

Narrative Identities and the Management of Personal Accountability in Talk about ME: A Discursive Psychology Approach to Illness Narrative

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Abstract

This article takes a discursive psychology approach to the analysis of illness narrative. The controversial topic of ME (myalgic encephalomyelitis), otherwise known as chronic fatigue syndrome (CFS), is used as a case study to examine the dilemmatics of illness talk. Using data from an ME narrative, I explore the complex and subtle discursive work performed by participants to show how attributional stories and identity formulations are linked together in a narrative that works to construct ME as a physical disease while countering potential accusations of malingering or psychological vulnerability. In working to counter such explanations, sufferers paradoxically implicate themselves in an interpretation of their illness as self-inflicted through overwork and mismanagement. In previous research, tales of frenetic lifestyles prior to the onset of ME have provided analysts (and journalists) with grounds for constructing their own attributional stories in the form of 'opt-out' or 'burnout' theories of ME/CFS. An ethnomethodologically informed discursive psychology provides a non-cognitivist approach to analysis which looks in detail at how sufferers *themselves* make sense of ME as a *practical activity* and how their identities are constructed as part of that process.

Keywords

accountability, discursive psychology, identity, illness narratives, ME (CFS)

IN A RECENT review, Michael Murray (1997) has drawn our attention to 'the whole of health psychology being nothing but stories about health and illness' (p. 18). We are encouraged not to discard such material but to consider its potential contribution to health psychology. In this article I address two related questions: what is the status of such stories and how should we analyse them? I shall use the case study of a controversial illness to demonstrate a discursive approach to the analysis of illness narrative. ME (myalgic encephalomyelitis) or CFS (chronic fatigue syndrome) has been at the centre of a long-standing debate regarding its physical or psychological status. While this article is not intended as a contribution to that debate, I shall be taking a detailed look at the way that interview participants (an ME sufferer and her partner) make sense of the illness and its causes.

My theoretical approach and analysis is based on a version of discursive psychology (Edwards, 1997; Edwards & Potter, 1992; Potter, 1996) that is informed by discourse analysis (Potter & Wetherell, 1987), ethnomethodology (Heritage, 1984) and conversation analysis (Sacks, 1992). Edwards and Potter (1992) describe their approach as a reconceptualization of cognitivist psychology: 'a viable perspective on psychological life rather than just a mode of empirical analysis' (p. 153). Specifically, psychological phenomena such as memories, attitudes, attributions and identities are respecified as situated discursive accomplishments.¹ Illness narrative can therefore be analysed as a performative domain of social action where identity construction is part of the practical activity of defining an illness and explaining its causes (Horton-Salway, 1998; 2001).

The discursive approach taken in this article is contrasted with cognitivist research that treats illness talk as a route to an inner world of cognitions and core identities. One such example is research on attributions which is based on the rationale that there is a human tendency to seek causal connections between events (Heider, 1958; Heider & Simmel, 1944). From this view, narrative is treated as 'a type of *causal* thinking' (Robinson & Hawpe, 1986, p. 111). When applied to illness narrative, attributional research focuses on people's illness attributions and explanatory models of disease (e.g. Abrams & Festinger, 1953; Bard & Dyke, 1956; Elder,

1973; Mabry, 1964; Markson, 1971; Monteiro, 1979; Samoral, 1962). For the practitioner, patients' illness attributions are seen as centrally important because they are thought to reveal the meanings they attach to symptoms, disabilities and bodily signs; these attributions are taken to influence their illness behaviours, coping responses and emotional reactions (Fabrega, 1973; King, 1962; Kleinman, 1973; Lipowski, 1969, 1974).

This rationale has been used as the basis for prescribing cognitive behavioural therapy as a treatment for CFS sufferers (Abbey, 1993; Butler, Chalder, Ron, & Wessely, 1991; Wessely, Butler, Chalder, & David, 1991; Wessely & Powell, 1989). For example, Wessely et al. (1991) claim that CFS patients' illness attributions (e.g. 'symptoms are the result of a virus'; 'physical activity is likely to result in a set back') are linked to avoidance of activity, physical deconditioning and a poor prognosis. In cases where patients' illness attributions are deemed to be dysfunctional, cognitive-behavioural therapy (CBT) is therefore designed to change the way that patients habitually *think* about their illness and its practical management. In the case of ME/CFS, patients' illness attributions are likely to be interpreted as constituting part of the illness cycle itself by working to guide the patient into abnormal and dysfunctional illness behaviour patterns. The high failure rate of CBT is attributed by clinicians to patients' resistance to therapeutic intervention and an unwillingness to change their illness attributions and behaviour rather than to any doubt about the legitimacy of the treatment itself.

