For these reasons, experiments are a way to expand the range of qualitative interviewing.

In order to observe a patients interactions with a partner as a fourth step in the research process, subjects are confronted with an artificial situation in a natural setting – accompanied by instructions and questions. The advantage of an experiment is that the cognition of a somatizer and exchanges of feelings with a partner can more easily be observed in an experiment. In the new situation of an experiment, it can be observed, to what an extent an interaction is an exchange of feelings, which is related to physical symptoms of the somatizer, and how physical symptoms are verbalised. Experiments do not have to be verbal, as non-verbal behaviour can be observed. Non-verbal experiments can generate a verbal expression to be analysed, and non-verbal experiments can transform a pre-verbal linguistic material into a verbal expression.

The experiment takes the couple into a liminal, interstizial zone between body and language and between language and feelings, and the interviewer/researcher becomes a witness to a process of verbalising pre-verbal linguistic material. The experiment may – or may not - change their pattern of interaction. In any case the experiment allows the couple to contact each other in a new way framed by the experiment. So, the experiment is an intervention, which allows both the researcher and the objects of the experiment to see an exchange at a deeper level for human interaction.

My experiences with 6 couples in Denmark and in Sri Lanka prove that the material produced is not a story, which portrays the interrelationship between physical symptoms and the psychological or cultural context of these symptoms. It is therefore not a meaningful analytical task to reduce this kind of material to a core narrative. It is rather the task to “unpack” the meaning and to reflect upon the genesis of a concrete and singular meaning. The language used in sharing the experience of an exchange of a physical exercise between the two partners can be scrutinized – i.e. “unpacked” - during the experiment itself as well as later, in the analysis together with a supervisor.

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34 Riessman (1993) explains “unpacking” in the following way: "Those who collect personal narratives, unlike historians who work with archival materials, can ask informants what they mean by what they say. Language used in an interview can be scrutinized – “unpacked”, not treated as self-evident, transparent, unambiguous – during the interview itself as well as later, in the analysis of interview transcripts", p. 32.
Qualitative Interviewing and Analysis of Narratives

In qualitative interviewing the researcher him/herself is the research instrument, and the quality of contact between the interviewer and the interviewee is essential to the quality of the linguistic material, which is object for a narrative analysis. In qualitative interviewing it is not only the questions themselves that take the interview into a certain inquiry, but also the quality of contact to the respondent, the quality of returning for a repeat interview, the quality of listening and the range of responses of the interviewer. Each of these aspects of qualitative interviewing generates a quality, which is different from quantitative research, and they all contribute in generating a linguistic material, which differs from quantitative interviews.

In qualitative interviewing the interviewee is an “objector”. The method of producing an “objector” is simple: the interview is introduced by a letter of introduction to the interviewee. Such a personal and singular letter to the interviewee is important, because the letter is an opportunity for the interviewee to be aware of the frame of the interview before, during and after the interview itself. The letter produces an “objector” - not by provoking the interviewee or by initiating a conflict about the content of the interview; but by allowing the interviewee to object to the meaning and purpose of the interview. The letter gives the interviewee an opportunity to negotiate the content of the interview.

The interaction between the interviewer and the interviewee before and during an interview co-determines the content of an interview, and in the interview situation they constantly react upon each other. When the interviewer listens to the answer of the interviewee, he or she must react and respond in order to continue the process of communication, which then becomes a circular process of communication (Andersen, 2001, Kvale, 1999, 1997, 1996, Mishler, 1986 A)35.

Qualitative interviewing is retelling of stories in the sense that researchers retell their respondents’ accounts through their analytic redescriptions, and qualitative interviewing is experimental in the sense that there are different ways of organising the setting of an interview. There are different ways and means of getting an interviewee to answer a question, and the interviewer construct a story and its meaning through concepts and methods – i.e. research strategies, data samples, transcription procedures, specifications of narrative units and structures and by interpretive perspectives.

35 Mishler (1995) formulates the circularity in this way: “… the story is always co-authored, either directly in the process of an interviewer eliciting an account or indirectly through our representing and thus transforming others’ texts and discourses. And a related point: the teller of the tale is also engaged in a retelling. The version we hear or read is shared both by the context of its telling and the history of earlier retellings” p. 117-118.
A series of qualitative interviews produces a material, which is a proper linguistic material for a narrative analysis – cf. Mishler (1995), (1986 A), (1986 B), Riessman (1993), Kvale (1996). E. G. Mishler suggests a typology for models of narrative analysis, which briefly claims that models of narrative analysis either focus on reference as a problem of representation or on narrative strategies through which different types and genres of stories are organized or as a third possibility on cultural, social and psychological contexts and functions of stories.\(^{36}\)

