

Justyna Ziółkowska*

The representation of illness manifestation during the first psychiatric interview with patients preliminary diagnosed with depressive illness

The aim of the study is the analysis of patients' and doctors' discursive representation of mental health problems during the first psychiatric interview. The data comes from 16 initial psychiatric interviews recorded by doctors in three psychiatric hospitals in Poland. Assuming the discursive character of representation the analysis of the data has shown that the representation of illness manifestations in doctors and patients narratives differs. The doctors constructed mental health problems mainly as static and timeless existence of medical symptoms and patients' traits. Conversely, the patients constructed illness manifestations in terms of action, as dynamic and contextualised processes. Interestingly, the patients deprived themselves of control over the acting illness manifestations. Doctors' static picture of illness manifestations eliminates the possibility of exploring the complicated relationship between patients and their problems. An examination of the way patients construct illness manifestations could be relevant diagnostic information.

Keywords: Discourse analysis; Doctor-Patient relationship; Mental health; Psychiatric interview; Representation of illness

Introduction

Conducting a psychiatric interview is a very important, yet very difficult part of clinical practice. Well conducted, the interview gives the psychiatrist insight into the patient's experiences and suffering, while building rapport and mutual understanding (MacKinnon, Michels and Buckley, 2009). Yet, poor interview training and skills, together with doctors' reliance upon their own experience or subjective impressions often impede good interviewing.

Describing a well-conducted interview, psychiatric textbooks focus predominantly upon clinicians' conduct, such as attentive listening or parallel nonverbal behaviour (e.g. Carlat, 2005; Pridmore, 2000; Shea, 1998), or types of questions asked. It could be argued, however, that these strategies are insufficient if, for example, doctors and patients understand mental health problems differently and cannot agree on their representations of illness or suffering. Indeed, Kirmayer notes that "Understanding stories of suffering and healing depends on a shared world of assumptions, ideas, values and motivations" (Kirmayer, 2003: 167). So, when the social worlds of the patient and the clinician are substantially different or unshared, the

stories they tell each other may be mutually unintelligible (Kirmayer, 2003: 168).

Consequently, in the article I aim to expand the current thinking about communicative strategies in psychiatric interview. I shall show doctors and patients' incompatibility of illness representations as an important source of failure to achieve mutual understanding in a clinical setting.

Aims and Assumptions

The aim of this article is the analyses of patients' and doctors' discursive representations of mental health problems during the first psychiatric interview. I shall analyse the ways doctors and patients construct illness manifestations during their first encounter and how their representations of mental health problems relate to each other. Also, I am interested in potential reasons for and consequences of illness representation disagreement.

I understand the psychiatric interview as a social phenomenon. I assume that interviews are reality-constructing and meaning-making events (Holstein and Gubrium, 1995; see also: Atkinson, 1998; Bavelas, Coates,

* Warsaw School of Social Sciences and Humanities, Wrocław Faculty, 53-238 Wrocław, ul. Ostrowskiego 30
e-mail: zjolkowska@swps.edu.pl

and Johnson, 2000), which are embedded in a social context that encourages specific meanings and discourages others (see also Foucault, 1980). Similarly, I see 'mental health problems' not as entities that inflict individuals and characterize them but rather as sets of concepts and practices that are constructed and maintained in mental health science and practice (Bilic and Georgaca, 2007, see also: Georgaca, 2000; Harper, 1995, 2004).

My study is anchored in the social constructionist paradigm. I reject the assumptions that the world reveals its 'true' nature to observers and that observation and knowledge which stem from it can be objective, value-free and unbiased (Gergen, 1985). Conversely, I assume historical and cultural specificity of all knowledge (Burr, 2003; Gergen, 1973, 1985). The ways in which we understand our experience and the concepts we use, I see as products of the specific culture and time in which we live (Gergen, 1973, 1985). Consequently, knowledge is not something that people have or don't have, but rather, it is something that people do together (Gergen, 1985; Burr, 2003), and every way of understanding, or construction, has ramifications for their action in the social world (Burr, 2003; Gergen, 1985).

