

DISCURSO E NARRATIVAS DA DEPRESSÃO

DISCOURSE AND NARRATIVES OF DEPRESSION

MODESTO LEITE ROLIM NETO ⁽¹⁾ KAZUE SAITO MONTEIRO DE BARROS ⁽²⁾ y DAISE LÍLIAN FONSECA DIAS ⁽³⁾

RESUMEN

Objetivo. *As narrativas do adoecimento carecem de respostas mais humanas ao traduzirem o tempo e o espaço das histórias de vida circunscritas à dor e ao sofrimento, por isso, esse trabalho avalia a importância delas, sobretudo no que concerne às experiências da depressão.*

Método. *Através do uso de uma abordagem qualitativa, voltada para o estudo dos discursos leigos sobre depressão, as narrativas orais com fins de pesquisa social foram analisadas a partir da perspectiva do informante, e de acordo com os critérios diagnósticos do DSM-IV*

Resultados. *Observou-se que o fator de risco emocional determinante a depressão dos pacientes analisados foi a história de distúrbios psiquiátricos prévios (79.5%), interligados à idade dos mesmos. Os indicadores psico-sociais evidenciaram associação aos fatores econômicos (89.9%), assim como aos eventos estressantes ligados à pobreza, carência de suporte social e seca (65.78%). As narrativas dos pacientes depressivos, consubstanciam traços factuais vividos no adoecimento, bem como uma estrutura enunciativa inserida na prática particular e social de cada um deles.*

Conclusão. *Ao determinar o diagnóstico, a interpretação clínica pode aproximar-se das histórias e significados envolvidos ao percurso do adoecimento, isto facilitaria entender a negociação entre paciente-médico no processo interacional a partir das pistas de contextualização.*

PALABRAS-CLAVE: Depressão, hierarquia, saberes.

ABSTRACT

Objective. *Narratives of sickness need more human answers, since they translate the ideas of time and space of life history related to pain and suffering, therefore, this work evaluates the importance of them, especially the ones on depression.*

Methods. *Through the use of a qualitative approach, focused on the study of common sense discourses on depression, oral narratives as part of a research concerned with social aspects were analyzed from the point of view of the patient, and according to the criterion of the DSM-VI.*

1 PhD. in Sciences of Health from Universidade Federal do Rio grande do Norte/UFRN.

2 PhD. in Language and Linguistic, Essex University, UK, UFPE/CNPq;

3 Master in Literature and Culture from Universidade Federal da Paraíba/UFPB, professor of the Course of Languages of Universidade Federal de Campina Grande (UFCG) – PB.

Results. *It was observed that the risky emotional factor determinant of the patients depression was the history of previous psychiatric disorder (79.5%), linked to their age. The psycho-social indicators highlight the association of economic factors (89.9%), as well as stressful events connected to poverty, lack of social support and drought (65.78%). Narratives of depressing patients show facts lived in the process of sickness, as well as a structure of discourse inserted in the private and social practice of each of them.*

Conclusions. *After the diagnosis, the clinic interpretation can get closer to the histories and meaning involved in the path of the sickness, and that would help understand the negotiation between doctor-patient in the interaction process based on the contextualization cues.*

KEY WORDS: Depression, hierarchy, knowledge.

INTRODUCTION

It is through language that man perceives the world and expresses reality, and it was Kant who gave language a potential never reached before when he replaced the interest on the ontological issue for an epistemological interest which valued the metaphysical aspects of language. Nietzsche defended that man is not a discoverer of "truths" which are independent from his will to power or his instinct of survival, but a producer of meaning and, thus, of knowledge that are established through the conventions that guide man in social groups.¹ It is in this context where man is understood as a being responsible for the production of knowledge that is a result of his metaphysical questions deeply guided by social conventions that this work tries to evaluate the importance of narratives of depression, according to the criterion of diagnosis of DSM-IV, and the role they perform or should perform in the hierarchical relation between doctor-patient, where scientific knowledge and common sense fight in the act of translating objective and subjective "realities".

