PART II

Narrative practices in health contexts

CHAPTER 5

Illness narratives in the psychotherapeutic session

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The systematic exploration of transcripts (narrative sequences in patient-therapist interaction) reveals that there are prototypical patterns of narrative self-thematization in the context of illness, suffering, and deficiency. The articulation of an illness career, the formulation of typical situations, the communication of disintegrative processes, the narrative evocation of emotionally stirring events are equally prototypical patterns of narrative self-thematization in the context of illness, suffering, and deficiency. Psychodynamically informed narrative analysis explores how dramaturgical organizations of oral narratives in the psychotherapeutic context are related to interpersonal dynamics and the curative potential of the patient-therapist relationship.

1. Introduction: Narrative and illness in the psychotherapeutic session[1]

This paper argues that – despite the neglect of the narrative as a product shaped by a narrator in early psychoanalysis – the field can gain important insights from narrative analysis. The systematic exploration of transcripts of narrative sequences in patient-therapist interaction reveals that there are prototypical patterns of narrative self-thematization in the context of illness, suffering, and deficiency. Psychodynamically informed narrative analysis explores how dramaturgical organizations of oral narratives in the psychotherapeutic context are related to interpersonal dynamics and the curative potential of the patient-therapist relationship. This

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paper first explores the concept of 'illness,' then focuses on the importance of illness as a specific condition in the context of human relationships, and then demonstrates how different patterns of narratives can be found in patient narratives.

2. The concept of 'illness' in the medical profession

Science-based medicine (Perrez & Baumann, 2005, p. 32 ff.) commonly defines illnesses as disorders of physical, mental, or social functions that are traceable to physical or psychic deficits, wounds, inflammations, or impairments. Illnesses have a beginning, run an acute or chronic, benign or malignant course, subside completely or have after-effects, respond to curative measures or resist treatment. Illnesses can be classified in terms of symptoms and researched in terms of their causes. Certain illnesses are hereditary whereas others are contagious and can be epidemic. Illnesses are treated with curative measures whose efficacy is scientifically tested. The occurrence probability of certain illnesses can be documented in terms of age, and historical, social, or regional factors.

Health policy and insurance law define illness in pragmatic terms. Such definitions establish the basis for decision making, for instance, about financial resources and the operation of treatment and aftercare facilities. Science-based medicine has a far-reaching bearing on insurance law and health policy. It focuses its research and treatment on biological and physiological findings, causes, and statistical data.

Through participant observation of staged attacks and displays of affliction by patients formerly diagnosed as "hysterical" (now, one would find them in the spectrum of dissociative, somatoform or perhaps borderline disorders), the psychoanalytic exploration of mental and physical disorders revealed that such persons enact and perform illness; patients offer themselves to the treating physician as sufferers, as individuals overwhelmed by dramatic affects, and overburdened by various demands in private or professional relationships. The patients diagnosed as "hysterical" at the time acted out illness as lived illness (Schmutz, 2012). Lived illness is also a major concern of narrative-based medicine (Sandholzer et al., 2003), which challenges evidence-based medicine and demands that face-to-face consultations and doctors' listening skills should be indispensable to treatment (Koerfer et al., 2005).

Based on the spectrum of somatoform and psychophysiological disorders, which have attracted much attention since the beginning of the twentieth century, von Uexküll et al. (2002; see also Adler et al., 2011) established the bio-psycho-social circle model still common today. According to this model, illnesses have various biological, mental, and social causes and effects. Causes and effects are

interrelated. Illnesses arise from certain dispositions of vulnerability and from stressors involved in coping with the physical and social challenges of daily life. Phenomenologically speaking, illnesses are articulations, presentations and communications of what suffering means to the affected person, and as such they point to relational factors.

On one hand, being ill relates to gratification and relief, or what psychoanalysis emphatically referred to as the primary gain from illness. The American sociologist Talcott Parsons (1951) described the sick role and its legitimation of relief. On the other hand, illness needs to be seen from the perspective of social deviance. Social deviance involves exclusion based on the social attribution of pathological abnormality. Such attribution has a powerful effect on the person positioned as ill. The process of attribution leads to exclusion and stigmatisation. This is particularly true for highly conspicuous personalities, behavioural, and physical disorders, as formulated in the 1960s and 70s by the labeling approach[2] (for a summary discussion see Perrez and Baumann, 2005).

Being ill affects human relationships. This observation marks the programmatic starting point for systemic family therapy. Thus, if a family member develops symptoms, then the family system can be investigated in terms of the sick person's function within that system (Stierlin, 2001). A broader perspective considers "which features characterise the proper functioning of social systems (triads or triples, families, more complex entities)" (Perrez and Baumann, 2005, p. 37). The abnormality, disorder, physical or mental impairment suffered by an individual or by several persons within a private or professional group also belong to a larger regulatory dynamics, within which the positioning of an individual or

2. Labeling Theory: One of the leading ideas of labeling theory was the prominent so-called Thomas theorem, first pronounced in 1928: "If men [sic] define situations as real, they are real in their consequences" (Thomas & Thomas, 1929, p. 572; see also Merton, 1995). Labeling theory is a sociological approach which offers an interactional perspective on the formation and maintenance of deviant, especially criminal behavior. Basically labeling theory operates with the assumption that deviance is not a descriptive but an ascriptive term. The ascription of deviance is executed by those in power through the formulation of laws and the interpretation of those laws by police, courts, medical and diverse educational institutions (for a highly qualified critical evaluation see Keckeisen, 1974). Persons who are labeled as deviant in juridical, medical and educational contexts risk conforming to the ascribed career of stigmatization. In his collection of seminal papers "Outsiders," Howard S. Becker, one of the most influential protagonists of the labeling approach, formulated that deviance is not correctly qualified as a person's characteristics but as the result of a powerful process of ascription-directed communication and authority-guided influence on behavior and status of the stigmatized person (Becker, 1963).

subsystem as "sick" may have a suboptimal stabilising function or lead to exclusion tendencies.

