Word Meanings in Oral and Written Psychiatrist-Patient Communication

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ABSTRACT

The evolving trends in today's institutional psychiatrist-patient communication give rise to non-transparent research methods and communication failures in psychiatry. We see the source of such problematic practices in fundamental misunderstanding and misuse of a word as a linguistic unit in modern psychiatric research. Our study focuses on the use of polysemantic words in psychiatrist-patient communication. We explore how psychiatrists and patients interact to infer meanings from words and expressions crucial for the outcome of psychiatrist-patient communication in various institutional settings. The study is qualitative and interdisciplinary: it is a semantic analysis supported by evidence from clinical interviews and enhanced by the observations of a psychiatrist. The results are presented in two parts. Part 1 focuses on the word meaning in an oral clinical interview. We analyze examples of mental patients' utterances from clinical interviews and describe how psychiatrists elicit meanings from their patients' utterances in a clinical setting. In Part 2 we describe the different ways in which words are used and interpreted by patients and clinicians in written communication mediated by a psychiatric clinical research questionnaire. We conclude this article by interpreting our results with regard to the objectives and values of the clinical discourse, and discussing whether or not the new ways of word usage boost the institutional capacity of mental health care.

Keywords: patient-psychiatrist communication; word meaning; polysemy; interpretation; discourse analysis

INTRODUCTION

Word meanings, specifically, polysemy, have always been at the center of linguistic studies. By contrast, in psychiatry, the nature of word meaning has largely been out of focus, since psychiatrists often regard words as raw data that are of no interest in and of themselves.

At the same time, both disciplines regard an utterance as a key unit of analysis. In psychiatry, a patient's utterance is a medium through which the clinician gains access to clinically significant phenomena. Indeed, a great deal of information about patients' health status and difficulties comes in the form of utterances. Over the past several decades linguists have paid very close attention to how word meanings are disambiguated, complicated, profiled and/or suppressed in dialogic utterances. A linguistic perspective on how the word functions in psychiatrist-patient exchanges can help with developing more humane and effective doctor-patient communication in psychiatry, as well as contribute to psychiatric research.

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BACKGROUND

The main objective of clinical discourse is to decode the clinical signs (manifestations of illness) coming from the patient. The participants of clinical discourse – the doctor and the patient – pursue their respective communicative goals in line with this objective.

The communicative goal of the clinician corresponds to the main objective of the clinical discourse: the psychiatrist tries to create an adequate atmosphere for conversation in order to obtain the patient's history as fully as possible and to further explore clinical signs of the illness: their qualitative, quantitative and temporal characteristics, their intensity, localization, and how exactly they are manifested. For that purpose, psychiatrists adjust their language to cater for patients' communicative abilities, depending on the patient's age, education, life history, character, and current health status.

The patient's communicative goal is to describe the essence of his/her suffering to the psychiatrist as precisely as possible. In practice, the way the mental patient verbalizes his/her experiences depends not so much on their communicative goal but on the patient's current health status and on the patient's understanding of what is indicative of his/her illness. Moreover, the patient's understanding of the function of utterances and the patient's idea of the motives of the interlocutor's verbal behavior may be the essence of the pathology, which the clinician is to detect. Therefore, such a discursive parameter as "communication goal" has to be applied to the speech of the mentally ill with caution. It would be more accurate to say that the mental patient feels a need to provide a feedback utterance as this is imposed by the structure of a dialogue. This need makes the mentally ill tap into their creative resources.

The current pragmatic principles dominant in psychiatry limit the variety of linguistic means that the clinician is allowed to use in communication with the patient. For example, the Foucauldian discursive mechanism "of prohibition" (Foucault, 1984) seems to underlie the present-day tendency to ban professional names of pathologies which are said to stigmatize patients. As of today, the International Classification of Diseases has excluded such terms as "*psychosis*" "*neurosis*", "*oligophrenia*" (as well as its variations "*idiocy*", "*imbecility*", "*debility*"), "*psychopathy*", "*hysteria*", and "*manic-depressive psychosis*". There is an ongoing discussion about abolishing the term "*schizophrenia*" as stigmatizing; and the term "*mental illness*" has been replaced with the vaguer "*mental disorder*" for decades. Psychiatrists pay special attention to avoid these terms when communicating with patients, both orally and in writing.

Over the past decades, we have witnessed significant changes in the discursive "procedure of exclusion" too, whereby individuals are selected or rejected as rightful agents of a discourse on the basis of the opposition between reason and madness (Foucault, 1984). Today the borderline between mental illness and mental health is virtually disappearing, with only the most severe psychopathologies set apart. This erosion is being made possible through various legislative changes and through transfer of psychiatric knowledge to the general public. Thanks to active mental health literacy promotion efforts, mental patients adopt professional vocabulary and become the rightful participants of psychiatric discourse. The current legislation provides for a mental patient's right to refuse or agree to undergo treatment, to choose a mental health facility and a medical practitioner, to opt not to take medication, to view his/her medical records, and to ask for the exact wording of the diagnosis.