Importantly, however, I reject the idea that language reflects, mirrors or purely describes reality in favour of an understanding of language as constructive (Curt, 1994; Gergen, 1985; Potter and Wetherell, 1987). I assume that discourse, language in use, is a form of social practice. Discourse is thus not only socially shaped but also socially constitutive (Fairclough, 1995), and representation of reality is selective and entails decisions as to which aspects of that reality to include and how to arrange them (Barker and Galasiński, 2001: 65).

So, in my study not only do I follow Radley and Billig (1996) in their assumption that people construct their state of health as something vital to the conduct of everyday life and as part of their ongoing identity in relation to others (Radley and Billig, 1996: 221), but, primarily, I assume that meaning is constructed in discourse (Fairclough, 1992; Halliday, 1994; Hodge and Kress, 1993) and any representation is thus inextricably linked to the language used to assign meaning to illness manifestations.

The study

The article is based on sixteen psychiatric interviews recorded between September 2005 and September 2006, in three psychiatric hospitals in Poland. Each interview was recorded by a doctor and I had no influence on its structure, form or content. They were initial conversations between sixteen residents and their patients immediately after admission. Each interview was also the first encounter between the doctor and the patient. Both the doctor and

the patient gave informed consent to the interview being recorded and analysed discursively. This was preceded by initial clearance by the chief consultant on the ward.

The preliminary diagnosis of the interviewed patients was depressive illness (WHO, 1998), and the doctors were residents training for specialisation in psychiatry, in their second or third year of residency. The procedure was as follows. After gaining the permission of the chief consultant, I met the residents to tell them about the study. I explained that I was interested in the practice of interviewing on psychiatric wards and I wanted them to record their first interviews with patients. The task of the doctors who agreed to take part in the study was to take a dictaphone to the first interview with the patient (whom the chief consultant qualified for the study on the basis of preliminary diagnosis of mild or moderate depressive illness) and, after gaining the patient's informed consent, recording the interview. During the year in which the study was conducted, sixteen residents agreed to record their first interviews; none of the patients declined to take part in the study. The mean duration of the recorded interviews was 33 minutes, ranging from 21 to 51 minutes. There were no significant differences in interview duration at different sites.

All the interviews were subsequently transcribed and the analysis of representations of mental health problems was based on the sections where the main complaint and the history of present illness were discussed. The analysis consists in reading and rereading of the transcripts in search of patterns in doctors' and patients' constructions of patients' mental problems. The analysis was based on the Polish data, however, for the purpose of this article the analysed data was translated into English. I aim for the translation, which is as close as possible in structure and format to the Polish original.

In the following sections I shall first show that doctors constructed mental health problems mainly in terms of static and timeless existence of medical symptoms and patients' traits. Conversely, the patients constructed illness manifestations in terms of action, as dynamic and contextualised processes. I finish the article with a discussion about the roots and consequences of illness representation disagreement.

The findings

The doctors' questions

Despite different possible ways of representing patients' mental problems the doctors constructed illness manifestations mainly in terms of existence and possession. Typical in the data were two kinds of questions: (a) starting with: 'Is/are there..', which enabled them to make statements about the existence of objects or actions and (b) starting with

'Do you have/had...' in which doctors spoke of possessed attributes and identities¹. Consider the examples below.

1.

'**Is** there a problem with continuation of sleep?'

'**Are** there thoughts about death?'

'**Is** there a problem with concentration?'

'**Is** there a feeling that somebody looks at you?'

'**Is** there a will to act?'

'**Is** there a time of the day that there is more willingness?'

'**Are** there problems with sleeping?'

'**Are** there any problems?'