Coping with physical and psychic disorders involving severe impairments and a protracted development places great strains on those affected. Their self-image begins to change, and an often volatile process of adaptation and reorientation occurs (Bengel et al., 2003; Schmutz, 2012). The affected use specialist vocabulary and specialist knowledge to portray themselves as persons experiencing specific symptoms (for instance, phobic patients, see Schmitz-Hövener, 2006; or borderline patients, Arboleda & Zschokke, 2013); in positioning themselves, they are mindful of their self-image and of their specific notion of illness (Lucius-Hoene and Deppermann, 2004). Biographical narratives often prove beneficial and important for such illness-oriented self-portraits and self-positioning (Lucius-Hoene, 2002; Lucius-Hoene and Deppermann, 2004; Sarbin, 1995).

3. Narrative patterns in psychotherapy

In the consultation room, the patient, rather than the medically or psychologically trained psychotherapist, is the narrator. The patient relies on the therapist's professional expertise and, if circumstances are favourable, will be prepared to talk about his or her illness and impairments, about their beginning and development. The patient will also enter into biographical self-thematization and is prepared to articulate personal matters, interpersonal problems and conflicts, directly relating or not relating to symptoms or deficiencies. The patient-therapist relationship is asymmetrical as far as self-communication, the steering of events, and the professional duty of care are concerned. The patient consults the therapist as a person seeking professional assistance. He or she gives the therapist credit for his or her professional capacity and trustworthiness (Hermann et al., 2012). The patient entrusts his or her narrative to the therapist in the seclusion and privacy of the consultation room. This sheltered environment allows the patient to temporarily retreat from professional and private commitments; the seclusion of the consultation room, moreover, invites the patient to engage in self-reflection.

Due to their sense of a ruptured continuity in their life trajectories, their retreat from domestic and social commitments, and their need to cope with a life situation altered by illness, patients are receptive to impressions, messages, insights, and experiences denied to others. Such openness, nurtured by suffering and weakness, deserves attention, at least in literary and religious contexts. Literature often depicts illness as an existential experience in diary form, such as Georges Bernanos's *Diary of a Country Priest* (1936). Or it may rest on the documentary evidence of a diary, such as Georg Büchner's *Lenz* (1839) (whose source were the

personal notes of one Jean Fréderic Oberlin, an Alsatian vicar). Or indeed, as in Franz Kafka's diaries (1909–1923), art and autobiographical self-assurance combine to form a new work. The cultural topos of illness as a state of receptiveness to the extraordinary, from which religious and artistic expression may grow, has a longstanding tradition. One programmatic (and also ironic) example of illness as a proverbial educative experience is the account of the impressive experiences of Hans Castorp. Arriving on Thomas Mann's "Magic Mountain" (1924) in good health, Castorp is taken seriously ill with a lung disease and becomes another person. Drawing on the great tradition of creativity born of suffering, Mann managed to radically emphasise and at the same time ironically subvert illness as a formative life experience. Echoing a powerful tradition, creativity springing from suffering has exercised great influence and is easily recognisable as a birth fantasy: an unknown force takes possession of our body, which as a result changes and becomes burdensome; suffering profound agony, distress, and danger of death, our body brings forth something new; the new, however, is weak and in need of protection and care and might have a future of its own.

Beyond religion and world literature, other relevant forms of the illness narrative include the chronicle, documentation, manifesto, personal testimony, and the self-assured autobiographical account. The self-testimonies of persons living with AIDS or cancer (see also Franziska Gygax's chapter in this volume), or who have suffered cardiac arrest or have undergone an organ transplantation are widespread. The sick as chroniclers of their own illness are legion in the media age. The stories of those whose relatives suffer from dementia-related diseases attract much attention in print and audio-visual media.

Narration allows a person to describe her experience without any claim to expertise. Illness narratives articulate and accentuate a personal perspective, requiring no medical expertise. Illness narratives in the clinical context make this impressively clear: patients deploy their own vocabulary, i.e. they articulate their personal relevance and preference, to describe their complaints, symptoms, illness careers, and previous treatment (Boothe, 2011; Boothe et al., 2010). Regarding the fact that people in the Western hemisphere face an ever-increasing life expectancy, with the rise of chronic diseases as its consequence, a better insight into patients' life styles, how they understand and handle their illness becomes more and more relevant for adequate and effective treatment (Schwartz & Schwartz, 2011).

The experience of illness as an opportunity for a new beginning, for self-transformation, and for renewing one's relationship experiences, together with the experience of a fatal illness, takes an important role in all psychotherapeutic discourses where close collaboration with the affected person is aimed at exploring the significance of illness as escape and avoidance, relief and regression, threat and failure, refusal and restriction (Boothe, 2012). Patients often arrive in their

first therapy session with a deep sense of imbalance, which is reflected in fragmented and often chaotic story telling. Their capacity to attribute meaning to what is happening to them in the course of their illness has eluded them. By telling and retelling their story to an attentive and compassionate listener until it has become a coherent narrative both the inner and outer experiences of the patient can be bridged, catharsis can set in and acceptance of and adjustment to a new experience of life – a life with an illness – can take place (Roberts, 2000).

