How co-narrative processes may work in insight-oriented psychotherapy[1]

Tilmann Habermas

In this contribution I introduce some of the narrative concepts I have developed and consider how they might be useful to conceptualize what may be helpful narrative and co-narrative processes in psychotherapy. These are preparatory ideas for future analyses of psychotherapy transcripts. The article starts (1.) with some general narrative concepts that might be useful for understanding psychotherapeutic change, (2.) sketches some typical psychopathological distortions of narratives, (3.) indicates socializing narrative practices, to finally (4.) consider some possible ways in which co-narrations may be helpful in insight-oriented psychotherapy. The term narrative describes a speech activity in which one of the communicating individuals is granted a longer-than-usual time to speak alone in order to tell a story. The term co-narration describes the activities of listeners that support, comment upon, and react to the narration.

1. Life story and narratives

Traditionally, psychoanalysis was an art of understanding neurotic illness by understanding the biography of patients, i.e. by reconstructing dominant unfulfilled wishes and unsolved conflicts on their biographical context and present constellation. When Freud (1905) reported the treatment of Dora, he excused the incompleteness of his biographical sketch by stating that neurotic defense mechanisms tore holes into the life story to cover up conflicting motives in the past. Only a successful treatment that would lift repression and render defensive distortions of the life story less necessary could help the patient to compose a more complete and consistent autobiography.

Now what does render a life narrative complete and comprehensible? Certainly leaving out relevant pieces will render a life narrative fragmentary and mysterious. But put positively, what does a comprehensible and more or less complete life story require? My initial approach to life narratives was developmental: When do we learn to construct a life story? To study the development of the life story Susan Bluck and myself came up with four kinds of biographical coherence that turns a pile of unrelated stories about the past into what we would recognize as a life story (Habermas & Bluck, 2000). We defined this coherence as global text coherence in a life narrative. First of all, a life narrative, like any narrative, requires a basic linear chronological order, creating *temporal coherence* and providing a temporal orientation for listeners such that they can locate events in the narrator's life. An important aid for creating a linear chronology is a *cultural concept of biography*, which defines for members of a given culture what to expect a life story to look like. An important element is a skeletal concept of a standard life, consisting of major normative life events and their normative timing, termed life script by Rubin and Berntsen (2003). Another aspect of global life story coherence is *causal-motivational coherence*, which is created by the causal and, more importantly, the intentional structure of the life story. It leads to an understanding of how the narrator has become the person she or he is today, and it conveys a sense of the path the narrator was and is pursuing in life. Finally global *thematic coherence* is created by implicitly and explicitly creating similarities between the very different parts of life, e.g. by similarities between experiences or by explicit pointing out a pervasive pattern, e.g. by using metaphor to describe an overall personality characteristic such as "I have always been a virtuous person" or "I am fighter". Developmentally, children are not able to construct a life narrative. When asked to narrate their lives, they tend to offer a series of more or less unrelated events. Only early adolescents succeed in constructing a temporally coherent life also with the help of an understanding of calendar time and a cultural concept of biography (Habermas, 2007). Mid-adolescents begin creating causal-motivational and thematic coherence, which increase up to early adulthood (Habermas & de Silveira, 2008).

The entire life story is rarely recounted in psychotherapy, except maybe in the first encounter.

While Freud expected neurotic defense mechanisms to render life stories less intelligible, Otto Kernberg (1984) pointed out that the ability to convey a sense of how one has developed to become the person one is today is more severely undermined by the use of primitive defense mechanisms such as splitting which are typical for borderline personality organisations. Maybe it is fair to say that while neurotic defense mechanisms lead to local contradictions and areas of incomprehensibility, splitting tends to destroy the global coherence of a life narrative.

Life narratives of depressed patients are not so much generally distorted, but rather in a specific way. Their life narratives are less chronologically linear, and narrators take less of a present perspective back onto past events than do non-depressed controls. Also, they use the same amount of explanations, only that they follow the well-known pattern of a depressive explanatory style, attributing positive events to forces other than themselves and blaming themselves for negative events (Habermas, Ott, Schubert, Schneider, & Pate, 2008).

