

# **Body Disclosures: Attending to Personal Problems and Reported Sexual Abuse During a Medical Encounter**

By Wayne A. Beach and Curtis D. LeBaron

*This study examines moments of mutual sensitivity during a health appraisal interview. Attention is given to how patient becomes visibly and audibly emotional when reporting personal problems, how these behaviors get attended to through subsequent interaction, and the delicacy involved in transitioning to discussion about reported childhood sexual abuse. Analysis reveals how delicate moments get closely monitored and collaboratively produced, why “medical” and “personal” distinctions are artificially dichotomous, ways “attending” should not be exclusively associated with the interactional responsibilities of interviewers, and how attention given to the patient’s body gets transformed over the course of the history-taking interview. Attending to a patient’s expressed and exhibited problems is an inevitable and valuable resource for generating a comprehensive understanding of psychosocial and biomedical circumstances.*

Medical history taking involves moments where patients raise sensitive issues about their personal, social, and family experiences. When faced with decisions about whether and how lifeworld experiences will be pursued, however, interviewers have been repeatedly shown to disattend patient-initiated concerns and thus overlook their significance for understanding symptoms and illness (Beach, 1995, 2001a; Beckman & Frankel, 1984; Cassell, 1985; Engel, 1977; Frankel, 1995, 1996; Jones, 2001; Mishler, 1984; Roter & Hall, 1992; Waitzkin, 1991).<sup>1</sup> Historically,

<sup>1</sup> Disattending actions occur routinely in a wide variety of casual (noninstitutional) involvements as well. For example, speakers frequently disattend others' complaints (Mandelbaum, 1991/1992), and family members withhold affiliation from positions taken by loved ones regarding alleged health problems (Beach, 1996).

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numerous explanations for these disattending actions have been offered: time constraints on interviews; contrasts in medical knowledge and experience; a displayed disinterest in patient-initiated questions; and an active avoidance of patients' psychosocial experiences in favor of biomedical (organic and physiological) diagnoses and prescribed treatment (Drew, 1991; Drew & Heritage, 1992; Felitti, 1997; Fisher, 1991; Frankel, 1990; Maynard, 1991; Robinson, 2001; ten Have, 1991; West, 1984).

An understanding of how patients initiate their concerns, and how interviewers respond, requires identification of specific practices shaping interactional involvement. For example, interviewers' questions are designed to enact history-taking agendas optimizing "no problem" responses by patients (Boyd & Heritage, in press). Occasionally, when patients elaborate and narrate about unsolicited topics, essentially answering more than the interviewers' questions asked for, minimal attention is provided to patients' "lifeworld disclosures" (Stivers & Heritage, 2001; see also Jones & Beach, 1995).<sup>2</sup> Institutional involvements such as medical encounters are thus best understood not by global reference to professional power, control, and status but through careful examination of how practical actions get socially organized. As Robinson (2001) recently observed, "Researchers need to take seriously the fact that interactional asymmetries can and should be initially accounted for in terms of the interaction *sui generis*" (p. 9).

In the context of a routine health appraisal interview, the purpose of the present study is to examine vocal and visible displays of mutual sensitivity as a patient's emotional concerns get immediately addressed. To better understand the diversity of moments comprising medical encounters, empirical attention needs to be given not only to moments where patients' expressions are disattended by interviewers, but also how attending to patients' problems gets interactionally organized and thereby achieved. As increasing attention is given to patient-centered care, the delicate balance between patients' needs and satisfaction and interviewers' responsiveness and reassurance is a primary concern (Gill, Halkowski, & Roberts, 2001).

We reveal how a patient and interviewer work together to address the patient's personal needs and emotional displays in the midst of moving forward with the "official" medical agenda. As the interview unfolds, talk about commonplace health concerns gives way to more serious disclosures and considerations. Attention is drawn to how the patient becomes visibly (e.g., tears) and audibly (e.g., voice quavers) emotional, and how these behaviors become a resource for subsequent interaction. The interviewer momentarily attends to a problem expressed by the patient and then begins transition to an item "checked off" by the patient in her medical questionnaire. The interviewer's return to the institutional agenda is then momentarily postponed by further attending to patient's tearfulness. These moments are akin to what Heath (1986, 1988) described as collaborative involve-

<sup>2</sup> A variety of studies (Gill, 1998; Gill, Halkowski, & Roberts, 2001; Gill & Maynard, in press; Robinson, 1999, 2001; Stivers & Heritage, 2001), however, address moments where patients initiate their concerns indirectly in ways facilitating their being ignored by interviewers. Such concerns are often addressed at a later point in the interview. In contrast, the data analyzed herein reveal how a patient's emotional display is both acknowledged and taken up immediately, though only for a brief period of time.

ments in which participants are “producing temporarily a distinct episode, a shift in involvement in which embarrassment bubbles over and subsides” (1986, p. 126). Once patient’s tearfulness is addressed, and only then, does the interviewer move back to a delicate item checked off by the patient: having been raped or molested as a child.

Because attending to the patient’s condition is implicated within movement toward what is understandably a delicate medical history-taking agenda (rape and molestation), the reliance upon patients’ records during medical interviews is a predominant feature of this and most encounters (Heath, 1984, 1986, 1988). In the midst of interacting about a patients’ medical conditions, interviewers simultaneously review, read, write or record, and somehow synthesize patients’ records into talk about specific topics and concerns (Frankel, 1989; Smith, 1978, 1983a, 1983b; Zimmerman, 1969, 1974). As both the interviewer and patient refer to the questionnaire at key moments during their encounter, we focus on the interactional environment within which both the patient’s body and the medical record emerge as central resources for communicating about personal health issues.