Psychotherapy narratives are often about childhood suffering, current life burdens, ruptures and disturbances in the continuity of the life trajectory. They are also about symptoms and afflictions. Narrators in the psychotherapy context often portray themselves as victims. Some persons suffering from psychic impairments report very little or nothing at all, either because they do not want to or because they are unable to. Patients may be reluctant to engage in narrative self-thematization out of a sense of shame, because they have behaved obnoxiously or suffered a significant personal defeat. Recalling and taking seriously such events is already difficult in itself. They may sense their resistance to recounting, and thereby to admitting such events. Disastrous events have the power to destabilise personal integrity so strongly that their retroactive narrative appropriation may fail.

Self-articulation can provide the attentive listener and companion with insight into an individual's response to specific life burdens and challenges. Mental suffering and the language of suffering are interconnected. Sufferers sometimes lack a language of their own. The experience of suffering may thus be situated beyond an individual's language and narration, such as in the case of children. In the eyes of attentive parents, care-givers, and teachers, children may become mental sufferers if adults act as their spokespersons. Thus, for instance, parent and expert advocacy can diagnose the shy and serious child as inhibited, and the impulsive child as aggressively dysregulated. Such diagnosis may result in therapeutic interventions. More generally, suffering becomes a social event not only through the affected person's self-articulation or through external advocacy, but also through custodians speaking on behalf of those concerned.

Gaining a sense of a patient's psychodynamic situation, and of psychotherapeutic or consultative cooperation, requires discussing the patient's personal perspective. The psychotherapeutic situation encourages narrative self-articulation on the side of the patient. Characteristically, therapists invite patients to narrate a past event to exemplify a symptom, affliction, or interpersonal conflict with a view to concretising matters with regard to the lived experience. Therapists will also actively inquire about the patient's early childhood memories. Such prompts will be made in particular during the assessment phase; they will be used later only if called for in a specific therapy situation, for instance, if patients are inclined to give abstract, summary, or nondescriptive accounts. Spontaneous narration should be expected

not only during diagnostic assessment but also during the majority of psychotherapeutic or psychoanalytic sessions. But clear differences should be expected between patients in terms of the number of narratives, the intensity of narration, and the preference for certain narrative patterns. Narration involves patients in individual drama and self-representation, and exposes them to a possible confrontation with pain. Individuals differ in regard to their inclination and willingness to make their personal drama part of psychotherapeutic communication.

Given the widely ramified family of narrative forms, actual conversations follow no unequivocal pattern. Described below are merely the particularly frequent forms of narrative self-communication occurring in psychotherapy. According to Gülich and Hausendorf (2000), spoken narration has a threefold informal use:

- **Dialogic narrative:** Here, interlocutors remind each other of earlier situations, which they either experienced together or which they know about, and which stimulate joint narratives ("We were talking about the old days," "Do you remember when Eugene …"). In the psychotherapeutic context, such narratives can begin only once the interlocutors have developed a joint narrative. Such co-narrative historicisation is revealing as regards the quality of cooperation, trust, confidence, the production of meaning, and the value of joint action. To my best knowledge, no systematic research on such narratives exists to date.
- **Iterative narrative:** This form captures situations in a model-like, exemplary fashion, in terms of an "whenever," "then" ("When my father came home, he would first, … and then"). This form is very common (at least initially) in the psychotherapeutic dialogue. Here, the narrator positions him- or herself as an informer and expert in relation to biographical structures and patterns.
- **Episodic narrative:** This proves to be the most productive form for exploring psychodynamic regulatory phenomena. It presents an event as a unique and individually experienced incident ("Once, it was a cold November, I … ").

Below, various examples of diverse patient narratives are discussed. These illness narrative patterns have been entitled the 'illness career,' 'this is how things go,' the 'catastrophe,' the 'metamorphosis,' the 'problematic ego,' and the 'problematic other.' The examples are taken from audio- or video transcriptions of a psychoanalytic research interview, of psychodiagnostic or psychotherapeutic sessions, documented in transcription corpora at the universities of Bielefeld, Magdeburg and Zurich. All examples are translations from original dialogues in German. A simple transcription system was used (Mergenthaler, 1986), which employs comma, full stop, exclamation marks, question marks, dashes as signs for voice-up, voice-down, intonations and pauses.

The 'illness career' narrative is illustrated by an excerpt out of a psychoanalytic research interview which took place in the context of a narratological and linguistic study on communicative and interactive procedures in patients' presentations of anxiety symptoms. In the foreground of Kerstin's symptoms is not anxiety, but she suffers from mild dissociative symptoms and had been admitted to an epilepsy centre for preliminary assessment. The psychoanalytic research interview takes place in order to explore Kerstin's experiences of anxiety. But first Kerstin tells about the incident which led to medical examination and the question if she has epileptic seizures. Characteristically illness career narratives are episodic but encompass longer portions of time. Our example "I fainted in December" is rather short. The presentation of symptom or illness evelopments can be much longer.