However, there has been more than a degree of uncertainty and disagreement about the appropriate balance of rest and activity for ME/CFS patients. This means that illness behaviour and level of physical activity is likely to be made relevant as an *accountable* (and controversial) issue by researchers, medical practitioners and patients alike. For example, there are other researchers in the field who have emphasized the need for rest and moderating activity in managing the illness (Gantz & Holmes, 1989; Jenkins, 1989; Spracklen, 1988). The following quotation from a patient (Ray, Phillips, & Weir, 1993, p. 385) displays an *orientation* to that accountability; 'it's the whole thing of how far to push yourself to keep that

level of fitness, and how far you push yourself because you're pushing yourself over the limit and consequently making yourself feel worse again'.

Within an analytic framework underpinned by cognitivist assumptions, researchers have typically ignored the rhetorical and interactive context of such accounts. In contrast, a discursive approach treats illness attributions as being constructed by speakers in the situated context of accounting for themselves to other people (cf. Antaki, 1988, 1994). Attributions from this view are therefore not seen as stable expressions of causal thinking; they are regarded as situated productions that work to manage blame and personal accountability (Edwards & Potter, 1992; Potter & Wetherell, 1987). In a deconstruction of the Multidimensional Health Locus of Control (MHLC) scale, Wendy Stainton-Rogers (1991) makes a similar observation regarding variability. While the MHLC (Wallston, Wallston, Kaplan, & Maides, 1976) categorizes people into those who make internal and those who make external attributions, Stainton-Rogers (1991) points out that people's health explanations are much more complex and flexible since they are constructed out of 'culturally available discourses' and vary according to situational demands. This version of discursive psychology is informed by Foucault (1972) and is typically referred to as macro (or critical) discourse analysis (e.g. Eccleston, Williams, & Stainton-Rogers, 1997; Ingham & Kirkland, 1997; Stainton-Rogers, 1991, 1996).²

The following analysis of an illness narrative is significantly different from such macro analyses. I shall neither assume the prior existence of such 'culturally available discourses', nor seek to categorize the content of people's accounts as *types* of 'discourses'. My analysis also differs from those which treat narrative accounts as a form of self-expression, self-exploration, or an opportunity for 'rewriting the self' (e.g. Frank, 1993; Freeman, 1993). Instead, I shall treat the narration of subjective experience and the construction of identity as situated productions that work to accomplish interactive business (Edwards & Potter, 1992; Gergen, 1994; Gergen & Gergen, 1986; Shotter & Gergen, 1989). This analysis follows an ethnomethodological concern with privileging participants' social practices over the analyst's prior theoretical or sociocultural

concerns (cf. Schegloff, 1997). Therefore, my analysis involves looking at how constructs such as motivation, belief, attitude, causal attribution and identities can be re-specified as the *topics* of participants' talk when they construct their illness narratives.³ The physical impact of illness (Yardley, 1997) is clearly an important aspect of such narratives; it is especially controversial in the case of ME/CFS where the precise medical status of the illness is itself 'at stake'. For sufferers, mind or body explanations raise delicate issues about their identities and credibility.

What, then, is the status of illness narratives and how should we analyse them? Edwards (1997) has emphasized that the analyst's task is neither to be drawn into the world of the narrative nor to disagree with it but rather to analyse its workings as a discursive accomplishment. This does not imply that discursive psychologists are less concerned about suffering than other analysts. It is rather that our theoretical position does not assume an equivalence between people's accounts and their internal experience and cognitive processes. Discursive psychology treats descriptions of past events, causal attributions and identity talk as complex *social* productions; they are constructed by speakers as part of activity sequences such as blamings or defendings (Edwards & Potter, 1992). This, however, should not be confused with treating people's accounts as motivated by insincerity or even impression management (Goffman, 1959). Indeed, in her analysis of an MS narrative using Goffman's framework, Riessman (1990) was very concerned to disclaim precisely such a cynical analysis of her participant's story.

