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Constructions of the self in interaction with the Beck Depression Inventory

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ABSTRACT In this article, I am interested in discourses of people completing the Polish version of the Beck Depression Inventory (BDI). I focus upon the negotiation of the spaces for constructing the self opened by the BDI. My corpus consists of transcripts of 50 sessions in which self-reportedly healthy people were asked to ‘think aloud’ while completing the BDI. I shall demonstrate that in interactions with the ‘depression scale’, the informants mostly rejected the spaces offered by it. Three strategies of such rejection are discussed: reformulation, recontextualization and an explicit challenge to the categories offered by the BDI. I shall argue that the concerns of lived experience in a particular context, when not subdued by the relationship of power in the situation of medical examination, overrule the frame imposed by the a-contextual questionnaire of sadness. Insight into depression or its intensity offered by ‘context-free’ psychological or psychiatric instrument, set outside lived experience, is extremely problematic.

KEYWORDS *BDI; depression; discourse; experience; psychiatric tests; psychiatry*

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The Beck Depression Inventory

The Beck Depression Inventory (BDI), now in its second version, is a self-assessment tool for gauging the severity of depression (Beck et al., 1961; and for the second version, Beck et al., 1996). It is one of the most widely used and reputed to be reliable and valid self-report measures of depression, for patients in psychiatric care as well as the rest of the population (Nezu et al., 2002). The second version of the scale, the BDI-II (Beck et al., 1996) was designed to reflect the DSM-IV diagnostic criteria of the major depressive episode. Intended not to reflect any theoretical stance of aetiology of

depression (Beck and Beamesderfer, 1974), it consists of 21 items, each to be answered by questions ranked from 0 to 3, representing severity levels from no symptom to the most severe.

The psychiatric literature on the BDI focuses mostly upon its psychometric features, quoting the level of its reliability and validity (e.g. Beck et al., 1988; Schotte et al., 1997) and commonly applauds them (see e.g. Nezu et al., 2002). Criticisms are relatively infrequent and focus mostly on what exactly the Inventory measures. Coyne (1994) suggests for example that the BDI might measure the level of general psychological distress rather than severity of depression and points out that the scores of BDI can be reduced drastically a few days after admission to hospital, despite the fact that the patient might not have received any significant treatment (van Praag and Plutchik, 1987; Katz et al., 1995). Endler and his associates (2000) point out that the BDI might measure trait-like depression and, significantly, different aspects and levels of depression in clinical and non-clinical samples. In addition, Richter and his associates (1998) also indicate, among others, high item difficulties or doubtful objectivity of interpretation. Finally, there are also reports that the BDI might be interacted with differently, depending on gender and age of those who complete it (e.g. Page and Bennesch, 1993; Wallace and Pfohl, 1995; Aben et al., 2002; see also Steer et al., 1999).

However, such criticisms are made predominantly within the parameters set by the discourses of quantitatively oriented psychiatry and clinical psychology, taking an explicitly positivist research perspective. It assumes that questionnaires can gauge a 'psychological reality' of or in the people who complete them. They are looked at only as instruments that are to provide researchers with data of 'good quality' and thus must be clear, accurate, complete, logical and must compute well (Gillham, 2000; also Conrad et al., 1999).

Interestingly, even though there is some literature interrogating psychological and psychiatric instruments qualitatively (e.g. Morse et al., 1998; Gilgun, 2004), there is very little literature looking at them as socially situated texts (e.g. Drennan et al., 1991). However, I have found practically no literature approaching such instruments as institutionally empowered texts with which those who complete them enter into interaction and thus as texts which open up interaction spaces within which the person must find her/himself within (Kozłowska, 2004). A notable exception is a recent study by Barroso and Sandelowski (2001) in which the authors interrogate the BDI in view of the interactions one of them had while administering the questionnaire. They point out not only the difficulty their informants had with the BDI, but also the fact that their experience of depression could not be squared to fit into the scale. A disadvantage of this significant study is lack of a systematic insight into the discourses of those challenging the BDI, and focusing on the shortcomings of the instrument. In this article, I am going to reverse the perspective and focus upon those who were completing the scale.

Aims

I am interested here in how people asked to complete the BDI enter into interaction with it, how they negotiate the questionnaire and, more particularly, how they discursively negotiate the spaces the text afforded the respondent for constructing her/himself and her/his experience. Exploring the ways in which the self is constructed in interaction with the BDI, I am also interested in the implicit power relations within the interaction and what they mean for lived experience of mental illness (that is what people make of their illness).

The study

The research this article is based upon is part of a larger study into respondents' experiences of depression scales, and in this article I am focusing upon interactions with the Beck Depression Inventory. A convenience sample of 52 self-reportedly healthy men and women, and with no incidence of psychiatric care, were asked to complete the BDI and 'think aloud' while doing it.¹ The sessions were carried out by 2nd-year students of the Warsaw School of Social Psychology studying for an MA in psychology, who also were those to approach the informants with a request for an interview. The decision to ask students to contact the informants and administer the questionnaire resulted from my wish to create as non-face-threatening a research context as possible, and thus one conducive to engaging with the instrument. The young researchers were unlikely to have been perceived as in a position of significant power over the informants. All interviews were recorded and transcribed. I hope it will be clear in the course of this article that the informants' choices were psychopathologically meaningless; their 'scores' were therefore ignored.