'This is how things go' is an iterative narrative which occurs very frequently in psychodiagnostic and psychotherapeutic sessions. Here the patient informs the therapist about prototypical situations or interactions. Again we discuss an example which stems from the psychoanalytic research interview with Kerstin. She illustrates a characteristic situation in which dissociative "attacks" or "lapses" occur and how she handles them.

Kerstin is also the protagonist of a type of episodic illness narrative which we understand as the presentation of traumatic events or 'catastrophes,' which means the experience of terrifying or horrifying intrusive attacks on personal integrity, security and self-determination. Here the process of telling is frequently marked by ruptures, by discontinuity and signs of being overwhelmed or overstrained by the act of narrative actualization.

Persons with schizophrenic disorders are captured by experiences which are clinically classified as delusions. If the patient is able to get into dialogue with someone who is prepared to listen, he or she can afterwards envision the experienced delusional episodes. In many cases, these are events in which 'metamorphosis' plays a central part. The 'metamorphosis' narrative, which is presented here as an example, stems from a schizophrenic patient's diary, which he had made accessible for scientific purposes after his suicide as a young man in his thirties.

We learn about the 'problematic ego' as an illness narrative by means of Therese's narrative; it stems from a diagnostic interview (Transcript Archive, Madgeburg University, original in German). We found impressively few narrative self-problematizations in the archives which were open to us and discussed the idea that forms of self-exploration and self-examination are not at home in the narrative field, but belong to the reflective forms of self-thematization. 'Problematic others' are typical protagonists in episodic narratives which show these others as malignant, as offenders or wrongdoers. One gets ill and is made suffering by other people. Once again Kerstin is the narrator; in the story of "the motorcycle crash" she tells how she became the victim of her irresponsible husband.

3.1 The 'illness career' as illness narrative

Excerpt (1) is taken from a video recording of a psychoanalytic research interview between a therapist and a patient with mild dissociative symptoms (the transcript followed the Mergenthaler-system (Mergenthaler 1986)).

(1) Kerstin (psychoanalytic research interview, Bielefeld Narrative Archive, original in German): I fainted in December

1 I fainted in December,
2 I was visiting a friend and felt dizzy
3 and knocked my head against the door frame;
4 like this (illustrates the event with a movement of her head),
5 I had a terrible headache afterwards,
6 and I was still feeling a bit dizzy afterwards,
7 and so I went to hospital,
8 so that—I had minor concussion.
9 you know,
10 and then they kept me there
11 you know

This narrative depicts various symptom-oriented processes: a young woman, Kerstin, who has been admitted to an epilepsy centre for preliminary assessment, reports the first occurrence of her symptoms – dizziness and losing balance – to a psychotherapist.

Kerstin suddenly lost her balance and fell over. This incident prompted a medical examination and later a psychodiagnostic assessment. The first-person narrator recounts how she unexpectedly lost bodily control, which consequences occurred as a result, and which measures were adopted. Her narrative follows the following pattern: "X led to Y and then to X." This pattern is typical of so-called career narratives, that is, sequentially organised accounts of processes following a developmental course or plan of action. Usually, such narratives are non-episodic in a narrow sense. They span larger, often unspecified units of time and create procedural sequences. In such sequentially organised narratives, narrators introduce themselves as a patient or advice seeker, that is, an individual with a medical condition, symptom, illness, burden, or impairment, who must cope with the consequences arising from this condition and who has decided to take action under the circumstances.

The career narrative epitomises the so-called illness narrative, in which the person suffering from an affliction, illness, or disorder speaks as his or her own witness. Being one's own witness means the person affected speaks about his or her illness, disorder, or life burden in terms of personal expertise. Kerstin's narrative exemplifies this in her dating the initial incident as follows: "I fainted in

December." She refers to the disruptive event as feeling "dizzy," which was followed by "fainting." Using everyday medical vocabulary, the narrator diagnoses "concussion" because she "knocked [her] head against the door frame." A bad "headache" and lasting "dizziness" prompt her to consult a professional facility ("and so I went to hospital"), which assumes responsibility. Kerstin presents her symptoms – dizziness and fainting – as a loss of stability and physical balance and as a mechanical change in position.

"The first time Kerstin fainted and went to hospital" belongs to the type of narrative account (of a procedural sequence of events resulting from an incident or a change in events), which attracts attention and then describes further developments, consequences, and measures. Using a personal linguistic frame of reference, and occasionally adding expert vocabulary, the narrator documents what happened to him or her and what action he or she took. The documentation claims to be correct, but it also provides scope for personal involvement.

3.2 'This is how things go' as an illness narrative

Once again, the transcribed extract (2) has been simplified for the sake of readability. The same patient is involved as in extract (1).

(2) Kerstin (psychoanalytic research interview, Bielefeld Narrative Archive, original in German): I try to touch something and utter a sound

because I've been having these attacks recently,
I've got these lapses,
that I've
it happens when I'm walking,
you know, just walking,
whether I'm going for a walk
or going shopping,
I've got this feeling
that I'm being torn out of the world, you know?
that I (clears her throat, breathy voice) think,
I'm going to faint any moment.
and to stop that happening,
I somehow try to hold onto something;
it doesn't matter if it's a table or a person or something else,
you know?
and mostly I make this kind of sound,
like this (imitates the sound:) hhh,
because I thought,
I'm going to faint.
and the person,
who hears this,

22 knows they need to hold me right then.
23 it's just a kind of sound to help me,
24 do you understand?