Not only in the initial session do patients speak about their lives and try to understand it. Roy Schafer (1983) suggested that since neurotic defense mechanisms serve to cover up conflicting motives, they tend to delete motives from life narratives, which turns intentional actions into passively experienced events for which the speaker is not responsible. Thus psychoanalysts try to understand the anxiety that motivates defensive distortions and the defended-against motives and wishes, aiming at restituting the motives to the patients past actions. This transforms a life story of things that happened to the patient into a life story in which the patient retrospectively attributes motives to events, turning events into her or his own actions. Thus psychoanalysis works with the life story in a piecemeal fashion.

However, to restitute motives to single past episodes it is not necessary to refer to the entire life story. Only if these motives reach beyond specific episodes do they gain biographical significance. We have termed the activity of relating a specific episode or its elements to other, distant life events and to the self and its development as *autobiographical reasoning* (Habermas, 2011). Autobiographical reasoning is an activity traditionally used by psychoanalysis when a present problematic experience is compared to earlier problematic experiences in order to understand the unconscious interpretation of the present in light of the past. So-called genetic interpretations compare a defended-against motive in a present situation to hat in an analogous past situation, in which it made more sense than in the present. Psychotherapy is thus especially interested in autobiographical reasoning that helps understand repetitions and central (troubling) themes that permeate a life. Autobiographical reasoning not only identifies similarities cross life, but may also create links that describe and motivate individual development and change, creating a sense of development and self-continuity across change (Habermas & Köber, in press).

2. Narrative dimensions that describe psychopathology

Life narratives are not an everyday phenomenon, and even taking a biographical perspective as in autobiographical reasoning is not very frequent. Psychopathology shows most in the processing of specific experiences, and psychotherapy may be most helpful when dealing with specific episodes. Therefore I now turn to five dimensions of narratives which allow describing distortions of the narrative processing of experience in psychopathology (Habermas, in press).

The two major aspects of narratives are their narrative structure, i.e. the linear structure that imitates sequences of events, and the evaluation of these events (Labov & Waletzky, 1967). This holds both for fictional and factual, often autobiographical narratives.

The narrative aspect can be subdivided into a temporal and an intentional one. The temporal sequentiality of narratives (level 1) manifests linguistically in narrative clauses, i.e. main clauses the order of which cannot be changed without changing their reference. They typically begin with "and then …, and then …". Their order imitates and signals the order of events in the past. The use of narrative clauses renders accounts of events vivid and detailed. It lets listeners and narrator alike follow the sequence of events, engaging them in narrative immersion in the past and evoking corresponding emotions. A lack of actual narrating has been termed overgeneral memory. These are more frequent in depression as well as in other psychopathological disorders. One prominent interpretation is that negative emotions are avoided by not narrating (Williams et al., 2007).

Related to, but more complex than the chronological structure of a narrative is its intentional

structure, the plot (level 2). The global structure of narratives provides the general frame for the plot, starting with an announcement of what is to come (abstract), an orienting section describing the context, the complication with what happened, i. e. the newsworthy event, attempts to solve the complication, a result, and a coda leading the listener back to the present situation. The complication defines the task for the rest of the narrative, and the result is evaluated in terms of whether the complication has been solved and the state of things has been returned to normality (Labov & Waletzky, 1967). The lack of an intentional structure in a narrative can also be described as a lack of agency. Thus the passive, non-agentic neurotic stories Schafer speaks about should lack a consistent linear plot and should also lack attempts to solve and the ensuing result sections. Narrative agency is a central characteristic that predicts recovery (Adler, Chin, Kolisetty, & Oltmanns, 2012; Dimaggio, 2011; Hauser, Allen, & Golden, 2006).