It is important to mention the importance of the interactionist study of those narratives concerning the experience of the psychic suffering, since it is the basis of the speech

activity,² as well as the contextualization cues.² In this sense, the interactionist studies allow us to perceive the way members of a community identify the events of speech, the way social input varies in the course of interaction and the way social knowledge produces the interpretation of the messages.³ Human beings occupy a great part of their time on interaction, and as the process goes on the interaction can be noticed not only as a mechanical and ritualized process of taking turns in conversation. It is a social activity in which the involved individuals negotiate meanings on what they think and feel about the world, about themselves and their addressers. This way, interacting is also a way of action upon the others. Thus, the making of sense in this kind of interaction is a task developed in a collaborative way by addresser or, in other words, the text produced in the conversation is a product of co-authorship of the participants.

The narratives of depression, included in the context of discourse, need more human answers, since they translate the time and the space of life histories related to pain and suffering, and are relevant in their identification with the experiences of the patient's illness. In this sense, the attempt to understand the notion of narrative as a way among others of expression

of the patient's thought and its communication to human beings, it is an understanding that sees these narratives not as a deviation or deformation of what was narrated, but as an extension of codes of a culture that allows reality to be narrated.⁴ So, the narratives as a way of remembrance of histories crossed in the process of illness, express not only what was said, but also the linguistic choices/references that the patients use in order to reveal their suffering. These references represent the way they see the world, that is, the presuppositions they use to define and delimit their experiences.⁵ Presuppositions are premises that in most cases are not said, but are experienced and show themselves in actions, guiding too, the analysis that the individual makes of his own experiences. Thus, the presuppositions also become clear in what is selected to be told and in what is given value in the process of telling the histories.⁵

The selection and sequencing of topics can reveal the meaning the speaker wants to give to his/her utterances. They work as true metamessages, that is, as contextualization cues.⁶⁻⁷ Which look for guiding the interpretation of the addresser in the desired direction. Gumperz⁶⁻⁷ defends that the cues can be of different nature (lexicon, prosody, switch of codes, dialect or style), but all of them indicate strategies to monitoring the text and, through them, the speaker communicates to the listener whatever he/she has in mind, and also the way to interpret the activity of production of the speech. The contextualization cues are means by which speakers signal and listeners interpret what the activity is, how semantic content is to be understood and how each sentence relates to what precedes or follows {...} Roughly speaking, a contextualization cue is any feature of linguistic form that contributes to the signaling of contextual presuppositions.⁶

The possibility of telling histories is, therefore, a way to understand what the patient in his discourse tries to say,⁸ having

as presupposition describing, expressing or representing the experiences related to his illness.⁴ In some cases, these experiences are connected to a complex net of medical check up and diagnosis whose results difficulty the patient interpretation of the value of his own discourse, which diminish his role as agent responsible for revealing information about the experience of his illness. In this aspect, as the perspective of the doctor who leads the interaction is different from the patient's, it is important to define the way the health problem is interpreted by the first, whose perspective occurs inside the terms of a specific taxonomy which constitute a medical nosography.⁹

As Ainsworth-Vaughn¹⁰ states, there is a great variety of studies on the interaction doctor-patient. This writer mentions that Lipkin et al¹¹ estimates that there are around 7000 studies on this theme inserted in the heart of the most diverse disciplines. The studies are framed by private interestes and the marjority of them do not include a theoretical concept of "language" which is seen as a vehicle transparent of expression of meaning and not as a cognitive, social and historic activity. Due to this fact, there are not many people checking these collected data in real situations of interaction, and there are a few people checking these collected data in real situations of interaction, and there are a few people who devote their time to observe the patient's speech. It is interesting to highlight that the marjority of the studies, even those that include observation of empiric data,¹²⁻¹⁴ they classify this kind of interaction as doctor-patient (not patient-doctor), which clearly identifies the perspective of observation.

It is important to highlight the importance of the theme to the doctor-patient relation, mainly because it involves kinds of knowledge that are aggregated to the narratives while being told, and which get the status of truth. The possibility of listening to narratives through the words which were pronounced

in their search for truth, leads the subject to different devices and ways of production of subjectivity designed in other truths and certainty, checking their basis in which the subject had been forming his subjectivity.¹⁵ In the interaction doctor-patient, it is clear that the semiotic approach is not appropriate, since it is taken from the doctor's perspective and it excludes the patient's and his experience with the illness and, thus, his narratives.⁹

METHODS

220 patients were analysed, males and females, from 20 to 59 years old, at "Hospital Municipal de Santa Cruz" (Santa Cruz County Hospital), in Paraiba. Through the use of a qualitative approach, focused on the study of illiterate depressive patients, were analysed the oral narratives classified as social research¹⁶⁻²⁰ from the perspective of the informer.²¹⁻²² The purposeful sampling was composed of 120 patients (70 females and 50 males), since they had the appropriate profile (depression) for the contextualization of the narrative, which was done through the understanding of their discourses.