Following Gülich und Hausendorf (2000), the passage is an iterative narrative and involves narrative typecasting: the narrator claims that a series of events has various characteristics in common, from which follow their repetition and the production of a situational model. The events concerned are related to illness. Based on her experience, Kerstin establishes a characteristic contextual frame of reference (consisting of events and actions). While she is casually strolling along shopping streets on her own, she feels dizzy and risks fainting. The model describes the specific nature of a situation leading to a loss of balance and the potential risk of injury. It also indicates how Kerstin seeks assistance or rather helps herself. She experiences the physical sensation as mysterious and accepts it as such.

There are different illness- and disorder-related situational models. Commonly, they involve a narrator who recounts being affected by a particular symptom (that is, pain, discomfort, moods, perceptions, or interpersonal stressors), how this experience affected him or her, what happened as a result, and what action he or she took.

Applying linguistic approaches and conversation analysis in a series of language diagnosis studies, Gülich and Schöndienst (1999, 2000) managed to distinguish the seizure-related iterative and episodic narratives of epilepsy patients from those of patients suffering dissociative (psychogenic) attacks. Epilepsy patients and patients with dissociative attacks systematically shape their narratives of such attacks differently. As Surmann (2002, 2005) has shown, their use of metaphors is also different.

Schmitz-Hövener (2006) has demonstrated by extensive conversation analyses that patients suffering panic attacks also employ a characteristic form of iterative and episodic narrative when relating their attacks. Among other features, the metaphor of struggling against an overly powerful opponent, to whom one ultimately succumbs, is a consistent feature of such narratives. Here, the narrators very commonly refer to a "panic attack." For patient and expert, the term functions as a micro-narrative, which provides a situational model. The same applies to many other characterisations of mental or physical disorders, such as compulsive-obsessive behaviour, snake phobia, fear of blushing, binge eating and kleptomania.

3.3 The 'catastrophe' as an illness narrative

(3) Kerstin (psychoanalytic research interview, Bielefeld Narrative Archive, original in German): Being careless
1 What else was up?
2 it was during

I was doing my training,
and was sitting in the tram,
and (audible breathing) and there were three Turks, sitting one carriage ahead of mine
and these Turks, they kept looking at me all the time,
you know.
and I wasn't really paying attention to them;
but I still noticed,
that they were looking,
but I didn't really take any notice (audible breathing).
and then I went to the main station,
I used to take the train,
because I didn't have a car at the time,
and I had just – just crossed the road,
and then one of them came up to me
and invited me for coffee.
but I said
no thanks
and kept on walking.
and right then,
when I (long pause)
you know,
kept on walking,
two of them came from behind
and pulled me aside;
(audible breathing) you know;
they didn't rape me or anything like that,
but they did grab hold of me (pressed voice),
and (longer pause) you know;
(long pause) you know;
(longer pause, audible breathing) and (audible breathing) that was that really (longer pause)
you know,
and that's why I'm, yes indeed!
and then I'm also that kind of type,
that I just don't go out in the evenings (longer pause) alone anymore;
you know?
and well yes.

This is Kerstin's last narrative message in this interview. Her interlocutor had repeatedly encouraged and prompted her to narrate past biographical events, in particular ones associated with fear. Kerstin followed her interviewer's prompts, either recalling several fear-related incidents or formulating corresponding

situational models. Her narrative of "being careless" sets in near the time of another biographical recollection, which she relates as a single narrative episode: when she was walking her dog in the forest, she was followed by a man and felt scared. She asks herself, "what else happened?," and begins a closely thematically-related narrative. Here too, she is out walking on her own, casually and without any interest in making contact with her surroundings. She is aware of people looking at her but disregards their gazes. She declines an invitation for coffee, after which she is pulled aside and overpowered by three assailants. The narrative excludes details of the attack, with the exception of "two of them came from behind and pulled me aside (audible breathing)" (l. 25–26). At this point, the narrator interrupts the continuity of her plot and screens out what happened after she had been grabbed. Instead, she uses a category of delinquency or harm ("rape") to convey the outcome of events. The vague expression "or anything like that" suggests what sexual violence might be involved in the context of rape. She concretises events, a voice still audibly strained, by adding, "but they did grab hold of me (pressed voice)." But her offer to concretise events remains restrained. The cumulative "you know" phrases, which are followed by pauses and audible breathing, lead the interlocutor to expect further comments. Kerstin, however, first decides to summarise events, "that was that really (longer pause)," before reporting the long-term consequence of the experience: "I just don't go out in the evenings (longer pause) alone anymore, you know?" By way of closure, the interrogative phrase "you know?" gives the floor to her interlocutor.

Also noteworthy is a phrase involving formulation and reformulation: "and that's why I'm" (l. 34). "That's why" clearly points to what the experience entailed for the narrator. "Yes indeed!" dissolves this decidedness and acts as a caesura. The self-typecasting, "and then I'm also that kind of type" (l. 35), reaches beyond the narrative to a general statement. Amending the statement, "that I just don't go out in the evenings (longer pause)," to "that I just don't go out in the evenings (longer pause) alone anymore, you know?" might seem to revoke a more detailed statement in favour of a concise final remark.

Kerstin's "being careless" narrative is about a disturbing event, and its organisation shows signs of disturbance. The continuous portrayal of events is interrupted. The speaker's agitation and tension disrupt smoothly coherent narration. Her narrative planning is blocked and corrected, in particular before the narrator reaches expectably precarious details. These features are often found in trauma-narratives (Boothe & Thoma, 2012). The "trauma" label is well-established in the media and its extremely broad application has blurred its meaning among professionals. On the one hand, traumatic events are considered to be catastrophic events involving significant potential damage, irrespective of whether the person affected subsequently develops a psychic disorder; on the other, traumatic events

are said to be catastrophic events causing great potential damage only if they entail mental impairment for the sufferer.

