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The McGill Illness Narrative Interview (MINI): An Interview Schedule to Elicit Meanings and Modes of Reasoning Related to Illness Experience

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Abstract This article summarizes the rationale, development and application of the McGill Illness Narrative Interview (MINI), a theoretically driven, semistructured, qualitative interview protocol designed to elicit illness narratives in health research. The MINI is sequentially structured with three main sections that obtain: (1) A basic temporal narrative of symptom and illness experience, organized in terms of the contiguity of events; (2) salient prototypes related to current health problems, based on previous experience of the interviewee, family members or friends, and mass media or other popular representations; and (3) any explanatory models, including labels, causal attributions, expectations for treatment, course and outcome. Supplementary sections of the MINI explore help seeking and pathways to care, treatment experience, adherence and impact of the illness on identity, self-perception and relationships with others. Narratives produced by the MINI can be used with a wide variety of interpretive strategies drawn from medical anthropology, sociology and discursive psychology.

Key words ethnography • explanatory models • health behavior • illness narratives • research methods • prototypes • qualitative interview

In this article we present the McGill Illness Narrative Interview (MINI), a theoretically driven, semistructured, qualitative interview schedule designed to elicit illness narratives in health research. The MINI can be a

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useful tool not only for research in medical anthropology and cultural psychiatry but also in related fields including medical sociology, medical geography, health psychology, public health, literary pathography, and other disciplines that aim to understand health behavior or illness narratives in sociocultural context. Working with the rich narratives obtained with the use of the MINI may stimulate exchange between disciplines and complement quantitative research methods.

In the first part of the article, we address the epistemological, disciplinary and theoretical contexts in which the MINI was developed. We then discuss the strengths and limitations of this instrument. As well, we outline the steps that should be taken before interviewing in order to maximize the validity and usefulness of the narratives produced. Finally, we provide explanations of each of the sections of the MINI along with guidelines for its use. A version of the interview schedule is reproduced in an Appendix.

THE NARRATIVE TURN: CONTEXTS OF NARRATIVE-BASED RESEARCH

The study of health behavior, illness experience and meaning can be approached through a variety of research methods, disciplines and scientific paradigms. While quantitative research methods have dominated recent psychiatric research, they have significant limitations in capturing the complexity of human behaviour and experience (Guba & Lincoln, 1994). In particular, quantitative measures tend to ignore the social and discursive contexts in which individual and collective understandings of illness experience emerge. Even the simplest, apparently straightforward questions of epidemiological interviews may be interpreted quite differently by people who employ different cultural frames. Understanding the meaning that individuals give to their experience may be crucial to explain the statistical associated between variables observed in quantitative studies of groups or populations.

Qualitative methods, in particular the narrative approach, are meant to overcome some of the inherent limitations of questionnaire-based research by studying health behavior as 'a means of examining the ways in which individuals make sense of their lives within a changing sociohistorical context' (Phinney, 2000, pp. 27–28). A variety of methods for qualitative research interviewing have been systematized and presented in texts and monographs in recent years (Arksey & Knight, 1999; Holstein & Gubrium 1995; Kvale, 1996; Mishler, 1985; Rubin & Rubin, 1995). Across the wide range of available methods, qualitative interview research shares a constructivist perspective that views the speaker or interviewee as actively involved in meaning making (Holstein & Gubrium, 1995; Whitley & Crawford, 2005).

This constructive process has both internal psychological dynamics and external social dynamics. The psychological dynamics include the ways in which narratives are shaped by processes of memory and emotion regulation and may undergo internal censorship, revision and reorganization to maintain an account of self and others that serves the individual's goals and adaptation (Neisser & Fivush, 1994). As a result of these psychological dynamics, narratives are always multilayered and polysemous, with traces of their genesis in internal conflicts, biases, dissonance reduction, and efforts to attain cognitive coherence.

The social dynamics of narratives reflect their use for communication, social positioning and rhetorical influence. Narratives are always situated: told from a specific social position, to someone for some reason (Harré & Van Langenhove, 1999). As a result, the audience plays a role in the construction of narratives, even in the case of private soliloquy, when there may be an imagined audience. At the same time, narratives serve to reposition the speaker and audience, claiming a social place and defending it against challenges or efforts at displacement. Traces of the social dynamics that give rise to illness narratives are found in the heteroglossia and the specific strategies employed to give a narrative the rhetorical power to influence others (Kirmayer, 2000).