Following an overview of data and methods, a brief description is offered of how talk can be examined to reveal the organization of *formulation cycles*. Next, we reexamine an excerpt by focusing on ways participants visibly employ their bodies to configure space and action when addressing delicate matters in a medical interview.

### Overview of Data and Methods

Our videotaped data were collected in 1994 as part of an annual review for health appraisal by the Department of Preventative Medicine at Kaiser Permanente in San Diego, California. Annually, nearly 60,000 Kaiser members undergo appraisal interviews to assess their current state of health, identify underlying health risks, and determine what treatments may be needed. Hundreds of these interviews are recorded on an ongoing basis to facilitate staff evaluation and to conduct research promoting the well-being of its clients. Our present analysis of a single health appraisal interview, then, is part of a more extensive research and educational program for understanding and improving communication in medical care.

The patient initially complained about sluggish feelings, difficulties with being overweight (feet and back pain), and problems with vaginal infections. Although she acknowledged that she has “a lot of stress at work,” she also claimed that “everything’s going good at home.” As the interview continued, however, the patient disclosed additional and relatively serious problems: She described herself as a workaholic who has little joy in life, little time for herself, is constantly giving to others without receiving in return, and thus is compelled to wear “many masks” with often conflicting personalities. Furthermore, she described her involvement in an extramarital affair and then reports being molested by both her grandfather and her brother at an early age (disclosed for the first time to a health care professional).

Our analysis of the interview has two parts. First, we focus on talk and its sequential organization, showing how participants create and orient to the social

order of their encounter. We review the work of Beach and Dixson (2001), who examined this same interview to explicate collaboratively produced formulation cycles: (a) The medical interviewer formulates understandings of the patient's adverse experiences; (b) the patient responds by confirming and/or expanding upon the interviewer's formulations; (c) through topic shift, over the course of the medical interview, the interviewer increasingly draws attention to "root issues" (e.g., weight gain, depression, and molestation) underlying adult health problems. Finally, we review implications for refining understandings of communication and patient care, including consequences for diagnosing and treating illnesses when bio-psycho-social histories are addressed rather than overlooked or discounted.

By providing this overview of Beach and Dixson's (2001) analysis, we intend to familiarize readers with the interactional organization of a selected excerpt from this medical encounter and to demonstrate how conversation analytic methods may be employed to examine talk as the primary resource for understanding social actions.

Second, to generate a more embodied or holistic understanding of their situation, we expand our focus from vocal to visible forms of interaction revealed through these same video recordings. We reveal how the patient's body becomes a primary site for the interplay between personal sensitivities and the pursuit of a medical agenda focusing on reported rape and molestation. Although not abandoning (but rather carefully utilizing) insights about how formulation cycles are sequentially organized through talk, we reexamine moments wherein participants visibly employ their bodies to configure their involvements, achieve copresence, secure visual and auditory access, and continually draw upon their affordances of a visibly built and material environment. As the patient both speaks and moves in ways that communicate personal troubles and evidence bodily discomforts, her bodily animations are visibly made available for the interviewer's viewing, understanding, and possible response. Specific attention is directed to participants' facial expressions, eye gaze, hand gestures, posture, and shifting orientations (head, torso, pelvis, knees) as these body parts are interactionally organized throughout the examined excerpt.

Our analysis thus recognizes that "body parts are the first mediating elements in our interaction with the people and objects around us" (Duranti, 1997, p. 322); that "human action is built through the simultaneous deployment of a range of quite different kinds of semiotic resources" (Goodwin, 1998, p. 2); and that culture may be in motion before it is spoken (Collier & Collier, 1992).

By treating social interaction as both a temporal and spatial accomplishment, analysis is aligned with how clinician and patient demonstrate, for one another and thus publically (Goodwin & Duranti, 1992), the delicate unfolding of talk about sensitive and personal experiences (i.e., fear of multiple personalities and early childhood molestation). In sum, our method of analysis is a convergence of conversation-analytic concerns with talk and its organization and the visible organization of nonverbal and visible activities. Historically, although conversation analysis has given primary attention to the ongoing orderliness of vocal behaviors within single cases and collections of social interaction (e.g., Atkinson & Heritage,

1984; Drew & Heritage, 1992; Sacks, 1992; Sacks, Schegloff, & Jefferson, 1974), attention has also been drawn to the interactional organization of gesture (Schegloff, 1984), gaze and body orientation (Robinson, 1998). Expanding analysis to a broader range of visible actions, including how people move their bodies and occupy space in orderly and socially meaningful ways (e.g., Birdwhistell, 1970; Goodwin, 1981, 1995, 1998; Heath, 1986, 1992; Kendon, 1990; Scheflen, 1973, 1974; Streeck, 1993, 1994), integrates naturalistic traditions that share similar commitments toward empirical, detailed, descriptive, and structural approaches to the study of human communication. The present analysis of a critical set of moments within a medical encounter is designed as responsive to calls for more fully integrated examinations of vocal and visible communication (e.g., Duranti, 1997; Heath, 1986; Moerman, 1990; Poyatos, 1983; Streeck & Knapp, 1992).

*Data Presentation and Analysis: Part 1*

In Excerpt 1, the interviewer (INT) and patient (PAT) collaborate in producing a basic formulation cycle comprised of INT's formulation (1→), PAT's confirmation (2→), and INT's topic shift (3→):

Excerpt 1: Kaiser #1:8

((PAT has related how she and her mom were having difficulty addressing their molestation by PAT's grandfather/mom's father.))

PAT: And when I brought it out (0.5) °you know it was the same thing°. [.hhh hhh]

1→ INT: [Okay so:]:hhh U:hmm from what I'm understandg your grandfather's death was his anniversary of his death was two days ago.