3.4 The 'metamorphosis' as an illness narrative

A disturbing narrative may also occur when a narrator shapes his or her narrative so that it puzzles the listener because its relation to reality defies common expectation. One such example is Robert's narrative of events at the "Lichthof" (atrium) of a university:

(4) Robert (Diary entry, 19 May 1987, JAKOB Narrative Archive, Zurich, original in German): Lichthof
1 The Lichthof last week
2 I was sitting [at] a small table and around me I saw
3 when about 10 metres from where I was sitting, someone's appearance changed from male to female
4 different realities of the world
5 heaped on top of each other
6 had dissolved within seconds
7 transvestism would be the technical term
8 although it isn't clear
9 whether my inner state or my outer appearance changed during the process of observation.

The narrative is a handwritten diary entry. The subject of various research papers, the diary narrative was later entitled "Lichthof" (Luif, 2003, 2006). The text is a first-person narrative in which events are specified in terms of time and space. The narrative is set in the Lichthof (atrium) of Zurich University's main building. Figures appear, and the plot unfolds. The narrative closes with the first-person narrator's comments on the various events. The text is a perfectly common or classic example of "narration as a text-generating pattern" (Gülich & Hausendorf, 2000). The narrator was present and personally experienced what he or she is talking about. There is an everyday narrative culture of conveying experiences and phenomena which elude understanding: if rare or unfamiliar events are involved, then the speaker engages in extensive formulation, and thereby reveals his or her struggle to articulate what proves difficult to express and barely communicable. Conversation analysis has impressively demonstrated this using the example of how epileptic auras are represented by those experiencing such states of consciousness (Gülich and Schöndienst, 1999; Gülich, Schwabe, Reuber & Schöndienst, 2008); comparable communicative strategies occur in dream narratives (Boothe, 2001); dreams and certain extraordinary states of consciousness, such as epileptic auras, confront the ego with impressions which, while unrelated to everyday

communication, are nevertheless highly relevant for an individual and which urge that person to recount them. Thus, a precarious tension exists between a narrator yearning for feedback, in the face of deeply disturbing impressions, and his or her capacity for expressing such experience in language understandable in everyday discourse. The work undertaken on this state of tension is ingenious and aimed at gaining the listener's, that is, interlocutor's willingness to respond and emotional involvement.

An affliction prone to overwhelming experiences without explanation is psychosis. Lysaker and colleagues (2011) discovered that people suffering from schizophrenia have lost their link to their dialogical self, leading to an inability to construct personal narratives and hence metacognition. Based on Lysaker's findings Bargenquast and Schweitzer (2012) have developed a psychotherapeutic treatment model for this patient group, which enhances their metacognitive abilities by eliciting narratives in psychotherapy sessions. In four therapy phases – three of which include extensive work with the patients' narratives – they found that patients progress to the construction of a holistic narrative of their lives, with the disquieting experiences of illness as well as empowering stories of hopes.

Robert's Lichthof narrative is different in respect to the "traditional" narrative of extraordinary experience. What begins in the style of a report ("The Lichthof last week"), then proceeds toward celebrating the effect of a supernatural event before engaging in professional jargon ("transvestism would be the technical term"), bears testimony to an experience hardly capable of approval. Robert's narrative does not hold out the prospect of common understanding, as is customary in uneventful ordinary everyday social practice. Emerging from a writer's solitary retreat, Robert's diary is not addressed to a living counterpart. This difference – between speech and writing – is important. That is to say, we do not know whether in spoken discourse Robert would have resorted to using a rhetoric of reformulation and to uttering the incomprehensible. As is well known, however, the rhetoric of reformulation occurs in spite of the absence of communication partners, as for example in dream diaries. Besides, Robert's account- unlike aura and dream narratives – is hermetically closed. His narrative captures a process which coincides with a detachment from different realities of the world. This detachment is followed by an attempt at categorisation, which remains suspended because of the open-ended outcome of the narrative. Gender certainty and the order of reality are lost "within seconds." Here, however, this induces neither linguistic agitation nor stammering, nor the emphatic expression of emotional drama. Robert often retreated from the outer world to record his particular experiences, filling many diaries. He dedicated his diaries to his psychiatrist, although he probably did not write it with this addressee in mind. When Robert's psychiatrist received what was intended to be his patient's legacy, Robert had already committed suicide.

The question remains if a patient's inner state can be judged from the linguistic characteristics of his narrative. Robert's narrative is coherent and leaves no question about its meaning (even though the reader might be puzzled). The narrative is not incoherent or disorganized. A clinician might therefore come to the conclusion that Robert is a healthy university student. But is he? Bianco (2011), in his case study of Connie, tells the story of a patient recounting a similar story to Robert's, full of science fiction elements such as her being cloned numerous times by strange, mighty and intangible creatures. However, this narrative is also coherent in itself and even offers a happy ending (with Bianco being her guardian angel). He concludes that by giving an explanation to her current situation and offering validation to her paranoia by providing a myth of their origin within her narrative Connie testifies the immunity of our minds to "the ravages of mental illness" (Bianco, 2011, p. 299).