The patients –were suggested to look for the psychological attention team– suffering from symptoms of depression, based on the DSM-IV criterion of diagnosis, had regular medical (clinical and/or psychological) treatment, and signed a paper which authorized their cases to be studied. Information related to the experiences with the illness –such as pain and psychic suffering, and social-cultural aspects– was registered in a diary; the tool for the collecting of data was made through oral interviews¹⁶ applied by the researchers. These oral interviews marked by an active participation of the researches were complements to the inclusion and the regular observation of the patients and through a test of free association of words, the researches detected some clinical variations in diagnosis and also psychological ones.

The procedures started after the research being approved by the Ethics Bureau of Universidade Federal do Rio Grande do Norte (UFRN), and they were: patient's authorization for the research; individual interviews; transcription of the interviews and explanation of verbal expressions; besides the divisions of the text in indexed and non-indexed material; grouping and identification of individual experiences; grouping similarities and identification of collective experiences.¹⁶⁻²² The thematic analysis and the social cartography guided the whole process in its theoretical and graphic way of interpreting the narratives.

The analytic procedure starts from the presupposition that the observation should be based, as it was said before, on contextualization cues activated by the speakers throughout the interactional process. In parallel, in the quantitative analysis the theoretical relevance is defended as singular data²³ in which the episodic, the singular and the idiosyncratic are observed. The non-existence of a cononic structure, for example, can be the key to get the content of the utterance. Thus, the analysis of data, at the same time that questions "Why does this happen here?" also questions "Why doesn't it follow the standard?"

RESULTS

It was observed that the emotional risky factor that determined the patient's depression analysed was previous psychiatric disturbances (79.5%), linked to their age; the psychosocial indicators showed association to economic factors (89.9%), so did stressful events linked to poverty, lack of social support and drought (65.78%). It is important to highlight that the narratives of the depressive patients show facts lived during the process of getting ill, as well as a structure of discourse inserted in their private and social practices. Here, there is a narrative on depression of a 57-year old woman: "I wake up crying and sleep groaning in agony. It is something that

comes and goes, a weird thing. It feels like fire inside my head burning our lives, it is like in the period of fires in the forest, destroying it, right when we need to plant". The narrator establishes a metaphoric parameter related to the facts of her daily life connected to agricultural aspects. Her discourse redefines her suffering; she recognizes the illness as something cyclical that "comes and goes, burns and goes out", never coming to an end.

As it can be observed, it becomes clear in the patient's speech the metaphor as a sign of experience due the suffering in the relationship with the production of a socio-cultural knowledge. The need to (re) tell those histories highlights the means by which health and illness are culturally produced.⁴ This process of (re) telling the histories also reveals a poetics of the social life that comes from an unexpected source, that is, the common sense, but it shapes itself as a rhetoric of enchantment in the attempt to express reality in a subjective way in a scientific and objective context.

Due to the consciousness of hierarchy involved in the interaction, the metaphor also shows the level of formation of the patient's identity, he knows that the doctor belongs to another social class, has a specific vocabulary which is technical and accurate—opposite from hers, which is confused, and "ignorant" about herself in relation to her inferior position in the interaction process. But she needs to be understood in order to be helped, so the use of metaphors.

Another statement expresses the conflict in the patient's relation—as the addresser of a message that usually is not appropriately decoded by the doctor/addressee—with the notion of time: "Life passes slowly and everything moves slowly. Nothing can call your {my} attention. Only the bedroom matters, only the bed can save you {me}. I have no plans; why am I supposed to dream? I live all the time from my past. Nobody understands

you {me}. Neither myself. Understanding is complicated. It is loneliness, anxiety, fear of death". This extract of the narrative signals the importance examining the contextualization cues, basically because of the use of marks of communicative intention²⁴ as well as in the relevance of some interpretations given by the patient in the specific moment of depression. In this moment, the depressive phenomenon has an excessive and unpleasant confrontation with the idea of time in the sense that it leads the patient to past situations and to question a variety of facts and episodes that were somehow pleasant in order to establish a comparative link between what happened before and the present moment and, also, what will no be anymore. So, for the patient, there is only a never ending search for the truth, and for a kind of answer to what is considered unexplainable in his illness; in this perspective, the depressive patient creates a kind of discourse that is particular to his illness. Thus, the doctor as the addressee is the responsible for decoding the message, which was sent for him to translate in a symbology that could create an atmosphere of understanding an comfort, as well as to transform it in a responsible and attentive dialogue engaged to the narrative.