This shift in the role of the mentally ill in the clinical discourse entails transformations in professional vocabulary. For example, psychiatric case histories used to be written only for a professional audience. In order to diagnose a psychopathology, a psychiatrist needs to analyze, assess and keep records of patients' life history, personality, behavior, and social activity. From the perspective of the medical professional, this kind of information is

exclusively factual and has no impact on the psychiatrist's relationship with the patient or on treatment. In contrast, the mentally ill patient will read such information as extremely emotionally charged. On the patients' side, the texts of case histories may be taken as an insult; they may be misunderstood, or they can cause disruption in doctor-patient communication; what is more, the texts of case histories can provoke various adverse reactions, ranging from a legal suit to direct physical aggression towards the doctor.

Therefore, in those cultures where the status and role of the patient in the doctor-patient communication is indeed growing, psychiatrists are switching to a new style in writing medical histories. It used to be a psychiatric tradition to rely on vivid, emotional, and evaluating descriptions of the patients' life history, behavior and actual status; nowadays we see a growing rate of set expressions and clichés from the International Classification of Diseases and various glossaries recommended for use in health care institutions. The free writing of the past is abandoned in favor of a dry protocol style. As a result, the psychiatrist's written language is getting increasingly formalized: psychiatrists need to envisage the possibility that patients may read their medical records.

Other trends in clinician's written production are connected with the impact of the precedent texts. The most authoritative precedent texts in today's medicine are the documents published by the World Health Organization. They set goals and priorities for health care development in United Nations member states and have a profound effect on the psychiatrist's professional language. Today, the expressions *"global burden of disease"*, *"mental health protection", "determinants of mental health",* and *"mental health promotion strategies*" have become routine. Some illnesses are called *"priority conditions"* (e.g. depression, dementia, autistic disorders) and are included in the WHO's action programs to *"address the mental health gap"*. From the WHO trend-setting texts, the language of medicine has borrowed numerous expressions typical of management and economics, for example, *"global burden"*, *"promotion"*, *"address gaps"*, *"determinant"*, and *"strategies"*. Thus, under the influence of the language of WHO resolutions, programs and recommendations, medicine has been pivoting its value system towards management and economics.

This shift in health care priorities has resulted is the emergence of numerous clinical linguistic tools whose purpose is to objectify and measure patients' complaints. Such tools are used to standardize data collection in *"quality"* clinical trials and to assess the effectiveness of health care during the *"quality"* of life studies. The developers of linguistic tools are constantly on the lookout for lexical means which would efficiently objectify the complaints of the mentally ill *and* be clear for patients.

PROBLEM

The current institutional changes in mental health care have an impact on the content and linguistic forms of the psychiatrist's and the patient's utterances. The patient's role as an agent of the discourse is becoming more important, and the linguistic forms used by clinicians and patients are changing accordingly. Patients' vocabulary, including the vocabulary of psycho-emotional states is expanding. In parallel, clinicians' professional language is shifting away from the traditional forms as some names of conditions and diagnoses are being banned, and the written, formalized communication between the doctor and the patient is expanding. The novel genre of written psychiatry-patient communication, communication mediated by an assessment tool, brings about new lexical usages. At the same time, even within older, traditional communicative practices, the patient's communicative competences have been described as impaired on all levels. Therefore, considering the role the patient plays now as a participant of this communication, the efficiency of the newer

strategies in psychiatrist-patient communication needs to be proved. Since the meaning and usage of individual words and expressions play are of crucial importance in psychiatric diagnostics, exploring the meaning of a word in traditional as opposed to novel institutional settings is one of the ways to compare the capacities of older and newer communication types.

LITERATURE REVIEW

Though the meaning of individual words and expressions is so significant for the outcomes of clinical discourse, the specialized literature has paid little attention to how these meanings are shaped and inferred in the course of psychiatrist-patient communication in various clinical settings.

One of the ground-breaking analytical works on the content of clinical discourse is by Michel Foucault, who analyses pragmatic factors underlying the forms of utterances in various discursive domains in different historical periods (Foucault, 1984). Important elements for our study are the Foucauldian mechanism "of prohibition", which determines what can and what cannot be said about an object, and the so-called "procedure of exclusion", whereby individuals are selected or rejected as rightful agents of a discourse on the basis of the opposition between reason and madness. The "procedure of exclusion" is a particularly relevant concept for our study as today we can see the borderline between reason and madness drifting, which has a major impact on the lexicon of psychiatrist-patient communication.

Another group of factors that certainly shapes the lexicon of psychiatrist-patient communication is described by Foucault as "internal". According to Foucault, internal factors are precedent texts which serve as a basis for production of utterances by other speakers within an institution. Mikhail Bakhtin called such utterances "authoritative":

> In each epoch, in each social circle …there are always authoritative utterances that set the tone – artistic, scientific, and journalistic works on which one relies, to which one refers, which are quoted, imitated and followed. In each epoch, in all areas of life and activity, there are particular traditions that are expressed and retained in verbal vestments: in written works, in sayings and so forth. There are always some verbally expressed leading ideas of the "masters of thought" of a given epoch. (Bakhtin, 2001, pp.1244-1245)

The concept of precedent authoritative texts helps to understand how today's attitude towards the role of health care institutions triggers new speech practices in clinical psychiatry.

The communicative situation of an oral psychiatric interview has been thoroughly described in literature (e.g., Targum, 2011; Ha & Longnecker, 2010). However, the areas most studied are conventional communicative strategies and typical speech acts, not the meanings of individual words. In order to understand how meanings of words take shape in the course of oral communication between the psychiatrist and the patient, we propose to look at the communicative background from the perspective of participants in that communication: the psychiatrist and the patient.