In recent decades, there has been an enormous growth of narrative research with diverse theoretical orientations and methodologies that include studies that focus on the content of narratives, identifying dominant themes relevant to social theory (Glaser & Strauss, 1967), and studies inspired by literary theory that focus on the form of narratives, where the interest lies in understanding their story-like structure (Czarniawska, 2002; Riessman, 2002; Smith 2002). These different analytical approaches are grounded in various disciplines of the social sciences and humanities, including sociology (Brown, 1977), literary theory (Bakhtin, Medvedev, & Wehrle, 1991), anthropology (Geertz, 1973), political science (Fisher, 1984), psychology (Bruner, 1990), philosophy (MacIntyre, 1981; Rorty, 1991) and history (White, 1987). Although each discipline has developed methodological strategies for narrative-based research, more basic theoretical models and allegiances remain crucial to the analytic and interpretive strategies and must be made explicit to avoid conceptual biases and to resolve potentially conflicting results among studies of the same subject (Wengraf, 2001).

Warren (2002) has argued that researchers who choose qualitative interviews over participant observation do so because their primary focus is on establishing common patterns of meaning within certain groups or types of respondents rather than examining cultural context per se. In this perspective, qualitative interviewing can be a useful tool for studying health behaviors such as treatment adherence or pathways to care within

or between cultural communities. But the capacity to compare narratives based on health behavior depends on the level of structure of the qualitative interview. Completely unstructured interviews may yield narratives that are too different across subjects, making systematic comparison impossible. For example, if a narrator does not produce a meaning relative to one aspect of the health problem discussed, it does not necessarily mean that he does not share the same meaning with another narrator who did mention it. It may simply be that he did not address this specific meaning because he was not explicitly invited to do so via a structured question in the interview schedule. Structured interviews with open-ended questions invite narrators to make statements on predetermined subjects without limiting their potential answers to a predetermined set of possibilities (as in the closed-ended questions typically used in quantitative research), and thus allow systematic comparison across interviews.

Qualitative interviewing is a form of 'guided conversation' in which the researcher systematically looks for and carefully listens to what is being conveyed 'so as to hear the meaning' (Kvale, 1996; Rubin & Rubin, 1995). Qualitative interviews must therefore also contain at least some *unstructured questions*, otherwise narrators will not have the opportunity to tell their story in their own way, thus limiting access to the sociocultural processes that influence their experience. This type of analysis was initially developed in literary theory but has since been widely used by researchers in medical anthropology (Garro & Mattingly, 2000). It seems then, for the purposes of comparison, and in order to access the sociocultural context involved in illness experience, interviews must contain both structured and unstructured elements.

Intensive, open-ended interviews have been a core methodology in ethnography and medical anthropology (Kleinman, 1980). Although narrative-based methods are increasingly recognized as a means of examining the multiple ways in which individuals make sense of their symptoms and illness in health research, studies based on qualitative methods are still uncommon in psychiatry (Whitley & Crawford, 2005). Only a few reports have been published on qualitative interviews designed to explore patients' illness experience and health behaviors. Kleinman's original set of questions developed to elicit explanatory models have been widely used and adopted in both clinical and research settings (Kleinman, 1980; Kleinman, Eisenberg, & Good, 1978) but there has been little work on how such questions actually function in the interview context.

Several interviews have implemented a mixed method approach, incorporating both structured-quantitative and open-ended qualitative components to facilitate systematic comparison. The chief example is the Explanatory Model Interview Catalogue (EMIC; Weiss, 1997; Weiss et al., 1992) which uses structured questions and an elaborate predetermined

coding scheme to produce quantitative measures of symptom attributions and other features of illness experience. The Short Explanatory Model Interview (SEMI; Lloyd et al., 1998) was developed to provide a brief method of assessing illness attributions and other aspects of explanatory models. Such mixed method interviews have varying levels of structure and may include checklists of symptoms and illness attributions. While this allows systematic comparison it may not produce narratives of sufficient spontaneity and depth to allow more intensive methods of narrative and discourse analysis.

