Stories in Action and the Dialogic Management of Identities: Storytelling in Transplant Support Group Meetings

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In this article, I examine the practice of storytelling in a transplant support group, investigating how individuals' participation in storytelling activities allowed them to coconstruct collective and individual identities. The sequential ordering and contexts of the storytelling activities in the support group meetings suggest that both the speakers and audience strategically negotiated the meanings of stories as well as identities that emerged. Both the storytellers and the audience incorporated storytelling activities into the management of multiple goals (e.g., identity management, uncertainty management, and communicative efficacy). I conclude with a conceptual framework that outlines the practice of dialogic management of identities through storytelling activities by individuals with chronic illness.

Recent developments in medical sociology, medical anthropology, and health communication highlight researchers' interest in illness narratives, an area that constitutes one of the most significant analytic perspectives for research on health and medicine (Atkinson, 1997). With the increasing volume of research on the narratives of individuals with illness, researchers have begun to examine the methods and claims of studies on personal narratives (Atkinson, 1997; Bury, 2001; Waitzkin, 1990). Atkin-

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son argued that many researchers have developed a romantic view of narratives that is stripped of social contexts and social consequences. Atkinson (1997) urged, "We need to put narrative in its place, therefore, by approaching it in the context of the multiple modes of performance, of ordering, of remembering, [and] of interacting" (p. 343).

This article is a response to such theoretical and methodological reflections. I examine elements that are brought into social contexts for identity construction and negotiation by individuals with chronic illness in support group meetings, focusing particularly on the practice of storytelling. The goals of this study included (a) to understand how patients manage identities through storytelling and (b) to examine the meanings of stories and the identities that emerge through ongoing interactions. I begin with a review of research on illness narratives, followed by a critique of the current research agenda. I use data to demonstrate the various ways that identities can emerge in storytelling events in support group meetings. Finally, I propose a conceptual framework to examine the dialogic management of identities in naturalistic settings.

STORIES, ILLNESS EVENTS, AND IDENTITY CONSTRUCTION

Researchers have long been fascinated by the revelation of personal experiences in which the speaking voice is presented as a unique and privileged locus of character and experience (Atkinson, 1997). Past research has suggested three characteristics of storytelling events that are essential to individuals' adjustment to illness. First, stories provide an alternative reality that allows storytellers to establish coherence and meaning in their experiences (Miller, Hengst, Alexander, & Sperry, 2000). Intrusive illness challenges individuals' taken-for-granted lives and forces them to reevaluate and to reformulate their roles and identities (Becker, 1997; Charmaz, 1994; Corbin & Strauss, 1987; Leventhal, Idler, & Leventhal, 1999; Maines, 1983). Research on illness narratives has suggested that patients often use stories to develop a coherent self, to make sense of their experiences, and to empower their existence (Charmaz, 1991, 1999a; Frank, 1995, 1997; Kleinman, 1988). More important, illness narratives enriched with suffering and moral values allow patients to create a believable self that is based

on a meaningful past and that extends to a projected future (Charmaz, 1999b; Maines, 1991).

Second, stories are essential tools for coping in patients' illness experiences. Researchers have shown that individuals use stories to educate novices about socially valued attributes and social rules (e.g., Brown, 1985; Miller, Wiley, Fung, & Liang, 1997), both of which can be important resources in coping with illness (Crandon-Malamud, 1991). Stories also provide individuals access to other important resources (e.g., social support, information, and hope) to cope with illness (Chelf, Deshler, Hillman, & Durazo-Arvizu, 2000; Roberts et al., 1999; Steffen, 1997). Researchers have found that in support groups, stories allow *both the speaker and the audience* to actively cope with illness, to express feelings to a receptive group, to seek validation and affirmation, to gain and exchange information, and to reflect and reconstruct their new identities (Banks-Wallace, 1998; Dickerson, Posluszny, & Kennedy, 2000).

Third, the interactive nature of storytelling allows both the storytellers and their audience to negotiate the meanings of the stories and the identities that emerge. Researchers have demonstrated that stories told in conversation are interactively constructed. Stories are triggered by, introduced into, and responded to through ongoing conversations between various participants, each of whom has specific responsibilities in turn-by-turn talk (C. Goodwin, 1984; Jefferson, 1978; Sacks, Schegloff, & Jefferson, 1974). The interaction between participants influences the meaning of the story and the identities of the individuals involved (Mandelbaum, 1987, 1989, 1993; Ryave, 1978). The coconstruction of storytelling events presents special challenges to a storyteller. If a story is not considered believable, for example, the audience may interrupt the storytelling process, challenge the meaning of the story, or disavow the speaker's right to tell the story (Maines, 1984, 1991); consequently, storytellers constantly are reminded that their stories are subject to others' evaluation (Bauman, 1986; Goffman, 1961).

These three characteristics of stories highlight the significance of storytelling in individuals' illness experiences; however, researchers have not fully appreciated the complexity of storytelling and its analysis. Past research on illness narratives has centered on the patients' subjective account of illness experiences collected through researcher-guided interviews (e.g., Charmaz, 1991; Frank, 1995; Kleinman, 1988). Researchers have developed theoretical frameworks (e.g., categories of illness narratives) by combining patients' stories with analysis of temporal orientation, ethics, ontol-

ogy, and spirituality (Davies, 1997; Ezzy, 2000; Frank, 1995). These studies have provided significant insights into patients' subjective framing of their illness events; however, researcher-guided interview data cannot account for the dynamic negotiations of (illness) identities and stories that individuals with chronic illness engage in everyday life.

In researcher-guided interviews, the participants' narratives inevitably center on their illness and suffering, which often are accepted without questions or challenges. An interviewee is granted creative license, a captive audience, and legitimacy and significance of his or her role and identity. In addition, a researcher often is expected to respond to these personal narratives with neutrality, demonstrating minimal emotions and reactions. In everyday life, however, a story is told with approvals, challenges, and even social sanctions from its audience (Goffman, 1961; Maines, 1991). Whereas an illness identity may still be salient, a patient may strategically construct his or her illness experiences and other identities to meet different communicative goals (e.g., empowerment or help seeking). Illness narratives solicited through researcher-guided interviews lack the complexity of the social contexts that are significant to storytellers and their audience's coordinated production, interpretation, and evaluation of storytelling events.

Several researchers who study illness narratives (e.g., Charmaz, 2002; Frank, 1998; Riessman, 1990) recently have pointed to the significance of interactions and social contexts to patients' stories and identities. Their data and methods (i.e., researcher-guided interviews), however, do not allow them to examine the dynamic and often strategic negotiations between storytellers and their audience in everyday life. For example, Riessman (1990) discussed the strategic use of illness narratives, but her method (i.e., the interviewer–interviewee format) provided the interviewee much more legitimate ground for storytelling and identity construction than a person would have had in everyday life. Frank (2000) argued that a narrator creates a dialogical narrative that is strategic and political by including the voices of others; however, he used the term *dialogical* in a Bakhtinian sense (i.e., a narrative that incorporates multiple points of view to achieve a moral status). Frank's (2000) analysis centered on a storyteller's perspective, a one person *internalized* point of view, instead of the actual interactive exchanges between participants of storytelling events. Charmaz (1999a) urged researchers to situate an illness narrative within its social fabric and temporal order. Charmaz's (1999a) work, nevertheless, focused on the larger sociocultural and socioeconomic contexts rather than on moment to moment emergent interactions between various individuals.

Researchers in other areas (e.g., sociology and conversation analysis) have contributed greatly to our understanding of storytelling activities in naturalistic settings. For example, researchers have noted that storytelling sequences may be consequential to individuals' construction of social identities. M. H. Goodwin (1982, 1993) has explored how the sequential development of a storytelling event is meaningful to individuals' enactment of social identities. Through the coconstruction of stories, the participants in a storytelling event can create competing versions of reality (Mandelbaum, 1993), enact relationships and identities (Mandelbaum, 1987, 1989), display shared knowledge and alignment (M. H. Goodwin, 1993; Lerner, 1992), demonstrate their understanding of the ongoing conversations (Jefferson, 1978; Ryave, 1978), and accomplish coordinated tasks (Eggly, 2002; Mattingly, 1994). Maines (1984, 1991) presented convincing arguments about how a storyteller's illness narratives can be challenged by and negotiated between fellow participants in self-help group meetings. These research findings highlight the complexity of storytelling activities and point to the tremendous potential for future development of research on illness narratives.