Previous work in health psychology (Eccleston et al., 1997) has used Q-Methodology to examine issues of blame and responsibility in relation to the topic of chronic pain. My analysis of Angela and Joe's story provides a different kind of analysis of how such issues are managed in the situated context of an illness narrative; this shows how an account of past events is constructed by two participants (and an interviewer) to manage the sensitive issues raised in the discussion of a controversial illness. My analysis will show how Angela's identity is constructed as part of an attributional story about her illness and its management. The 'theory of ME' that is formulated and the accounting for 'self as sufferer' of (or 'self as believer' in) ME

can be seen as interrelated in a narrative that works to manage competing explanations (Billig, 1987).

An analysis of Angela and Joe's story

'Scene-setting' (or where the story starts)

Consider the following extract that has been taken from the beginning of an interview with a married couple on the topic of the wife's chronic illness.⁴ While there are many interesting things here for a conversation analytic study of 'joint remembering' (see Edwards & Middleton, 1986; Sacks, 1992; Tannen, 1989) I shall focus on how Angela and Joe actually *begin* their story and consider the implications of that for the attribution of cause.

Extract 1

- 21.Mary mm and how did it (.) can you remember much about how it started? =
- 22.Joe = heh heh
23. (.)
- 24.Angela it started off with =
- 25.Joe = it started with a sore throat =
- 26.Angela = I had a sore throat and I had the very worst headache I've ever had in
27. my life (.) it was one evening =
- 28.Joe = go back to where we believe it was caught at the swimming baths in
29. (town) =
- 30.Angela = yeah =
- 31.Joe = we'd been going down in the evening (.) swimming once a week (.)
32. and er it was after one of our sessions =
- 33.Angela = yeah we thought we'd picked it up =
- 34.Joe = I went swimming one week (.) you didn't feel up to it (.) then the following week =
35. = you were alright weren't you? =
- 36.Angela = yeah and this ties in because it's now known that ME is caused by
- 37.Joe er (.) an enterovirus which is a

- prime place to pick up an enterovirus
39. a swimming baths (.) it's also the classic(.) used to be the classic place
40. to catch polio in the old days (.) hot summers (.) and I think with swimming (.) kids being in the bath all through the day (.) at the end of
41. the day the water wasn't getting through the cleansing plant quick enough (.) I suspect if you'd gone first thing in the morning it would be
42. absolutely spot on clean (.) but er I suppose by the time we got there (.)
43. I suppose the enteroviruses were still there (.) yeah (.) just unfortunate

At the beginning of any narrative there is likely to be a sequence that provides some background 'scene-setting' detail or orientation (Labov, 1972). Rather than interpreting such a sequence as merely giving neutral information that sets the story in its proper context, discursive psychology analyses 'scene-setting' to see what interactive business it performs. For example, beginning a story at one point in time rather than another sets the parameters for what is to be made relevant. This has profound consequences for the kind of causal account that the speakers go on to construct. In other words, the scene-setting provides their grounds for what will follow in the narrative as an attributional story.

Riessman (1993, p. 18) has made a similar point, noting that; 'where one chooses to begin and end a narrative can profoundly alter its shape and meaning'. As an example of this, we can see how Angela's problems are being dated very specifically to a point in time and are grounded in the activity of a visit to the swimming baths. Joe scripts this as part of their normal routine by describing it as 'one of our sessions' (line 32).⁵ In this instance, life events that predate this point are not made relevant to the process of becoming sick. This account can be contrasted with another that might begin a few years earlier, drawing on psychosocial evidence to make life events and individual

psychology relevant as predisposing factors in the origin of Angela's illness.

Descriptions of events and causal attributions are inextricably linked together in this account. *Any* description of events necessarily involves the construction of particular kinds of causal links.⁶ Joe's 'theory of ME' as a medically recognizable organic disease caused by an enterovirus (lines 37–45) and the sequence of events that link Angela's illness with the ordinary everyday event of going swimming are being constructed here initially as uncontroversial in the first instance. This is accomplished by Joe's scientifically informed explanation (lines 41–5) for why enteroviruses might be in the water at the baths and resonates with his earlier assertion about the baths being the *classic* place to catch polio. His theory is being worked up here as not a new or untested idea; his claims are warranted by the authoritative voice of established science which is represented at lines 37–40 as the 'classic' script of a polio story. The point of critical contrast for my analysis of scripting is how events and actions can be *described* as 'instances of some general pattern, or as anomalies or exceptions' (Edwards, 1997, p. 144). What is at stake here for participants is the normative basis of such events or actions, and relatedly, the accountability of the actors. In this case the detail of Angela's *personal* narrative is being blended with a *classic* narrative of how people used to catch polio in the old days. This accomplishes alignment between the two accounts and makes her personal story more easily recognizable as an instance of an organic disease.