THE MCGILL ILLNESS NARRATIVE INTERVIEW

The MINI, a semistructured qualitative interview schedule, was initially developed to explore individuals' illness experience in a community study of help seeking, medically unexplained symptoms and use of mental health services (Young & Kirmayer, 1996). The initial protocol was based on Young's experience with ethnographic interviewing in Ethiopian communities and in primary care settings in Israel. The interview was field tested and refined by discussion among the investigators and with six interviewers (who had Masters-level training in anthropology, psychology or social work) who conducted a total of 120 interviews in English, French or Vietnamese.¹

The MINI was subsequently adapted to explore treatment adherence and delayed emergency room presentation in first-time postmyocardial infarction patients (Groleau, Hudon, Lespérance, Rosberger, & Kirmayer, 2006, and the behavior and meaning systems of patients with hyperemesis gravidarum (Groleau, Jimenez, Zelkowitz, & Kirmayer, 2005). The current version of the MINI represents the fourth major iteration in its development. Although the questions included in the MINI reflect the focus of specific projects on illness experience, symptom attribution, help seeking and treatment adherence, the structure of the MINI emerged from more basic assumptions about the nature of knowledge structures underlying illness narratives.

The MINI was initially developed in response to Young's (1981, 1982) critique of the explanatory model perspective in medical anthropology. Young argued that there is a tendency in health psychology and medical anthropology to suppose that lay accounts of illness experience form logical and coherent schemas organized around causal attributions. On the basis of his ethnographic work in community and clinical settings, Young suggested that, in fact, individuals use multiple representational schemas and modes of reasoning to produce illness narratives that are complex and sometimes internally inconsistent or contradictory. In particular, Young pointed to the importance in illness narratives of salient *prototypes*, which

are used to reason analogically about one's own condition, and to *chain-complexes* (a term borrowed from Vygotsky, 1962, 1978), which involve representations of association by contiguity and which are used to reason metonymically (Young, 1981; see also Kirmayer, Young, & Robbins, 1994).

Studies have indicated that patients facing serious illness do not always offer causal attributions for their illness (Weiner, 1985). Explanatory models based on patients' causal attributions of their disease reveal only a small portion of the many representations that come into play with regards to illness and health-related behavior (Groleau, 1998, 2005; Groleau & Kirmayer, 2004; Groleau et al., 2005, submitted; Groleau, Soulière, & Kirmayer, 2006).²

Based on this more complex picture of illness representation, the MINI was designed to elicit three distinct types of reasoning about or representations of symptoms or illness:

1. *Explanatory models* are based on causal thinking which may involve conventional models, causal attributions or more elaborate models involving specific processes or mechanisms (Examples: 'I have a cold, you know a virus'; 'I had a heart attack because I was too stressed'; 'I'm depressed because my boss has been harassing me for the past year and it has really undermined my self-esteem');
2. *Prototypes* involve reasoning based upon salient episodes or events in one's own or others' experiences, which allow individuals to elaborate the meaning of their illness through analogy (Example: 'Last year, my uncle and aunt died of lung cancer, so I got scared and decided to quit smoking');
3. *Chain-complexes* in which past experiences are linked metonymically to present symptoms through a sequence of events surrounding the symptoms without any explicit causal connection or salient prototype. (Example: 'Around the time of my divorce, I starting having this pain in my chest. Then I got a cough that wouldn't go away').

Although these modes of reasoning tend to co-occur in any account of symptoms or illness, they can be distinguished in interview transcripts and reliably coded (Stern & Kirmayer, 2004). These three modes of reasoning often coexist but they are not all equally stable. Repeated chain complexes may come to constitute a prototype. Once an explanatory model is made explicit, individuals tend to use it to organize their narrative and impose a coherent structure and causal order on their memories of symptoms and illness experience. Chain-complexes represent implicit learning and procedural knowledge that is structured in terms of links or associations without a specific model, image or prototype. As a result, they are largely outside awareness; once an individual's attention is directed to the chain-complex, they tend to elaborate it as a prototype or assimilate it into an

explanatory model. For this reason, the MINI is structured to elicit chain-complexes first, followed by prototypes, and only then to explore explanatory models.