Using such questions, the doctors constructed patients' illness as phenomena independent from their experiences. The patients' experiences, behaviours and actions become unconditionally existing self-contained objects which are not involved in any kind of 'going on' (see Thompson, 2004). Thoughts, desires, behaviours exist rather than are thought, spoken or acted by concrete people. Thus the questions are suggestive of doctors wanting to obtain evidence, learn of 'facts' about patients' illness.

The second dominant group were questions where doctors construct illness manifestations as possession of some attributes, for example:

2.

'**Have you got** any plan for future?'

'**Have you got** any problems with sleep?'

'Did it happen that you **had had thoughts** of not being alive?'

'**Have you got** hope for recovering?'

'**Have you got** the ability to mobilize yourself?'

'**Have you got** a sense of persistent fatigue?'

'**Have you got** such an anxiety that something could have happen with the daughter?'

The patients' experiences, behaviours, actions are constructed mainly as attributes possessed by patients. Similarly to somatic medicine where someone *has*, say, agallstone, here patients' experiences of illness are also 'owned' by them. In this way, the doctors positioned the patients' illness as a static feature rather than a dynamic condition (see Galasiński, 2008) and, consequently, lend the patients' behaviours/experiences a more factual tone.

The prevalence of verbs deprived of any dynamic (to be; to have) in the doctors' questions co-occurs with the practice of talking about a process using a nominal phrase or a noun (Fairclough, 1992, 1995; Fowler *et al*, 1979; Halliday and Martin, 1993). And so, changeable and contextual patients' experiences and mental problems become reified objects of 'sleep', 'thoughts', 'troubles' or 'angst' (for example: '*Is there a feeling that somebody looks at you?*'), which in some cases are assigned to patients (for example: '*Have you got the ability to mobilization?*'). Such constructions

complement doctors' representations of illness which are devoid of action, and construct mental health problems as a reality of impersonal, atemporal and a contextual existence of medical symptoms and patients' traits.

The patients' narratives

Considering doctors' interactional dominance during the interview (Frankel, 1990; ten Have, 1991), analyses of the patients' constructions of illness manifestations must be limited to extracts where the patients had space for developing answers without a clear prompt from a doctor. The analyses of those extracts show that patients' constructions are significantly different from those of the doctors. For the patients systematically prefer to show their illness as something happening, choosing material processes conveying the notion of an actor doing something (Halliday, 1994). So, while in doctors' narratives the reality of illness manifestations is based on the existence of static and timeless objects, patients construct illness manifestations in terms of action. In their narratives mental health problems are related to actions like grabbing, taking, getting etc., and thus illness becomes dynamic and contextualised.

Interestingly, patients ascribe activity to illness manifestations rather than to individuals who experienced them. In their narratives, it is the illness which acts, and patients are only objects of external forces' operation, often ones with power over them. Consider the following example:

Extract 1.

D: [...] how do you remember the beginning of the ailment?

P: the beginning it was. simply **sleeplessness came**.

D: yeah.

P: **and persistent thoughts** of different kinds. so this was the beginning.

The experienced insomnia and intrusive thoughts are constructed by the material process of *coming*. However, the subject of the patient's narrative is not her experiences, but the independent objects of sleeplessness and thoughts, much like in the narratives of doctors. However, here sleeplessness and thoughts become actors, and the patient becomes only a recipient of their actions. For she did not say that she had stopped sleeping and started thinking, quite the contrary, she conceals her activity and describes these traits of her behaviour as phenomena which happen to her. So, even though the described problems characterized her functioning, they don't have origins in her. Similar constructions appear in other interviews.

Extract 2.

D: [...] recently, can you describe what happened that you came to the hospital?

P: I mean, recently, before Christmas I always **get such unpleasant sensations**. I realise that by and large it is family holiday, and I am practically alone with a little daughter.

Extract 3.

D: [...] and what did you do in the housing association?

P: also infrastructure business.

D: here you resigned yourself.