3.5 The 'problematic ego' as an illness narrative

Narrative accounts problematizing the self are common among narrators suffering from depressive disorders and self-esteem disorders (see also Boothe, 2005).

(5) Therese (1st narrative, diagnostic interview, Transcript Archive, Madgeburg University, original in German): There were people wanting to buy my pictures

1 I mean
2 I missed, well messed things up because of my behaviour
3 there were people interested in buying my pictures
4 and I came up
5 I had applied for a scholarship in Paris
6 you know
7 I thought
8 it would be good
9 half a year in Paris would do you good
10 you know
11 you'd get out of here
12 because I've got the feeling
13 I know everyone here or I know a lot of people superficially
14 and they know me
15 and I'm so trapped here
16 because I can't get out of my role
17 and well yes
18 and then I came up and saw the lists
19 and that I hadn't got the scholarship
20 and then these people all rushed toward me and wanted to buy my picture
21 I'd have had plenty of money and needn't have taken a job
22 but I was so unfriendly

because I was so angry
so that I you know
this is also so typical
that I can't adjust to a new situation but am completely upset
because I hadn't gotten this scholarship
so sad
now that was during the gallery tour, on 5 February or so
and I mess things up
and I was so mad afterwards
things just
I was so mad at myself for so long
that I'd messed things up
other people contacted me
but those other people would have really bought the picture
you know
so that, well you know, that I think
I keep messing things up
I keep getting everything
and then I mess everything up

Narrative self-problematization is quite unlike reflective self-problematization. Therese clearly wishes to possess resources capable of fostering her potential which would allow her to flourish; she would also like to be a promising artist, a good prospect in her parents' eyes. She should be the one who keeps "getting everything"; strikingly, Therese portrays herself, in what amounts to the ultimate moral of her narrative, as the person to whom everything is given even though she has not been awarded a scholarship. The first part of the utterance in question expresses her wish-fulfilling concept of herself, the latter her defensive self-resistance: "and then I mess everything up." Thus, Therese's narrative presents an angry self-accusation.

Therese's narrative conclusively stages the rhetoric of remorse: the prospect of a profitable deal – that is, the lucrative sale of a painting – fails because the first-person narrator's adverse behaviour denies the customer, a potential resource owner, the chance to make a final purchase decision: Therese puts off the customer. In the narrative, the ego is confronted first with an opportunity which she then squandered ("I'd have had plenty of money and needn't have taken a job"), secondly her self-sabotage ("but I was so unfriendly"), and finally her concluding self-incriminating assessment ("I keep getting everything and then I mess everything up"). Entirely in line with Sarbin (1986), Therese's remorseful mood is narratively organised. It manifests itself as a missed opportunity and as such as another possible pattern of development, one situated between opportunity and anti-opportunity as two possible types of development.

The missed opportunity follows pity narrative organisation:

- I am presented with what seems to be a relevant opportunity, either now or later.
- I miss the opportunity presenting itself or sabotage my chances of seizing it.
- The window of opportunity is closed.
- Looking back, I am desperate to rectify my mistake or to make amends for my sabotage,
- but correction holds out no prospect of success.
- In a state of great emotional involvement, I evaluate the original opportunity as still or even as increasingly relevant.
- Still highly agitated, I disqualify my failure to seize the opportunity, that is, my self-sabotage.
- I rectify my behaviour and imagine myself seizing the opportunity on offer.
- The rectifying imagination heightens my self-disqualification.
- The rectifying imagination can be turned into something positive if the self-quarreling gradually subsides and if a phase of self-consolation commences, during which hopeful images of new opportunities can be crafted.

The outlined progression of remorse impressively demonstrates how sharp-edged certainty is produced retroactively, quite possibly where no such degree of certainty existed at the time. The unfolding of remorse, moreover, reveals a strong interest in control and regulation, as becomes apparent, amid the pain of remorse and self-quarrelling, precisely in the self-incriminating attribution of agency, which the narrator acknowledges she has made poor use of. Finally, the progression of remorse marks the irrevocable nature of the missed opportunity. Remorse negates the accidental, because the narrator's self-quarrelling suggests, albeit after the event, that a successful course of action would have been possible. The narrator's rhetoric of remorse highlights the missed opportunity – that is, the chance which presented itself but was not taken – as particularly worthy of esteem and her self-sabotaging action as particularly malignant: "With any effort of mine one of my works attracted such great interest that people wouldn't have minded spending a tidy sum of money for it, if I hadn't wrecked the opportunity because of a bad mood." Therese portrays herself as unfit to market herself, as inept at contending with her momentary anger at being hurt for not being awarded a scholarship. She has not been deemed worthy of promotion. Further pursuing the narrative structure of "self-handicapping," the narrator invites her interlocutor to afford her narcissistic gratification, along the lines of her being "talented, coveted, and self-ruinous."