*Why she never recovered:
'Catch-22'*

A little further on in the same interview, the narrative builds an account to explain the reasons why Angela became a chronic ME sufferer.

Extract 2

76. Joe one of the problems which caused (.) we suspect which pushed the
77. ME (1.0) was ((coughs)) she had a friend in the village (.) the same friend who's now got a granddaughter with a funny name (.) and she

79. came round to see Angela (.) I think your mother had gone back (.) or
80. your mother had gone back because she'd begun to become very
81. slightly better but she was still ill when she arrived (.) but Janet came
82. round and said 'oh you wanna get out you wanna fight it y'know' =
83. Angela = 'push yourself (.) [you push yours]elf you'll be alri[ght']
84. Joe ['push yourself']
[and]
she did =
85. Angela = and I did (.) and I got worse and worse and worse after that =
86. Joe = and I'll always remember the time I came home from work (.) the
87. kids were out (.) the house (.) when I opened the back door the house
88. was *dead* silent y'know (.) and I knew she was back in bed again and
89. that really was the thing that pushed her [into]
90. Angela [push]ed it over the top =
91. Joe = *my* Mum came back again (.) she thought Angela was ill (.) she came back for three weeks initially I—I initially was off work for two
92. weeks anyway (.) that was special leave to look after her (.) so there was two weeks and then another three (.) both parents (.) that brings it
93. to nine weeks =
94. Angela = well *this* can't[go on forever can it? (.) so in] the end everybody had
95. [and then she pushed herself]
96. Angela gone back (.) Joe was at work (.) cause I've got two children there's
97. a lot of washing isn't there? I

- used to crawl round the floor and hang
 100. over the sink and the washing machine trying to do a bit of washing (.)
 101. and of course now we *know* this is the last thing you must ever *do* is to
 102. push yourself when you first go down with ME (.) and I was doing *all*
 103. the wrong things (.) and I think that's why I've never ever recovered

There are two analytical points I wish to make about this extract. The first of these concerns the status of Angela and Joe's story as a piece of analysable data. Non-discursive analysts would need to consider how far Angela's description of events can be treated as an accurate representation of reality; what is revealed about Angela's personal experience, identity or perception of events? This question of accuracy and authenticity in people's narrative accounts, can be construed as a methodological issue that threatens to undermine the validity of traditional qualitative analyses. With reference to personal accounts of illness, Robinson (1990, p. 1173) points out:

On the one hand they provide a density of texture, a depth of personal meaning, and an insight into the experience of illness not readily available through other means. On the other hand these very qualities seem to make any systematic, valid and reliable attempts to create generalisable propositions difficult, if not impossible.

Here, Robinson is attending to issues of factuality and authenticity as an analyst's problem that might be potentially solved by the application of rigorous and systematic research methods. This can be contrasted with a discursive approach which treats factuality and authenticity as participants' concerns. Rather than needing to adjudicate upon the accuracy of the description, the construction of personal experience is treated here as a discursive accomplishment. My analysis of Angela and Joe's narrative identifies discursive devices that are commonly used by participants in mundane,

everyday talk to accomplish such factuality and authenticity.

One such device is the construction of fact through the inclusion of contextual detail. This has been well documented in ethnographic literature on 'I-witnessing' (Geertz, 1988); while the textual construction of eye-witnessed reports is analysed in studies of courtroom cross-examination of witnesses testimony (Atkinson & Drew, 1979; Drew, 1990; Edwards & Potter, 1992; Molotch & Bogen, 1985). Examples in this narrative, such as Angela's account of struggling to manage the household chores (lines 98–103), Joe's story about the day he came home from work to find Angela in bed (lines 86–88) and his account of the care arrangements (lines 91–95), provide vivid details which *constitute* the factual and authentic nature of their descriptions. The provision of fine detail works to give some assurance that the account is not inaccurate or fictional.

The second point I wish to raise about extract 2 relates to the attributional story beginning at line 76 ('one of the problems which caused') and ending at line 103 ('and I think that's why I've never recovered'). Having previously (in extract 1) established an external, but invasive, organic cause for her illness (rather than, say, an internal psychological one) the question of possible blame and personal accountability is oriented to at this point as a *participant's* concern. The severity and chronicity of Angela's illness is explained here as a consequence of following bad advice from a friend. Angela and Joe use the voice of a friend in a way that mitigates the circumstances of her deterioration; 'oh you wanna get out (.) you wanna fight it y'know' (lines 81–82), and 'push yourself (.) you push yourself you'll be alright'. Angela's account of how she struggled to comply with this advice also provides an illustration of how badly she was affected by her illness and how she made huge efforts to overcome her problems: 'I used to crawl around the floor and hang over the sink and the washing machine trying to do a bit of washing' (lines 99–100).