P: here I resigned myself. I feel better now so I regret that it somehow so inadvertently but I felt dreadfully unwell in November that I decided that I didn't manage. **now I am haunted by such thoughts, even persistent, which I fend off**, that I did wrong, that it is a pity that I did it. there is no going back. no going back.

Similarly to extract 1., the sensations which the patient in extract 2. experiences and the thoughts which the patient in extract 3. thinks are constructed as objects without origins in them. Again, although actions are referred to here, it is not the patients who are the actors. They are sensations and thoughts which acted, which came, haunted or fell on those actually 'doing' them.

The autonomy of illness manifestations in patients' narratives goes further than their independence from the patients. They are often constructed as having impact on patients' functioning. I present examples of such constructions below, but it can also be observed in extract 3, where the patient used the verb 'haunt' (Polish: *nawiedzać*) and in such a way she highlighted the supremacy of the thoughts over her. Interestingly, in this narrative the capacity to act is attached not only to thoughts, but also to the patient who fends them off. However, the patient constructs herself only as a defending actor, since she used the verb 'fend off' (Polish: *odganiam*), which refers to forcing somebody/something back/away (SJP, 2008), yet it does not imply that the haunting thoughts will be suppressed and will not come back. This example is, however, an exception. Usually the impact the illness has on patients' functioning goes without any response from those affected. Consider the following typical constructions.

Extract 4.

P:[...] I guess, I even don't have such unpredictable anxiety states because I feel unwell all the time

D: such persistent anxiety all day long, right?

P: yes and this

[

D: with constant intensity.

P: yes yes yes. anyway **something suppressed me from any action** especially like I said some bills something has to be cleaned, something has to be done.

Extract 5.

D: [...] precisely, I am interested since when you have had these associations?

P: it has built up since Christmas. **then it grabbed me hard. because I felt it, that something happens with my head. that I am closed somewhere in some crystal chest.**

In extract 4 the patient not only discursively detached herself from her anxiety, but she additionally ascribed worsening of her functioning to 'something' which starves her of any action. In extract 5 the patient constructs 'it' as the reason for her experiences. Here, the supremacy of 'it' contrasts with the patient's passivity as she describes the process as lasting in time and herself as conscious of what is happening to her. The patients construct themselves only as objects of mysterious forces operations which impair their lives. Such constructions indicate yet more clearly that patients' problems are detached from patients' experiences and become a foreign body which has prevalence over patients' lives.

Summing up, in contrast to doctors' focus on stable objects of psychiatric symptoms and patients' traits, the patients constructed their mental health problems as actions of thoughts, ailments and other experiences. Importantly, the patients not only equipped them with ability to act and impair their lives, but, in contrast to doctors' constructions, also they located their origins outside them.

Discussion and Conclusion

I started the article with a reference to Kirmayer's (2003) argument about the role of worldview agreement in patient and doctor's mutual understanding. Following his thesis it can be argued that reciprocal understanding cannot be achieved since the representations are incompatible. Additionally, it can be speculated that doctors' static picture of illness manifestations focused on the existence and possession, eliminates the possibility of examining the complicated relationship between patients and their problems. It is important because the exploration of the way patients construct their illness manifestations could be relevant diagnostically and therapeutically (e.g. White, 2007). For example, by constructing the symptoms as independent phenomena the patients exposed an absence of a relationship between them and the experienced problems. Thus, such constructions could suggest a field of patients' functioning which is not under their control, and which could have been enhanced in the therapy process.

Incidentally, this process of externalising of the problem (White, 2007), which can be observed in doctors' questions about the existence of symptoms, might be seen as a strategy. The doctors might have sought to construct a weaker relationship between the problem and the patient's

life. If so, the static representation of patients' problems should be seen as its 'side effect'. However, the doctors' use of relational processes in other questions suggests that such an interpretation might be implausible. For such questions positioned the patients' illness as their characteristic, internalising it, rather than externalising. In the process, it is doubtful that the interviewing psychiatrists see (and, indeed, want to see) something more than individual symptoms of diseases; particularly that, as Verhaeghe (2004) argues that the goal of the first interview is to 'extract whatever symptoms are present' (Verhaeghe, 2004: 197 see also: Bokey and Walter, 2002). In such a way, the patients' story can be easily removed from the clinician's focus, even though it should be the centre of it. For if the analysis focuses also upon representation of illness manifestations, the psychiatrist will have access to the entire system of relationships between the patient and his/her problems, while seeing it in its social context, and thus, diagnose the problem comprehensively.