The informants were chosen on the basis of their age (young and elderly), education (with primary/vocational and at least an MA in a discipline of the social sciences) and domicile (living in villages/small towns and in large cities). There were four groups of informants: (1) young, educated living in cities; (2) elderly, uneducated living in small towns or villages; (3) elderly, educated living in cities; (4) young, uneducated living in small towns or villages. They were told that they were participating in a study on how people fill out questionnaires such as the one they were about to complete and they were asked to 'think aloud' while doing it. During the session, those administering the BDI were instructed not to engage in any interaction with the informants. Thus, even in cases of being directly addressed by the informants with any issues concerning the research, the researchers were instructed not to answer them and limit their responses to the information from the beginning of the session.

By asking the informants to 'think aloud', I refer to the fact that people occasionally speak to themselves, and/or to other people, while doing

something. It is a social and discursive practice consisting in commenting upon or explaining one's actions as those actions are being done. Although it does not have to, the practice may involve interacting with those observing the activity. I decided to keep the term, rather than change it to something more 'scientific' such as 'on-line commentary' or the like, not only to reflect that I tried to anchor the research within an existing social practice, making my research more 'ecological', but also to make it more intelligible for my informants. For them what they were asked to do was 'thinking aloud'. Needless to say, using the term I do not wish to claim that in the process we tapped into the informants' underlying thoughts.

This is in sharp contrast to pre-testing techniques in psychological research and as a cognitive interview technique. On-line commentary is used to test the contents and the design of questionnaires. Informants are asked to report on their understanding of questions and options given and emotions towards them, or to comment on potential omissions (e.g. Blair and Presser, 1993; Gray et al., 2005). Such sessions are also claimed to provide insight into the informants' underlying thinking (e.g. Ericsson and Simon, 1993; Conrad et al., 1999). I wish to make no such claims.

The request to 'think aloud' while completing the BDI was the only instruction given to the informants. I thus attempted to get the respondents to take on the identity of informants trying to negotiate their 'interests', their 'real' answers, with the choices they were offered by the instrument. It is important to note that the technique, which was used in a qualitative 'replication' of a questionnaire (Kozłowska, 2004), resulted from a spontaneous commentary during completing of a questionnaire by informants, rather than from an instruction. My research attempts to capitalize on what Kozłowska observed as a social need to comment and account for questionnaire choices.

In the research I used the Polish version of the Beck Depression Inventory (e.g. Bilikiewicz et al., 2002: 511–13; also available as a hospital resource, published as promotional material for Lerivon, an anti-depressant medication), which is based upon the first edition of the BDI. The Inventory consists of 21 items, all with 4 options, numbered from 0 to 3, with 0 consistently indicating no depressive symptoms (yet, nil score on the scale still indicates depression, see later) and 3 the most severe ones (but see the critique of the language of the scale suggesting that in fact it is not a scale at all, Galasiński, 2008). The items gauge the severity of such symptoms as sadness, pessimism, sense of failure, self-dissatisfaction, guilt, punishment, self-dislike, self-accusations, suicidal ideas (items 1–9; see also Beck et al., 1996) and others.

Theoretical assumptions

Methodologically, the article is anchored in the constructionist view of discourse underpinned by the assumptions of the critically oriented

discourse analysis. I assume that social reality is constructed through and within language and that every language use designed to represent reality necessarily entails decisions as to which aspects of that reality to include, and decisions as to how to arrange them. Each of these selections, both in content and the lexico-grammatical form, made in the construction of a message carries its share of these ingrained values, so that the reality represented is ideologically constructed (Hodge and Kress, 1993: 5). It is also through discourse (i.e. practices of language use) that language users constitute social realities: their knowledge of social situations, the interpersonal roles they play, their identities and relations with other interacting social groups (van Leeuwen and Wodak, 1999). No text, spoken or written, including such 'scientific' instruments as questionnaires, presents reality in a neutral or objective way; representation is never of reality 'as it really is', rather it is always looking at it through the tinted lens of ideological assumptions (e.g. Fairclough, 1992; van Dijk, 1993; Halliday, 1994; Barker and Galasiński, 2001).

In my analysis I focus on both the content and the form of the message, relating it to the larger socio-political context in which they are used. Also, each act of analysis carries with it a decision regarding which of the aspects of the message to focus upon as the most relevant in constructing the realities under consideration. Using both the systemic-linguistic analysis (Halliday, 1994) as well as a hermeneutic-like interpretation of discourses in terms of the context in which they were submerged (see Titscher et al., 2000), I am attempting to reach the ideological underpinnings of the informants' experiences.

I am not interested in discourses used in designing the questionnaire (see also Galasiński, 2008). Rather, I am interested in discourses produced by informants as a result of dealing with an imposed version of reality. Thus, I want to approach the issue from the opposite end to what has been done so far. I want to take the perspective of the respondent and their experiences of having to deal with the institutionally empowered instrument designed to gauge their state of emotions and mind. To my knowledge there has been no research exploring the issue. Studies such as Houtkoop-Steenstra's (2000; also Suchman and Jordan, 1990; Antaki et al., 1996; Antaki, 2001) analysis of interaction in survey interviews explore standardized instruments, which are designed for interaction between the researcher and the respondent. In contrast I am taking on board an instrument that has not been designed for such interaction.