2→ PAT: °Umhmm°.

1→ INT: From it was one year ago. .hh uh:mm And apparently your mother was molested by him and you were molested by him. .hh A:nd the two of you shared this about six months after his death.

2→ PAT: °Right°.=

3→ INT: =You said you and your mother are going through a difficult time right now.=

The formulation cycle is initiated by INT in (1→), who uses "Okay" to acknowledge PAT's immediately prior reporting, yet also momentarily puts on hold further elaboration (see Beach, 1993, 1995). This makes it possible for INT to summarize events described by PAT. Notice that INT's paraphrase is explicitly offered as an "upshot" of PAT's reportings, not a direct reconstruction nor an "owning" of PAT's experience. Only following PAT's confirmation (2→) of INT's understandings-thus-far does INT invite additional talk about "you and your mother" in (3→), which is a solicited expansion of the current topic rather than a shift to a new issue for discussion.

Apparent in both Excerpt 1 (above) and Excerpt 2 (below), interviewer's paraphrase/summary/upshot of the gist of patient's reportings (1→) is preparatory to initiation of a topically adjacent item (3→), but it is because interviewer's (1→) also embodies a "bounding off" of prior topic that a new yet related topic might be raised.

This basic formulation cycle (1→, 2→, and 3→) is sometimes protracted when various emergent and intervening problems get addressed. For instance, an expansion occurs in Excerpt 2 when PAT becomes tearful, INT temporarily attends to PAT's emotional displays, and INT twice moves the medical agenda forward by referencing what PAT had checked off on her questionnaire:

Excerpt 2: Kaiser #1:8

PAT: U:h But uh everyone else sees different parts of (1.0)  
of I- I can't say Lynda (0.4) I won't <sup>o</sup>say Lynda<sup>o</sup>.

1→ INT: So:o in other words uh uh you have this like kind of a fals:e  
(.) person, [<sup>o</sup>in these different areas of your life<sup>o</sup>].

2→ PAT: [I do: I feel like every ] where  
I'm going, I'm putting on a play- a performance for every  
place I go.  
(0.4)

A→ INT: You're almost tearful, as you talk about this no:w.  
(I can hear the chokingness in [your voice].

B→ PAT: [ <sup>o</sup>\$Yeah\$.<sup>o</sup> ]  
(0.7)

3→ INT: U:mm one of the things I noticed that you checked

C→ off on your uh:m (1.0) pt I'm sorry this  
looks like [a lot of pain for you.]

D→ PAT: [T h a t's o k a y. ] <sup>o</sup>It's okay.<sup>o</sup>

E→ INT: .hh Would you like uh tissue?

F→ PAT: <sup>o</sup>Okay.<sup>o</sup>

3→ INT: One of the thi:ngs that I was concerned about when  
I reviewed your- yer history was, you checked off you  
had been raped or molested.

Once again, INT's formulation (1→) involves a summarized version (i.e., "fals:e (.) person") that immediately follows P's own description. By confirming yet also elaborating how she "feel[s]" in (2→), PAT essentially let's go in response to INT's affiliative summary of her stated troubles (Jefferson, 1988). Rather than moving to shift topic at this point, however, INT draws attention to PAT being "tearful" and having a choking voice (A→). Only after PAT agrees (B→) with INT's observation, and following a (0.7) pause, does INT attempt to move the medical agenda forward (3→) by stating "one of the things I noticed that you checked off," which refers to a questionnaire in PAT's medical record. However, INT's agenda-driven

action gets momentarily set aside as she apologizes to PAT (C→), who is continuing to display strong emotions. After showing sensitivity to PAT's tearful condition, INT draws specific attention to PAT's evident feelings and personal experience ("this looks like a lot of pain for you"). With "That's okay" PAT acknowledges INT's apology (D→), followed by "It's okay" as one type of self-talk offering assurance and minimizing the trouble she is experiencing. With the questionnaire momentarily set aside, the participants talk about another object in the room: INT offers (E→) and PAT accepts (F→) a tissue. Finally, INT shifts topic again by referring to what PAT had checked off (3→) in a questionnaire.

INT's second attempt to reference the questionnaire involved a noteworthy change in word choice: Previously, INT talked about what she had "noticed" in the questionnaire; now she talks about what "concerned" her. Her change from "noticed" → "concerned" is a direct upshot of INT and PAT having both attended to PAT's emotional displays. With "concerned," INT treats as inherently delicate a second attempt to move the medical agenda forward, contributing to an interactional environment in which INT displays sensitivity to the patient's tearfulness even before talking about her being "raped or molested."

In sum, the formulation cycle apparent in Excerpt 2 is protracted. As the participants temporarily attend to PAT's personal and present sensitivities, rather than details about her reported health history, INT delays and momentarily withholds topic shift (3→).

#### *Data Presentation and Analysis: Part 2*

In this section, we reexamine Excerpt 2 by focusing on visible forms of communication achieved through participants' body positions, spatial maneuvers, and bodily behaviors. Six contiguous and contextually configured activities are examined: (a) attending to a bodily "performance"; (b) managing a "tearful" display; (c) initial reference to "checked off"; (d) apologizing, touching, and acknowledging the patient's "pain"; (e) the "tissue" as a private/public artifact; and (f) attempting to "remember" adverse childhood experiences.

When Excerpt 2 begins, the participants already occupy space in structured ways (Figure 1). The health appraisal interview occurs within a typical examination room that somewhat constrains the interaction, for "doing always entails a relationship to the space which has in it the objects or people with which the doing is concerned" (Kendon, 1990, p. 210). Although the furniture doesn't obligate a facing formation (Kendon, 1990), the participants sit mutually oriented as involved interactants who are visibly and physically accessible in ways embodying their definition of patient and interviewer in this clinical encounter.