Clearly, her account constitutes a paradox which attends to the dilemmatics of illness management talk (Radley & Billig, 1994). In citing the friend's 'bad advice' Joe orients to a concern that people should not 'give way' to illness. In accounting for Angela as an ME sufferer, the account would ideally need to strike

a balance between the importance of rest for recovery and Angela's will to 'fight' the illness. 'Giving way' could implicate her in discrediting definitions of malingering and allowing herself to deteriorate whereas in 'fighting' the illness she risks being held accountable for a self-inflicted worsening of symptoms. Paradoxically, one of the things that makes her case recognizable as ME/CFS in the first place is the worsening of symptoms following a period of 'soldiering on'. As I pointed out earlier with reference to Ray et al. (1993, p. 385), illness behaviour and level of physical activity is oriented to by *participants* themselves as a contentious and accountable issue.

At this point in the account, Angela also introduces the suggestion of a more *general* consensus of shared knowledge about illness management; this is used as a resource to underwrite their argument: 'of course now we *know* that this is the *last* thing you must ever do is to *push* yourself when you go down with ME'. Although the use of the term 'we' is not specific, it does convey the sense of an authoritative consensus about coping with the illness. In this way, speakers make available some notion that fighting the illness (on the advice of a friend) has itself created the conditions for going down with ME and that Angela's case is a recognizable instance of a typical ME story. This is constructed here as a 'Catch-22' dilemma in which she admits 'I was doing all the wrong things' (lines 102-3). This is rather a risky admission since, by definition, 'doing all the wrong things' is a morally accountable issue. However, the virtue of not 'giving in' to illness has already been made available through Joe's reference to the friend's advice. Therefore, the account works as a defence against a possible suggestion that this could be a self-serving illness and also to mitigate Angela's own responsibility for her worsening condition. Note how the personal narrative and the classic script are co-constitutive, each serving to reinforce the other. Stories of illness are constructed in such a way that the single instance (the details of the case) conform to a 'typical illness script' where both the details of the individual case and the normative order of the script are constructed alongside each other in a co-implicative way. This (and Joe's account at lines 37-40) are both examples of the 'documentary method' (Garfinkel, 1967) where the

case fits the theory and the theory is further evidenced by the details of the case.⁷

Corroborative evidence

The link between scripts, causal attributions and identity is made clear in the following section of talk where Angela uses corroborative evidence to support her case. Jonathan Potter (1996, pp. 158-9) has pointed out that the production of reliable independent witnesses who provide consensus reports is one way to transform a description of events into a more solid factual account. The following section of transcript shows how Angela assembles such corroborating evidence using a device called 'active-voicing' (Wooffitt, 1992, 1998, pp. 225-6). This is where speakers use the voices of others to 'warrant the factual status of claims and undermine the possibility of sceptical responses'. We rejoin the narrative immediately after Angela has given an account of her GP's suggestion that she might be suffering from a psychosomatic illness. This dispreferred interpretation of her illness has the potential to undermine the 'theory of ME' (as a physical disease) that Angela and Joe have so far been constructing in their narrative. What is at stake here for Angela is both the authenticity of her account and her identity as a sufferer of a controversial medical condition.

Extract 3

189. Angela I think my mother was around at one of these times when *that* was
190. mentioned too (.) *my* mother said 'I know my daughter' (.) I can always
191. remember my mother saying that (.) 'I *know* my daughter' (.) because I
192. was always *so* active heh heh hyperactive in some respects
193. actually (.) because my Mum used to say to me 'for goodness sake
194. Angela sit down' (.) this was before I went down with ME (.) I never
195. wanted to sit down (.) I wanted to be on the go all the while (.) I was

196. happy that way (.) but er (.) things change (.) you're forced to sit
 197. down =
 198. Joe = to his credit (.) the consultant never *did* ever voice that thought =
 199. Angela = no (.) he didn't believe that

Here Angela tells a story using her mother's 'voice' to script herself as the kind of person who is unlikely to have a mental illness, or to be a malingerer: (lines 189–90) 'my mother was around at one of those times when *that* was mentioned too (.) my mother said 'I *know* my daughter'. . .'. This is supported by Joe's reference (lines 198–9) to the consultant's opinion. At lines 191–2 Angela fills in the details of what her mother knew about her disposition: 'always *so* active heh heh hyperactive'. Her mother's complaint at lines 193–4, 'for goodness sake Angela sit down' provides the occasion for Angela's account of her pre-ME disposition and activity: 'I never wanted to sit down (.) I wanted to be on the go all the while'.