This study advances past research on illness narratives by investigating identity construction and negotiation in naturalistic settings. In this article, support group meetings are understood as a social environment that allows participants to develop communicative contexts (e.g., supportive or educational interactions). The participants' identity as individuals involved in a life-changing illness event is just one of many that can be claimed in their interactions. By examining patients' storytelling practices, researchers can investigate "the active process of negotiation in which participants reflexively examine the discourse as it is emerging, embedding assessments of its structure and significance in the speech itself" (Bauman & Briggs, 1990, p. 69). From this perspective, identities are not fixed objects that exist before an interaction; rather, they are shaped by emergent communicative contexts and are negotiated between participants of a storytelling event (Antaki & Widdicombe, 1998).

There are several reasons why support groups are a particularly useful context for researchers to investigate *how illness stories and identities are produced, evaluated, and negotiated in naturalistic settings and how these processes help individuals to cope with illness.* First, researchers have found that personal narratives are a prevalent and essential theme of support group interactions that help individuals to cope with illness (Banks-Wallace, 1998; Chelf et al., 2000; Dickerson et al., 2000). Second, the

shared experiences of participants and the helping characteristics of support groups allow individuals to participate in the coconstruction and negotiation of stories and identities (Dickerson et al., 2000; Roberts et al., 1999). Third, personal narratives in support groups may serve other pragmatic functions (e.g., argument and encouragement) that are important to the meaning of the narratives and the participants' identity construction (M. H. Goodwin, 1993; Mandelbaum, 1987). The dynamic interactions between support group participants allow researchers to investigate how individuals shape their illness narratives and identities in response to others' comments in ongoing conversations.

This study goes beyond past literature on storytelling in support group settings by exploring the process of storytelling and its implications for identity construction. Many researchers (e.g., Chelf et al., 2000; Dickerson et al., 2000) have validated the importance of stories in support groups; however, their methods (i.e., surveys and group interviews) failed to exemplify *how* individuals can strategically use stories to construct and negotiate their identities. Although Maines (1984, 1991) has demonstrated that stories can be challenged by and negotiated between support group participants, he has not examined how the process becomes consequential to individuals' identity construction and adjustment to illness. By observing the interplay of stories (e.g., story soliciting, swapping, and competing) between various participants in support group meetings, in this study I demonstrate how the sequential placement in a conversation and the dramatic portrayal of self in stories is meaningful to identity construction and negotiation for individuals with chronic illness.

METHOD

Participants

The transplant support group, located in a medium-sized Midwestern city, holds monthly meetings that generally last 1.5 to 2 hr in a local hospital. Attendance at the meeting typically was around 8 to 12 people; however, the leader and the social worker of the support group estimated that there were over 50 members. In the 9-month period (October 2000 to June 2001) that I observed the support group, all meetings included at least 2 to 3 novices who were pretransplant or were transplanted within the last 2 years, 4 to 5 experienced posttransplant patients who had received a transplant at least 5 years

ago, and 2 to 3 friends or family members of the patients. In the same period, 18 members of the support group agreed to participate in this study. The mean age of participants was 45.18 (SD = 11.14). In most meetings, there was a balance of male and female transplant patients, although most participating family members and friends were female. All identifying information (e.g., names of participants, locations, and persons mentioned in the interviews) has been replaced with pseudonyms.

Although the meeting was always held in a local hospital, its participants were not necessarily patients of that hospital. The members of the support group also differed on other important aspects. First, the participants had varied experiences with organ transplantation. Some participants were friends or family members of the patients; some were in the process of deciding whether to receive a transplant; some just started their pretransplant treatment; some had received a transplant over a decade ago; some had gone through more than one transplant; and some had received organs from cadavers, whereas others had received organs from their living family members (i.e., live transplant). Although most patients are kidney transplant recipients, other types of transplant recipients (e.g., heart and liver) also attended the meeting. Second, the patients of the support group have had different experiences with chronic illnesses. Most patients reported that they have experienced other chronic illness (e.g., diabetes, kidney disease, asthma, stroke, hepatic fibrosis, and cholangitis) for periods of time ranging from 5 to 36 years. Finally, the patients received or planned to receive their transplants in different facilities, mostly located in Midwestern states. It was not uncommon for a participant to drive over an hour to participate in the meeting. In short, the support group is a diverse collection of individuals.

Procedure

Nine support group meetings were observed in two stages from October 2000 to June 2001. In the first stage of this study (from October 2000 to December 2000), support group observation allowed me to be introduced and accepted by the group, to immerse in the culture of a community that is established for specific purposes (e.g., providing social support), and to observe the subtle communication techniques used in socialization process. Therefore, in the first 3 months, I used only field notes to document the socialization process. Beginning in January 2001, as the participants became

more comfortable with my presence, I audio recorded and transcribed the conversation that took place in addition to taking field notes, which includes information that cannot be audio recorded (e.g., nonverbal behaviors and late arrivals of participants during a meeting). Because it was not feasible to record everyone's nonverbal behaviors, I only took notes on the nonverbal behaviors of the current speaker and of the participants who may have behaviors (e.g., dramatic facial expressions) that made them stand out from others. It is possible that many subtle nonverbal behaviors were not collected as data; nevertheless, the audio data combined with my field notes are sufficient to demonstrate the dynamics of group interactions. I remained an observer of the meeting rather than a participant throughout the process. More specifically, I only participated in the roundtable self-introduction, a routine activity at the beginning of every meeting, and did not participate in the group discussions afterwards.

Data Analysis

I used grounded theory in the development of research themes (Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1994). Grounded theory is essentially a constant comparative analysis because it focuses on the interplay of data collection, analysis, and theory development (Potter, 1996). Grounded theory as a research method puts emphasis on theory development, develops theory that is grounded in data systematically gathered and analyzed, and strives toward verification of its hypotheses throughout the course of a research project (Strauss & Corbin, 1994). Because my objective was to generate a theory on the dialogic management of identity through storytelling activities, grounded theory provided a clear guideline for the procedures.

A research assistant and I reviewed the transcripts of the support group meeting. We independently identified each storytelling event, including the triggers of the storytelling activity and the responses and evaluations of the story. We then compared the cases identified and discussed differences between our analyses. If one of us was not able to convince the other about the trigger(s), body, or responses of a storytelling event, the particular case was dropped from the final analysis. Finally, with an identical set of cases, we examined the functions of the storytelling events (i.e., how the storytelling process influences the dialogic management of identities) independently and developed the final categories of the identity construction and negotiation together. It is important to point out that the themes were not chosen

because of their perceived importance or frequency in the support group meetings. Rather, the excerpts were chosen because they best illustrate the process of identity construction and negotiation in the emergent interactions of storytelling events.

Despite the fact that the methodological approach (i.e., grounded theory) chosen for this study is well developed, the unit of analysis remained a complicated issue. Many researchers have used stories of personal experiences as units of analysis in their studies on identity construction (e.g., Brashers et al., 2000; Charmaz, 1991, 1994, 1995; Goldsmith, 2001). Although that approach provides insights into individuals' interpretations of topics, few researchers have acknowledged the fact that these interpretations were not what is "out there" but were jointly produced by the interviewer and the interviewee (Briggs, 1986).

In ordinary conversations, a story is constructed as a response to what the conversational partners said earlier and is shaped moment by moment by their response as well as the speaker's anticipation of later responses (Miller et al., 2000). When analyzing a series of stories as a conversational achievement, Ryave (1978) noted that

> The sorts of relationships that exist between the two stories extend well beyond the simple matter of sequential adjacency. … The relations displayed between the two stories are not capricious and happenstance, but are instead the products of the conversational participants' attention and careful management. (pp. 120–121)

From this perspective, a storytelling event can be composed by the immediately preceding utterances, any interactions, and all directly responding utterances of *one* story as well as the *series* of stories that are triggered by and introduced into the storytelling event.