The experience of the BDI

There were three kinds of responses to the BDI's items. First, there were those where the informants accepted the item's requirement and made their choices accordingly, minimally narrating what they were doing. Second, there were those where the informants did not offer any comment (in fact

there were a few interviews in which the informants offered barely any comment at all). Such responses must be taken only as indicating that the informant would not make comment, rather than that s/he found the item/s acceptable. These two types of response accounted for a small minority of all the responses.

Third, there were those which the informants found problematic, unacceptable. These were instances where the experience of the informant could not be framed by the BDI. In this article I am focusing solely on this kind of response. There were three strategies with which the informants coped with the BDI. When they chose to interact with it, they reformulated the instrument's items in the way that suited them or, alternatively, they recontextualized the BDI and provided the context that allowed them to challenge the instrument's categories. On the other hand, some informants chose to construct the instrument as one with which one cannot interact and rejected it altogether. This was a blanket contestation of the BDI as inappropriate for one reason or another.

In my analysis I was interested in the discursive 'fit' between what the items demanded from the informant and what the informant actually decided to do with such demand. Just as with any communicative action designed to elicit a response, the items of a diagnostic instrument demand a particular answer. They project a 'demand', the meeting of which makes the response relevant (on relevance and conversational demand see, for example, Dascal, 1977; Holdcroft, 1987). Thus, the BDI, as other instruments, requires one not merely to make a choice from a selection provided, but also, implicitly, demands that the response is underpinned by the assumptions made in the question/item.

The three strategies I have identified subsume all those answers of the informants in which this was not the case. In other words, there was a hiatus between what the items demanded from the respondent and what s/he did in her/his account of what s/he was doing.

However, rejecting the instrument's relevancies is done at different levels in the three strategies. In the first one, the informants choose to ignore the demand projected by the item; the strategy is identified on the basis of a semantic relationship between the item and the response. It can be seen in terms of pretence (Galasiński, 2000) in that while providing a semantically irrelevant response, the informants maintain the pretence of co-operative completion of the instrument. The other two strategies offer an explicit challenge to the instrument in that they problematize its items. In the second strategy, the respondents re-interpret the items in different contexts, pointing out that they cannot be seen outside a particular context, while the third strategy rejects the items completely. Importantly, despite these challenges, the informants chose to co-operate at the basic level of filling out the BDI (see also later).

Reformulations

The first strategy I am going to discuss is reformulations and consists of responses in which the informants answer a different question from the one posed by the BDI. The informants re-constructed the items and the questions became those which the informants wanted to answer, rather than those which the BDI asked.

However, by suggesting that what the informants did is strategic, I am implicitly proposing that what they said was serving the goal of not engaging with the BDI as it was likely to be designed, and thus their strategy was deceptive or manipulative. Such an assumption is problematic. I have no evidence to suggest that this is the only explanation for what happened. It may well have been that the informants understood the items in a particular way and answered to the best of their understanding. Either way, however, the situation is quite unacceptable from the point of view of a quantitative instrument. Consider the following.²

Extract 1

AB, female, young, 'uneducated', town

(on item 12, Social Withdrawal)

Perhaps answer two, I have lost most interest in other people, now everything focuses round home, my nephew. He interests me the most, because he is tiny, lovely.

Item 12 in the BDI, gauging the level of social withdrawal was not meant to apply to people who lost interest in others because they had a new baby in the family. It was placed into the context of the informant's experience and she chose to mark a high score on the social withdrawal item. The extract shows the extent to which there is a mismatch between the BDI and the way the informant reformulates an item. The application of the scale in the local context of the informant's life reconstructs the way the item can be understood and thus interacted with. And the new baby is quite enough to overrule the relevancies of the BDI by the concerns of the day.

In the next two pairs of extracts I would like to show both how the informants interacted with an item, as well as the differences between them. The following two extracts are both made in reaction to item 14, Body Image Change.³

Extract 2

BC, female, young, 'uneducated', town

Indeed, I do worry that I look old or unattractive. I always think whether I am well dressed or not. Is it hip or not? And I worry, like in the question, that I look old and unattractive and I am thinking whether I look good, whether I am hip or well dressed at all, so I do pay attention to it.

Extract 3

MU, female, old, 'uneducated', town

I worry whether I look old and unattractive. I have not got the means to take care of my looks 'cause everything costs money.

Not only did neither informant take the item as it was likely to be meant – thus as one gauging the level of satisfaction with one's body – but they also differed in their understandings. MU takes the question in terms of her economic situation – she cannot afford to take care of herself; BC on the other hand interprets it in terms of her 'fashion judgement', both reformulating the question to reflect their experiences. The two women supply their own relevancies and their own contexts in the interaction with the questionnaire, the relevancies most likely related to their age and, possibly, gender.

Interestingly, both informants take over the linguistic form of the option they choose: 'I worry that I look old and unattractive'. They both 'worry' (*martwić się*), still they subvert the item. The space offered by the BDI is rejected and the informants offer a reformulation thereof. Yet, despite the rejection, they both opted for option 1, which suggests that they might present some symptoms of depression, even though, in view of their comments, their choices on the questionnaire are just about meaningless.

Similarly, it is primarily the context of age that underpins the following two responses to the item gauging Loss of Libido (item 21).

Extract 4

BC, female, young, 'uneducated', town

I am not particularly interested in the sexual problem for the time being. I don't think about it, I have not got a boyfriend, so somehow I have not thought about it, so even though I am of certain age, I am not concerned, I am not interested. Somehow, I have not thought about it, even though my [girl] friends do have boyfriends.