What is an explanation for the prevalence of static and timeless picture of patient's illness in doctors' questions? First I would suggest the doctors' level of specialisation. The doctors were in their second or third year of residency in psychiatry and their interview practice might result from the level of their skills. It must be noted however, that in Poland interview skills are barely touched upon in medical schools and teaching is focused on psychopathology and treatment (Puzyński, 2000). I do see another explanation, though. The source of the doctors' constructions can be traced back to the discourse of psychiatric disorders presented in academic books, papers and, especially, manuals. The language of the manuals (ICD and DSM) becomes the *lingua franca* of mental health professionals (Wylie, 1995), and as such it can impact not only the doctors' written assessments (Berkenkotter and Ravotas, 1997), but also interview practices. Indeed, the data confirms such a suggestion. Previous analyses have shown that symptoms described in the manuals are constructed as invariable objects (Galasiński, 2008, Ziółkowska, 2009). Complex, dilemmatic, extended-in-time processes are described with nouns. Similar constructions can be found in my corpus. The doctors typically described broad and complicated processes by nouns, and thus patients' contextual and changeable experiences became invariable objects. Hence, in order to ask questions about such nominalised objects, doctors have to use the existential or relational processes. For example, if a doctor wants to ask about graspable and fixed thoughts rather than dynamic and contextual process of thinking s/he is constrained to use static relational verb 'to have' (Do you have.../ What are...) or existential verb 'to be' (Are there...). Importantly, when using relational processes the doctors locate the illness manifestations 'in' the patients. They become patients' attributes or traits and thus the doctors' representations

yet more clearly refer to the language of the manuals (see Frances and Link Egger, 1999; Jablensky, 1999; Zachar and Kendler, 2007).

Conversely, the patients' constructions of illnesses manifestations as independent and impairing their life objects can be linked with a picture of the illness in the depressed people's testimonies, where depression is constructed as totally overwhelming and devastating the patients' life (Moreira, 2003; Karp, 1992, 1994, 1996). Moreover, equipping illness manifestations with the potential to impair the patients' life is similar to Galasiński's (2008) analyses of narratives of men in depression. He showed that men positioned depression as an unfettered agent in actions that had had direct impact upon their lives. In their narratives depression also had the power to rise or withdraw, independently of any treatment the informant might have had.

As my findings are preliminary, I argue for more qualitative discourse studies on representations of mental health problems in clinical context. So far, researchers based their investigations about illness representations on the Leventhal's Self-Regulation Theory (Leventhal, Nerenz, and Steele, 1984) and studies were thus mainly concerned with patients' beliefs and expectation about an illness (e.g. Witteman, Bolks, and Hutschemaekers, 2011). The findings of my study suggest, however, that it is time to consider also the discursive world of illness representations and the complicated relationship between patients and their problems. Such analyses can help in developing the interview competence conducive to reciprocal understanding. Furthermore, the analysis of patients' discourse can be the source of useful and important information about their perspective on illness. Discourse analysis should play a particular role in those studies, as it offers a significant depth of exploration of the process of communication. At the same time, more attention should be paid to the training of interview techniques, and new versions of the manuals should become more sensitive to the lived patient experience in order to enable getting it back more firmly into the diagnosis.