Therefore, in this study, the unit of analysis for storytelling cannot be the disembodied text and formal features of a single story alone because such an approach would fail to account for the dialogic, functional, and performative perspectives of storytelling events (Bauman, 1986; Frank, 1995; Miller et al., 2000). To account for these perspectives, the unit of analysis for storytelling must be extended beyond the story itself to include the utterances before and after the story. In determining the unit of the analysis for this article, I struggled to provide a large picture of the storytelling episodes without being constrained to the structure of stories. Although conversation analysts have provided detailed analysis of the components and sequences of a single story (e.g., C. Goodwin, 1984; Jefferson, 1978), a

storytelling event is much more complicated. For example, when six stories are produced one after another in a 20-min period, all sharing similar story structures and moral lessons, these six stories need to be understood as a single storytelling event, what Ryave (1978) defined as a *cluster* of stories. When a story preface failed to elicit the audience's reciprocated stories the first time but succeeded the second time (30 min later), I treated the first introduction as the beginning of a storytelling episode and examined the reasons for the audience's different responses. As a result, the unit of analysis in this study cannot be neatly identified as stories that have clear beginnings and endings. Rather, the unit of analysis was storytelling events, including all utterances related to the particular storytelling event (e.g., how an utterance triggers, sidetracks, challenges, or complements the storytelling). In other words, my analysis may include a story, a question, a response, a comment, or feedback. Although the structural features of these units differ, the functional nature of these units was the same (i.e., they were produced in relation to a particular storytelling event).

RESULTS AND DISCUSSION

Past research has demonstrated that storytelling plays an important role in patients' illness experiences and identity construction (Charmaz, 1999a, 1999b; Dickerson et al., 2000; Frank, 1995). The stories in the support group meetings, despite the fact that they were still about personal interpretations of illness experience and identities, functioned in much more complicated ways. At times they were used as a socializing tactic, a call for help, a self-image booster, or an argument, all of which confirm the recent emphasis on the interactive and dynamic nature of storytelling activities. My analysis of this study centers on the identity construction and negotiation through storytelling between participants of a transplant support group who are all in one way or another involved in an illness event. The themes exemplify the emergence and negotiation of identities in storytelling events. These categories are not mutually exclusive.

Identity Socialization

Polanyi (1985) suggested that stories are told to make a point, which is "often some sort of moral evaluation or implied critical judgment" (p. 12).

This is particularly true for individuals involved in illness events because those narratives are essentially struggles and claims for moral righteousness for both the story and the storyteller (Charmaz, 1999b; Frank, 1995). The following example can be examined from several perspectives, which lead to different points and moral claims on the storytellers' identities (e.g., empowered individuals, companionate fellow patients, or survivors of hardship). For example, the participants of the support group (a) socialized each other with valued behaviors and identities in illness events, (b) affirmed each other's illness experiences, and (c) educated each other about patient empowerment by providing stories that illustrate a similar or shared concept.

In this particular sequence, several speakers contributed a total of *six* stories, all of which provided an explicit statement of the *moral of the story* at the end of each story. The similarities in the structures (e.g., formulaic closings), the underlying themes (e.g., having an advocate in health care settings), and the close proximity of the stories (e.g., six stories introduced into the conversation one after another) showed that this is a cluster of stories in *one* storytelling event. As new stories were added into the cluster, the meanings of stories changed and patient identity shifted from disempowered to empowered. The storytelling sequence was first initiated by Yvonne (Y), a sister of a kidney transplant patient who recently had a stroke. She initiated the discussion by revealing a recent experience:

Extract 1

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11   Y: Well (.), I have a little something to share regarding to
12   Bi:ll. (.2) uhh ((cough)) uhh in his situa:tion, uhh he had a
13   severe brain stem stroke. (.5) and uhh (.) he was here at [name
14   of hospital] and they let him become dehy:drated. (1.0) A:nd uhh
15   so he was hospitali:zed because that was very ha:rd on the
16   kidney.
17   ?: =mmm
18   Y: =(.5) And uhh his blood sugar shot up to 700↑.
19   V (Victor): =hhhh [oh, m:y].
20   Y:                 [And (.2)] uhh- (.2) So, it was really pu:re neglect.
21   (1.0) 21And of course-, he was in a situation where he couldn't
22   communicate.
23   B (Bob): =Yeah.
24   (.)
25   Y: And (.) so, (.5) be sure to have your fa:mily me:mbers or
26   whoever your advocate is on top of a::ll situations and question
27   e:very ste:p of the way. Because thi::ngs ha:ppe:n and uhh- They
28   said <he was not going to make it>.
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In essence, although this is a story about Bill's misfortune in the hospital, the story was also understood by participants as emphasizing the importance of taking charge in medical-related events. Other members of the support group started to contribute various stories to support this point. For example, another patient, Laura (L) commented the following:

Extract 2

    31   L: I think that happens not o:nly like here though.
    32   Y: = wha-
    33   L: = At [name of hospital], I had the sa:me thi:ng.
    34   Y: = Oh, I th[ink this has-]
    35   L: [I ha:d blood clots]. They were suppose to–
    36   nurse comes in- (.) one comes in- You know, [you ge]t s::o many
    37   different ones coming and going,
    38   Y: [Ye:ah.]
    39   L: I don't know what they are do:ing.
    40   V: =Yap.
    41   A (Ann): =Yeah.
    42   L: Luckily, my mom was the:re. so, you have to have somebody on
    43   top of it and b:e there. (.5) It's like- (.) you've got to baby-
    44   sit. (.5) You know. (.2) Make sure the nurse does the right
    45   thing.

In the narrative thus far, the storytelling activity was done in a complementary manner. Different individuals provided similar personal experiences that illustrate the importance of having an advocate in illness events. These speakers were not just talking about their illness experiences in the past. The content and the structure of the concluding remarks were similar to each other (e.g., lines 25–27 in Extract 1 and lines 42–43 in Extract 2). These directives were to advise or persuade others to have an advocate at all times, which were the points of the stories. Ryave (1978) categorized this type of storytelling sequence as a *Type 1 procedure,* which involves a succeeding storyteller utilizing the same significance statement of a preceding story to construct his or her own recounting and to achieve the series of stories relation. By utilizing the Type 1 procedure, "a succeeding storyteller can show, in and through his [or her] story, that and how they understand, support, sympathize, and agree with the preceding story" (Ryave, 1978, p. 128).

Subsequently, Mary (M), a liver transplant patient, followed the preceding stories told by other patients with a different point. The moral of the

story shifted from having a family member as an advocate to taking charge as a patient. She commented the following:

Extract 3

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51   M: One of the things that really he:lp(ed) me in my situation was
52   that I chronicled e:verything that happened e:veryday. (.5)
53   And I put down wh::o was the nurse (.)and wh:o was the
54   technician. (.) Anything that ha:ppened. And there were some
55   occasions they ha:d to come to me (.)and ask me some
56   information cause they didn't remember whether or not they
57   ha:d done something. But I ha:d it recorded. They would come-
58   and say, "look, what was the count on tha:t?"
59   K (Kevin): =ha.
60   M: And I had it written ri:ght there. (.) [You   ] know, what it wa:s.
61   K:                                         [mmm]
62   V: Sure
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Mary then continues for 26 lines, expanding on her theme of being actively involved in one's own care by keeping a record of her medical treatment and the names of those providing it. Mary concludes her stories with formats similar to prior stories and other participants respond, affiliating with this idea, with one offering their own brief story:

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90    M: [...] When I needed the information, I still have it now. With everything that
91    happened,(.2) it's very important. (.) So, when I couldn't
92    remember then, I have stuff for my fa:mily members or whomever
93    or my friends can take a look at it and see what happened.
94    (2.5)
95    ?: good idea. Very good idea.
96    A: Yeah.
97    Y: I had a little notepad and I wrote e:verything. (.5) I felt
98    like I was (.) in the lala land. and I wasn't the pa:tient. He
99    was, I mean- I was- you know, I didn't have the anesthetic and
100   a:ll that. (.) but I am still- you know, all the days start
101   ru:nning together and things like tha:t.
102   M: And with all the medication, you don't know- sometime,
103   sometimes what's reality and what's (.) no:t.
104   J (John): True.
105   (.2)
106   M: But if you got it wri:tten down. Then you know you'd be sure.
107   Be certain.
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These stories were told in response to what was going on in the support group meeting, and often the moral of the story was reinforced in its ending. "Be sure to have your family members or whoever your advocate is on top of all situations and question every step of the way" (lines 25–27). "Luckily, my mom was there, so, you have to have somebody on top of it and be there" (lines 42–43). "When I needed the information, I still have it now. With everything that happened, it's very important" (lines 90–91). These conclusions were used to reinforce the specific steps individuals can adopt to ensure the quality of their health care services. These comments were reflections and metacommunications that were incorporated to reinforce the lessons embedded in these stories.