Another narrative is that of thirty-eight-year old patient who had tried to commit suicide: "The rose in my garden did not bloom, it remained only one branch trying to survive. I am thirsty. Since I became ill life has lost its meaning. It is terrible to lose what you should have lived. I am afraid of my thoughts. This is the world: some people have got their gardens, others have no fertilizer. They say I am depressed... I look like a passionfruit full of wrinkles. I feel a huge emptiness". Another patient, 42 years old, reveals: "I am always tense, I think I have no place in the world anymore. It is so bad. My body trembles, it is just like caustic soda eating us from the inside. I have gone from doctor to doctor". As it can be seen,

the discourses show the idea created by the patients about depression, and that characterizes the illness as something that causes abandonment and uncertainty. The feeling of doubt that causes fear and anxiety in the depressive patients is clearly expressed in their discourse, either when they search for the truth, for an answer, for escape from the pathological imprisonment, or when they create a rethoric rooted in emotions, fiction and myth.

The terms/codes used by the patient, however, denote popular knowledge inserted in their daily lives. When they say that depression is like “a passionfruit and caustic soda”, in their attempt to define the feeling of disturbance caused by the depression, they are associating their dialects and regional allegories to their discourses, and that works like a mitopraxis, that is, something that forges the local history in a variety of symbols—allegories and metaphors—so that history gets a particular sense for those who live it, since it offers the decoder some signals to make the interpretative work.²⁵

DISCUSSION

In this perspective of mitopraxis, the patients' narratives can not be seen as a single act of telling and understanding their illness, they also have particular social sense, since there is an interaction with *the other* that result in interpretation of life experiences, and due to that, there is a search for people to decode them as an attempt to establishing a connection in the discourse of the depressive person that can translate the intensity of the suffering.²⁶⁻²⁷ So the patients who allow their discourses to be analysed, show that the rethoric of the illness, linked to pain and psychic suffering, (re) tell histories that can determine the ways of interpretation of their life experiences. Below, there examples of previous psychiatric disturbances:

EXAMPLE 01

My mother suffered from depression, my grandfather died of depression, I think I inherited it from the family {...} I live with it disturbing me the whole day, it is something inside you that destroys your fate. I'm too old to bare this suffering.

(Narrative 32)

EXAMPLE 02

This problem has been causing agony in my family for a long time {...} It doesn't reach an end, it is weird, it kills you slowly, it goes from one person to the other. The strongers will bare it a bit longer {...} I'm about to quit, the weight of age has weaken me. What should I live for?

(Narrative 33)

EXAMPLE 03

The worst thing in the world is family sickness; you inherite it even if you don't want to. I think the problem I have today my folks have already had it, others have just started to suffer from it. They say I'm strong. I don't believe that it will do, it is too much grief; I don't know if I'll bare it any longer. I have a doubt: do I have a nervous problem or am I suffering from depression? Is it the same thing? I'm 42 years old and I'm dying little-by-little from the inside.

(Narrative 34)

As it can be seen, the patients that utter their depressive speech show the way the rethoric of sickness and its meanings linked to pain and psychic suffering (re) tell histories

that can determine the way of interaction of the episodes lived with the meaning given to the familiar setting. This Knowledge is in the basis of interpretations about the communicative relation of the roles and utterances produced by the participants.³

The narratives are related to time and spaces which are essential to the understanding of the psychic suffering. The time of the illness –being it socially inserted– as well as the space/context of the events and social relations, establish cultural references that can support the mentally sick person or make other people avoid the patient, stigmatize and adhere to specific ways of treatment, where humanization is a reference in a regular exchange and negotiation of meanings of those experiences that were narrated.^{28, 29} The extract below should be considered in the association of the sickness and economic factors:

EXAMPLE 04

Having nothing to do can kill you. Here in this town there are few opportunities. My wage allows me to pay only for the medicines. I got this depression because I think too much about my life, my children. It is too bad when you want to do something and you don't have the opportunity to improve your style.