Narrative evaluations may be more immediate or more reflected. Evaluations always have a perspective from which they are made, i.e. a *personal and a temporal perspective*. Immediate evaluations (level 3) tend to be made from within the episode by the involved protagonists (e.g., "It scared the shit out of me"), but may also be made from the present, future, or counterfactual, by the narrator, the listener, or others (e.g., "My mother would have disapproved of me, had she ever known about it"). Immediate evaluations comprise *reported speech*, *mental clauses* with perceptual, emotional, cognitive, or volitional qualities, and *global evaluations* ("That was really bad", "That had never happened to me"). A reduced use of immediate evaluations is typical for alexithymia and can be interpreted as a low degree of mentalization and psychological mindedness.

Reflective evaluations (level 4) are comments on or explanations of the events or of the immediate evaluations, such as when narrators explain their past emotional reactions. Autobiographical arguments put events in a biographical perspective. A lack of reflective evaluations in narratives lets the narrator appear unreflective. An overload of reflective evaluations, however, may give a narrative a dry, intellectualized flavour, as is typical of an obsessional personality style and possibly also depressive rumination.

There are special combinations of immediate and reflective evaluations, resulting in specific styles. A *dramatizing narrative style* draws listeners and narrators into the past scene. This highly immersive potency results from the use of a cluster of linguistic devices. Dramatizing narratives use narrative clauses, exclusively represent the first person perspective of the past protagonist, excluding others' perspectives and evaluations from other temporal perspectives, and preferably use immediate evaluations. These are perceptual mental clauses rather than cognitive and volitional mental clauses. Further means to displace the listener to the past event are direct speech, historic present (using present tense when speaking about the past), and the shifting of the reference or origo of deictic temporal and local expressions from the present narrator to the past protagonist (using 'here' and 'now' for the 'then' and 'there' of past events; Chafe, 1994).

Such a dramatizing narrative style is typical for narrator's experience of being overwhelmed by the memory and the accompanying emotions. Laub and Auerhahn (1993) coined the term *overpowering narratives*, which signal a reliving of the past event, as is typical for narratives of still traumatic events. They contrast them to what they term *witnessed narratives*. These do not use a dramatizing style, but also contain evaluations from others' and present or counterfactual perspectives as well as reflective evaluations. A dramatizing narrative style has also been described in the case study of a woman with agoraphobia when narrating experiences of panic attacks (Capps & Ochs, 1995).

A final narrative level is more semantic and pragmatic in nature, and comprises the completeness of narratives as well as their consistency. Leaving out essential parts, or flooding a narrative with irrelevant detail, both render it incomprehensible. Implicit contradictions created by splitting also undermine comprehensibility. This level reflects an orientation towards the listener.

The five narrative levels allow describing the major distortions of the form of narrating in psychopathology. Before turning to the therapists' role in patients' narrating I will briefly describe how narrating and its use for the moulding of emotions are formed during childhood.

3. Co-narrative processes in socialization

Children learn to narrate in interactions with adults. The shared telling and reading of fictional

stories is an important socializing practice in which children learn basic narrative structures and conventions early on. To learn to share experiences, children have to rely on narrative structures. However, narrating one's own experiences is a more complex task than retelling a fairy tale, as anyone knows who ever wanted to learn from a three year old what happened at the nursery. Children between two and five learn in extensive adult-child co-narrations how to narrate their own experiences. Adults play an essential role in this process, by asking questions, encouraging and supporting, picking up and elaborating what the child said. More elaborative interactions with adults support the development of the child's ability to remember and narrate own experiences (Fivush, Haden, & Reese, 2006). Co-narrating of experiences also helps children learn how to understand and to deal with emotions (Eisenberg, Cumberland, & Spinrad, 1998). For example, elaborating negative emotions in a supportive way (Fivush, Haden, & Reese, 2006) and co-narrating with the use of mental clauses (mental state terms; Doan & Wang, 2010) are related to better emotion knowledge and to better emotion regulation abilities as well as a more secure attachment in children.