Of course, prototypes and explanatory models are not only personal or idiosyncratic but also refer to cultural models that are part of popular theories of health. Such popular theories of health influence the adoption of preventive and curative behaviors (Groleau & Kirmayer, 2004; Groleau et al., 2005). However, in line with contemporary culture theory, the MINI does not sharply distinguish between personal and cultural meanings, which are intertwined in any individual's account. The distinction between these levels of knowledge and discursive practices can be determined by additional explicit questions or, more effectively, by a research design that allows comparison of interviews across groups of individuals from specific cultural backgrounds or social positions.

The generic version of the MINI presented here can be used to explore meaning and experience linked to any health problem, condition or event and is not limited to symptoms, symptom cluster, syndromes, biomedical diagnoses or popular labels. Depending on the research question, the MINI can be used to compare individuals, categories of health behaviors, or cultural groups. The narratives it elicits are largely retrospective accounts of illnesses or symptoms experienced in the past but it may include descriptions of ongoing symptoms and future concerns or anticipated events, as was done in a study of patients in the period immediately following a first heart attack (Groleau et al., submitted).

USING THE MINI

In this section we outline the steps and considerations in adapting and applying the MINI to the study of specific health problems. In particular, we discuss: (1) Preparatory steps in research design and interview modification; (2) negotiating the interview process with the patient; and (3) conducting the interview, with notes on specific questions in the MINI. The current version of the MINI in use by our research team is presented in the Appendix.

PREPARATION

The MINI provides an overall structure and sequence of questions but interviewers must improvise additional questions and probes to clarify responses. Like any open-ended form of interviewing the MINI depends on the interviewer's understanding of the underlying research questions and the broader conceptual framework guiding the inquiry. Training interviewers in the use of the MINI, therefore, involves not only technical

aspects of its use but also knowledge of the discipline and familiarity with theoretical framework. Our experience with the MINI in different settings suggests that extensive initial training of interviewers is crucial and should be followed up by ongoing meetings between researcher and interviewers in which process of the MINI is monitored, and audio and video recordings of completed interviews are reviewed.

Open-ended interviews guided by the MINI are lengthy: The time required to complete the full interview schedule is an average of 2 hours per participant but varies widely with the illness history, as the emotional quality and interactional process of the interview. Some interviewees are loquacious and require refocusing to stay on topic, others have difficulty expressing themselves and require multiple interviews to build trust and rapport and elicit a rich narrative.

One of the strengths of the MINI is that it allows for the exploration of diverse meanings and ways or reasoning held by interviewees about their symptoms, whether contradictory or complementary. As well, the unstructured part of the MINI enables researchers to explore how personal illness experiences of narrators are embedded in social processes and cultural contexts. It also allows identification of idioms of distress and popular labels linked to specific health problems and sociocultural contexts (Groleau & Kirmayer, 2004).

Sampling must reflect these research objectives; this in turn will guide the selection of participants according to whether they share a common health problem or sociocultural background, or whether certain health behaviors can be compared on the basis of participant narratives.

The MINI guides a conversation that produces narratives that can be used to study individual illness meanings, modes of reasoning, historical sequences, and the sociocultural contexts of illness experience. The MINI does not produce a monolithic account of individuals' knowledge and experience of illness or symptoms. Instead, it aims to capture personal knowledge and experience in its complexity, allowing for the internal contradictions and inconsistencies often present in everyday life. In subsequent data analysis, this complexity can be contextualized both in terms of the interview process (e.g., how individuals construct and reconstruct their account over the course of the interview vis-à-vis a specific interlocutor) and in terms of larger social, cultural, political and historical contexts.

NEGOTIATING THE INTERVIEW PROCESS

At the start of the interview, two important issues need to be discussed and negotiated with interviewees: (1) The object or focus of the interview, that is, what specific health problem (HP) will be discussed during the

interview; and (2) the identity and social positioning of the interviewee and interviewer.

Negotiating the object of the interview is fundamental and may require time in order to reach a shared understanding of the focus of the conversation. For example, a participant may experience symptoms not related to the research question. Conversely, some symptoms such as 'hearing voices,' although considered a symptom in psychiatry, may not be considered a nuisance for some patients in a specific cultural context. The idea here is to clarify with interviewees which symptoms will be discussed and how they will be named throughout the interview. These symptoms could be affective (e.g., sadness) or somatic (e.g., headaches), or a group of symptoms related to an illness or disease recognized as such by biomedical or even traditional nosology. Once the health problem and symptoms are agreed upon, their actual names should be used in all subsequent MINI questions.