(Narrative 35)

To Gumperz,² the social meaning is negotiated from the level of importance given by the participants to aspects present in the event they narrate. The contextualization cues do not determine the meaning, but limit the interpretation highlighting some aspects of world view and diminishing some others. That is, there, in the interpretation latent meanings that are not highlighted, but are present. The meaning that should be focused is exactly what is in negotiation.³

Thus, the narratives, as part of the discourse, have an analytic characteristic in the process of interpretation of the depressive phenomenon. However, it is the doctor who should see them as a priority, offering them an “attentive” listening, that is, a predisposition to decode them appropriately, understanding what is said and the unsaid, since the descriptions of the process of illness and that of the treatment of the mental disturbances become alive by the voice, in the shape of the narratives, of those that share the experiences of identifying, explaining and reacting to the mental illness.²⁸ Those voices, many times express in relation to the stressful events linked to poverty, lack of social support and drought. Observe the following example:

EXAMPLE 05

I want to improve my income, but the drought is cruel, it kills you. It is your own suffering plus the suffering due to impossibility of offering something better to our children. Last week, my daughter asked me for some wafers and I didn't have money to buy them; it hurt me. It's too much suffering that I believe I'll die of depression. The solution is to drink in order to forget the pain of being poor. It's the first step to fights that start with my woman, I get sad and then go back to drinking again. I can't see a way out of it.

(Narrative 36)

CONCLUSIONS

The doctor, as the addressee/decoder, is supposed to filter and find in the discourse that is particular in each patient the understanding of each reality, considering it in his diagnosis, since depression have a pre-established diagnosis, which becomes alien to

the patient when his own discourse is not well interpreted in the hierarchical relation of knowledge. This alien process is present in those histories which were silenced by pain, emotion and in the devastating aspect of the illness. When the diagnosis is determined, the clinic interpretation can become closer to those narratives, that would make easier the undestading of the psychic pain experienced during the depression period. In this sense, the discourse is in search for the truth that can translate a possibility of listening o the moments of suffering³⁰ caused by the illness.

The rational aspects of the diagnosis should be based on humanization, in order to restore the attentive listening, linking "moments", forming sequences and other links⁴ connected to the results of the pain and psychic suffering of the depressive patient. In this process, the rational knowledge is not in confrontation with the rethoric appeal, but it enriches the definition of the diagnosis.

Concerning the oral aspects of the narratives, it is important to highlight the elements that guide the order of the discourse, in the sense that they give to the context a possibility of understanding of desired truth from the perspective of a real, effective, practical and emotional tendency. Therefore, the discourse covers what is said and what is to be said; it is in its material reality of uttered or written thing, an anxiety because of its transitory existence destined, doubtless, to fade. It is an anxiety for feeling in this daily and common activity, either power and danger, and also anxiety because of the fights, victories, wounds, and control and servitude contained in so many words.³⁰ This way, the discourse of the depressive patient is a material, expressive and a touchable way of translation of determined truths and realities, since it is a criterion of analysis the guide the act of saying words that have in them the truth about what the patient

feels, his life experiences and his search for possibilities of cure.

The relation with what is said establishes in the discourse a parallel between the scientific and the common sense, which gives itself a specific place in the attempt and way to understanding the kinds of knowledge that are articulated in the process of pain and suffering of the patient. In this sense, in the doctor-patient relation, it can be noticed that there is a need for the truth to be removed from a simple act of utterance for a real and attentive dialectics that can be engaged to the form, object, and relation.³⁰ The analysis of the discourse, therefore, consists in the identification—in the uttered word—of what is highlighted in this process of narration,⁵ having as its support, an attentive listening of those words.³⁰ Considering, however, that the act of telling histories of madness happens as if the addresser were showing the experience, it is important that those data should be considered in the process of interaction between doctor-patient so that each level of knowledge could have its truth taken into consideration. In this sense, the diagnosis of depression, through the narratives of the depressive patient, after being "read" and interpreted professionally by the doctor/decoder, it is seen as illness and thus, naturally, interpreted according to criterion, parameter and guidelines.

It is interesting to notice that the analysis of the discourse of the depressive patient is guided by the order of the discourse through a social pre-established practice that awakens some interests, dreams, desires and disgust. Even when the patient does not recognize himself as depressive, he shows some features of the illness in the way he narrates the events, since he gives them a particular meaning. This way, these features are seen as symbols that shape systematically the words that express the problem.³¹

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