Extract 5

PK, male, old, 'educated', city

I am less interested in the issues of gender and sex and so on, and it results from, well, the age, and, obviously, that at present there is the unfavourable situation for men, 50 per cent, as they say on TV, have problems with the prostate, so this kind of thing happened to me.

While BC understands the questions aimed at probing into loss of libido as those about her interest in forming relationships (she still chooses option 2: 'Sexual problems are distinctly of less interest to me!'), PK understands it in terms of his ability to engage in sexual activity. Both reformulate the intended meaning of the item to reflect their own concerns.

It is perhaps worth noting that the instrument assumes that people have a 'healthy' appetite for sex. Within the world of the BDI, one cannot answer the question of whether one is interested in sex with 'well, it depends with whom'. It does not feature all sorts of reasons why people might be less interested in sex: illness, religion and other convictions, arduous lifestyle, or simply might not want it at all!

Recontextualizations

The informants also recontextualized the BDI items. They explicitly provided a context for items that were problematic for them. So, while in reformulations the informants took the item to mean something different from what was intended, here, they understood it in the intended way, yet, they showed its limitations. This is a strategy in which the BDI was constructed as a-contextual, an instrument in its own world with little contact with the 'real' one. Witness the following extracts.

Extract 6

DW, female, old, educated, city

(responding to item 7, Self-Dislike)

One is never fully happy with oneself. One always thinks one could be better, could do better, could be prettier, be healthier, could be something, I don't know, I am not particularly interested in wealth.

Extract 7

BO, male, young, 'uneducated', town

(responding to item 6, Punishment)

Looking from the point of view of the faith, every man deserves punishment. No one is sin free and everybody commits sins. And everybody deserves the punishment to a degree. And it depends on what kind of sins we commit, that kind of punishment we shall have, right? I think I deserve punishment. I think I deserve punishment.

Both informants chose to see the items in broad philosophical and religious contexts, invalidating thereby their points. If you cannot ever be happy with yourself, there is little point in asking whether you are; if you always deserve punishment, there is little point in asking whether you do. By recontextualizing the items, the informants not only invalidate them, but, more generally, they undermine the very basis upon which a questionnaire such as the BDI is founded: the possibility of asking a question of immensely complex experiences, which will be understood in a uniform way by people regardless of who they are, what outlook on life they have, what kind of experiences they have had. While reformulations cast doubt upon such a possibility implicitly, recontextualizations undermine the scale explicitly.

The two strategies of interacting with the scale are a lived translation of the academic arguments against standardized probes into people's experiences (e.g. Potter and Wetherell, 1994; Speer, 2002). Implicitly, therefore, a recontextualization is also a contestation of the scale, a rejection of the instrument and its assumptions. But the informants also contested the scale explicitly.

Challenging the BDI

There are two ways in which the informants contested the BDI. First, they explicitly challenged the items as problematic, unanswerable. Second, they rejected the scale altogether. Witness first the following two extracts in which the informants challenge the Sense of Failure (item 3) and Pessimism (item 2) items, respectively.

Extract 8

MM, female, young, educated, city

I don't think I fail more than, but this is a little strange question, because it should refer to a situation, I think, right? I don't know, a specific situation. And not just yesterday but a longer period ...

Extract 9

JG, 70 years old, male, educated, large city

... the second question, I don't care what it means, here is an interesting question. Is it my future? Or the future of the family, people or what? I do worry about the future of the children, family. As regards myself, for me, I don't care about the future.

The informants explicitly challenge the items for being unclear, impossible to answer. But in the context of a medical or psychological interview, they would not have had the luxury of voicing their problems, there is a sheet to mark, and whatever their misgivings about the answerability of the items, each item must be scored – and yet, it is difficult to see the meaning of the score in the situation when the respondent thinks s/he cannot answer the question.

But the challenge launched by the informants went further. In the next extract, the informant explicitly rejects the validity of asking certain questions. Witness:

Extract 10

PP, male, old, educated, city

(responding to item 14, Body Image Change)

You can't make one feel so down. I mean, damn it, everyone has been born, even the one most fucked up, a man, twisted, broken, head between his legs, but even he wants to live and he himself values himself. You can see it often.

What is most interesting in the rejection by PP is that he positions the item as a potential trigger for low mood. The BDI is constructed not so much as asking about things, but, rather, as suggesting them. This crippled, twisted person in PP's utterance has a right not to be reminded about his or her disfigurement, his or her dissatisfaction. This rejection, made on the basis of humanity and rules of social conduct, is particularly forceful because of the initial *nie można* ('one must not'), a phrase referring to a general, a-contextual rule. One just does not do this kind of thing, the informant can be interpreted to say.

The last extract and others unquoted here raise all sorts of methodological, clinical and ethical issues. The BDI (and like instruments) must be seen as imposing the clinician's frame of reference upon the experience of the patient with an almost complete disregard to that particular experience. The patient is asked to answer the questions constructed by the psychiatrist, posed by the psychiatrist and of interest to the psychiatrist. There is no possibility of negotiating the 'illness narrative' (Kleinman, 1988b; Frank, 1995), one which is far from set once and for all, but, rather, social, context-driven and rhetorical (Radley and Billig, 1996).