By the communicative background of a participant of communication we understand linguistic knowledge, knowledge of the world and initial communicative context, the importance of which was explored and emphasized by the founder of critical discourse analysis Teun A. van Dijk (van Dijk, 1977). Following van Dijk, we adhere that the initial communicative context with respect to which an utterance is interpreted includes "general semantic information (memory, frames), final state information from immediately preceding

events/act, and global (macro-)information about the whole previous interaction structures/processes" (van Dijk, 1977, p. 218).

In order to describe the psychiatrist's communicative background in the institutional setting, we take Foucault's idea of the structure of clinical knowledge as a starting point (Foucault, 2003). Foucault maintains that the structure of clinical knowledge is similar to the structure of a language. The words "signifier" and "signified" have a special meaning in clinical discourse: "signifier" refers to an observed clinical manifestation that "signifies" a disease. Bodily and mental manifestations of a disease are a system of signs, like any natural language. Foucault points out that clinical signs are described in linguistic terms: a "meaning" is attributed to any clinical sign (that is, every clinical sign means something to a clinician); symptoms are "interpreted": a symptom itself can have many variants of meaning, but it acquires a specific value and meaning when combined with other elements (e.g., other signs or symptoms). An experienced clinician is one who is capable of interpreting clinical signs in a patient. Foucault claims that "the form of composition of the being of the disease is of a linguistic type…To ask what is the essence of a disease is like asking what is the nature of the essence of a word" (Foucault, 2003, p. 119). In Part 1 of this paper we develop this idea, and show how psychiatrists interpret words of various lexical groups in the course of clinical interviews.

As for the mental patient's communicative background, which is essentially an object of psychiatric research, it has been partially described in the psycholinguistic literature in terms of linguistic performance (e.g., Chaika, 1974, 1982; Hinzen & Rossello, 2015). The linguistic disturbances in the mentally ill include the way in which the patient maintains oral communication and how s/he chooses lexical and grammatical forms, as well as abnormal verbal modeling and the use of individual neologisms that make comprehension more difficult. At a textual level a mental patient may have difficulty establishing coherence between parts of the utterance. At a pragmatic level we occasionally observe active or passive refusal to communicate, or utterances that are not relevant or are superfluous/insufficient in the context of preceding utterances.

The literature review has shown an apparent conflict between our existing knowledge of the mental patient's communicative background, the current understanding of a word as a linguistic phenomenon, and how that word is used in a psychiatric research questionnaire. The practice of questionnaire development is based on two interwoven and linguistically ungrounded assumptions: (1) that a word is a linguistic unit inseparable from a fixed meaning; and (2) that language communication provides undistorted information transmission. Let us consider each of these in turn.

The idea that the word is a linguistic unit inseparable from a fixed meaning has been repeatedly repudiated in theoretical and applied studies. Survey researchers have described how in the communicative situation of completing a questionnaire, respondents apply specific strategies in order to infer meanings from the words. It has been shown that, in the absence of an interlocutor, a respondent has no choice but to decode the meaning of the question based on the entire text of the questionnaire as a verbal substitute for the interlocutor. The following constituents of the text of a questionnaire serve as the substitute for an interlocutor: the order of the questions, their arrangement in relation to one another, response choices, and the order of response choices. For example, the cognitive experiments conducted by Sudman, Bradburn, and Schwartz (Sudman et al., 1996) show how the meaning of the label "irritated" varies depending on the content of response choices. The elicited meaning depends on whether the responses reflect low or high frequency: if the responses are from "less than once a year" to "more than once a month," the patients will think they are being asked about instances of major irritation. If the responses range from "less than once a day" to "several

times a month," respondents will understand they are being asked about cases of minor irritation.

The order of questions in a questionnaire also influences the interpretation of a label. Under the influence of Grice's "maxim of quantity", whereby one gives as much information as is needed and no more, the content of the preceding questions will automatically be excluded from the following questions; for example, if a question about life satisfaction is preceded by a question about marital satisfaction, marital satisfaction will automatically be excluded from the content of the question about life satisfaction. The question about life satisfaction will be interpreted as "Leaving aside marital satisfaction, how satisfied are you with the other aspects of your life?" (Sudman et al., 1996)

However, developers select words and expressions for survey questions during special linguistic experiments: conversations with patients and experts (the WHOQOL group, 1998), focused interviews of individuals or in groups, or structured / semi-structured interviews. In the course of such interviews, developers register how patients verbalize their problems and then, with the help of various statistical procedures, developers select patients' "own" words to be used as labels for health problems under investigation, for example, "irritability", "feeling anxious", etc. Developers then select labels to be introduced into the text of a questionnaire assuming that these words and expressions mean the same in a questionnaire as in the course of the interviews they had conducted. Therefore, the idea that words can be mechanically moved from oral communication to a written instrument and render the same content is incorporated into the procedure of questionnaire development.

As for the presumption that language communication provides undistorted information transmission, it does not stand up to scrutiny. Indeed, the respondent does not answer the question asked by the author but rather the question as s/he (the patient) has understood it (Sudman et al., 1996). This difference between transmitted and received messages is acknowledged by specialists in very different fields, from biology to linguistics. Understanding a text is not just decoding, but rather the conversion of a code or appropriation of the content of the text by the reader. The reader appropriates the content in a form that is clear to him/her: within the framework of the cognitive units, structures, links corresponding to the reader's background and worldview. As hermeneutic practice shows, the author of a text can never predict all the possible interpretations of the text or the reactions to it, nor the degree to which the content will be digested by the reader. The famous neurobiologist Maturana claims: "when it is recognized that language is connotative and not denotative, and that its function is to orient the orientee within his cognitive domain without regard for the cognitive domain of the orienter, it becomes apparent that there is no transmission of information through language" (Maturana, 1980, p. 32).