The links between scripts, attributions and dispositions are developed in this section of talk. Script formulations, applied earlier (in extracts 1 and 2) to the narrative construction of Angela's illness as conforming to a typical ME/CFS story, can also be used to construct ones own or other people's identities in particular ways. People's actions can be scripted as being *in* or *out* of character as the kind of actions they are likely or unlikely to perform. In the context of narrative accounts, this scripting accomplishes rhetorical business that attends to issues of blame and accountability.⁸ This can be further illustrated with reference to the following extract from the illness narrative of a person who suffers from multiple sclerosis:

I used to enjoy dancing, gardening and general 'busyness'. I now sit down all day either in a chair, wheelchair or motor car and I am fed up with having to ask people to do things for me and pass things to me. (Robinson, 1990, p. 1183)

Robinson's example resonates with the account that Angela has provided in extract 3 and in extract 2 (lines 98–103) where she gives an account of her struggle to do her household

chores. Even Joe's remarks about 'one of our sessions' at the swimming baths (extract 1, line 32) help to construct a normative image of Angela as a physically active person who would rather not lead a restricted life.

In narratives of biographical disruption such as Angela's (and the example from Robinson's study) what is at stake for the person telling the story is what Charmaz has termed a 'fundamental loss of self'. She expresses this idea as follows:

Over time many debilitated chronically ill persons become dependent and immobilised. As they suffer losses of self from the consequences of chronic illness and experience diminished control over their lives and their futures, affected individuals commonly lose not only self-esteem, but even self-identity (Charmaz, 1983, pp. 168–95).

Charmaz's account assumes an essentialist model of an identity that can be fundamentally changed by illness. Rather than making inferences about 'loss of self' in the way that Charmaz's account suggests, my analysis examines how people construct identity formulations in the context of telling a story about an increasingly restricted and dependent existence. In such a context, when giving an account of how illness has disrupted ones life, the identity narrative is hearable as a way that the narrator can *script* herself as being a particular kind of person, one who would not normally choose to live a restricted existence: 'I *used* to enjoy dancing [. . .] I *now* sit down all day' (Robinson, 1990, p. 1183, emphasis added). This is similarly represented in Angela's account: 'I never wanted to sit down (.) I wanted to be on the go all the while' (lines 194–5). Thus, 'sitting down all day' is constructed as deviating from the normal routine of life before MS (or ME/CFS). This effectively manages the dilemmatics where 'illness talk carries with it the threat that one might be seen as a potential malingerer or even a habitual complainer' (Radley & Billig, 1996). Notice how the appropriate balance of activity and rest is again oriented to by the participants themselves as an accountable issue. Such accounts are clearly risky business since getting the balance wrong could be interpreted as a self-inflicted aspect of the illness cycle of recovery and relapse.

A 'before and after' story

The following account of biographical disruption provides further support to show how identity is constituted in situ to manage the dilemmatics of illness talk and to counter a competing explanation for Angela's illness.

Extract 4

480. Joe mm (.) it has had (.) 'cause it's altered my way of life really (.) I feel at
481. times frustrated y'know (.) after all this time (.) frustrated (.) I suppose
482. you could say 'yes we could go out and have a walk' but er (.) you feel
483. there's things to be done perhaps (.) but you get out of the habit of
484. doing that [anyway]
485. Angela [because]we did it together you see (.) we always used to go
486. fell-walking [and hik]ing cycling heh heh heh heh =
487. Joe [cyclists]
488. MHS = outdoor people =
489. Angela = yeah (.) swimming (.) physical things 'cause I know some couples
490. aren't in to that sort of thing (.) they're quite happy to stop at home and
491. sit (.) aren't they? =
492. MHS = yes =
493. Angela = well we were never like that (.) but we've been forced to be like that
494. in a way (.) to be sedentary instead of active

At lines 480–4, Joe begins an account of how Angela's illness has affected him as her husband and carer. Specifically he explains how it has restricted his lifestyle. At line 485 Angela intervenes to provide corroborative details of the vigorous outdoor leisure activities they used to enjoy. This is made relevant as a contrast to the sedentary lifestyle they are now forced to accept because of Angela's ME (lines 493–4). This