More important, the shift of the moral of the story event (i.e., from having an advocate to taking charge as a patient) is significant at several levels. First, at a personal level, Mary created a patient identity that is more independent and empowered than the patient identities depicted in the preceding stories. In the earlier stories, patients were portrayed as individuals that are passive, powerless, and dependent on others; however, in her story, Mary did not adopt the identity of a passive or powerless person who needs to be taken care of but a responsible patient who is actively involved in negotiating and maintaining her health care. Second, at an interactional level, the interactively constructed and performed stories allow both the storytellers and other participants to identify valued identities (M. H. Goodwin, 1993). From this perspective, "socialization is an interactive process between knowledgeable members and novices … who are themselves active contributors to the meanings and outcomes of interactions with others. Socialization is a product of interaction. It is constructed by participants" (Schieffelin, 1990, p. 17). Mary's story about her empowered patient identity provided other participants with opportunities to learn the skills to be self-advocates (e.g., note taking), a valued self-presentation. In addition, the subsequent story (lines 97–101) from another patient's family member supported not only Mary's ideas about empowerment skills (i.e., the family member also took notes on everything) but also the valued empowered patient identities. The subsequent story attributed the patients' powerlessness not to their spoiled identities but to the external environment (e.g., an overwhelming treatment process and medications; i.e., even a competent healthy individual may be overwhelmed by the event). These two stories, together, portrayed a patient identity that is much more empowered, independent, and valued.

Finally, Mary's story *altered* the meaning of stories told earlier. Ryave (1978) used the term *Type 2 procedure* to categorize the stories that supply

listeners with a new sense of what the preceding stories are actually about. Mary's story provided new meaning to the earlier stories: The moral of those stories was to be empowered as a patient whether by having an advocate or by taking charge of their illness events. The shift in the meaning of the stories also presented a major change in patient identity, redefining the patient identity portrayed in earlier stories. In summary, the sequential placement of the series of stories allows succeeding storytellers to develop contexts to validate, to challenge, or to redefine meanings by their (non)alignment to the interpretive framework of those previous stories.

Search for Individual Identities

Readers may have noticed that in addition to the similarities in the morals of the stories in the preceding example, another interesting feature was the readiness of the support group participants to share their parallel experiences. The participants of a support group are homogeneous in certain aspects (e.g., sharing similar experiences such as organ failure and depression) and that allows them to relate to each other better (as opposed to nondiseased others). Mary, who had to go through a second liver transplant after the first one failed, commented that "It's hard to explain it to anyone else or to imagine what the person goes through." The shared experiences of organ transplantation allowed the participants to be more understanding and empathetic than others who did not share the experience.

Despite the fact that the participants have comparable experiences with organ transplantation, the parallel stories were understood and interpreted distinctively by different individuals. To both the speaker and the audience, stories were not only about their shared experiences but also about who they were as a patient, a distinct individual. A good example to demonstrate a participant's effort to understand his or her distinct status as a patient was the sidetracked conversation during a storytelling sequence that was introduced by Mary. After a more experienced patient asked how often she visits hospital, Mary replied the following:

Extract 4

111 A: How often do you go back?
112 M: Once a month. (.) One of the things that I experienced quite a
113 bit ea:rly is a lo:t of chest pai::n, going down my a:rm, joint
114 pai:n and a:ll of that↑. They tell me that it might be (.2) uhh

115   side effects of Neosporine cyclosprone.
116   J: =Probably.
117   M: They do <u>heart</u> test(s) on me all the time.

In this brief narrative, Mary strayed from the requested information and introduced her uncertainty about the pain as side effects she experienced. Her vocal performance (i.e., the stretching of sounds when describing the pain she experienced) showed that she was especially concerned about the side effects (i.e., chest and joint pain). Instead of sharing parallel stories of side effects, other participants requested more factual information regarding Mary's drug regimen. The questions that followed were "What are you taking, do you take Cyclosporine or Neoral?" "How much do you take?" "Once a day or twice a day?" Then, rather than shifting back to Mary's concern for her side effects, other participants commented on the drug regimens they have such as "That's what I am taking, 175 mg twice a day," or "I am taking 100 twice a day and I was way up there. Now I am way down there."

Mary's side effect story, in fact, led to other participants' interest in John's drug regimen, who was 8 years post-transplant, when he stated, "I haven't changed my medication in the last four and half years." Details of his medication were requested: "How much Prednisone do you take?" "Take anything else?" "What size do you take?" "Do you take capsule or pill?" Answers to these questions were followed by other participants' self-report of their drug regimens. After the long discussions, one patient concluded, "Some of us take Cellcept, some of us take Neoral, and some of us take Cyclosporine."

Was Mary's story wasted then? After all, her concerns were not addressed and the sidetrack from the story led to discussions about individuals' drug regimens. In fact, Mary had to reintroduce the same topic later for a second time after almost 30 min, during which time several different topics (e.g., new information on medication, meeting with a donor family, and pretransplant anxiety) had been discussed. During the last 10 min before Mary's reintroduction of her chest pain, the participants discussed concerns about weight gain, loss of eyesight, and warts as side effects caused by medication. When the participants joked about whether the increasing warts were caused by posttransplant treatments or aging, Mary interrupted the group's laughter and reintroduced concerns about her pain:

Extract 5

121   M: Uhhm (.5) One thing I want to share with you (.2) is uhh you
122   said that there was some kind of tingling↑(.) and sensation

123   that you had↑.
124   K: You are talking about your a̲rm.
125   M: O:h, yea:h. Rea:l ba:d che̲st pai:n (.2) and usually (.)
126   travels down my left arm.

It is important to note that Kevin's (K in transcript) discussion about his tingling sensation was not in the immediately previous talk (or the last 15 min of the conversation). Kevin's immediate response ("You are talking about your arm"), however, suggested that he remembered Mary's earlier attempt to introduce her concerns about the side effects that she experienced and that he recognized Mary's statement (lines 121–123) as an attempt to request responses to her earlier story. In the second try, Mary successfully reintroduced the topic, which led to extensive discussions on *pain* as side effects experienced by the other individuals. If storytelling was only about sharing experiences, why didn't other participants provide their stories about the side effects they experienced the first time the topic was introduced?

If comparable stories were shared, the participants would have had the opportunity to validate and to reaffirm their symptoms, emotions, and identities. I want to emphasize that I am not suggesting that individuals do not use stories to these ends. In fact, the success of Mary's second try showed that support group members do use stories to validate and reaffirm their experiences, developing a *collective* identity by recognizing their shared experiences as transplant patients. However, I want to point out that the "failed" or sidetracked responses after Mary's first introduction of her side effects story have other meanings and functions.

These responses helped the participants decide *how* to construct and to understand these side effect stories. The succeeding questions about Mary's drug regimen (e.g., "What are you taking, do you take Cyclosporine or Neoral?") can be viewed as the other participants' efforts to locate Mary's standing in an illness event; on the other hand, the other participant' self-report responses on their own drug regimen can be viewed as the speakers' effort to situate their identities and experiences against Mary's (i.e., a not so successful patient's) standing. The later interest in John's (i.e., a successful patient's) drug regimen served similar purposes and allowed the participants to compare themselves against successful experiences.