Narrative self-problematization is relatively frequent when one is confronted with depressive patients and patients with self-destructive tendencies. Narrative self-problematization is rather infrequent, when one is confronted with non-depressive patients; thus such narratives are striking when encountered. Klara, a young woman suffering from an anorexic eating disorder, provided the following account:

(6) Klara (2nd narrative, 2nd therapy session, JAKOB Narrative Archive, Zurich, original in German): Diplomatic mediation

and ehm once again this took place in St. James Park
where my father suffered a bout of *déformation professionelle*
he
just as if he had been teaching a class
he wanted to show us three women
my mother, my sister, and I
another castle
but we were tired
and we had already been to a museum
it was a nice spring day
and in St. James Park there's already so much to do, children
playing
donkeys, recuperation areas, just so much, so much that invites one just to be
that
well, I'm not being perfectly honest
it was actually my sister
my sister who first said, who was defiant, you know, who just defied him
no
I can't go on
I'm tired
and then I got involved and started to argue diplomatically
Dad
we really haven't got any energy
we just don't want to
we just want to enjoy the park
we're tired
and then things grew more intense
and harder
and then we attacked him
or
well
when we said
one realised he was a teacher

34 and ehm we didn't want to
35 well yes
36 I think
37 we raised that issue with him in particular
38 that one realised he was a teacher
39 and that deeply offended him of course
40 and then in the end I just suggested
41 that he should go alone and meet us at a certain time
42 my mother took our side and was very feeling or you know
43 she seldom became headstrong and spoke her mind
44 she
45 well anyway things spilled over
46 and I suddenly had the feeling that
47 they, ehm these two other women, were almost being nasty to my father
48 and then I tried to calm things down, somehow, and tried to find a solution
49 which would allow us to meet him halfway
50 but that was one of those occasions
51 where we simply said
52 no
53 now, now that's enough museums, enough castles
54 we just want to relax

Personal everyday oral narratives usually claim to be historical fact and often guarantee such factualness explicitly. The same applies here. Klara interrupts her narrative at one point to correct herself: "invites one just to be/that/well, I'm not being perfectly honest/it was actually my sister." Intent on continuing her account, she nevertheless revises what she intends to say, claiming a lack of honesty. This example suggests that the narrative representation of past events demands factual accuracy on all accounts, in terms of a commitment to avoid distortion of any kind. Further, Klara's narrative shows that factual accuracy presupposes sincerity, that is, an attribute a narrator must demand of him- or herself. Notwithstanding a powerful emotional interest in casting oneself in the best possible light, listeners expect speakers to be mindful of their tendency to swerve from truthful recollection and to favour themselves in their narratives. Klara problematizes herself by rectifying her account for the sake of honesty, albeit quite possibly to the detriment of her favourable self-portrayal: she would have liked to have presented herself as a rebellious and self-confident daughter who knows how to stand her ground and to set limits with her father.

3.6 The 'problematic other' as an illness narrative

Many patients report how they are made to suffer by other people. Their narratives plainly reveal that their complaints and impairment stem from problematic

personal relationships. They often position themselves as victims in such narratives. Kerstin, for instance is troubled by a problematic relationship:

(7) Kerstin (psychoanalytic research interview, Bielefeld Narrative, original in German): The motorcycle crash

it was my husband's motorbike
and I didn't have a licence
and we were on a kind of farm road
and he wanted to teach me how to ride a motorbike
but to be honest I wasn't really keen
I'm the type
who prefers to sit on the back
but he said
I should try, just have a go
you know
and there was this hill
which was quite steep
ehm he jumped off, and let me ride
you know
and I couldn't turn the bend
you know
and so I just went straight into the forest … and fell
you know
and then I didn't really fancy trying again
(faint smile) because I had pain in my leg and
because the thing was lying on top of me
you know
but my husband wanted me
to have another go
you know
because that would help me conquer my fear
and he said
you know
and so I did that just
so that he would shut up
and then we went to the doctor's

Kerstin suffers because her husband makes her suffer. He forces her to undertake a hazardous manoeuvre for which she is inadequately equipped and even lacks a licence. Her husband lacks a sense of responsibility. Her narrative account disqualifies him as a bad protector and inept teacher, and she suffers as a result of both shortcomings.

To begin with, psychotherapy narratives often concern problematic relationships. Similar to Kerstin's narrative, individuals recounting their suffering in

problematic relationships cast their partners as antagonists, as factors jeopardising the narrator's well-being. Psychotherapy patients portray themselves primarily as sufferers in personal relationships. For them, suffering is often caused by another person rather than by themselves.

4. Conclusions

Despite Freud's studies of the formal elements of dream narratives *Jokes and their Relation to the Unconscious* (1905) and *Creative Writers and Day-Dreaming* (1908), at the time psychoanalysis hardly acknowledged narratives as a product shaped by a narrator. Consequently, the role of the narrator was seldom systematically distinguished from that of the observer, witness, or reporter. This was the case despite the fact that Freud developed the notion that some of his patients reported sexual abuse during childhood which he considered to be "invented" (in a letter of 1897 to Wilhelm Fliess). The fact that the role of the narrator was systematically neglected in psychoanalysis had consequences. One can assume that the failure of psychoanalysis to attend to how narrators shape their narratives meant that it favoured an all-too simple view of narrative productivity. While the authenticity and credibility of a narrative attracted much attention, the actual act of narrating, as a productive human achievement, was of scant interest. Important exceptions are Freud's *Screen Memories* (1899) and *Jokes and their Relation to the Unconscious* (1905). (Important and well-known studies were published some decades ago, for instance, Brooks, 1984; Schafer, 1995, 1980; Spence, 1982a, 1982b, 1983).

The representation of a development, the formulation of typical situations, the communication of disintegrative processes, and the articulation of emotionally stirring events are prominent and important parts of psychotherapeutic communication. The opportunities provided by such communication must be used in practice. In psychotherapeutic research, narrative speech events must be much more carefully paid heed to in order to gain insight into a patient's personal perspective.

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