Such socializing practices are mostly studied in the preschool years, and emotion regulation practices are thought to be internalized by middle childhood (Holodynski & Friedlmeier, 2006). However adolescence is a developmental phase in which the acquisition of emotion regulation and coping skills is still a huge challenge for adolescents themselves as well as for their parents. We have conducted a small study of co-narrations focussing on the shared telling of the adolescents' life story (Habermas, Negele & Brenneisen Mayer, 2010). Besides showing that mothers scaffolded the child's life narration so as to help with those aspects of coherence the child had not yet mastered, we could informally observe large differences in the style of co-narration. For instance the degree of mutual interrupting and correcting, and also the way of correcting varied widely. Some mothers simply denied any validity of their child's statement, while others more cautiously suggested additional ways to view the past, or tentatively suggested a somewhat differing view. If their mothers co-operated, middle to older adolescents began to inquire about their mothers' perspectives, aiming not at one true version of the past, but reconstructing differing experiential perspectives of their mother and their own onto events, finding an interest in these differences. Mothers also picked up quite different aspects of the child's narration, which had to do not only with the children's age but also with the mothers' preoccupations. Some mothers focussed on elaborating their children's motives and emotional experiences, while others added more of their own concerns. One mother showed a quite disruptive interactional style by being obsessed with the correctness of dates, again and again correcting the temporal indications of her child. I suspect that these co-narrative styles have a strong influence on the child's ability for and style of coping with events by narrating them. At the level of the content of life narratives, it was interesting to see how mothers managed to base character attributions to the child on their privileged knowledge of the child's earliest years, by recounting very early episodes in which a certain personality trait already showed. Adolescents, on the other hand, were eager to demonstrate that during their adolescent years they had succeeded in working on a betterment of their character.

4. Co-narrative processes in psychotherapy

Discussing co-narrative socialization practices served to illustrate how typical ways of processing problematic experiences possibly develop. Psychotherapeutic interaction is different, insofar as adults have a well-established style of narrative processing of experiences. Also, because of the exclusively professional aim of helping the patient with maladaptive patterns, psychotherapeutic co-narrative strategies differ from those of parents or friends. What adults expect from listeners in everyday life is sympathy and solidarity. Listeners typically show their interest by asking for additional detail, and their solidarity by validating the narrators' evaluations, through exclamations such as "Oh no!", "That's impossible!", "What an idiot!", "That's unbelievable", or "That's terrible" (Fiehler, 1995). Such evaluative confirmations are suspended in psychotherapeutic discourse, especially in psychoanalytic abstinence and neutrality.

Rather, psychotherapists are there to enable patients to start telling their stories differently. To arrive at a taxonomy of psychotherapeutic co-narrative strategies, one might start with typical narrative distortions as outlined above, and consider which kinds of intervention might help to change them. Thus therapists may encourage patients to narrate the sequence of a specific incident

(level 1), point out the lack of a motive (level 2), of immediate reactions, feelings and thoughts (level 3), or of reflections (level 4), ask for reasons for the lack, and suggest what may be missing. Or therapists will point out missing parts or contradictions and interpret motives for the lack (level 5). Giancarlo DiMaggio (2011) spelled out this kind of top down approach convincingly in much more detail.

However, to describe more specific strategies therapists actually use, in order to later be able to study which ones may be more or less helpful, it is necessary to also follow a bottom up approach by studying psychotherapy transcripts. In addition, to study which co-narrative strategies are more helpful, it is necessary to describe interactional patterns which are initiated by the therapist co-narrations, i.e. to study the quality of the patients' reactions and, mainly, the quality of the interaction, and not just of the therapists' actions.

For a start, I will refer to an initial therapy session with "the student" by Horst Kächele (e.g., Kächele & Albani, 2001). The patient initially describes a scene typical for his symptom. The therapist intervenes to clarify specific aspects of the narrative by reformulating in his own words what the patient is saying and by asking for a detail. The patient may confirm or reject, or may offer additional details (levels 1, 5). A special case of clarification occurs when the patient ends his proto-narrative of a typical symptomatic event with an ambivalent evaluation, saying "one could live with the symptom, it is not too conspicuous. But it bothers me!" The therapist reformulates tentatively that the symptom was not extremely bothersome at the moment, but was becoming more and more so (level 3).