The side effects story was understood by the participants not only as an account of the side effects experience but also the distinctive status and identity of a transplant patient. In other words, the sidetracked responses to

Mary's story were not a failure on the part of other participants to uptake Mary's story; rather, these responses were about sharing experiences with personal interpretations. Although transplant patients share many similarities (e.g., taking similar drugs and going through similar procedures), patients still differ greatly in their recovery time, their response to certain drugs, and their uncertainty about their future outlook. Individuals' identities and experiences are incorporated into their own interpretation of the story. They locate themselves in the stories by examining the details about the experiences they seemingly share (or will share). Detailed information about other patients' treatment regimens allows patients to (a) understand the current status of their symptoms, emotions, and identities and (b) anticipate future experiences. By doing so, the participants (i.e., speakers and their audience) are able to actively construct their identities by both telling and *hearing* stories.

Authoritative Display of Identities

In earlier studies on storytelling in support groups, researchers often noted the relationship and information-enhancing aspects of storytelling (Banks-Wallace, 1998; Chelf et al., 2000; Dickerson et al., 2000). However, if support group participants treated storytelling as activities that can offer morals and construct identities, we might expect that an individual would disagree with the morals or identities presented in others' stories and use stories to make specific arguments against each other. In these situations, storytellers may strategically portray their experiences and identities to reinforce the pragmatic functions of their stories.

In the following example, Bob (B in transcript), a newcomer to the support group, explained his treatment choices before transplantation surgery. Because he needed to have dialysis before his kidney transplant, he had to make a choice of having either a vascular catheter (i.e., a temporary treatment by inserting a tube into the vein between the shoulder and the neck) or a fistula (i.e., a long-term treatment by joining a vein to an artery, usually in the upper arm or wrist, to form a bigger, stronger blood vessel) for his dialysis. He explained the following:

Extract 6

131   B: No. I told them I didn't want it [fistula] because I figured
132   the transplant was pretty soo::n and why have all that
133   permanently put i:n when I won't- hopefully won't need it.

Shortly after Bob's comment, Victor (V in transcript) stated the following:

Extract 7

141   V: uhh I got a quick story on that. uhh if you don't mind.
142   (1.0)
143   V: umm doc Johnson set me up with this fistula (1.2) and that's
144   that's all they kept telling me and and I was waitin' and waitin'
145   for kidney transplant (.5) an:d the doc said, "uhh well you jus-
146   you know you got to we got to go through this a step at a
147   ti:↑me." And I said, "okay that's fine." he said, "and the first
148   step is getting this fistula in." I said, "o:↑kay. I want a
149   transplant." he said, "°okay °okay." (.5) So in other words he
150   knew I wanted, you know, just let's get <with it> and get the so
151   anyway uhh in all his wisdom uhh he made me get the fistula in my
152   arm first. (1.2)and uhhh (.5) if that you know that's stressful
153   (.2) just going in because you don't know what a fistula was then
154   ((turn to at Phil))
155   P: °right
156   V: ((turn to Bob))you know you remember it not knowing what- what
157   you are going in for. they're operatin' on you so you can go on
158   dialysis is all you know.
159   B: yeah
160   V: and you don't know the things is gonna buzz in your arm and
161   you don't know (.8) you know (.5) a lot of a lot of things and
162   you're just scared to death anyway. (.8) so I went in an:d got
163   the thing in my arm and then he lays the heavy hand on me and he
164   said, "now I want you to go home and you do these exercise this
165   uhh person's gonna show you." And he says, "you do them right
166   because they're gonna be sticking a needle in that access and
167   you're gonna be whinin' and cryin' to me because you don't have a
168   big enough access." So went and did that. (1.0) and so uhh got
169   everything all ready to go and I still wasn't on di↑alysis I
170   said, "all right let's talk transplant." (1.2) and so you know I
171   really forced his hand at it. and got him to where he would uhh
172   we started to talkin' [name of hospital] down in [name of place]
173   and uhh I started sending things out to uhh my brother out in
174   [name of place] and uhh my other family here about gettin' uhh
175   blood mi- uhh mixed up, and matched and stuff. (.8) everything
176   was ready to go in fact uh the day I went on dialysis (1.0) umm
177   (3.2) was- was like five days before my transplant was scheduled
178   and they said, "we're gonna do this so that you can uhh clean out
179   your system and your new kidney has a better chance." (.) so you
180   know here I am with this and we might just as well use it is (.)
181   kind of the attitude. so uh we got down to Bar- I went three or
182   four times to dialysis. uhh it's good I'm glad I don't have to do

183   that (.) anymore. And went down to [name of hospital] in [name of
184   city] and my mom decided that she was gonna be the one that gave
185   me the kidney and uhh thirteen hours before the transplant [my
186   mo:m] uhh found
187   B: [((cough))]
188   V: they found in my mom a clot- clogged coratcel artery because
189   when- when you have somebody that's donating (1.0) uhh they just
190   look you over like (1.0) you know (.) nobody's business. well
191   anyway this guy was in there uhh he was a resident uhh surgeon
192   and he was (.) just practicing on my mom and he found this
193   thirteen hours before (1.2) surgery hhhhh called the surgery
194   off↑ (1.0) and I went back on dialysis. it was a darn good
195   thing I had that fistula in there and old doc Johnson knew what he was
196   talking about. (1.0) so uhhh I- you know
197   (1.2)
198   V: he's not got the best uhh manner in the world but uhhh he sure
199   knows his business and that really uhh that- that was a big help.
200   °anyway uhh I wished I'd a ( ) uhh that I don't know I don't
201   know that- that neck thing maybe it's not (1.5) does it hinder
202   (.5) bother you at all?=
203   B: =no. it did for this first week or two and I had to get used
204   to it, but- and now I don't even know it's there. I don't even-
205   most of the time I'm not even aware of it.

Although in many aspects Victor aligned himself with Bob's uncertainty about treatment choices, the sequential consequences and the main theme of the story clearly disagree with Bob's previous utterances. In addition, Victor's vivid descriptions of his experience with physicians and his anxiety about having a fistula and not having a transplant surgery not only aligned himself with Bob but also implied that, as a more experienced patient, he knew what was going on and what should be done. Bob's response after Victor's "quick" story showed that he was aware of the argument embedded in Victor's story. Soon after Victor's story, Bob commented the following:

Extract 8

211   V: because you are not getting needle sticks or nothing.
212   B: no. and I didn't I was not aware that- that [fistula would
213   hinder physical activities] would have occurr:ed. uhh the reason
214   I didn't I mean you said this goes in permanently you don't take
215   it out and this is temporary. the actual reason I pu:shed for
216   this one is I'm a musician and I played piano and guitar and I
217   was afraid that might(.) somehow hinder my ability (.) to play.

218   so I said let's go to the neck that's <u>really</u> why I did it. and he
219   said this was temporary, this was permanent. I thought well I
220   don't want to potentially harm my hands and arms let's go to the
221   neck. so that's really <u>why</u> I did it.
222   V: yeah w[ell it]
223   B: [mo-] more for <u>that</u> reason.

Bob's repeated emphases of "the reason" (line 213), "the actual rea-
son" (line 215), "that's really why I did it" (line 218), "that's really why I
did it" (line 221), and "more for that reason" (line 223) showed that Bob did
not simply treat Victor's story as an account of past events. Rather, Bob
treated Victor's story as an argument that was made to oppose his choice of
treatment and that required his immediate response. In addition, as Bob
presented a "counterargument," he actually *retold* his story, establishing an
alternative reason for his choice. In fact, in the second story, he presented a
different patient identity. Bob's identity as a novice patient experiencing
uncertainty in the first story (lines 131–133) was changed in the story he
retold to the same audience (lines 212–223) in which he became a fellow
patient who was an assertive musician and chose a treatment option that
best fit his career. The shift in patient identity allowed Bob to change his
relationships with other patients, replacing a novice identity that may
require guidance from more experienced patients with a fellow patient
identity (i.e., equal status with others). The second story provided Bob
more authority in his choice of treatment and thus increased the argumenta-
tive force of his story. Other participants accepted Bob's reasoning and
used stories to support Bob's argument. For example, Ron (R) said the
following:

Extract 9

231   R: [I think my hand] (grow) a little <u>weaker</u> sometimes. I have my
232   fistula. I don't think that hand, it doesn't have the endurance
233   it did before.
234   A: but the- the problem with this is just the risk of infection.
235   K: yeah. you see I've done both. I- I got a fistula November
236   eighty nine mine still works I was on dialysis for five years
237   before I got a transplant. uhh[h
238   R: [mine is all clogged up. is
239   yours clogged up?
240   V: oh:: yeah yeah mine is gone.=
241   K: =but u[hh]
242   R: [do]es yours hurt when it clogged up?