Since the questionnaire performs its instrumental function (to serve as a means of collecting data) on the basis of the meanings elicited by patients, every patient who participates in a survey becomes a co-author of the questionnaire, and the process of the interpretation of a survey question becomes an important communicative step which determines the success of communication. That is why in sociology, from which the genre of the clinical research questionnaire has been borrowed, the cognitive processing of a survey question has been thoroughly studied. The cognitive process begins with understanding the question and ends with articulating the answer. Many cases have been described where, under the influence of various communicative parameters (situational, demographic, the subjective feelings of the respondent), individuals' interpretations of key words have significantly distorted the meaning intended by the authors (Sudman et al., 1996).

With mentally ill patients, the process of interpretation of a survey question is even more ambiguated, and, to our knowledge, has not been described. In Part 2 we report the results of a cognitive experiment we conducted with mentally ill patients to fill this gap.

METHOD

Our paper is focused on how individual words and expressions are used and understood in psychiatrist-patient communication, because 1) psychiatrists often base their clinical judgment on their observations of the patients' use of individual words and phrases; 2) the results of psychiatric survey research rely on the interpretation of individual words and phrases that are used as labels of patients' experiences in clinical research questionnaires.

We analyze how psychiatrists and patients use specific words and word combinations. In doing so, we look only at so-called "face valid" psychiatric research questionnaires, which contain questions that developers think are straightforward. Such questionnaires typically ask patients about their psycho-emotional state, their physical well-being, and their ability to socialize, communicate, or work (such as the Toronto Alexithymia Scale, Spielberger's Self-Trait Anxiety Inventory, Beck's Depression Scale, etc.).

In line with discourse analysis methodology, we explore psychiatrists' and patients' utterances in connection with the communicative situation, in particular, the institutional setting, the status and roles of the communicants, the subject matter of the exchanges, the formality of the style, the communicative channel (oral/written), and the mental mechanisms relevant for perception of an utterance as a whole.

In Part 1 we explore how meanings are inferred from individual words and phrases in the course of oral psychiatrist-patient communication; the examples are drawn from clinical interviews recorded in 1996 – 2000 as part of a larger research project dedicated to pathological bodily sensations in the mentally ill (Davtian, 2002). The interviews were conducted with 105 mental patients (47 male and 58 female) from 18 to 79 years and with a control group of 64 mentally healthy patients suffering from various somatic diseases associated with painful bodily sensations (25 male and 39 female). The mentally ill patients suffered from disorders of the schizophrenic spectrum (58), organic mental disorders (32), and affective disorders 15).

All the interviews for Part 1 were conducted in Russian in a neuropsychiatric day hospital in St.Petersburg, Russia. For the purposes of this article, the patients' utterances cited in this paper have been translated into English by a Russian-English translator and proofread by an English native speaker.

In Part 2 we report results of our discourse analysis of 175 English clinical research questionnaires (Koudria, 2012). In order to investigate how the meanings of words are elicited in questionnaires, we conducted two cognitive debriefing experiments: one was conducted to see how a label functions within one linguistic culture, the other was conducted to compare the meaning of a label across two linguistic cultures. In the first experiment we asked respondents to explain the meaning of the expression "I have a headache" (У меня болит голова). This debriefing was conducted with the sample of respondents described in Part 1. The second experiment was aimed at verifying the functional equivalence of an English psychiatric questionnaire and its Russian translation. We have compared the meaning of the label "*feel at ease*" from the English version of Spielberger's State Trait Anxiety Inventory and the meaning of its translation "*чувствую себя свободным*" (back translation "*I feel free*") recommended for clinical use in Russian public research institutions. The semantic analysis of the English expression "*feel at ease*" is conducted on the basis of 96 contexts of use from COCA (Corpus of Contemporary American English). The meaning of the translated Russian item "чувствую себя свободным" ("*I feel free*") was tested on 10 mental patients and 5 healthy respondents. The mental patients were a mix of male and female respondents aged from 21 to 60 with diagnoses: schizotypal disorder (2), schizophrenia (4), involutional depression (1), cyclothymia (1) and bipolar affective disorder (2). The number of years of education they received was from 9 to 15. The group of mentally

healthy respondents included 5 people, male and female from 24 to 50 years of age, with the number of years of education received was from 9 to 15. The interviews were conducted in 2018 in a neuropsychiatric day hospital in St. Petersburg, Russia.

All the interviews for Part 2 were conducted in Russian with native Russian speakers. For the purposes of this article, the patients' utterances cited in this paper have been translated into English by a Russian-English translator and proofread by an English native speaker.