Finally, the extracts in this and previous sections show that the patient's (or respondent's) interaction is riddled with relations of power. Medical questionnaires are invested with much institutional, and particularly, medical power; they are not to be questioned, but to be filled in without the possibility of negotiation or rejection. The research reported here encouraged negotiation and commentary on what the informants were doing, and reformulations, recontextualizations and challenges were frequent. But, importantly, regardless of the strategy of interacting with the scale, the informants still made marks on the article upon which the questionnaire was printed! In the last two extracts, this power of the instrument was highlighted explicitly. One informant objected to the liberties taken by the item; the other resisted by ticking a different option from the one she might have wanted to select. But the ultimate challenge to the questionnaire's power, however, was actually changing it, crossing out words that offered a position impossible to take, an action actually taken by a few informants. There is little doubt that such actions would not have taken place in 'real life', in front of a psychiatrist; or perhaps *especially* in front of a psychiatrist.

Discussion

In this article I set out to show how people interact with the Beck Depression Inventory. I have discussed three strategies in which people coped with problematic items. They reformulated them – answering different questions from those posed by the instrument. They recontextualized them – providing such contexts in which the items were rendered nonsensical. Finally, they contested the scale, rejecting it altogether. I have argued that the study showed lived evidence for a sizeable literature arguing

against standardized psychological and psychiatric instruments as silencing people's voices expressing their experiences.

Now, my initial expectation was that it would be only the better educated social scientists who would reject at least some of the BDI's items, while the rest of the informants would be largely co-operative in completing the instrument, either finding it too face-threatening to challenge the questionnaire or simply playing the game and expediting the process. I was wrong in these expectations. I have found no patterns in how the informants interacted with the questionnaire, regardless of the level of their education, age and domicile. The three strategies were used by three groups without significant change in the level of rejection of the instrument or the kinds of strategies that were employed. In other words, all the informants rejected the items, or the assumptions that did not allow them to complete the questionnaire in a way that they considered accurately rendering their experience.

But I can see at least three significant reservations that can be made against my argument. First, my research was carried out with self-reportedly healthy people outside of the medical context, whereas the BDI is an instrument explicitly designed to gauge the severity of an already diagnosed depression and to be administered by a clinician. Second, the BDI is only one of a plethora of psychiatric instruments and cannot be seen outside the context of the patient's full examination. Third, whatever the problems, it actually works; people who get better while undergoing therapy score better on the BDI. Moreover, it correlates with other measures and thus can be shown independently that it works. Incidentally, such reservations have been raised in my discussions with practising psychiatrists and psychologists.

Of course, I am not claiming to be able to deal with all the issues resulting from the problems I am going to discuss; they go right to the heart of psychopathological research and diagnosis by standardized instruments. Thus I am attempting to show the possible reservations as problematic and unobvious and propose my comments as a platform from which further research and critical reflection is needed.

BDI and interaction with healthy people

What is crucial here is that the BDI assumes a nil score. The problem is that even the nil score is still taken to indicate depression (Beck et al., 1996) – most likely because the primary goal of the BDI is to gauge the severity of depression in those already diagnosed. The consequences of such a stipulation are quite profound. For if the nil score still means depression, then either the scale does not gauge the severity of the symptoms, or it is a scale whose (at least ancillary) aim is that of confirming and thus co-constructing depression, regardless of the merits of the diagnosis, a position untenable in view of a relatively large body of literature on the problems faced by psychiatric diagnosis, including Beck's own classical studies

(Beck, 1962; Beck et al., 1962, see also Kleinman, 1988a; Caplan and Cosgrove, 2004; Sadler, 2005).

Yet, in view of the scale itself, the nil score must actually mean ‘no depression’, as it is constructed in terms of denying symptoms (in itself extremely problematic, Galasiński, 2008) and it is taken to mean this in quite a number of studies in which it is used in detecting possible depression in non-clinical populations (Lasa et al., 2000; Dutton et al., 2004). Quite obviously such research assumes the possibility of getting non-depressed people to complete the scale and it would be implausible to assume that everybody whose score is nil is depressed. There is no reason why the non-clinical scale examined in this research should be seen as significantly different.

Second, the reservation implicitly assumes that the BDI works only in medical or quasi-medical (clinical psychological) contexts. If its respondents must necessarily be ill, then the BDI is actually an instrument of co-constructing the sick role, reinforcing it and providing a hurdle for the patients in depression to clear in their attempts to shed it. Moreover, it assumes that there is a ‘right’ way of completing the questionnaire and it depends on the *patient’s* sharing the discourse of psychiatry, or at least the discourse of the testing session and understanding what exactly is meant by the questions, and what kind of answers are expected of them. This, in turn, relies on medicalization of the patient’s experience of ‘professionalization’ of patienthood. Indeed, the responses of the informants suggest that they are not familiar with the notion of a depression scale, and they reject the idea that it is possible to square their experiences into a frame provided by the BDI.

The BDI in the context of the entirety of the patient’s experience

The second reservation might be that the doctor or therapist should see the BDI score in the larger context of the information on the patient. Admittedly, also such a score cannot be seen outside the larger context of the entire doctor–patient interaction and other diagnostic tools at the disposal of the clinician.