The second key element to negotiate prior to the MINI interview is the social positioning of interviewer and interviewee. This is important because the unfolding process of the interview depends on the social context. The way in which the interview process reflects the social context provides a source of data rather than something to be eliminated from the interview process (Warren, 2002; Wengraf, 2001). Luff (1999) points out that interviewees and interviewers speak to each other not from stable and coherent standpoints but from varied perspectives involving the socially structured and historically grounded roles and hierarchies of their society (see also Campbell, 1998). In this context, interviewers should acknowledge their social identities such as class, gender, race, ethnicity, marital status, age, family position, religion, education, sexual orientation, professional status, and so forth (Schutz & Wagner, 1970). In the case of an interviewer and interviewee from different societies this larger social context may involve a history of colonization, domination or conflict that will complicate the conversation. The information interviewees are willing to disclose is greatly influenced by these social standpoints. It is therefore crucial to acknowledge the latter rather than simply rely on supposition.

Although the social background of the interviewer may have been disclosed at the beginning of the interview, interviewees may later requestion the interviewer's professional or family-related identities and reorient the interview. It is usually helpful to accede to this request, as the social positioning of narrators may change with the topic under discussion, and hence require renegotiation. Our experience has shown that the interviewer's willingness to answer these questions not only creates an atmosphere of trust and confidence but also may help to clarify the sort of information that is *not* disclosed because of social or professional status or a social desirability bias on the part of the interviewee. In certain cases

where an interviewee is found to be withholding too much information as a result of social identity, power and position, the only solution may be to replace the interviewer by one whose social status is deemed more appropriate in terms of gender, ethnocultural background or other salient aspects of identity.

For interviewers coming from a clinical background, it is important to emphasize that the MINI is not a clinical interview in which the interviewer has the role of expert, but rather an ethnographic interview, in which the *interviewee* is in the expert position. It is assumed that interviewees are the most knowledgeable sources on the meaning they give to their own illness experience. To conduct this type of interview, the interviewer must adopt the position of the neophyte, listening respectfully to learn about the experience of the narrator while inviting interviewees to reason in different ways about their illness experience. The aim is 'to give primacy to the patient's voice, to listen for meaning rather than for facts, and to provide a relationship enabling the evolution of the patient's story' (Sakalys, 2003, p. 228).

CONDUCTING THE INTERVIEW

According to Rubin and Rubin (1995) most qualitative interviews are structured in terms of three types of questions: (1) Main questions that begin and guide conversations; (2) probe questions that clarify answers by reformulating them back to the interviewee or requesting further examples; and (3) follow-up questions that pursue the implications of answers to main questions. The goals of these three types of questions should be kept in mind as the interviewer moves through the basic structure of the MINI.

SECTION 1: INITIAL NARRATIVE

The introductory section of the MINI is intentionally unstructured and aims to collect a narrative organized by spatial and temporal contiguity of events. If interviewees introduce a disease label, prototype or explanatory model, it is noted, but the basic questions are repeated to encourage the narrator to return to recounting the basic sequence of events associated with their symptom or condition.

Questions 1–4 invite participants to produce an initial illness narrative in such a way as to minimize the influence of a social desirability bias. This is the least structured part of the interview. The aim here is to invite participants to tell their story in their own way. Questions 5 and 6 are probes that aim to ensure that interviewees tell the full narrative related to their pathways to care (i.e., the use of medical services). This part of

the interview can be fairly long for participants with many symptoms or a lengthy illness history. Because the aim of the unstructured interview is to allow interviewees to tell their story at their own pace and in their own way, no time limit should be imposed at this stage of the interview (Morse, 2002).

SECTION 2: PROTOTYPES

Questions in this section are more structured and aim to elicit narratives which reveal prototypical experiences of self and others, and how such prototypes are used by the interviewees to reason analogically about their health problem and related health behavior. Prototypes may be very influential for some participants and not for others. This may be because some people predominantly use an analogical way of reasoning in relation to their health problem and related health behavior; it could also be because prototypical knowledge is experienced-based knowledge, rather than theoretical or objective (Groleau et al., submitted). Also, it is knowledge embedded in one's own experience or that of a close one, endowing it with an emotional significance which, for some people, gives it precedence over rational or causal types of reasoning.