The room contains an examination table (somewhat elevated and located in the middle of the room), a counter against the wall (with built-in sink and drawers), and a movable chair (in front of the table and located next to the counter) on which the interviewer is seated. By sitting up on the table, essentially above the interviewer (her knees are at interviewer's chest level), PAT makes herself available for viewing and inspection in a seated position as well as when lying down (which occurs following the history taking, during the physical examination). By sitting down in the chair, INT has many objects available and within reach: She

faces the patient and her body parts, and on INT's right is both the medical file (on the cabinet) and drawers containing various medical supplies. Throughout the interview, INT points to and at times turns away from PAT to examine the medical file. This file is located beyond PAT's reach, though it can be viewed by her if she glances down and to her left. Importantly, printed contents of the file, including records from prior visitations and results from PAT's questionnaire, are not made available to PAT for her reading and inspection. Also included is a summarized profile of significant and potentially high-risk health issues, designed to assist interviewers both when reviewing medical histories prior to meeting with patients and during interviews as a resource and reminder of key issues for discussion.

It is noteworthy, then, that INT's divided attention stance and privileged access to records instantiates her institutional role: By alternating her centered orientation between the patient and medical records, she assimilates information and registers her expertise by turning from one to the other. This built space resembles constraints and resources that are recognizable across diverse forms of institutional interaction (LeBaron & Streeck, 1997).

*Attending to a bodily "performance."* Our reexamination of Excerpt 2 begins with Figures 1, 2, and 3. These three displays are interactively accomplished across turns at talk that include INT's formulation (1→) and PAT's confirmation (2→):

[*(Figure 1: PAT gestures)*]

PAT: U:h But uh everyone else sees different parts of  
(1.0) of I- I can't say Lynda (0.4) I won't <sup>o</sup>say Lynda<sup>o</sup>.

1→ INT: So:o in other words uh uh you have this like kind  
[*(Figure 2: INT reproduces gestures)*]  
of a fals:e () person,  
[<sup>o</sup>in these different areas of your life.<sup>o</sup>]  
[*(Figure 3: PAT reproduces gestures)*]

2→ PAT: [I do: I feel like everyl where  
I'm going, I'm putting on a play- a performance for every  
place I go.

Sitting face to face, the participants gesture in ways that evidence keen attention to each other's bodily behaviors. First, PAT performs emphatic gestures as she talks about the trouble of wearing many masks. With the word "sees," her hands are raised into her gesture space, palms facing each other several inches apart (Figure 1). When PAT says "different parts," her hands move up and down, chopping emphatically and in rhythmic alignment with pronounced syllables of her speech. At the same time, her chopping motions progress from side to side, hand-work that divides horizontal space. Thus, PAT's gestures appear to serve a dual function: (a) They are process-oriented "beats" (McNeill, 1992), motions accompanying and emphasizing everyday speech; (b) They are also descriptive and verb-like, segmenting the air in ways that project and correspond with the lexical affiliate (Schegloff, 1984; Streeck & Hartge, 1992) "different parts." In sum, PAT's



Figure 1.



Figure 2.



Figure 3.

emphatic and horizontally arrayed gestures are designed to visually portray “different parts” as sources of trouble, that is, inherently problematic features of PAT’s life.

Next, INT provides a summary of prior talk (1→), the first step in the formulation cycle, by selectively employing not only words (e.g., “different”) but also body behaviors that PAT has enacted. With the word “false,” INT moves her hands (see Figure 2) up and down, mimicking the rhythmic and emphatic chopping of speech syllables previously performed by PAT. Here INT’s hands also progress from side to side and thus segment horizontal space, a motion that projects and corresponds with her lexical affiliate “different areas.” Notice that INT’s gestures are recognizable as a reproduction because they are temporally proximate, spatially proximate, and structurally similar (LeBaron, 1998) to PAT’s immediately prior gestures. The resemblance is unmistakable: Gestures are “one place where the temporal and sequential organization of conversation intersects with its spatial organization” (Goodwin, 1986, p. 35), a fine-grained achievement that is nonaccidental.

Understood as a formulated reenactment (Beach & Dixson, 2001), the vocal and visible actions comprising INT’s (1→) reflect a strong display of alignment accomplished through jointly employed symbolic forms (LeBaron & Koschmann, in press). In addition to listening and summarizing a version of what PAT had previously uttered, INT advances the health appraisal process by attending closely to PAT’s use of body. Through shared emphasis and utilization of horizontal space to depict different parts or areas of PAT’s life, INT’s reperformance of PAT’s gestural expression embodies an identification with PAT’s psychosocial concerns that simultaneously complement, but also transcend, what utterances alone can accomplish.

When PAT responds to INT’s formulation by confirming (2→) and elaborating how she “feel[s],” her confirmation involves yet another performance of the gesture that she introduced. As her hands again chop the air across a horizontal plane (Figure 3), she reproduces what has emerged as a conventional form of embodied action (LeBaron & Streeck, 2000). Her gesture is no longer coordinated with the lexical affiliate “different parts” but it is nonetheless recognizable and meaningfully understood because of its placement within a sequence replete with an interactional (albeit recent) history. By formulating talk (1→) and then confirming (2→), the participants achieve a state of mutual alignment by closely monitoring one another’s vocal and bodily behaviors.

*Managing a “tearful” display.* As PAT describes “putting on a play- a performance” (2→), her eyes become tearful and voice is audibly unstable:

2→ PAT: [I do: I feel like everyl where  
I'm going, I'm putting on a play- a performance for every  
place I go.  
(0.4)

[(Figure 4: PAT blinks and gazes up))

A→ INT: You're almost tearful,  
as you talk about this no:w.