Now, as much as discourse is context-dependent (how what is said is meant or understood depends on the context), it is also context-renewing (i.e. what is said influences the context). Test scores are not only to be viewed within the context of the clinician’s story of the patient, they also co-construct the story. It is implausible to assume that clinicians who administer such tests as the BDI, do it only to reject them because of the ‘wider context’. Indeed, it is equally implausible to assume that there is some true and complete knowledge of the patient that can be seen as the ultimate context in which to view such measures, one to which the scores of standardized measures do not contribute. The doctor’s knowledge of human experience (extremely complex and difficult to pin down, even for the most experienced clinicians, as acknowledged also by mainstream

psychiatry, see, for example, Zimmerman, 1994), is discursive, contextual and subject to change, probably at a moment's notice, depending on, among others, test scores.

Moreover, the assumption that such contexts exist presumes a certain transparency of the patient. It assumes that the patient's symptoms can be 'read off', or as Verhaeghe (2004: 197) puts it, they can be 'extracted' from the patient, whose story is actually hindering the clinicians' task. Not only is the knowledge of the patient ever-provisional (even if the institutions provide means to reify it, for example in the form of patient notes), but it is gathered through interaction which is as much imbued with power relations and 'face' concerns as any other social situation. Patients are not transparent actors saying the truth, only the truth and nothing but the truth. Face concerns might be an overarching contextual consideration for the patient.

But it works!

Finally, one could argue that, social and discursive critiques notwithstanding, the BDI and other such measures simply work and do offer insight into the patients' condition and recovery. After all, people have different scores during and after therapy – indeed improving BDI scores are taken to be evidence of therapy's effectiveness (e.g. Grant et al., 2004). So, the argument continues: people might not exactly know what the author meant; still, they are able to fill in the scale consistently and one is able to have insight into their depression.

There are a number of problems with such an argument. First and most important is that the argument relies on the patient's 'professionalism'. S/he knows what is involved and plays along so that the doctor can have the data they need. Once again it assumes operating in medical discourses. The cross-instrument correlation often given in evidence would result not so much from the instruments' ability to gauge experience, but, rather, from their roots in the same dominant psychiatric discourse in which the patient is also submerged. Knowing what might be at stake – especially in a psychiatrist's surgery – the patient co-operates more or less willingly, trying to give the 'right' answers. Incidentally, such co-operation is not very difficult in the case of the BDI – it is extremely easy to realize after reading the first couple of items that there is a pattern to how the scoring is made and one can give answers without even reading the items (Dahlstrom et al., 1990).

The model of quantifying the experience of mental illness necessarily results in the dominance of medical discourse. The patient's experience cannot surface as s/he plays the game, getting more 'professional' every time s/he is asked to complete a questionnaire. Regardless of the theoretical standpoint assuming either that experience is primarily discursive or that there is a depression to be discovered behind the words, the situation is hardly acceptable. By having to respond to instrument items, the patient cannot access their depression. As Edgar (2005) points out, diagnostic

instruments impose themselves and their institutionally sanctioned goals upon the patient, inhibiting, at the same time, the possibility of the patient's reflecting upon her/his illness and its meaning. The situation of completing a questionnaire is one in which the patient cannot find their voice and offer a story of suffering rather than a measurement of madness (Kangas, 2001). Finally, it is one in which the potential diagnosis is institutionalized and becomes non-negotiable and thus adds to the trauma of being a psychiatric patient (Sayre, 2000; also Phillips, 2003).

The situation is exacerbated by the fact that psychological and psychiatric testing does not account for the power relations involved in the activity. It is crucial to understand that completing the BDI, and indeed other such instruments, is a socially situated, context-dependent activity, with its particular configuration of power relations, particularly relevant in the context of a psychiatric examination. Patients are not empowered to challenge the test itself, as the informants in my study were – they are to get on with the task; the co-operation is more than likely to be obtained.

The BDI cannot be seen outside its anchorage in the dominant discourse of psychiatry and clinical psychology. It works within the parameters of such discourse, and so it successfully measures something, because it corresponds with the rules of what constitutes such measurement. And while it might identify the (Major) Depressive Episode (ICD F32–33 or DSM, 296.2–3), it is unlikely to pin down the experience of low mood, sadness, the experience of what we call 'depression'.

The obvious final question to be considered is the value of the BDI (or indeed any other standardized psychiatric instrument's) score. Is it useful? As a linguist, I cannot see the point of it. As I have argued above, completing the questionnaire is part of a set of practices that turn people into patients and professionalize their patienthood. It does not offer a platform upon which a patient's experience can be meaningfully translated offering a clinician a shortcut insight into the patient's illness. In this sense, my point is not about coming up with a yet newer version of the BDI or any other such instrument. The practice of administering scales cannot be seen as having much to do with the experience of mental illness; rather, it is a means of getting the patient to submerge themselves into the dominant psychiatric discourse. The medical evaluation of this point is beyond the scope of an article by a linguist.

I would like to end this article with a plea for more concerted research leading to development of methods of assessment which would allow insight into experience of distress, ones which are framed by this experience and not put a frame on it which is only relevant to the researcher/clinician. It is important for such research to cross the boundaries of disciplines traditionally dealing with mental illness and its assessment. I hope to have shown here that discourse analysis can play a role of a critical but useful friend providing a fresh outlook on assessing psychological distress.