243   K: n:o no
244   R: (mime I mean) it was terrible it was the pain was so bad I
245   couldn't shake my arm. if I'd just move my arm it would hh it
246   hurt o:h I mean it was ba:d. I was about ready to <u>cr:y</u>.
247   (1.2)
248   R: and it lasted for a couple of weeks like that. then it's okay
249   now.
250   (.)
251   V: good.

The elaborate details of the stories enabled the storytellers to construct their identities *and* to strengthen the pragmatic force (e.g., arguments) of the stories. For example, Victor's lively depiction of his interaction with his physician portrayed himself as an assertive and experienced patient yet at the same time aligned him with Bob who was experiencing similar uncertainties. These stories were understood as arguments made to challenge or to support what was described earlier. Therefore, although Victor created various contexts (e.g., transplant surgery involves tremendous uncertainty) that aligned himself with Bob in his story (see the discussion in the next section), Bob's reaction after hearing Victor's story was not sharing his parallel uncertainty experiences. Bob perceived Victor's objection to his choice of treatment; therefore, he was eager to reconstruct his story and thus provided a counterargument.

In addition, when other participants agreed with Bob's arguments, they did not simply say, "I agree with you." Instead, they provided stories, acting as arguments, to support Bob's position. By doing so, these arguments were validated by the most intimate knowledge a person can have, their real-life experiences. The speakers not only informed their audience about their stance on the prior arguments but they also *lived* these arguments and thus are legitimized to make their claims and obtain an authoritative voice in their stories. Other participants cannot readily dismiss the validity and pragmatic force of the stories. In addition, the storyteller was able to protect the pragmatic force of the story and to reduce the face threat to other participants if disagreement arose (Hayashi, 1996). For example, Victor's comment in lines 200 through 202 (i.e., "I don't know that- that neck thing. Maybe it's not- does it hinder- bother you at all?") showed that he acknowledged that his argument was based on his experience and may not apply to Bob (i.e., not posing a threat to the validity of Bob's personal narratives). In short, by using stories to perform speech acts, a speaker can strategically construct identities, protect the pragmatic forces of the story,

obtain an authoritative voice, and avoid direct confrontation with other participants' illness identities and experiences.

Negotiations of Identities

Many self-introduction stories told in support group meetings were embellished with conflicting information that provided examples of individuals' uncertainty about their current health status and their efforts to portray a coherent self. Self-introduction was a routine event at the beginning of each meeting. Usually, speakers gave their name and described their transplant status, their surgical site, recent events, and, sometimes their emotions. To a certain degree, these were self-contained units not triggered by any particular utterances. The speakers were less concerned about topic continuity and more obligated to provide an image of themselves. For example, when Bob, a newcomer, introduced himself to the group the first time, he said the following:

Extract 10

261   B: and I'm Bob and I'm a uhh live transplant and I'm on the list
262   and I have several family members that match so uhh he is ready
263   to go and I just need to lose some more weight then we are doing
264   it. so it's going to be done in [name] clinic. (they're off) in
265   [name of city]. I suppose [name of city] is the place to get
266   (it). it's only a couple of hours so we are down in [name of
267   city] (we can get his organ) and come back here (.5) aft[er I-]
268   V: [I di]dn't hear you
        right. now are you
269   waiting?
270   B: I'm I'm u[hh]
271   V: [do]nating?
272   B: my uhh I have a brother that matches_
273   (0.2)
274   V: oh uhhuh
275   B: and he's ready to go. (1.2) I just need to lose a little bit
276   more weight_ and they'll and that's it (.) and then we can have
277   a transplant.

In the narrative about his current identity as a pretransplant patient, Bob's emphasis was "a little bit more" weight he needs to lose and the critical surgery for his future survival was simplified to a ready-to-go-that's-it event.

The negative circumstance that Bob was (a) in a potentially life-threatening situation and (b) too overweight for a life-saving surgery was mitigated by the alternative reality he created in which he was relatively healthy and the surgery was simple.

Because health maintenance is a lifelong activity that needs to be observed and monitored for all transplant patients, experienced patients also may face the problems of reconciling conflicting information and identities. For example, in the routine self-introduction at the beginning of a support group meeting, John, who was 8 years posttransplant at the time of the meeting, talked about his recent abnormal changes in health status:

Extract 11

281   J: My name is John. I received a kidney transplant in August 92.
282   (.5) I uhh (.) was on the waiting list about ele:ven days, was
283   transplanted before dialysis, went back to work within four
284   months after the transplant, have been working ever since. I see
285   the doctor about every six months,(.) the last checkup I had- (.)
286   my creatine level went up (.2) so they just gave me another blood
287   test last week. (.5) So this has been about three weeks now. It
288   went from 1.5 to 2, the first time since I have had the
289   transplant. (.) So, haven't heard back from the doctor yet to see
290   what else was up. But I think he is just double-checking, making
291   sure. (1.0) Two is not bad, it's just not normal for me.

In this brief account of an unpleasant and scary event that indicates a potential problem in his health status, John provided information that allowed him to maintain a relatively healthy identity. First, he was never really on dialysis. Second, he was able to start working within a short period of time and has been working since. Third, the new change in his creatine level is really "not bad" (line 291) but just not normal for him (i.e., he is typically healthier than most). Overall, despite the fact that John's health status had changed recently and both his physician and he were cautious about such a change, the identity John constructed in the narrative was a healthy and successful transplant patient.

Bob's and John's self-introductions can be viewed as self-contained units in which the speakers' goal was to provide a coherent and desirable image of themselves. However, identity negotiations are not limited to stories of self-introduction. In fact, as individuals strive to provide a cognitive and emotional coherence to their experiences, they often use storytelling to construct and negotiate their identities (Bauman, 1986; Herzfeld, 1985).

More specifically, storytelling allows individuals to envision reality from a personal perspective, to select reportable experiences, and to represent such experiences in a meaningful way to the speaker (Miller et al., 2000). In other words, *any* story is about the storyteller's identity and identity management.

Identity and identity management through storytelling in support group meetings are generally more dynamic and dialogic than the self-introduction stories. Stories often are produced in response to the prior conversation and are shaped by the immediate response of the audience as well as the speaker's anticipation of later responses (Miller et al., 2000); therefore, the storytellers' identity and identity management also are constructed through the dynamics of group interactions.

A good example of a storyteller's strategic portrayal of identities was the exchange of stories as arguments between Victor and Bob that I introduced earlier. As Bob explained his reason for not wanting a fistula, his repair sequence ("Why have all that permanently put in when I won't- *hopefully* won't need it" [lines 132–133]) showed some uncertainty about his future. In response, Victor aligned himself with Bob by constructing a similar experience of uncertainty. For example, he said, "That's stressful just going in because you don't know what a fistula was then" (lines 152–153); "they're operatin' on you so you can go on dialysis is all you know" (lines 157–158); and "You don't know the things is gonna buzz in your arm and you don't know, you know, a lot of- a lot of things and you're just scared to death anyway" (lines 160–162). These statements portrayed Victor as a patient faced with great uncertainty, which was supposedly the same problem faced by Bob.

Victor also constructed a different identity that portrayed him as a persuasive speaker trying to change Bob's mind. For example, he was persistent and assertive (e.g., "I said 'okay I want a transplant'" [lines 148–149] and "I said 'all right let's talk transplant.' And so you know I really forced his hand at it and got him to where he would uhh we started to talkin'" [lines 169–172].) Despite the physician–patient tension, he *learned* that doctors are better at deciding what's good for the patient (e.g., "In all his wisdom uhh he made me get the fistula in my arm first [lines 151–152]," and "old doc Johnson knew what he was talking about" [lines 195–196]). Although Victor's story was used and understood as an argument by both the speaker and the audience, Victor still provided vivid details about his identity in his story. The identities he portrayed responded to Bob's uncertainty about treatment choices. More important, Victor constructed these

identities to strategically align himself with Bob and to make him seem convincing and persuasive (e.g., he is more experienced than Bob) at the same time.