[(Figure 5: INT gestures to throat; PAT smiles & nods))  
(I can hear the chokingness in [your voice])

B→ PAT: [°\$Yeah\$.°]  
(0.7)

The onset of these behaviors is subtle, but following a (0.4) pause INT (A→) draws attention to the changes in PAT's body (eyes) and voice. INT's utterance is not a question that obligates an answer, but it creates an opportunity space for PAT to respond in some way. The video record shows (only partially represented in Figure 4) that PAT produces three simultaneous actions. Immediately following INT's word “tearful,” PAT gazes up and away from INT, repeatedly blinks her eyes, and directs her gaze toward the upper wall to her left (INT's right). Although PAT may simply be attempting to draw her attention away from her emotional displays, these exhibits also embody what Heath (1988, p. 138) summarizes as “characteristic signs of embarrassment, in particular a loss of composure and an inability to participate, if only momentarily, within the encounter.”<sup>3</sup> This is what Goffman (1967) described as “the objective signs of emotional disturbance” (p. 97). The visible behaviors represented in Figure 4 occur simultaneously with talk between the participants and thus are embodied features comprising central lines of activity—displaying and attending to a loss of composure—which are consequential for shaping the evolving interview.

Apparently haphazard, PAT's behaviors are nevertheless systematically organized and responsive to an interviewer who has not only observed (through extended gaze), but just drawn specific attention (through verbal description) to her apparent loss of composure. Although PAT's upward gaze may appear misdirected, it momentarily averts focused contact with interviewer, temporarily suspending the interview and its projected focus on different parts/areas. PAT's repeated blinking, while appearing uncontrollable, meaningfully displays her difficulty in managing the unsolicited consideration being given to her tearing and voice change. Understood as conjoint actions, it appears that PAT is enacting a

<sup>3</sup> Goffman (1961b) described “flooding out” as a strong display of emotion (e.g., laughing, crying, fearing) such that the participant is momentarily “out of play” (p. 55). To illustrate how Goffman's flooding out is not sufficient for describing systematic and interactionally responsive actions, Heath (1986) provided an extended example of how a doctor and female patient collaborate in managing a delicate set of moments.



Figure 4.



Figure 5.

private place in an interactional space: Having been caught in the act, as it were, she seeks and momentarily inhabits a gazed-upon place where INT's gaze is avoided while her line of activity (i.e., a momentary loss of composure) plays itself out.

During these few seconds of interactional time, PAT's smiling (see Figure 4) displays her resistance both to the troubles she is personally confronting and those addressed by INT (Beach, 1996, 2001b; *in press a, b*; Jefferson, 1984a, 1984b, 1988). A brief gaze-directed retreat to a private place, therefore, may involve ongoing sensitivity to the contingencies of interactional involvement (Emerson, 1970; Robinson, 1998). In essence, there is no "time out" from a medical encounter. This is especially true during an interview on health issues, where participants are seated directly in front of one another and the explicit purpose of gathering is to review and inspect the patients' personal and bodily functioning.

Within seconds, PAT regains sufficient composure to continue. By the end of "no:w.", precisely at the completion of INT's turn, PAT begins to draw her gaze back to INT. As she does so, INT initiates another speaking turn "(I) can hear the chokingness in [your voice.]". A number of concurrent actions accomplish what is eventually revealed in Figure 5. First, latched onto "no:w." is INT's initiation of an open-handed gesture that ultimately is drawn to her own throat. This gesture functions in three key ways to (a) resolicit PAT's gaze; (b) project the lexical affiliate "chokingness"; and (c) begin a "partitioning" of her left and right hand. These three functions of INT's throat gesture require more detailed elaboration:

(a) Although PAT appears to synchronize her reestablished gaze with the completion of INT's first turn constructional unit (TCU), so does INT attempt to recover mutual gaze by gesturing to her throat. These are not competing but complementary orientations, mutually yet independently designed to facilitate moving forward with the interview. The coauthored upshot is a shared temporal and spatial juncture for addressing patient's interrelated emotional expressions (tearful and choking). The actions comprising these moments provide an interesting contrast to Heath's (1984, 1986) descriptions of how patients utilize gaze, leg movements, body position, and objects to solicit attention from doctors as they read patients' medical records. Here, the reverse occurs as INT's gesture functions to refocus PAT's attention.

(b) Interviewer's reference to "chokingness" is a distinct, perhaps odd, choice of words. This vocal reference is "projected" (Schegloff, 1984; Streeck & Hartge, 1992) by INT's hand gesture, and in turn the word provides for a situated interpre-

tation of INT's gesture. Although it is typically patients who are shown to touch themselves during medical interviews as they describe their symptoms, as with Heath's analysis of how pain gets embodied through gesture during physical examinations (this issue), here it is seen how an interviewer may utilize self-touch to display empathy with the patient's sensitivities: to register on her own body what she sees and hears the patient is undergoing.

(c) Throughout the excerpt examined, INT employs her left hand to accomplish various communicative displays: gesturing, touching her throat, and (as described below) touching the patient and pointing to the questionnaire. In her right hand INT holds a pen, displaying a state of readiness for writing comments for the patient's record. Thus, one of the ways that INT mediates between PAT and paper is to partition the use of her hands: The left does more work with patient's body, while the right "officially" retrieves, accesses, and records notable events on paper. In sum, although INT's hands are obviously finely coordinated to achieve different actions, they are also partitioned to visibly orchestrate the interaction (left hand), and to accomplish official and textual tasks unique to history taking.