The purpose of this section of the interview is to gauge whether or not participants are using prototypical experiences of self or of others, and whether they are using them to reason analogically about their own health problem and related health behavior. Question 7 elicits self-prototypical experiences of participants. Questions 9, 11 and 13 aim at revealing family, social and media prototypes, respectively. Questions 8, 10, 12 and 14 invite interviewees to explore whether they reason analogically and how they may be using prototypical experiences to explain their health problem and related health behavior.

SECTION 3: EXPLANATORY MODELS

This section aims to elicit explanatory model narratives of the interviewees' HP produced by a causal type of reasoning. Question 15 verifies whether interviewees use an alternative label to describe their HP. This question may, in some cases, give access to an idiom of distress or another popular cultural construct related to somatic conditions not yet documented in the literature. Question 16 elicits the perceived cause(s) of participants' HP. Question 17 may uncover new information related to attributions. Question 18 may help to clarify the bodily aspects of explanatory models, that is, how participants perceive their HP operating within their organs and body. Bodily metaphors with a cultural significance may emerge from this question. Questions 19 and 20 may stimulate an answer

that gives access to a social context for the explanatory model. For example, if one of the attributions for their HP is stress, participants should be able to explain the social context of their stressful experiences in a short narrative. Questions 21 and 25 aim to reveal whether a popular label linked to participants' HP exists in their social context, and if so, how it contrasts with their own HP in terms of meaning, expected prognosis, treatment and social expectancies (e.g., stigma or access to support). Question 27 aims to clarify how participants' explanatory models apply to the story of their personal experience.

SECTION 4: *HELP SEEKING AND SERVICE UTILIZATION*

This section of the interview schedule is optional and should be used only if it is relevant to the research question. Its purpose is to invite interviewees to produce, where applicable, a narrative of their experience with health services and hospitalization, and their response to received treatment. This section can be omitted if the focus of the study is limited to meaning and experience of illness without paying attention to pathways to care or the impact of biomedical services. If interviewees mention in Section 1 having consulted a healer of any kind, the interviewer asks Questions 30–31 by replacing the word *doctor* with *healer*. If patients consulted both a healer and a medical doctor, the interviewer asks all questions in this section for each type of healer or help. Questions 34–36 aim to invite narrators to produce a rationalization for their health behavior in terms of incitements and deterrents to compliance with treatment recommendations. This rationalization may reveal important practical issues but, because it serves to justify the individual's actions, it may also obscure understanding of the predominant individual and cultural meanings. Questions 36–39 explore satisfaction with health care without asking the question directly to minimize potential desirability bias. At this point, it is particularly important to put interviewees at ease in order that they provide truthful answers. These questions are purposely asked toward the end of the interview to allow sufficient time to create an atmosphere of confidence. Before asking these three questions, interviewees should be reminded that the interview is confidential and their identities will not be disclosed. This is particularly important in cases where participants may fear offending a helper or losing access to services.

SECTION 5: *IMPACT OF ILLNESS*

This section aims to explore the impact of the health problem on narrators' life in general and to see if and how they believe the illness has led to changes in their identity and way of life since its onset. Questions

39–42 aim to elicit a narrative that explores possible changes in identity, roles and functioning that are linked to the health problem. This may be particularly relevant if the problem is a chronic disease or mental illness that, because of its nature, may provide a rite-of-passage or transformative experience for the narrator. As well, since health problems may require substantial adaptations or accommodations by others, a changed sense of self may originate in or be mirrored by these reactions. Questions 43 and 45 ask about ways of coping, social supports and other resources and can be tailored to the specific domains of interest. In the case of afflictions that confront patients with their own mortality, their illness experience may be embedded in a spiritual narrative.

CONCLUDING THE INTERVIEW

The MINI ends with an open-ended question allowing the interviewee to add anything they deem relevant. Depending on the course and conduct of the interview other loose ends will need to be tied up to provide a comfortable level of closure. This may include discussion and debriefing on the specific purposes of the study and arrangements to provide later feedback after the data are analyzed. This may be essential for purposes of validation and, in some cases, to follow ethics guidelines for the use of interview material.