I propose a method of analysis of the whole range of narratives, and a method, which analyse both processes of “true” and “facultative” somatization. I propose a method of analysis, which handles a heterogeneous linguistic material, that cannot be reduced to core-narratives to be compared across a sample. I propose to interpret and explain the meaning of various kinds of narratives in front of a supervisor.\(^{37}\)

Traditionally supervision is a relation in which the supervisor is a model to be copied by the supervised person; but in qualitative interviewing the supervisor is not a role-model to be copied. The supervisor is merely a mirror, which stimulates and encourages the interviewer in his or her own way of analysing the materials. So, a supervisor can take part in the analysis by being a mirror, which reflects the analytical problems. The presentation of the interview materials in front of a supervisor implies that the materials are analysed up a standard, which makes it meaningful to present to another person, who listens to it. The quality of contact between interviewer and interviewee and the quality of insight of both parties into the reality, which is the theme and focus of the interview, can be assessed in a session with a supervisor.

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\(^{36}\) Mishler (1995), p. 90, table 1. The typology addresses primarily issues of concern to researchers in the human sciences, who focus on the production and functions of narratives in social contexts – i.e. conversations, rituals, professional encounters etc. – and on the analytic use of narrative modes of interpretation in historical and scientific accounts. Mishlers classification was initially developed inductively (cf. p. 89); but three general categories have emerged, which correspond to the triad of language functions: (1) reference (temporal order: The “telling” and the “told”), (2) structure (textual coherence: Narrative strategies) and (3) function (narrative: Contexts and consequences).

\(^{37}\) A first step of analysis before meeting the supervisor is to get a general view of each interviewee and the context of interviewing. A second step is a detailed analysis of words, sentences, events and/or meaningful relationships. The supervisor does not directly take part in step 1 and 2; but the supervisor helps to energize the two steps and makes it meaningful to stay with the process of analysis, since the supervisor is there to listen to the outcome and to appreciate the findings. The contact with the supervisor takes the analysis into a third level of analysis, where results are presented to readers or an audience of researchers.
The setting of a supervision should be controlled by rules and instructions like an experiment in a natural setting in order to increase validity and reliability. Both trustworthiness (validity) and dependability (reliability)\textsuperscript{38} are increased in a process of analysis together with a supervisor.

**Implications for future intervention in somatizing illness behaviour**

Narratives link individual dilemmas with an individual illness behaviour in a process of attachment, and each narrative must be analysed according to the nature of the linguistic material. Some material has – and some has not – been vitalised by the meaning of a narrative, and an intervention into private zones of a ‘true’ somatizer without allowing the patient to object to the statements of the doctor is most probably doomed to fail. A joint session with the patients partner - or a member of the family - broaden the agenda and may make a link to important life events, since the family is a resource and/or a stressor in the treatment of somatization. A collaborative stance by the family doctor is particularly relevant to working with somatizing patients and their families. The collaborative attitude stands in contrast to the “expert position”, which can create enormous resistance and resentment in “true” somatizers and their families.

The reaction of the health care system towards ‘true’, persistent somatizing patients are more or less the same as towards other patients. For some somatizers the frequent changes of family doctors will lead to difficulties for their treatment and to unnessesary admissions. For many reasons the family doctor is best in facilitating a transformation process of a somatizer, especially because the family doctor is potentially an important co-author of a new story about the physical symptoms and about an illness behaviour, which has become a structure in life. The family doctor performs in a liminal situation, and persistent somatization can thus be defined as a permanent state of liminality.

When the family doctor allows multiple viewpoints and allows the patient to reconstruct a new meaningful story, he allows the patient to detach the meaning, which has been attached to the old problem. The doctor then heals his patient; but he must distinguish between “true somatization” and “facultative somatization”, since the narratives are different and his therapeutic approach consequently has to be different. “True somatizers” have many private zones, which are not verbalized or vitalized by the meaning of a narrative, and which should not be approached by the family doctor. Only when the “facultative” patient is well prepared and allowed to object to the utterances of the family doctor, and when the doctor understands the nature of a particular illness

\textsuperscript{38} Lincoln & Guba (1985) chap. 11 defines validity as 'trustworthiness' and reliability as 'dependability'. The reliability of a singular qualitative interview can be tested, and the validity of a series of interviews can be tested.
behaviour, because the doctor has learned to analyse and interpret the meaningful narrative, which links individual dilemmas with an individual illness behaviour, and which the patient offers the doctor to listen to, is an intervention from a narrative perspective not doomed to fail.

References


Bowlby, J., (1951) *Maternal Care and Mental Health, A report prepared on behalf of the World Health Organization as a contribution to the United*