'before and after' story is also corroborated by Angela's account of her mother's testimony (extract 3) and works to manage the 'double-jeopardy' of illness talk (Radley & Billig, 1996). Where the legitimacy of an illness is itself 'at stake', one is more likely to be treated as the type of person who is looking for secondary gain. The 'before and after' story is well designed to counter such explanations by working up, as prior to the illness, an active 'self' who was not the type to enjoy or wish for a sedentary lifestyle (lines 485–95). She formulates the consequence of her illness as now being deprived of the things that are most enjoyable to her, her sports and leisure activities. This example is noteworthy because it shows how the psychological concept of *motivation* can be reconceptualized as a participant's (rather than an analyst's) concern (cf. Schegloff, 1997). My analysis focuses on questions of how Angela accomplishes 'stake management',⁹ rather than going beyond the data to make inferences about her internal psychological state. Her account itself orients to the implicit rhetorical question: what possible motive could she have to give up all the things that would make her life more enjoyable?

Discussion

Tales of frenetic lifestyles prior to ME/CFS (and many other kinds of disabling illnesses) are common themes in literature where researchers have collected illness narratives (e.g. Charmaz, 1983; Kleinman, 1988; Robinson, 1990; Ware, 1992). The type of business that such descriptions perform is clearly dependent on the interactional situation, the kind of illness they suffer, and the precise nature of the concerns that are at stake for participants. One of the discursive functions performed by the 'before and after' story in Angela and Joe's narrative is to do the contrastive accounting business that makes relevant a physical rather than a psychological illness attribution. In the context of a story about a life blighted by illness, the construction of Angela's pre-ME identity does the work of providing adequate grounds to dismiss a possible psychosomatic explanation. Another function of these kinds of accounts is to 'script up' the individual case as a recognizable instance of a more general pattern (Garfinkel, 1967). It is constructed as a 'typical ME story' since being

typical is what constructs her symptoms as ME in the first place.

In previous research on ME/CFS, illness narratives such as this one have been taken at face value and participants' tales of hyperactive people and frenetic lifestyles have been used as documentary evidence for an analysts' theoretical interpretation of the causes or social meaning of the illness. For example, Norma Ware (1992) used tales of frenetic lifestyles in CFS narratives as evidence to explain the profound fatigue of CFS as a symptom that is meaningful in the context of a highly stressful existence in the 20th century. She claimed that CFS allows sufferers to 'opt-out' of previous frenetic lifestyles and adopt a less stressful pace. However, if we treat such accounts as more or less accurate representations of reality we overlook the complex discursive work that is well designed to dismiss *precisely* such motive explanations. It is indeed paradoxical that frenetic lifestyle accounts, designed to counter accusations of malingering, can implicate sufferers in yet a *further* range of discreditable interpretations about the nature and cause of their illnesses. If we overlook the work that participants do to manage such dilemmas, we are in danger of treating their stories as disingenuous. In a discussion of Ware's (1993) paper, Simon Wessely made the important point that 'face value' interpretations of sufferers accounts had reinforced an unhelpful 1980s media stereotype of 'yuppie flu' as a self-inflicted illness of the young, upwardly mobile. However, he went on to give his own 'motive' account to explain why and how people try to avoid the stigma of psychological illness by persuading others that their illness is physical: 'I wonder if these people were emphasising these aspects of their lives to prove to you how physically and psychologically robust they were before they became ill . . . they are emphasising a point rather than giving a true description' (Wessely, 1993, in Ware, 1993: 77). Although Wessely is right to take account of the issues that are at stake for CFS sufferers, his argument entails a form of ontological gerrymandering (Woolgar & Pawluch, 1985); it is based on a realist assumption that there might be a more accurate 'true description' existing beyond the constructed version. This paradox—that I have referred to above as 'treating their stories as disingenuous'—is also at the root of

Riessman's concerns that she might be heard as making a 'cynical analysis' of her participant's story. Clearly, none of us would want to treat participants in such a dismissive way.