Although for the purposes of systematic comparison it is important that all questions of the MINI be asked of each participant in a study, the narratives produced may be very lengthy. Participants should not be subjected to a time limit or feel pressure to complete the interview as this will truncate and distort their narratives. If the interviewee seems tired, it is best to schedule another meeting.

ANALYZING DATA FROM THE MINI

The MINI produces narratives that can be analyzed according to their form or structure (e.g., genre, plot, characters, temporal structure, modes of reasoning) or their content (e.g., themes, images, metaphors) at both individual and collective levels. The collective level is identified as recurrent themes or structures among narrators from the same background or in similar social positions, or through explicit links to popular theories of health, and specific social contexts and relationships.

The transcript of the MINI interview should be viewed not as a static snapshot of the individual's current state of understanding of their illness but as a record of the coconstruction of meaning over time. Meaning making is central to the interviewing process and reflects: (1) Previously acquired and organized interpretations of illness; (2) new reflections on

illness experience prompted by the interview situation and specific questions; and (3) the unfolding relationship of interviewer and respondent. As Holstein and Gubrium (1995; Gubrium & Holstein, 2002) point out, during the interview the perspective of respondents may shift as they take into account the standpoint of others present in their story. A shift in standpoint or emotional state also may occur when the interviewer invites the respondent to reason in a different manner.

The verbatim transcript of the MINI interview allows for analysis with a wide range of interpretive strategies drawn from critical and interpretive medical anthropology (Good, 1994), literary theory (Czarniawska, 2002; Riessman, 2002; Smith 2002), grounded theory (Glaser & Strauss, 1967) and cultural analysis (Quinn, 2005). Analysis of the form of narratives is possible because, Section 1 of the MINI is unstructured and elicits an illness narrative or story from the outset of identified symptoms and the patient's help-seeking behavior. The theory guiding the structured part of the MINI concerns the multiple modes of reasoning and knowledge structures (that can be individual or collective, e.g., popular theory of health) that contribute to illness narratives, not the social themes they may contain. For these reasons, the MINI also lends itself to a grounded-theory approach, which focuses on thematic analysis for the purpose of building social theory (Whitley, Kirmayer, & Groleau, 2006a, 2006b).

Regarding practical issues, our experience has been that some interviewers tend to pursue certain topics more avidly than others (e.g., use of traditional healers), serving to potentially signal their theoretical or practical biases. In order to avoid large variation in the ways that interviews are conducted, it is thus important that interviewers receive adequate training and close supervision over the course of a study using the MINI. Training of interviewers should facilitate their understanding of the theory guiding the use of the MINI and how this is related to the research question of the ongoing project.

CONCLUSION

There is increasing recognition of the value of qualitative interview and data analysis methods in psychiatry to access accounts of illness experience, explore individuals' social and cultural worlds, and address basic questions of meaning and validity in health measurement (Whitley & Crawford, 2005). We have presented a method of eliciting illness interviews that may be of use in research and clinically applied medical anthropology and cultural psychiatry.

The MINI invites narrators to explore different meanings and modes of reasoning (metonymical, analogical, causal) in relation to their health problem. It also permits the interviewer to determine whether or not

interviewees are employing popular labels or idioms of distress related to their symptoms or condition (Groleau & Kirmayer, 2004). Finally, the MINI is readily adapted to explore links between specific meanings and health behaviors including: pathways to care, use of home remedies, traditional healing and biomedical care (Whitley et al., 2006a, 2006b); treatment adherence; adoption of health-promoting behaviors; satisfaction with health care; impact of health problems on other domains of life activity; and potential changes in identity (Groleau et al., 2006). The rich data produced by the MINI can be used in many different ways depending both on the researchers topic of interest, theoretical concerns, and level of analysis.

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NOTES

1. The first author (DG) was an interviewer in the original study and played a central role in refining the initial questionnaires to make the flow more natural and acceptable to a range of community participants.
2. For example, in a previous MINI-based study, in response to the questions in this section, a patient revealed that her mother had a myocardial infarction (MI) similar to her own (Groleau et al., submitted). The prototypical narrative of her mother also revealed that, although the latter had stopped smoking, she suffered soon after from a second MI and subsequently lost both of her legs and ultimately died of a third MI. The narrator used her mother's experience as a prototype to reason analogically about her own health situation in the following way: There was no reason for her to stop smoking after her own MI because, based on her mother's experience, it wouldn't have made a difference.