In summary, the identity negotiation in Victor's storytelling reflects Victor's multiple communicative goals. The identities were created not only to tell a story but also to make the story a convincing argument. The stories told were not only about who the speakers were or how they felt when a past event took place; rather, the speakers constructed stories and their identities in a manner that best served their current communicative goals.

STORYTELLING AND THE DIALOGIC MANAGEMENT OF IDENTITY

This study demonstrated that individuals' participation in storytelling events in support group meetings allowed them to actively co-construct collective and individual identities. By examining the sequential ordering and contexts in the storytelling activities, I showed that both the speakers and their audience strategically negotiated the meanings of stories as well as the identities that emerged. Both the storytellers and their audience incorporated storytelling activities into the management of multiple goals (e.g., identity management, uncertainty management, and communicative efficacy).

These findings suggest that the dialogic management of identities in storytelling events involves several processes. First, a patient may generate a self-contained unit of story that provides a coherent self (as in the case of self-introduction stories), an area that has been investigated carefully by researchers who study illness narratives (e.g., Charmaz, 1991; Frank, 1995; Kleinman, 1988). Although these illness narratives are self-contained, the narrators often incorporate multiple perspectives (or voices) in their stories (Ezzy, 2000; Frank, 2000). The multiple points of view allow storytellers to embrace the uncertainty and complexity of their experiences (Ezzy, 2000) and at the same time challenge them to maintain a coherent and meaningful self (Frank, 2000).

Second, a participant may use a story to perform a specific speech act (e.g., argument), and identities are constructed to meet the communicative goals of the speech act. The sequential placement in a conversation and the dramatic portrayal of self in stories can also serve other pragmatic purposes

(e.g., constructing identities and aligning with others). From this perspective, a storyteller's identities can be very flexible and strategic (as in the case of Victor's story). This aspect of identity management is unlikely to be observed in researcher-guided interviews. For example, an interviewee's stories are unlikely to have the pragmatic functions (e.g., persuasion or encouragement) that are perceived by other support group participants. A researcher is not in a position to use personal stories to support or challenge the interviewee's stories; whereas in this study, Victor used his personal experiences to challenge Bob's account of his treatment choice. As researchers have recognized that stories of the same event may differ depending on their timing and audience (Charmaz, 2002; Crandon-Malamud, 1991), researchers should explore (a) *how* and *why* the stories are constructed differently and (b) what the impacts are of the strategic storytelling on a storyteller's adjustment to illness. Research on illness narratives should begin to explore how patients' strategic narratives empower them in their everyday life as they interact with others, striving to make sense of their experiences and adjusting to a life-changing event.

Third, support group participants used stories dialogically to formulate a *collective* as well as *individual* understanding of their experiences and identities. Researchers have noted that participating in support groups helps patients generate collective identities for their shared experiences (Barker, 2002; Steffen, 1997) and individual identities for their subjective experiences (Dickerson et al., 2000); however, these studies did not explore how these identities are generated through the interactions between patients. In this study, I showed that these two identities may be jointly produced through storytelling activities.

The audience of a story actively incorporated their interpretation of the story and formed their responses accordingly. When stories were told as lessons to be learned, the audience responded with stories of related lessons that could be learned. When stories are heard as arguments, the audience responded with stories to oppose or to support those opinions. When stories of personal experiences were told, the audience requested details that not only informed them about who the storyteller was but also allowed them to assess who they were. Through storytelling (e.g., story sharing, listening, self-locating, and arguing), both the storytellers and their audience coconstructed and comanaged their identities, including their collective identities (e.g., transplant patients) and individual identities (e.g., identities that are based on their distinctive experiences of illness). This aspect of identity management is crucial to individuals' adjustment to illness be-

cause it requires patients to negotiate the meanings of illness and illness identities and to coordinate their communicative behaviors *with others.* A person who is more skilled in these areas may be more successful in coping with illness than a person who is not. Again, researcher-guided interviews do not allow researchers to examine this aspect of identity management. Researchers need to observe individuals with chronic illness in naturalistic settings to (a) identify the communicative behaviors for the coordinated identity management and (b) explain why certain communicative strategies are more or less effective than others in coping with illness.

Finally, the dialogic interactions in storytelling events allow the participants of support group meetings to socialize valued identities by their (non)alignment to the interpretive framework for the stories. The sequential placement of the series of stories allow succeeding storytellers to validate and affirm illness experiences and identities by replicating the interpretive framework set by preceding stories and by reciprocating stories of similar experiences. However, such reciprocation is not a passive response. These reciprocated stories also can create new contexts that influence the meanings and identities of preceding stories (as in the case of Mary's empowered-patient story). In addition, in everyday life, patients have various opportunities to refine their illness stories to improve their acceptability and believability by observing others' reactions (as in the case of Bob's vascular catheter stories). The developmental process of a patient's illness narratives and identities (e.g., developing and testing believable stories) has rarely been discussed in past literature on illness narratives. This process is of great significance to individuals' adjustment to illness as they learn about the kinds of identities and stories that are valued, acceptable, and believable to others (and to different kinds of audiences). A patient who is effective in developing believable stories for different audiences is more likely to obtain important resources (e.g., social support and health care services) for coping with illness.

These four aspects of the dialogic management of identities create a larger picture of the study of individuals' communication practice in various contexts (e.g., social support, uncertainty management, and identity management). Several researchers have highlighted the importance of a normative approach, studying how individuals enact specific behaviors in everyday life and what makes these behaviors more or less effective (e.g., Brashers, Goldsmith, & Hsieh, 2002; Goldsmith & Fitch, 1997; Rogan & Hammer, 1994). Recognizing that the "negotiation of meaning and coordination of action" (Goldsmith, 1995, p. 415) with others is essential to

individuals' production, interpretation, and evaluation of messages, researchers have introduced new perspectives to conceptualize human communication. To treat storytelling as isolated activities that serve only one or two specific purposes (e.g., developing a coherent self or reducing anxiety) is to oversimplify and decontextualize human behavior. Researchers need to recognize the multiple functions and meanings of storytelling, as individuals utilize stories to achieve, incorporate, and reconcile other objectives. Acknowledging the complexity and multidimensionality of individuals' communication practices will allow researchers to broaden and strengthen the development of communication theories in various fields.

REFERENCES

Antaki, C., & Widdicombe, S. (Eds.). (1998). *Identities in talk.* Thousand Oaks, CA: Sage.

Atkinson, P. (1997). Narrative turn or blind alley? *Qualitative Health Research, 7,* 325–344.

Banks-Wallace, J. (1998). Emancipatory potential of storytelling in a group. *Image: The Journal of Nursing Scholarship, 30,* 17–21.

Barker, K. (2002). Self-help literature and the making of an illness identity: The case of fibromyalgia syndrome (FMS). *Social Problems, 49,* 279–300.

Bauman, R. (1986). *Story, performance, and event: Contextual studies of oral narrative.* New York: Cambridge University Press.

Bauman, R., & Briggs, C. L. (1990). Poetics and performance as critical perspectives on language and social life. *Annual Review of Anthropology, 19,* 59–88.

Becker, G. (1997). *Disrupted lives: How people create meaning in a chaotic world.* Berkeley: University of California Press.

Brashers, D. E., Goldsmith, D. J., & Hsieh, E. (2002). Information seeking and avoiding in health contexts. *Human Communication Research, 28,* 258–271.

Brashers, D. E., Neidig, J. L., Haas, S. M., Dobbs, L. K., Cardillo, L. W., & Russell, J. A. (2000). Communication in the management of uncertainty: The case of persons living with HIV or AIDS. *Communication Monographs, 67,* 63–84.

Briggs, C. L. (1986). *Learning how to ask: A sociolinguistic appraisal of the role of the interview in social science research.* New York: Cambridge University Press.

Brown, M. H. (1985). That reminds me of a story: Speech action in organizational socialization. *Western Journal of Speech Communication, 49,* 27–42.

Bury, M. (2001). Illness narratives: Fact or fiction? *Sociology of Health and Illness, 23,* 263–285.