Notes

1. These two kinds of questions correspond with the linguistic concept of process, understood as the aspect of representation usually rendered by a verb in a clause (Halliday, 1978, 1994). Processes enable to represent the same reality in different ways and Halliday distinguishes 6 types of them: material (doing things), mental (e.g. thinking or seeing), behavioural (e.g. crying, listening, sleeping), verbal (promising, talking, warning), relational (having an attribute or identity), existential (existing). So, when the doctors construct questions with verbs 'to be' and 'to have' they use

existential and relational, processes, respectively, and in such a way they build a static picture of illness representation.

References

- Atkinson, R. (1998). *The life story interview*. Thousand Oaks, CA: Sage.
- Barker, C., and Galasiński, D. (2001). *Cultural Studies and Discourse Analysis: a dialogue on language and identity*. London and Thousand Oaks: Sage.
- Bavelas, J. B., Coates, L., and Johnson, T. (2000). Listeners as co-narrators. *Journal of Personality and Social Psychology*, 79(6), 941-952.
- Berkenkotter, C., and Ravotas, D. (1997). Genre as Tool in the Transmission of Practice over Time and across Professional Boundaries. *Mind, Culture and Activity*, 4, 256-274.
- Bilic, B., and Georgaca, E. (2007). Representations of 'mental illness' in Serbian Newspapers: A critical discourse analysis. *Qualitative Research in Psychology*, 4, 167-186.
- Bokey, K., and Walter, G. (2002). Literature and psychiatry: the case for a close liaison. *Australasian Psychiatry*, 10(4), 393-400.
- Burr, V. (2003). *Social Constructionism* (2nd edition). London: Psychology Press.
- Carlat, D. J. (2005). *The psychiatric interview: A practical guide* (2nd edition). Philadelphia: Lippincott Williams and Wilkins.
- Cassell, E. J. (1976). Disease as an "it": Concepts of disease revealed by patient's presentation of symptoms. *Social Science and Medicine*, 20, 29-37.
- Curt, B. (1994). *Textuality and Tectonics: Troubling Social and Psychological Science*. Buckingham: Open University Press.
- Fairclough, N. (1992). *Discourse and social change*. Cambridge: Polity Press.
- Fairclough, N. (1995). *Critical Discourse Analysis*. London: Longman.
- Foucault, M. (1980). *Power/Knowledge: Selected Interviews and Other Writings, 1972-1977*. (C. Gordon, Ed.). New York: Pantheon.
- Fowler, R., Hodge, B., Kress, G., and Trew, T. (eds.). (1979). *Language and Control*. London: Routledge.
- Frances, A.J., Link Egger, H.L. (1999). Whither psychiatric diagnosis. *Australian and New Zealand Journal of Psychiatry*, 33, 161-165.
- Frankel, R. M. (1990). Talking in interviews: A dispreference for patient-initiated questions in physician-patient encounters. In G. Psathas (Ed.), *Interaction competence* (pp. 231-262). Washington: International Institute for Ethnomethodology and Conversation Analysis and University Press of America.
- Galasiński, D. (2008). *Men's discourses of depression*. Basingstoke: Palgrave.
- Georgaca, E. (2000). Reality and discourse: a critical analysis of the category of delusions. *British Journal of Medical Psychology*, 73, 227-242.
- Gergen, J. K. (1973). Social psychology as history. *Journal of Personality and Social Psychology*, 26, 309-320.
- Gergen, J.K. (1985). The social constructionist movement in modern psychology. *American Psychologist*, 40, 266-275.
- Halliday, M.A.K. (1978). *Language and Social Semiotic*. London: Edward Arnold.
- Halliday, M.A.K. (1994). *An Introduction to Functional Grammar* (2nd ed.). London: Edward Arnold.
- Halliday, M.A.K., Martin, J.R. (1993). *Writing Science: Literacy and Discursive Power*. London: Falmer.