RESULTS

PART 1. WORD MEANING IN INDIVIDUAL ORAL PSYCHIATRIST-PATIENT COMMUNICATION

In a situation where the communicative goal of the patient is not always clear and the patient's speech contains deviations from normative word use, so hindering interpretation, the clinician's previous experience in communication with other mentally ill people is the only context which enables the psychiatrist to interpret the patient's utterances. The informational field developed in the clinic allows the doctor to see a system of signs behind the patient's individual signs-utterances. Our clinical experience proves just that: since a linguistic sign is part of the structure of the psyche, it has a diagnostic value in psychopathology. This creates a peculiar semiotic situation: the patient attributes and the clinician determines the pathological meaning of the linguistic signs.

Our clinical experience shows that the doctor has specific anticipations of topics a patient is likely to bring up. These thematic expectations stem from the clinician's theoretical knowledge and experience of communication with the mentally ill in general, as well as with the individual patient. We suggest considering these thematic expectations as the background context of communication in which the psychiatrist interprets the utterances of the mentally ill patient.

For example, in psychiatry, there is an important conceptual opposition "external threat" vs. "internal threat", which is a key element in diagnostics. The psychiatrist, when listening to the patient, is trying to detect all the linguistic forms that are indicative of either threat. In this light, the strings *"feel nervous in public"*, *"feel ill at ease on a subway train"*, *"too many people"*, *"stressed out in a crowd"*, and *"feel safer at home"* in the patient's speech require further comment from the patient's side: these strings do not indicate where the patient thinks the threat is coming from. These linguistic forms may signal that the patient feels an external threat coming on him/her from the outside world (which corresponds to the paranoid mindset). On the other hand, these same linguistic forms can indicate to a vague feeling of threat coming from the inside of the body: fears that they will *"feel unwell"* outside, *"no one will be there to help"*, *"when my blood goes crazy – I can feel the blood flow in my veins, my skin is tender to touch, the heart is palpitating and I fear it will stop"*(that corresponds to hypochondriac fears with fixation on the distorted body self-perception).

Naturally, the mental patient is in a difficult situation: they have to speak about experiences that healthy people have not been through, yet there are no ready-made, common linguistic forms that would describe these experiences. At the same time, everything that the patient verbalizes not only has a communicative effect on the addressee (advances the clinician in understanding of the patients' state), but also has an auto-perlocutionary effect: every word that the patient speaks allows the patient to categorize their feelings and emotions, change their assessment of their suffering, and change their attitude towards the illness. In this situation the linguistic forms that help to categorize, establish similarities and differences, qualify and characterize experience become clinically important. Our

investigation shows that the most common linguistic means mental patients resort to are the following.

In order to verbalize their specific experience, some patients create unique semantic objects: they combine common words in an unusual way, for example, we have registered phrases like *"filthiness in the chest"* and *"sensation of depravity between my brain and my skull"*. In these examples, we see an obvious tendency towards abstract word-building patterns (*filthiness*, *depravity)* typical of the academic style, which reflect the patients' need to objectify their experience. We also observe abnormal use of the words "*filthiness*" and "*depravity*". How can any clinically significant information be obtained from such abnormal word uses? A lay listener may rely on general linguistic and cultural experience and interpret "depravity" as referring to moral corruption or perversion. However, clinicians will interpret such phrases on the basis of their thematic expectations: psychiatrists expect to hear references to bodily experiences from mental patients, therefore, clinicians will understand this usage of "depravity" as expression of physical deterioration, or decay. In the course of our conversation with the patient who said *"sensation of depravity between my brain and my skull"*, the thematic expectations proved to be accurate, the patient indeed confirmed that they meant a physical sensation that the brain was deteriorating, "*shrinking in volume*", as he put it: *"This is a feeling that the brain is smaller than the skull, and the brain is bouncing and rolling as I walk"*.

In order to explain their condition mental patients also resort to comparisons. In these cases they use common literary comparisons and metaphors such as *"like a stone in my chest"*, *"blood boiling",* and *"my heart is empty"*. In the norm, the expression "blood is boiling" will signal that the person is describing an emotional peak, extreme nervous tension. For a psychiatrist, however, it is likely to refer to a bodily experience rather than a psycho-emotional one. In our practice, the topical comment that the mental patients provided for the expressions "*like a stone in the chest*" and "*blood is boiling*" showed that the person was speaking about their physical sensation of heaviness and burning in the chest, and of boiling blood. When we went on to ask "*Is it a bodily sensation or an emotion?*" the patients confirmed: "*This is a bodily sensation*". Therefore, the use and meaning of comparisons and metaphors in the speech of mental patients are incomparable with their meaning and use in the norm, their meaning always has to be further explored.

High frequency clichés like "difficulty concentrating", "come to senses", "make decisions", "anxiety", "feel anxious", "complete", "see something through" are also sometimes used by mental patients, but in a special way. From the mental patient's perspective these lexical means are not specific enough to describe their unique experiences because they are associated with the normal states of affaires. In order to signal that these are approximations, the mentally ill patients tend to precede these lexical means with adverbs, particles, and other types of hedging expressions that indicate uncertainty and hesitation: *"like", "somewhat", "sort of", "some kind of*": "*to sort of make some kind of a decision*", "*I have to kind of pull together and think*", "*to, like, come to senses*", "*we would typically, like, try to sort of finish what we started"*. We think that the function of these hedgers is to dissimilate, to alienate one's individual experience from common linguistic forms. The mental patients show doubts that these words indeed describe how they have been feeling. It is interesting that the patient who used the expressions cited above did not make a single use of the hedges "like", "sort of", "kind of" when describing specific events of her life. This serves as evidence that these are not junk words typical of this particular speaker, but rather filled pauses that signal uncertainty before using a certain semantic group of words. The occurrence of such clichés in the mental patient's speech makes the clinician ask for further elaboration, for a semantically related comment. The clinician tries to explore what exactly

the patient is describing: like in the case with the common comparisons and metaphors, any common set expression may refer to very uncommon, clinically important experiences.