Notes

1. The research adhered to the ethical guidelines for research issued by the Polish Psychological Association (PTP). It was approved and monitored in the Wrocław Faculty of the Warsaw School of Social Psychology.
2. For space and practical reasons, I have decided to show only the translations of the Polish original discourses. The originals can be obtained from me by request. All translations of the data are mine. Sometimes, the extracts may seem somewhat disjointed and presented in 'poor' English. This is because I have attempted to render the originals as closely as possible.
3. This item was dropped from the BDI-II. I have decided to include the data resulting from the interaction with it, for my aim here is to show how people interact with a questionnaire. Moreover, my critique posits that quantitative instruments do not and cannot offer a meaningful insight into such complex and ideologically underpinned experiences such as that of mental illness. Amending the instrument (for example, by dropping an item) is not at issue.

References

- Aben, I., Verhey, F., Lousberg, R., Lodder, J. and Honig, A. (2002). Validity of the Beck Depression Inventory, Hospital Anxiety and Depression Scale, SCL-90, and Hamilton Depression Rating Scale as screening instruments for depression in stroke patients. *Psychosomatics*, 45(5), 386–93.
- Antaki, C. (2001). 'D'you like a drink then do you?': Dissembling language and the construction of an impoverished life. *Journal of Language and Social Psychology*, 20(1&2), 196–213.
- Antaki, C., Houtkoop-Steenstra, H. and Rapley, M. (1996). 'Quality of life' talk: The liberal paradox of psychological testing. *Discourse and Society*, 7(3), 293–316.
- Barker, C. and Galasiński, D. (2001). *Cultural studies and discourse analysis*. London: SAGE.
- Barroso, J. and Sandelowski, M. (2001). In the field with the Beck Depression Inventory. *Qualitative Health Research*, 11(4), 491–504.
- Beck, A.T. (1962). Reliability of psychiatric diagnoses: A critique of systematic studies. *American Journal of Psychiatry*, 119, 210–16.
- Beck, A.T. and Beamesderfer, A. (1974). Assessment of depression. In P. Pichot (Ed.), *Modern problems in pharmacopsychiatry: Vol. 7. Psychological measurement in psychopharmacology*, pp. 151–69. Basel: Karger.
- Beck, A.T., Steer, R.A. and Brown, G.K. (1996). *Beck Depression Inventory II*. Manual. San Antonio, TX: The Psychological Corporation.
- Beck, A.T., Steer, R.A. and Garbin, M.G. (1988). Psychometric properties of the Beck Depression Inventory. *Clinical Psychology Review*, 8(1), 77–100.
- Beck, A.T., Ward, C.H., Mendelson, M., Mock, J. and Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, 4(June), 561–71.
- Beck, A.T., Ward, C.H., Mendelson, M., Mock, J. and Erbaugh, J.K. (1962). Reliability of psychiatric diagnoses: A study of consistency of clinical judgments and ratings. *American Journal of Psychiatry*, 119, 351–7.
- Bilikiewicz, A., Pużynski, S., Rybakowski, J. and Wciórka, J. (2002). *Psychiatria*. Vol. 1. *Podstawy psychiatrii*. Wrocław: Wydawnictwo Medyczne Urban & Partner.

- Blair, J. and Presser, J. (1993). Survey procedures for conducting cognitive interviews to pretest questionnaires: A review of theory and practice. *1993 Proceedings of the section on survey research methods*. American Statistical Association, pp. 370–5.
- Caplan, P.J. and Cosgrove, L. (2004). *Bias in psychiatric diagnosis*. Lanham, MD: Jason Aronson.
- Conrad, F., Blair, J. and Tracy, E. (1999). *Verbal reports are data! A theoretical approach to cognitive interviews*. Federal Committee on Statistical Methodology Research Conference in Arlington, USA.
- Coyne, J.C. (1994). Self-reported stress: Analog or ersatz depression. *Psychological Bulletin*, 118(1), 29–45.
- Dahlstrom, W.G., Brooks, J.D. and Peterson, C.D. (1990). The Beck Depression Inventory: Item order and the impact of response sets. *Journal of Personality Assessment*, 55(1–2), 224–33.
- Dascal, M. (1977). Conversational relevance. *Journal of Pragmatics*, 1(4), 309–28.
- Drennan, G., Levett, A. and Swartz, L. (1991). Hidden dimensions of power and resistance in the translation process. *Culture, Medicine and Psychiatry*, 15(3), 361–81.
- Dutton, G.R., Grothe, K.B., Jones, G.N., Whitehead, D., Kendra, K. and Brantley, P.J. (2004). Use of the Beck Depression Inventory-II with African American primary care patients. *General Hospital Psychiatry*, 26(6), 437–42.
- Edgar, A. (2005). The expert patient: Illness as practice. *Medicine, Health Care and Philosophy*, 8(2), 165–71.
- Endler, N.S., Macrodimitris, S.D. and Kocovsky, N.L. (2000). Depression: The complexity of self-report measures. *Journal of Applied Biobehavioral Research*, 5(1), 26–46.
- Ericsson, A. and Simon, H. (1993). *Protocol analysis: Verbal reports as data*. Cambridge, MA: MIT Press.
- Fairclough, N. (1992). *Discourse and social change*. Oxford: Polity Press.
- Frank, A. (1995). *The wounded story-teller*. Chicago, IL: University of Chicago Press.
- Galasiński, D. (2000). *The language of deception*. Los Angeles, CA: SAGE.
- Galasiński, D. (2008). *Men's discourses of depression*. Basingstoke: Palgrave.
- Gilgun, J.F. (2004). Qualitative methods and the development of clinical assessment tools. *Qualitative Health Research*, 14(7), 1008–19.
- Gillham, B. (2000). *Developing a questionnaire*. London: Continuum.
- Grant, A., Mills, J., Mulhern, R. and Short, N. (2004). *Cognitive behavioural therapy*. London: SAGE.
- Gray, N.M., Sharp, P., Cotton, S.C., Avis, M., Philips, Z., Russell, I. et al. (2005). Developing a questionnaire to measure the psychosocial impact of an abnormal cervical smear result and its subsequent management. *Quality of Life Research*, 14(6), 1553–62.
- Halliday, M.A.K. (1994). *Introduction to functional grammar*. London: Edward Arnold.
- Hodge, R. and Kress, G. (1993). *Language as ideology*. London: Routledge.
- Holdcroft, D. (1987). Conversational relevance. In J.J. Verschueren and M. Bertucelli-Papi (Eds.), *The pragmatic perspective*, pp. 477–95. Amsterdam: John Benjamins.
- Houtkoop-Steenstra, H. (2000). *Interaction and the standardized survey interview: The living questionnaire*. Cambridge: Cambridge University Press.