- Harper, D. (1995). Discourse analysis and "mental health". *Journal of Mental Health*, 4, 347-357.
- Harper, D. (2004). Delusions and discourse: moving beyond the constraints of the modernist paradigm. *Philosophy, Psychiatry and Psychology*, 11(1), 55-64.
- Hodge, R., and Kress, G. (1993). *Language as Ideology*. London: Routledge.
- Holstein, J. F., and Gubrium, J. A. (1995). *The active interview*. Thousand Oaks: Sage.
- Jablensky, A. (1999). The nature of psychiatric classification. *Australian and New Zealand Journal of Psychiatry*, 33, 137-144.
- Karp, D. A. (1992). Illness ambiguity and the search for meaning. A case study of a self-help group for affective disorder. *Journal of Contemporary Ethnography*, 21(2), 139-170.
- Karp, D. A. (1994). Living with depression: Illness and identity turning points. *Qualitative Health Research*, 4, 6-30.
- Karp, D. A. (1996). *Speaking of sadness*. New York: Oxford University Press.
- Kirmayer, L. J. (2003). Failures of imagination: The refugee's predicament. *Anthropology and Medicine*, 10(2), 167-185.
- Leventhal, H., Nerenz, D., and Steele, D. (1984). Illness representations and coping with health threats. In A. Baum, S. E. Taylor, and J. E. Singer (Eds.), *Handbook of Psychology and Health* (pp. 219-252). Hillsdale: Erlbaum.
- MacKinnon, R. A., Michels, R., and Buckley, P. J. (2009). *The Psychiatric Interview in Clinical Practice*. Washington: American Psychiatric Publishing.
- Moreira, V. (2003). The ideological meaning of depression in the contemporary world. *International Journal of Critical Psychology*, 9, 143-159.
- Potter, J., and Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London: Sage.
- Pridmore, S. (2000). *The Psychiatric Interview: A Guide to History Taking and the Mental State Examination*. Amsterdam: Harwood Academic Publishers.
- Pużyński, S. (2000). Zaburzenia depresyjne w praktyce lekarza podstawowej opieki zdrowotnej [Mood disorders in General Practice]. *Przewodnik lekarza*, 2, 68-76.
- Radley, A., and Billig, M. (1996). Accounts of health and illness: Dilemmas and representations. *Sociology of Health and Illness*, 18, 220-240.
- Shea, S.C. (1998). *The Psychiatric Interview: The Art of Understanding*. Philadelphia: The Saunders Company.
- SJP, Słownik Języka Polskiego (2008). Warszawa: Wydawnictwo PWN.
- ten Have, P. (1991). Talk and institution: a reconsideration of the "asymmetry" of doctor-patient interaction. In D. Boden, and D. Zimmerman (Eds.), *Talk and Social Structure. An Introduction* (pp. 138-163). Cambridge: Polity Press.
- Thompson, G. (2004). *Introducing Functional Grammar* (2nd edition). London: Arnold.
- Verhaeghe, P. (2004). *On being normal and other disorders: A manual for clinical psychodiagnostics*. New York: The Other Press.
- White, M. (2007). *Maps of narrative practice*. New York: W.W. Norton & Company
- WHO, World Health Organization (1998) *Klasyfikacja zaburzeń psychicznych i zaburzeń zachowania w ICD-10. Badawcze kryteria diagnostyczne (Polish translation of WHO, 1993)*. Kraków-Warszawa: Vesalius-IPiN.
- Witteman, C., Bolks, L., and Hutschemaekers, G. (2011). Development of the Illness Perception Questionnaire Mental Health. *Journal of Mental Health*, 20(2), 115-125.
- Wylie, M. S. (1995). Diagnosing for dollars? *The Family Therapy Networker*, 23-33.
- Zachar, P., Kendler, K.S. (2007). Psychiatric Disorders: A Conceptual Taxonomy. *The American Journal of Psychiatry*, 16, 557-565.
- Ziółkowska, J. (2009). Positions in Doctors' Questions During Psychiatric Interviews. *Qualitative Health Research*, 19(11), 1621-1631.

* The publication was financially supported by Foundation for Polish Science.