Finally, mentally ill patients sometimes use psychiatric terms and general academic terms like *"depression", "sleep deprivation", "phobias"*, and *"panic attacks"*, but this does not guarantee accuracy. Such terms may be misused by the patient, or may result from a specific manner of speaking typical of some mental disorders in which the patient likes to speak in a highbrow, scientific-like style. Therefore, psychiatrists tend to ask the patient to elaborate in this situation, just as with the clichés described above. The clinician, too, uses common set expressions like *"intensity", "irritability", "difficulty conducting a dialogue", "perceive the world around you", "to withdraw", "energy",* and *"imagination is developed"*, but the clinician only uses such expressions as a topic for further comment from the patient's side. The clinician will ask the patient to agree or disagree with such verbal descriptions of their experience, to argue with it or to specify or to comment in any other way.

The mental patient's reality is often fully changed. These changes do not occur at a fast pace; many patients can remember what their reality was like when they were in good health and compare to the distorted reality they experience in sickness. However sometimes changes accumulate year after year, and the patient simply lives in this pathological (grey, sinister or unrealistic) world and does not remember (or does not know) any other world. In order to make a clinical judgment, the doctor has to try and look at the world through the patient's eyes, to stand in the patient's shoes. That is why the psychiatrist stimulates meta-communicative utterances (*"I really want to understand…"*, *"Did I understand you correctly…?"*) for further comments, explanations, specification, further elaborations. According to the clinicians, these elaborations are the core of an individual clinical interview: it is with words that the patient constructs his or her pathological reality, so speaking is the only way to understand the pathological reality.

Thus, the words in the patient's speech function as thematic markers, "signs" of the illness because the clinician places the patient's utterance into the context of all other utterances of other patients that the clinician has dealt with. Individual neologisms, clichés, comparisons and metaphors, as well as words of general academic vocabulary and professional terms used by the patient do not function in psychiatrist-patient communication in the same way as in any other type of communication: they acquire meanings within the system of signs with which only a clinical psychiatrist is familiar. Now we will go on to consider how such words and expressions function in the psychiatric clinical research questionnaire.

PART 2. WORD MEANING IN THE WRITTEN COMMUNICATION MEDIATED BY THE PSYCHIATRIC CLINICAL RESEARCH QUESTIONNAIRE

Psychiatric clinical research questionnaires rely on standard linguistic forms like "*I am nervous", "difficulty making decisions", "irritable" "difficulty concentrating/paying attention",* and *"difficulty seeing things through*". As shown above, such linguistic forms serve as a starting point in the oral psychiatrist-patient conversation: they serve as a topic to be followed by a comment from the patient's side. On the contrary, in a clinical research questionnaire, such expressions serve as a finishing point. They describe or qualify the patient's condition in a somewhat dictatorial tone: patients have no chance to produce new utterances, they only can agree or disagree. There are no ways to find out what significance each linguistic form bears for a particular suffering individual within their system of values, what role each symptom plays in the patient's understanding of his/her condition, and how

s/he interpreted specific questions in the clinical research questionnaire. The questionnaire blocks this clinically crucial information from the psychiatrist.

Why are such reverse communicative strategies applied within the same institutional discourse? We think that they are not perceived as being reverse by clinical investigators. Even though the procedure of selection and the use of labels for psychiatric questionnaires contradicts the current linguistic theory, clinical investigators act in disregard. Even more so, it is a common practice to use translated questionnaires as full communicative equivalents in cross-cultural psychiatric research, whereby interpretation problems multiply.

Let us begin with one language and consider an example of how labels selected for questionnaires receive different interpretations depending on psychopathology within one linguistic culture. In our cognitive debriefing experiment the Russian expression "*I have a headache*" ("*У меня болит голова*") invited a vast variety of interpretations by Russian speakers, and the differences were clinically significant. Russian mental patients explained the meaning of "headache" in this expression as follows: *"pain and strain at the back and top of the head, as if two centimeters had been cut off from the upper part of the head"*; *"the sensation of transition in the head from the left to the right part…. like water, like a river flowing"* (this comment is indicative of sensopathia); *"blackout in the head"*, *"sensation of cracked tiles"*(indicative of autopsychic depersonalization); *"headache in the morning that goes away in the evening"*(indicative of a vital component of depression with circadian dynamics); *"tumult in the head"*, *"buzz of thoughts"*, *"impossibility to calm thoughts down"* (indicative of mentism); *"they cause a burning sensation in my head"*, *"they cause a headache"* (indicative of cenesthopathic automatism).

As we see, the variation in interpretation of one label can be clinically significant; however, a questionnaire conceals this clinically important information behind the labels. The patient just ticks a response choice and goes on, the patient's real mental condition being neglected by the circumstances of communication. It seems that the psychiatric clinical research questionnaire does not decode clinical signs but rather encodes them, contrary to the main goal of communication in clinic that we indicated at the beginning of this article.