Charmaz, K. (1991). *Good days, bad days: The self in chronic illness and time.* New Brunswick, NJ: Rutgers University Press.

Charmaz, K. (1994). Identity dilemmas of chronically ill men. *Sociological Quarterly, 35,* 269–288.

Charmaz, K. (1995). The body, identity, and self: Adapting to impairment. *Sociological Quarterly, 36,* 657–680.

Charmaz, K. (1999a). From the "sick role" to stories of self: Understanding the self in ill-ness. In R. J. Contrada & R. D. Ashmore (Eds.), *Self, social identity, and physical health: Interdisciplinary explorations* (pp. 209–239). New York: Oxford University Press.

Charmaz, K. (1999b). Stories of suffering: Subjective tales and research narratives. *Qualitative Health Research, 9,* 362–382.

Charmaz, K. (2002). Stories and silences: Disclosures and self in chronic illness. *Qualitative Inquiry, 8,* 302–328.

Chelf, J. H., Deshler, A. M., Hillman, S., & Durazo-Arvizu, R. (2000). Storytelling: A strat-egy for living and coping with cancer. *Cancer Nursing, 23,* 1–5.

Corbin, J., & Strauss, A. L. (1987). Accompaniments of chronic illness: Changes in body, self, biography, and biographical time. In J. A. Roth & P. Corad (Eds.), *Research in the sociology of health care: The experience and management of chronic illness* (Vol. 6, pp. 249–281). Greenwich, CT: JAI.

Crandon-Malamud, L. (1991). *From the fat of our souls.* Berkeley: University of California Press.

Davies, M. L. (1997). Shattered assumptions: Time and the experience of long-term HIV positivity. *Social Science & Medicine, 44,* 561–571.

Dickerson, S. S., Posluszny, M., & Kennedy, M. C. (2000). Help seeking in a support group for recipients of implantable cardioverter defibrillators and their support persons. *Heart and Lung, 29,* 87–96.

Eggly, S. (2002). Physician–patient co-construction of illness narratives in the medical in-terview. *Health Communication, 14,* 339–360.

Ezzy, D. (2000). Illness narratives: Time, hope and HIV. *Social Science & Medicine, 50,* 605–617.

Frank, A. W. (1995). *The wounded storyteller.* Chicago: University of Chicago Press.

Frank, A. W. (1997). Enacting illness stories: When, what, and why. In H. L. Nelson (Ed.), *Stories and their limits: Narrative approach to bioethics* (pp. 31–49). New York: Routledge.

Frank, A. W. (1998). Just listening: Narrative and deep illness. *Families, Systems and Health, 16,* 197–212.

Frank, A. W. (2000). Illness and autobiographical work: Dialogue as narrative desta-bilization. *Qualitative Sociology, 23,* 135–156.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Hawthorne, NY: Aldine de Gruyter.

Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other in-mates.* Garden City, NY: Doubleday.

Goldsmith, D. J. (1995). The communicative microdynamics of support. *Communication Yearbook, 18,* 414–433.

Goldsmith, D. J. (2001). A normative approach to the study of uncertainty and communica-tion. *Journal of Communication, 51,* 514–533.

Goldsmith, D. J., & Fitch, K. (1997). The normative context of advice as social support. *Human Communication Research, 23,* 454–476.

Goodwin, C. (1984). Notes on story structure and the organization of participation. In J. M. Atkinson & J. Heritage (Eds.), *Structures of social action: Studies in conversation analysis* (pp. 225–246). New York: Cambridge University Press.

Goodwin, M. H. (1982). Process of dispute management among urban black children. *American Ethnologist, 9,* 76–96.

Goodwin, M. H. (1993). Tactical uses of stories: Participation frameworks within girls' and boys' disputes. In D. Tannen (Ed.), *Gender and conversational interaction* (pp. 110–143). New York: Oxford University Press.

Hayashi, T. (1996). Politeness in conflict management: A conversation analysis of dispreferred message from a cognitive perspective. *Journal of Pragmatics, 25,* 227–255.

Herzfeld, M. (1985). *The poetics of manhood: Contest and identity in a Cretan Mountain village.* Princeton, NJ: Princeton University Press.

Jefferson, G. (1978). Sequential aspects of storytelling in conversation. In J. Schenkein (Ed.), *Studies in the organization of conversational interaction* (pp. 219–248). New York: Academic.

Kleinman, A. (1988). *The illness narrative: Suffering, healing, and the human condition.* New York: Basic Books.

Lerner, G. H. (1992). Assisted storytelling: Deploying shared knowledge as a practical matter. *Qualitative Sociology, 15,* 247–271.

Leventhal, H., Idler, E. L., & Leventhal, E. A. (1999). The impact of chronic illness on the self system. In R. J. Contrada & R. D. Ashmore (Eds.), *Self, social identity, and physical health: Interdisciplinary explorations* (pp. 185–208). New York: Oxford University Press.

Maines, D. R. (1983). Time and biography in diabetic experience. *Mid-American Review of Sociology, 8,* 103–117.

Maines, D. (1984). The social arrangements of diabetic self-help groups. In A. L. Strauss (Ed.), *Chronic illness and the quality of life* (2nd ed., pp. 111–123). St. Louis, MO: Mosby.

Maines, D. R. (1991). The storied nature of health and diabetic self-help groups. *Advances in Medical Sociology, 2,* 185–202.

Mandelbaum, J. (1987). Couples sharing stories. *Communication Quarterly, 35,* 144–170.

Mandelbaum, J. (1989). Interpersonal activities in conversational storytelling. *Western Journal of Speech Communication, 53,* 114–126.

Mandelbaum, J. (1993). Assigning responsibility in conversational storytelling: The interactional construction of reality. *Text, 13,* 247–266.

Mattingly, C. (1994). The concept of therapeutic 'emplotment'. *Social Science & Medicine, 38,* 811–822.

Miller, P. J., Hengst, J., Alexander, K., & Sperry, L. L. (2000). Versions of personal storytelling/versions of experience: Genres as tools for creating alternate realities. In K. S. Rosengren & C. N. Johnson (Eds.), *Imagining the impossible: Magical, scientific, and religious thinking in children* (pp. 212–246). New York: Cambridge University Press.

Miller, P. J., Wiley, A. R., Fung, H., & Liang, C.-H. (1997). Personal storytelling as a medium of socialization in Chinese and American families. *Child Development, 68,* 557–568.

Polanyi, L. (1985). *Telling the American story: A structural and cultural analysis of conversational storytelling.* Norwood, NJ: Ablex.

Potter, W. J. (1996). *An analysis of thinking and research about qualitative methods.* Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Riessman, C. K. (1990). Strategic uses of narrative in the presentation of self and illness: A research note. *Social Science & Medicine, 30,* 1195–1200.

Roberts, L. J., Salem, D., Rappaport, J., Toro, P. A., Luke, D. A., & Seidman, E. (1999). Giving and receiving help: Interpersonal transactions in mutual-help meetings and psychosocial adjustment of members. *American Journal of Community Psychology, 27,* 841–868.

Rogan, R. G., & Hammer, M. R. (1994). Crisis negotiations: A preliminary investigation of facework in naturalistic conflict discourse. *Journal of Applied Communication Research, 22,* 216–231.

Ryave, A. L. (1978). On the achievement of a series of stories. In J. Schenkein (Ed.), *Studies in the organization of conversational interaction* (pp. 113–132). New York: Academic.

Sacks, H., Schegloff, E. A., & Jefferson, G. (1974). A simplest systematics for the organization of turn-taking for conversation. *Language, 50,* 696–735.

Schieffelin, B. B. (1990). *The give and take of everyday life.* New York: Cambridge University Press.

Steffen, V. (1997). Life stories and shared experience. *Social Science & Medicine, 45,* 99–111.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury, CA: Sage.

Strauss, A., & Corbin, J. (1994). Grounded theory methodology: An overview. In N. K. Denzin & Y. S. Linfoln (Eds.), *Handbook of qualitative research* (pp. 273–285). Thousand Oaks, CA: Sage.

Waitzkin, H. (1990). On studying the discourse of medical encounters: A critique of quantitative and qualitative methods and a proposal for reasonable compromise. *Medical Care, 28,* 473–488.