As PAT draws her gaze back to INT and quietly responds with a smile voice "◦\$Yeah\$◦", she is interactionally responsive to INT's open-handed gesture to her throat which (as noted) culminates in uttering "chokingness". Having thus acknowledged the correctness of INT's observation, a (0.7) pause occurs reflecting a closure of prior management of PAT's tearful display and movement toward next topic, PAT's questionnaire.

*Initial reference to "checked off."* Beginning with "U:mm", and with PAT now gazing directly at INT, a shift of topic occurs via reference to PAT's questionnaire:

3→ INT: U:mm one of [the things I noticed that you checked off on  
your [uh:m (1.0)]  
((Figure 6: INT's left hand points toward file))  
((Figure 7: PAT briefly glances toward file))

The left hand used to touch INT's neck (and secure PAT's attention through gesture) is now directed toward the medical file and PAT's questionnaire. As INT points discreetly (Bergmann, 1992) to these materials, notice in Figure 6 that she does not avert but maintains her gaze at PAT. By pointing but not looking at the medical records, INT displays both her memory of what PAT had checked off and its relevance for discussion at this point in the interview. The phrase "checked off" is offered as a literal description of PAT's reporting, one way of representing PAT's prior actions as responding to a list of yes-no items.

Responding to INT's noticing requires that PAT access her memory of an item she had reported and thus make it available for some interviewer's attention. Filling out health appraisal questionnaires is not done with specific recipients in mind, but for the inspection of anonymous medical professionals during some unspecified and future appointment. By pointing and referencing the questionnaire in this manner, INT seeks to establish with PAT a shared and intersubjectively understood history. Further, by pointing to what PAT had checked off, INT is able



Figure 6.



Figure 7.



Figure 8.

to legitimately raise a very delicate topic (“raped or molested”): She visibly clarifies that PAT had volunteered this information and, thus, was its originator. Essentially, by pointing and thus attributing her noticing to PAT’s reporting, INT detoxifies what might otherwise come off as inappropriate probing into sensitive events the patient has experienced and lived with (as evident below) for a considerable period of time.

Following “checked off” and as an upshot of INT’s pointing, PAT very briefly glances (to her left) toward written materials comprising her medical history (Figure 7). She then glances back again to maintain focused gaze upon INT. The brevity of PAT’s glance may signify her recognition of the questionnaire, but also a close monitoring of INT’s topic shift. In this way, PAT displays both a willingness to attend to INT’s movement to the next topic (i.e., to take a time-out from ongoing action) and a readiness to move forward with INT as the reference item is made explicit.

*Apologizing, touching, and acknowledging the patient’s “pain.”* In overlap with PAT’s brief glance in Figure 7 (above), INT shows uncertainty by producing “uh:” and pausing for 1 second. During this extended pause, INT directly gazes at and closely assesses PAT’s body and ongoing emotional expression:

3→ INT: U:mm one of the things I noticed that you checked  
C→ off on your uh:m (1.0) pt I’m sorry this  
looks like [a lot of pain for you.]

[*(Figure 8: INT touches PAT’s knee)*]

Rather than continuing with her utterance about the questionnaire, INT offers an apology with “pt I’m sorry”, which immediately contrasts with the clinical talk about things checked off. At the same time, INT extends her left hand and arm to touch PAT’s knee. As Scheflen (1974) observed, “The relations of posture, orientation and distance indicate the degree of involvement, intimacy, and type of affiliation of the participants” (p. 55). By reaching and leaning forward to touch, INT achieves a series of interrelated actions: She shifts her posture, orients more intently toward PAT’s body, and decreases her physical distance from PAT. In these ways, INT displays increased intimacy and sensitivity to PAT’s tearful condition, while also acknowledging the inherent difficulty of discussing such delicate topics.

Further, the onset and termination of INT's touching are precisely organized. Just as it is apparent that her touch was initiated not prior to, but immediately following her offered apology, so too does she maintain physical contact with PAT only through her comment that "this looks like a lot of pain for you." Her hand and arm are withdrawn at the exact completion of her turn ("you"). In these ways, INT officially frames her touch as a momentary expression of concern but nothing more than that: Recruited as a central feature of displaying sensitivity, INT does not extend her touching even a moment beyond the construction of "apologizing" as a bounded social action.

Notice also that INT's "this looks like" formulates, but does not claim ownership of, PAT's experiences. In this way INT further mitigates her personal involvement with PAT's problems, therefore retaining distance and maintaining her status as medical interviewer.

It is important to clarify that INT's "a lot of pain for you" is in reference to PAT's earlier "putting on a play- a performance for every place I go" (2→), not the as yet unarticulated "raped or molested." Although INT is no doubt aware of these issues being the focus of upcoming discussion, at this time PAT remains uninformed (her medical file includes a very long list of potential topics). It is possible and perhaps even likely, then, that INT's postponement-by-apology is designed with full knowledge that precautions should be taken to create an interactional environment conducive to raising such a delicate next topic ("raped or molested"), especially "on the back" of PAT's prior emotional expressions. A discrepancy thus exists between what INT and PAT know about where and how the medical agenda will emerge, and how this knowledge manifests itself within the interaction. On one hand, an interviewer is enacting an agenda by working to integrate questionnaire results in a timely fashion, but not at the expense of displaying insensitivity to PAT's behaviors; on the other hand, a patient is attempting to manage her tearful display and the attention given to it by INT while appearing ready to move onto whatever items INT has selected as "next topic."