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APPENDIX

McGill Illness Narrative Interview (MINI)

Generic Version for Disease, Illness or Symptom

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Section 1. INITIAL ILLNESS NARRATIVE

1. When did you experience your health problem or difficulties (HP) for the first time? [*Substitute respondent's terms for 'HP' in this and subsequent questions.*] [*Let the narrative go on as long as possible, with only simple prompting by asking, 'What happened then? And then?'*]
2. We would like to know more about your experience. Could you tell us when you realized you had this (HP)?
3. Can you tell us what happened when you had your (HP)?
4. Did something else happen? [*Repeat as needed to draw out contiguous experiences and events.*]
5. If you went to see a helper or healer of any kind, tell us about your visit and what happened afterwards.
6. If you went to see a doctor, tell us about your visit to the doctor/hospitalization and about what happened afterwards.
- 6.1 Did you have any tests or treatments for your (HP)? [*The relevance of this question depends on the type of health problem.*]

Section 2. PROTOTYPE NARRATIVE

7. In the past, have you ever had a health problem that you consider similar to your current (HP)?
[If answer to #7 is Yes, then ask Q.8]
8. In what way is that past health problem similar to or different from your current (HP)?
9. Did a person in your family ever experience a health problem similar to yours?
[If answer to #9 is Yes, then ask Q.10]
10. In what ways do you consider your (HP) to be similar to or different from this other person's health problem?
11. Did a person in your social environment (friends or work) experience a health problem similar to yours?
[If answer to #11 is Yes, then ask Q.12]
12. In what ways do you consider your (HP) to be similar to or different from this other person's health problem?
13. Have you ever seen, read or heard on television, radio, in a magazine, a book or on the Internet of a person who had the same health problem as you?
[If answer to #13 is Yes, then ask Q.14]

14. In what ways is that person's problem similar to or different from yours?

Section 3. EXPLANATORY MODEL NARRATIVE

15. Do you have another term or expression that describes your (HP)?
16. According to you, what caused your (HP)? [List primary cause(s).]
- 16.1 Are there any other causes that you think played a role? [List secondary causes.]
17. Why did your (HP) start when it did?
18. What happened inside your body that could explain your (HP)?
19. Is there something happening in your family, at work or in your social life that could explain your health problem?
[If answer to #19 is Yes, then ask Q.20]
20. Can you tell me how that explains your health problem?
21. Have you considered that you might have [*INTRODUCE POPULAR SYMPTOM OR ILLNESS LABEL*]?
22. What does [*POPULAR LABEL*] mean to you?
23. What usually happens to people who have [*POPULAR LABEL*]?
24. What is the best treatment for people who have [*POPULAR LABEL*]?
25. How do other people react to someone who has [*POPULAR LABEL*]?
26. Who do you know who has had [*POPULAR LABEL*]?
27. In what ways is your (HP) similar to or different from that person's health problem?
28. Is your (HP) somehow linked or related to specific events that occurred in your life?
29. Can you tell me more about those events and how they are linked to your (HP)?

Section 4. SERVICES AND RESPONSE TO TREATMENT

30. During your visit to the doctor (healer) for your HP, what did your doctor (healer) tell you that your problem was?
31. Did your doctor (healer) give you any treatment, medicine or recommendations to follow? [List all]
32. How are you dealing with each of these recommendations? [*Repeat Q. 33 to Q. 36 as needed for every recommendation, medicine and treatment listed.*]
33. Are you able to follow that treatment (or recommendation or medicine)?
34. What made that treatment work well?
35. What made that treatment difficult to follow or work poorly?
36. What treatments did you expect to receive for your (HP) that you did not receive?

37. What other therapy, treatment, help or care have you sought out?
38. What other therapy, treatment, help or care would you like to receive?

Section 5. IMPACT ON LIFE

39. How has your (HP) changed the way you live?
40. How has your (HP) changed the way you feel or think about yourself?
41. How has your (HP) changed the way you look at life in general?
42. How has your (HP) changed the way that others look at you?
43. What has helped you through this period in your life?
44. How have your family or friends helped you through this difficult period of your life?
45. How has your spiritual life, faith or religious practice helped you go through this difficult period of your life?
46. Is there anything else you would like to add?

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