In this article, I have used the topic of ME/CFS as a forum to explore how the approach of discursive psychology can make a general contribution to the analysis of illness narratives. Although there is much more that could have been said about each of these data extracts, I have tried to give some idea of what is likely to be overlooked by non-discursive analyses especially as this relates to storied descriptions, attributions and the scripting up of narrative identities. Given that all kinds of research in health psychology rely on verbal reports of one kind and another, it would be useful to consider how a discursive psychology approach can *respecify* the focus of investigation. Language is treated as a form of social action rather than as a representational system (see endnote 1). From this view, accounts are *always* constructions; there are no exceptions to this that might be treated as a bottom line 'true description' (Edwards, Ashmore & Potter, 1995). Where participants themselves have oriented to the Scylla and Charybdis of 'fighting the illness' or 'resting appropriately', such narratives have previously been used as face-value grounds for constructing 'opt-out' or 'burnout' theories of ME/CFS (e.g. Ware, 1992, 1993). In my view, people's narratives should be treated as more complex and *situated* discursive productions, taking seriously the dilemmas that are 'at stake' in talking about illness. I have tried to show how Angela and Joe have constructed an illness narrative in which issues of stake and personal responsibility are related to concerns about the cause of ME, its management, and the status of sufferers. Identities are constructed in situ to support an attributional story that manages such delicate business. This is not only a feature of research interviews and clinical consultations, but it is also an important aspect of the practical management of interactional accountability that is part of the everyday experience of sick people. Therefore, the content of illness narratives should be treated as related to participants' interactional concerns rather than being appropriated by analysts as the grounds for their own 'motive accounts' or attributional theories about the causes of ME/CFS.

Notes

1. Edwards (1997) refers to discursive psychology as a 'type three' analysis and contrasts it with 'type one' and 'type two' analyses which both assume some kind of prior reality existing independently of our descriptive practices. These can be either external realities 'out there' in the world, or else cognitive perceptual representations that are said to inform our narrative accounts. Edwards has referred to cognitivism as 'a perspective that reduces all of psychological life, including discourse and social interaction, to the workings of cognitive, or even computational, mental processes' and which is 'currently psychology's dominant theoretical and methodological perspective' (Edwards, 1997, p. 19).
2. In a paper presented to the 1994 Conference of the British Psychological Society Special Group in Health Psychology, Wendy Stainton-Rogers positions her own research in the arena of 'macro-discourse analysis' based on the work of Foucault (1970). She points out that 'The approach is less concerned with what individuals say in particular settings than with the way discourse operates as a social and cultural resource. Thus rather than a fine-grained analysis of, say, segments of conversation, the methods used are more taxonomic, seeking to identify and describe, for any particular topic or issue, what are the main discourses in play' (Stainton-Rogers, 1994).
3. For a discussion of grounding analysis in 'observable features of participants' talk and conduct' rather than being prompted by analysts' prior theoretical or sociocultural concerns see Schegloff (1997). Participant concerns are those that are at issue in the talk itself, either as the topic of talk, or oriented to by participants as relevant.
4. The line numbering of extracts in this article follow the trajectory of the illness narrative as it occurred in the interview.
5. The term 'script' is used in cognitive psychology to describe mental representations that are ongoingly abstracted from perceptual experience (Mandler, 1984; Schank & Abelson, 1977). This can be contrasted with a discursive psychology treatment of scripting, where events and actions can be described as 'instances of some general pattern, or as anomalies or exceptions' (Edwards, 1997, p. 144).
6. Jocelyn Cornwell (1984) has described this interweaving of event description and causal attribution. However, she distinguished between 'public' and 'private' accounts arguing that her respondents were more likely to be concerned with moral accountability in 'public' accounts when questioned by an 'expert'. She claimed that

'private' accounts are characteristic of a more informal interviewer–respondent relationship in which the respondent takes more control and moral accountabilities are likely to fade into the background. I have found no such distinction between 'public' and 'private' accounts in my data. The management of accountabilities is a robust characteristic of all kinds of interactional talk.

7. Compare this with the diagnostic case constructions of medical practitioners on the same topic (see Horton-Salway, 1998).
8. See for example, Edwards (1997) analysis of couple-counselling talk, where participants 'Connie' and 'Jimmy' script up each others actions as being typical and dispositional. Connie builds up an account of Jimmy's 'jealousy' by describing his actions as an enduring feature of his disposition. In Jimmy's account, Connie's actions are constructed as habitually 'flirtatious'. This scripting up of identities is designed to manage issues of blame and accountability in the context of talk about the breakdown of a relationship.
9. One of the concerns that participants attend to in constructing their version of events is that their description might be contested on the grounds that they have 'an axe to grind'. They attend to this possibility by means of a discursive device that Jonathan Potter (1996) has termed 'stake inoculation', which works to dismiss any suggestion that the speaker might have a vested interest in constructing one version of events rather than another.

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