*The "tissue" as a public and private artifact.* In overlap with INT's "a lot of pain for you" and with a troubles-resistant smile (Jefferson, 1984a, 1984b), PAT's "That's okay" assures INT that her apology was heard and appreciated. In so doing, she downgrades and thus minimizes the need for INT's offering (Pomerantz, 1978). Following the overlap, PAT gives another quietly uttered assurance, "It's okay°", which hearably addresses PAT's own reflection on her emotional condition. In the midst of these two utterances, notice that PAT glances to her left (Figure 9), toward a box of tissues sitting on the counter next to the medical folder:

[*(Figure 9: PAT glances toward tissues)*]

D→ PAT: [T h a t's      | o k a y. ] °It's okay.°

E→ INT: .hh Would you like uh tissue?

F→ PAT: °Okay.°

INT remains attentive to PAT's visible behaviors and notices PAT's glance at the tissues. It is apparent that INT treats PAT's gaze as an indirect request or hint,



Figure 9.



Figure 10.

giving rise to her next ".hh Would you like a tissue?" In this way, PAT's gaze preceded and actually occasioned INT's vocal and physical offering of a tissue, which PAT quietly accepts ("Okay").

The tissue is treated as another momentary but sufficient solution to PAT's emotional difficulties (in addition to INT's apology), for the participants immediately resume discussion of the questionnaire. As the box of tissues is offered and PAT reaches to take one (Figure 10), INT simultaneously recycles her turn beginning (see Schegloff, 1987) with the words "one of the thi:ngs," indicating her return to the clinical task at hand and accomplishing the third step of the formulation cycle (3→).

3→ INT: [ (Figure 10: PAT reaches for a tissue))  
One of the thi:ngs that I was concerned about

With this second attempt to move forward discussion about questionnaire items, INT does not point or gesture toward the medical history materials on her right. The absence of such pointing, employed as an earlier resource for establishing shared reference, indicates a recognition that intersubjective understanding has already been achieved. Furthermore, INT's recycled turn involves a noteworthy word change: Having attended to and assisted PAT in managing her emotional expressions, INT shifts from the word "noticed" to the word "concerned." This shift reflects movement from a relatively objective upshot of reading the record, to a more personalized and empathetic stance. Even though both versions involve past-tense language, the second version is a tailored display of compassion not apparent in her first. With tissue in hand, PAT maintains eye contact with INT, signaling ongoing and close monitoring of INT's return to the next topic. Thus, a shared (albeit brief) history is evident as the participants return to clinical matters; they show that they have worked through their prior emotional involvements *together*.

Having received a tissue, PAT is now faced with using it. She uses *both* hands, one folded over the other, not to wipe but rather to delicately dab a tear from her right eye through a series of methodical hand movements. During this activity, she does not maintain direct eye contact with INT, though she does hold a gaze sufficient to be aware and thus monitor that and how INT's gaze is being focused



Figure 11.



Figure 12.

upon her. In a sense, by initiating an activity akin to mopping up after a momentary spill, a noticeable aftershock of prior involvements, PAT presents an emergent state of composure by methodically managing her private activity in the confines of a focused interactional time and place.

*“Remembering” adverse childhood experiences.* While PAT continues to use her tissue, INT pursues information about “raped or molested”:

3→ INT: One of the thi:ngs that I was concerned about when  
I reviewed your- yer history was, you checked off you  
had been raped or molested.  
[((Figure 11: PAT gazes at tissue and nods))]  
PAT: Lpt Yes::.

When PAT responds to INT's question with an elongated “Yes::”, PAT also shifts her gaze from INT toward her tissue (Figure 11), which is held between PAT's hands and in front of her chest. At this moment, the tissue is not (or, perhaps, not only) being examined by PAT to determine its condition (e.g., how wet it is). Rather, the tissue becomes an artifact for focusing her attention while confirming rape or molestation, a momentary haven for realizing that the topic INT had been working toward was not just any item she had checked off on her questionnaire, but those items representing adverse childhood experiences.

As INT now pursues this information, PAT continues to gaze at and manipulate her tissue, employing those body parts (e.g., eyes) that might otherwise display strong emotion for the other's view. At this juncture, INT asks about PAT's age when she was raped or molested:

INT: How old were you when this happened?  
[((Figure 12: PAT gazes up while remembering))]  
PAT: ↑well Lu:m phh .hhh (0.3) u:hmm eh- I can remember (.)  
>when I was about three or four years old.<

Marked by an intonational shift to a higher voice (↑), repeated dysfluencies, and a pause, PAT displays considerable difficulty “remembering” as she searches her past (Goodwin, 1987). While her gaze is drawn to the same general place as

earlier in the interview, when her being “tearful” was addressed by INT, she now extends her gaze upward and to her left—beyond the upper wall (as with Figure 4) and to the ceiling. During this moment, however, she is not smiling as before; she does not exhibit resistance to her described problems. Instead, she appears serious and perhaps even solemn as she attempts to retrieve a removed and troubling past. The obvious contrast here involves reporting about “rape or molestation” in her questionnaire and being requested to talk about these adverse events with a medical professional she is meeting with for the first time. Therein lies yet another dilemma to be managed in the altogether routine course of a history-taking interview.

## **Discussion**

There are no time-outs from history taking when psychosocial concerns become a primary focus for health care. The brief episode analyzed herein reveals how an interviewer manages the tension of being both a troubles recipient and service supplier, effectively balancing what Parsons (1951) proposed as a general norm that clinicians be “affectively neutral” while also sensitive to patients’ experiences. Attending to a patient’s expressed and exhibited problems is thus not tantamount to abandoning a medical agenda, but an inevitable and valuable resource for generating a comprehensive understanding of lifeworld circumstances (Engel, 1977; Felitti, 1997; Mishler, 1984).