Labels in translated questionnaires borrowed from other cultures (especially from English and US culture as major suppliers of mainstream clinical research questionnaires) present a specific source of deviations in psychiatrist-patient communication. Since the English language is now the lingua franca of cross-cultural clinical research, translated questionnaires contain categories that are part of the clinical discourse in the English-speaking world: *"satisfied"*, *"satisfaction"*, *"to enjoy"*, *"to enjoy life"*, *"depression"*, *"happy"*, *"happiness"*. These words categorize psycho-emotional experience in a way relevant to the English linguistic culture, and are built into the lexical system of the English language. The disciplines that objectify psycho-emotional states (psychology, psychiatry) use such words to denote the subject matters of their fields, as if these words existed out of the linguistic and cultural context. When using such words in psychiatric questionnaires, the authors seem to try to create universal epistemological units on the basis of meanings specific to the English language lexical system.

Such labels cannot always be fully translated into the target languages because they include a lot of cultural information as part of their meaning, and are clinically significant only within the culture of origin. Nevertheless, they have to be translated somehow, and translation often boils down to using the first equivalents provided in a dictionary. Such translations, which are called "literal", include a different set of conceptual and culture-specific meanings and show the greatest variety of interpretations during cognitive debriefings.

We have conducted a set of cognitive debriefings to test whether such a translation technique can distort meaning in any **clinically** significant way. We tested one of such

translated labels on the target population of 10 mentally ill patients and a control group of 5 healthy respondents during individual cognitive debriefings. We compared the semantic structure of the expression "to *feel at ease*" from the STAI (Spielberger Test Anxiety Inventory) with its current Russian language counterpart, which can be approximately back translated as "*I feel free*". We described the meaning of the English expression "*to feel at ease*" on the basis of a semantic analysis of contexts from the COCA (Corpus of Contemporary American English); the total number of contexts we analyzed is 96. Then we described the meaning of its translation "*I feel free*" ("чувствую себя свободным") on the basis of cognitive debriefings with target language speakers. In the course of cognitive debriefings we asked each respondent "*Please explain in your own words how you understand the meaning of the statement "I feel free*" ("чувствую себя свободным").

Let us first consider how "*I feel at ease*" is used in English in order to establish the specific linguistic and cultural meaning that this expression bears. Here are three typical examples we found in COCA. Example (1) *"In Occupational Health it is important to introduce yourself in a warm and friendly manner and to make your client feel at ease"*. Example (2) *"I know that, as a black man, I am not safe," Mr. Corley said. "If I am driving and I pass a police car, I do not feel at ease. I feel apprehensive, especially if the police are white"*. Example (3) *"We feel at ease with people in a way that was impossible in daily life: included, accepted, cherished"*. Examples (1) and (2) describe situations where the doer of the action does *not* "*feel at ease*", for example, the doer of the action experiences an opposite feeling. The doer feels anxious, tense (the marker *"apprehensive"*), feels a threat (the marker *"not safe"*) as a client of an institution in example (1) and as an Afro-American who encounters a white police officer in example (2). In examples (1) and (3) the state "*feel at ease*" occurs as a result of a good, sympathetic attitude (the marker *"warm and friendly"*), or as a result of the sensation of belonging to a group of like-minded, being equal (the markers *"included, accepted"*). There are also a lot of linguistic markers that when one "*feels at ease*" he or she can behave naturally, casually, like they are used to (the marker *"in daily life"* in (3), as well as the markers *"natural"*, *"casual"* in other contexts). Therefore, the contextual analysis of the source English "*feel at ease*" shows that in modern English, "*feel at ease*" refers to a positive experience connected with a feeling of security, absence of tension, especially when the person is in an unfamiliar and uncomfortable situation (for example, in an institutional setting, in a situation of a mandatory, or involuntary communication with others).

The testing of its Russian counterpart "*I feel free*" ("чувствую себя свободным") shows that mental patients who are speakers of the target language (Russian) mainly understand this statement as describing the absence of burden caused by their current psychopathological status. Here are some patients' explanations of what "*I feel free*" means to them: *"this is when you stop taking medications, you feel that you are free from medications"*, *"this is when I do not have my obsessive thoughts, they do not affect me"*, *"this is when nothing bad is going on"* (by *"nothing bad"* the patient means that the symptoms of the illness do not bother him), *"bodily freedom"* (in a patient with a cenesthopathic-hypochondriac syndrome), *"negative thoughts do not occur in my head"* (here: thoughts that occur as if out of nowhere, by themselves, in neurosis-like syndrome). The second thematic group observed in the mentally ill respondents is the absence of rules or constraints: *"I feel free means the person can do anything they want, there are no obstacles in life"*, *"it means I can do anything I want to"*, *"it means I am free from everybody, no one controls me"*. In one case, a patient with schizotypal disorder spoke about the component of meaning which is very close to the source "*feel at ease*": *"I feel free" means that I do not feel a threat over me"*. This seems to correspond to the concept of security, absence of threat described above for the English "*feel at ease*". However, in the context of her illness, this

linguistic form denotes an experience that is absent in healthy people; it is a rudiment of a paranoid position, a pathological experience of a threat coming from the world around. As we can see, the text of the translation (and possibly the text of the source) does not possess sufficient "resolution power" to differentiate such clinically important semantic nuances.