- Kangas, I. (2001). Making sense of depression: Perceptions of melancholia in lay narratives. *health:*, 5(1), 76–92.
- Katz, R., Shaw, B.F., Vallis, T.M. and Kaiser, A.S. (1995). The assessment of severity and symptom patterns in depression. In E.E. Beckham and W.R. Leber (Eds.), *Handbook of depression*, 2nd edn, pp. 61–85. New York: Guilford Press.
- Kleinman, A. (1988a). *Rethinking psychiatry*. New York: Free Press.
- Kleinman, A. (1988b). *The illness narrative*. New York: Basic Books.
- Kozłowska, O. (2004). *ʔyæ bezrobociem: Analiza dyskursu bezrobotnych* [Living unemployment. An analysis of the discourse of the unemployed]. MA dissertation, Institute of Psychology, University of Opole, Poland.
- Lasa, L., Ayuso-Mateos, J.L., Vazquez-Barquero, J.L., Diez-Manrique, F.J. and Dowrick, C.F. (2000). The use of the Beck Depression Inventory to screen for depression in the general population: A preliminary analysis. *Journal of Affective Disorders*, 57(1), 261–5.
- Morse, J.M., Hutchinson, S.A. and Penrod, J. (1998). From theory to practice: The development of assessment guides from qualitatively derived theory. *Qualitative Health Research*, 8(3), 329–40.
- Nezu, A.M., Nezu, C.M., McClure, K.S. and Zwick, M.L. (2002). Assessment of depression. In I.H. Gotlib and C.L. Hammen (Eds.), *Handbook of depression* (pp. 61–85). New York: Guilford Press.
- Page, S. and Benesch, S. (1993). Gender and reporting differences in measures of depression. *Canadian Journal of Behavioral Science*, 25(4), 579–89.
- Phillips, J. (2003). Psychopathology and the narrative self. *Philosophy, Psychiatry and Psychology*, 10(4), 313–28.
- Potter, J. and Wetherell, M. (1994). *Discourse and social psychology: Beyond attitudes and behaviour*. London: SAGE.
- Radley, A. and Billig, M. (1996). Accounts of health and illness. *Sociology of Health and Illness*, 18(2), 220–40.
- Richter, P., Werner, J., Heerlein, A., Kraus, A. and Sauer, H. (1998). On the validity of the Beck Depression Inventory. *Psychopathology*, 31(3), 160–8.
- Sadler, J.Z. (2005). *Values and psychiatric diagnosis*. Oxford: Oxford University Press.
- Sayre, J. (2000). The patient's diagnosis. *Qualitative Health Research*, 10(1), 71–83.
- Schotte, C.K.W., Maes, M., Cluydts, R., de Doncker, D. and Cosyns, P. (1997). Construct validity of the Beck Depression Inventory in a depressive population. *Journal of Affective Disorders*, 46(2), 115–25.
- Speer, S. (2002). 'Natural' and 'contrived' data: A sustainable distinction? *Discourse Studies*, 4(4), 511–25.
- Steer, R.A., Ball, R., Ranieri, W.F. and Beck, A.T. (1999). Dimensions of the Beck Depression Inventory-II in clinically depressed patients. *Journal of Clinical Psychology*, 55(1), 117–28.
- Suchman, L.A. and Jordan, B. (1990). Interactional troubles in face-to-face survey interviews. *Journal of the American Statistical Association*, 85(409), 232–41.
- Titscher, S., Meyer, M., Wodak, R. and Vetter, E. (2000). *Methods of text and discourse analysis*. London: SAGE.
- Van Dijk, T.A. (1993). Principles of Critical Discourse Analysis. *Discourse & Society*, 4(2), 249–83.
- Van Leeuwen, T. and Wodak, R. (1999). Legitimizing immigration control. *Discourse Studies*, 1(1), 83–118.

- Van Praag, H. and Plutchik, R. (1987). Interconvertability of five self-report measures of depression. *Psychiatry Research*, 22(3), 243–56.
- Verhaeghe, P. (2004). *On being normal and other disorders*. New York: Other Press.
- Wallace, J. and Pfohl, B. (1995). Age-related differences in the symptomatic expression of major depression. *Journal of Nervous and Mental Disease*, 183(2), 99–102.
- Zimmerman, M. (1994). *Interview guide for evaluating DSM-IV psychiatric disorders and the mental status examination*. East Greenwich, RI: Pscyh Products Press.

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