Just as reported anxieties about present problems may be rooted in prior adverse experiences (Beach & Dixson, 2001; Felitti et al., 1998), it remains for the interviewer to discern possible relationships between patient’s history and any present health issues. Risk assessments can be facilitated by close monitoring of how patients describe and respond to their own stories, acknowledging the apparent difficulties triggered by such revelations, and identifying patients’ emotional concerns as critical resources for prescribing and proscribing treatment options (Platt & Gordon, 1999).

It is apparent that, although “attending actions” are those most commonly associated with health providers as they care for clients, such conceptualizations are extremely limiting. Specific social actions have been identified that reveal why medical and personal distinctions are best understood as falsely dichotomous, how delicate moments get collaboratively produced, and indeed how attending is necessarily coenacted by both patient and interviewer throughout history taking. Consider the key actions that we have identified:

1. It was the patient who initiated and voluntarily disclosed “different parts” as a dilemma she is currently facing in her everyday life, an issue the interviewer drew further attention to by next paraphrasing and thus formulating with “with false person.” Both speakers enacted emphatic and rhythmic gestures, bodily and symbolically dissecting horizontal space to visualize patient’s problems.

2. The patient’s momentary loss of composure, through recognizable changes in her eyes (tearful) and voice (choking), not only occasioned her repeated blinking and upward gaze but interviewer’s unsolicited consideration through extended

gaze, verbal description, and touch of her own throat. Through self-touch, interviewer's gesture was multifunctional: designed to draw patient's attention back to an attempted display of empathic concern and to initiate conjoint movement to next topic (questionnaire).

3. As interviewer enacted her institutional role (in part) by partitioning her use of hands (i.e., left for communicative displays, right for record keeping), one usage was pointing to the record to legitimate her raising of a delicate matter volunteered by patient. By briefly gazing at the record, the patient acknowledged both her understanding of interviewer's reference and recognition that a topic shift was underway.

4. It is apparent that initiation of this questionnaire-driven topic shift occurred before the patient had fully gained composure: Interviewer extended pause and gaze, giving rise to the simultaneous offering of an apology, touching of patient's knee, and "looks like a lot of pain for you." In these ways the interviewer displayed appropriate sensitivity and momentarily suspended movement to questionnaire items, perhaps as a preventive measure to moving prematurely to what was known by her to be a delicate next topic.

5. By minimizing the need for interviewer's apology ("That's okay."), and by quietly offering self-reassurance ("It's okay."), the patient relied on gaze to indirectly solicit and receive a tissue. This action was not recruited by patient to ward off topic shift, which the interviewer reinitiated as the tissue was offered, but now more empathically as an upshot of having shared immediately prior and emotional moments with the patient (i.e., "one of the things I noticed that you checked" → "one of the things that I was concerned about"). Further, as the tissue was delicately employed to dab tears, patient once again was faced with managing a private activity in an interactional environment in which she was nearly constantly being inspected.

6. As the interviewer explicitly raised "you checked off you had been raped or molested.", the patient employed the tissue as an artifact for focusing her gaze while realizing, and confirming, her reported abuse. When the interviewer asked "how old were you," the patient again shifted her gaze up and to the left as she attempted (with repeated dysfluencies) to remember her past—a delicate topic, and activity, when meeting with a medical professional for the first time.

Throughout these sensitive moments, the patient's body was not simply a disembodied object for clinical attention. Rather, this medical encounter underwent an embodied transformation shaped by both participants' observed, enacted, and verbally described actions: from a verbal and gestural enactment of personal problems to interviewer's reperformed summary and gesturing; from tearful, choking displays to a verbal and nonverbal (touching throat) characterization of these behaviors; from ongoing emotional expression to empathic acknowledgment via apology, touching (knee), and verbalization of "pain"; from referencing an "official" artifact (medical record/questionnaire) to managing a "personal" tissue; from initial and momentarily suspended topical movement to a second and more "concerned" raising of the delicate topic, "raped or molested." All of these subtle and contiguous exchanges were finely coordinated through gaze toward one another and their material surroundings (walls, ceilings, records, tissue).

The patient was emphatic as she voluntarily offered disclosure about personal problems, vocal and visible actions that were closely scrutinized by the interviewer. As the interviewer repeated words and formulated utterances that the patient provided, she also reperformed some of the patient's hand gestures to demonstrate heightened awareness of, and identification with, what the patient was saying and bodily doing. Through such interaction the participants worked toward mutual alignment, sharing understandings that may have facilitated meaningful entries into the patient's record as informed decisions about diagnosis and treatment regimens were made. Eventually, the patient's body received immediate attention: less for what she was saying, and more for how she was saying it. When the patient involuntarily displayed emotions, through voice quaver and tearing eyes, the interviewer acknowledged patient's here-and-now difficulty en route to continued historical reconstruction focusing on reported abuse of her body through "rape or molestation."

Though we have offered detailed observations about an excerpt comprising less than 1 minute in real time, such attention is required in order to lay an empirical foundation for understanding how soliciting (Marvel et al., 1999) and attending to delicate moments get adequately accomplished during history taking. It has often been described in terms of "empathic opportunities" (Bellett & Maloney, 1991; Branch & Malick, 1993; Brown, 1989; Suchman et al., 1997), or moments of "embarrassment" (Goffman, 1956, 1959, 1969; Heath, 1986, 1988), but ongoing work is needed to anchor conceptualizations about interaction within specific moments and practices organizing exchange. By closely examining the vocal and visual organization of this excerpt, a grounded understanding emerges of moments wherein attending gets interactionally accomplished. During these involvements, the actual time invested in accommodating the patient's disclosures—demonstrating interest in, appreciation for, and sensitivity about troubling topics—is but a small investment of the overall medical encounter. Yet the implications are considerable for developing collaborative approaches to preventive health care, and thus extended healing (Spiegel, 1999) rooted in connections drawn between patient's past and present experiences.

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