Mentally healthy respondents all reported their inability to interpret the statement "I feel free" definitively (some said they could not explain it at all); each respondent suggested several different interpretations. In the first place, healthy respondents related the statement to personal freedom: *"it means I am not in prison"*, *"it is my first day on vacation, so I feel free"*. Also, the statement was associated with bodily freedom: *"it means I feel free in the physical sense, physically free"*, *"I feel free when clothes do not restrain my movements"*, and with the freedom of mind: *"I feel free" means "I feel mentally free"; "I feel free means to be free in public, free when you socialize, when you interact with people*".

As we see, the translated expression only partially covers the meaning of the source expression, and the difference is important for diagnostics. The translated expression contains a lot of additional information which is undesirable for a psychiatric study of anxiety. In particular, the translated expression includes an additional concept of freedom from rules and regulations, absence of obstacles, and personal and physical freedom. For some patients, the translated expression refers to a specific psychopathological meaning of "an outside threat" that has nothing to do with the personal anxiety, which the text of the questionnaire has to measure. Besides, the translated expression lacks clinically important concepts of the sensation of security and the ability to behave naturally.

We conclude that the current translation of the expression "*feel at ease*" is not functional, it does not correspond to the function of this word in clinical communication. The considerable discrepancies in interpretation between the source and the translation outlined above do not allow the source and the translated survey question to be used for a cross-cultural study of anxiety in mentally ill patients. Our experience shows that this is true of many words that are selected as labels of psycho-emotional states including *happiness, enjoy, enjoyable, satisfied, control, depressed, frustrated, tired* and others.

Interestingly, some borrowed labels of psycho-emotional experiences penetrate into the oral speech of clinicians in target cultures. For example, traditionally, in some cultures, apathy and depression used to be probed with questions about absence of interest or unwillingness to do something, etc. Nowadays, with English as a contact language in cross-cultural psychiatric research and high rates of linguistic interference, it is quite common for a psychiatrist in cultures other than English or US to ask whether the person is able to "*enjoy life*". Clinicians testify that such wording is often puzzling for mental patients in countries other than English-speaking because, even if this expression can be literally translated into a target language, the concept is still perceived as foreign and somewhat vague. How adequate it is to use borrowed labels for the purposes of cross-cultural psychiatric studies has to be further explored and proved.

Our experiment illustrates that words live a totally different life and acquire quite different meanings in the context of a questionnaire as compared to how they are used in oral doctor-patient communication. Firstly, the words selected as labels during focus interviews have a different function in questionnaires: they function as stimuli for qualitative or quantitative assessment, not as a commentary. This means that in questionnaires, words are not used to comment on meanings, but rather they function as a starting point in a dialogue between the patient and the psychiatrist, thus opening possibilities for a variety of interpretations.

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CONCLUSION

We have compared strategies and results of interpretation of words during a clinical interview and during completion of a questionnaire by a patient. Each word acquires its meaning only as a constituent of an utterance, in compliance with the function that this word plays in a specific communicative situation. In spite of numerous linguistic studies that prove just the opposite, there is an assumption underlying the use of psychiatric questionnaires that any word of a natural language means "the same" in different genres. This assumption does not correspond to our observations of word functioning in different clinical contexts. Our experiment with mental patients only confirms Bakhtin's concept that the word is a product of social interaction, a social event rather than an abstract linguistic value.

Therefore, it is an illusion that psychiatric questionnaires use "the same words" as the patients speak in focused interviews as part of questionnaire development. This illusion stems from the fact that the words and word combinations, clichés, general academic vocabulary and borrowed words used in questionnaires belong to general everyday vocabulary as well as psychiatrists' professional vocabulary. These linguistic forms are used by patients and doctors, but differently and with different communicative purposes. For a practicing psychiatrist the linguistic forms "*happiness*", "*enjoy life*", "*frustration*", "*difficulty concentrating*" and "*anxiety*" are terms from a textbook which have a fixed meaning in an academic text. From the patient's perspective these words are part of their everyday communication and each speaker, using these words, refers to unique content, depending on the function of the word in the utterance and the context of communication. This is exactly why, in the course of a conversation with a patient, the psychiatrist will see such words as clinical signs subject to further exploration.

As we can see, in a clinical research questionnaire three functional domains are combined in one word: the domain of professional description of the illness, the domain of common linguistic description of an illness, and the domain of the patient's subjective description of the pathological reality. The questionnaire developers leverage this multiple orientation of the word in a questionnaire in order to try objectifying patients' complaints and speaking "the same" language as the patient. Seeking a common language with a patient is one of priorities in the modern psychiatry. Firstly, the development of a common language with the patient is in line with the present-day rise of the status of the patient as an agent of communication. Secondly, a common language with the patient is necessary in order to bypass the subjective clinical judgments of the psychiatrist and to objectify the patient's complaints. Both of these objectives correspond to the present-day values of health care as outlined in Part 1 of this paper.

However, such word use is not justified from the perspectives of the values of clinical discourse. Thus, study of the word meaning in psychiatrist-patient communication shows that multiple orientation of a word in a psychiatric clinical questionnaire does not mean that the institutional interests of all communicants are equally met. Psychiatric clinical research questionnaires are insensitive and blind to the patients' interests because they do not allow patients to create their own utterance. The use of words in the psychiatric clinical research questionnaire therefore contradicts the main goal of the clinical discourse – to decode clinical signs. Therefore, clinical research questionnaires seem to have little pragmatic value in psychiatrist-patient communication and curtail the institutional capacity of psychiatry.

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