A little later the patient narrates a childhood experience to which he dates the beginning of something being wrong in his life. The patient recounts how peers had locked him I a closed space, sitting on top of it, and how the day after he returned to the place. The therapist repeats in a demanding tone "You went back to that place to have a look at it?", pointing out that the motive for this action as not self-evident, *asking for a clarification of the motive* (level 2). Instead of supplying a motive, the patient continues to describe the result of the return to the place of his imprisonment, which was a "feeling that something was missing". The therapist then *elaborates the patient's vague sensation*, described by the patient with a comparison to a rudimentary hypothetical situation, by suggesting "Just like you were grasping in your pockets and searching, and something was missing, as if something had been taken away from you?" The therapist *elaborates and dramatizes* the patient's comparison by adding an emotion expressive action and suggesting an eliciting cause. Little later, the patient states that by himself he was stuck in understanding the meaning of his childhood memories. The therapist then tries again to offer his suggestion, by stating that the other kids had indeed taken something away from him, namely his self-esteem, his freedom. Little later he specifies that they had taken his self-assurance. The patient does not react directly, but produces a narrative of what followed that basically confirms the therapist's intervention. In the course of this first interview, the therapist the uses the figurative comparison of feeling robbed of one's freedom to interpret several other occurrence, e.g., applying it to feeling constricted by a university program in law, or feeling trapped in his relationship. Gradually the therapist widens the use of figurative comparison to a hypothetical situation by adding related metaphors, speaking of the patient's superficial friendliness as a way of enclosing his accumulating anger. Also the therapist uses the image of being robbed of freedom to create a direct link to what is going on in the here and now between the two of them. He likens the patient's taking off his jacket to feeling imprisoned on the here and now, and the patient's possible feelings regarding the video cameras as feeling cornered and wanting to flee.

This therapist thus uses figurative language for an unclear part of a narrative to find a similar constellation and emotion in various autobiographical narratives and in the present situation. The therapist thus succeeds in relating narrative with drama (Lothane, 2011), in relating narrative that points to the past or to phantasy with the mise-en-scène of an emotion in the here and now (Argelander, 1970). Depending on the psychoanalytic school, this relating narrative to drama is conceived of, and, more importantly, is achieved differently, but all schools see this link as essential for the possibility of insight and change. Ferro (1999) and Civitarese (2013), for example, see spontaneously emerging narratives as desirable for giving form to the unconscious emotions of the bipersonal field of patient and also the therapist, but consider an explicit translation of narrative into the present experience or vice versa not as a necessary step. They would hope that the introduction

of an image by the therapist would inspire the patient to come up with new ideas and stories.

These observations illustrate how psychotherapeutic narration abstains from mere confirmation of the narrator's evaluation. Rather it tries to go beyond the narrator's narrative by questioning it, by asking for complements, by accentuating and creating new evaluations.

I have described the co-narrative strategies used in this particular session in detail to exemplify how co-narration may work. Because psychotherapists, even of the same school, have widely differing styles, and because each therapist-patient constellation develops differently, I believe it is necessary to study transcripts of a variety of therapies to describe a range of co-narrative strategies and co-narrative developments in the course of psychotherapy. Possibly some dominant patient and therapist styles could be defined. In a second step, such a taxonomy might be used to guide studies of whether some co-narrative interventions and styles are more or less helpful to patients.

To sum up, I suggest that narrative is a central means for forming and understanding problematic experiences, but also for protecting oneself against their impact and implications. It is not just what, but also how people recount events that indicate their problematic ways of processing. At the same time, narrative opens a door to helpful co-narration, a shared enterprise of patient and therapist to liquefy ossified psychological defenses.

References

Adler, J. M., Chin, E. D., Kolisetty, A. P., & Oltmanns, T. F. (2012). The distinguishing characteristics of narrative identity in adults with features of borderline personality disorder: An empirical investigation. *Journal of Personality Disorders, 26*, 498-512.

Argelander, H. (1970). *Das Erstinterview in der Psychotherapie*. Darmstadt, GE: Wissenschaftliche Buchgesellschaft.

Capps, L., & Ochs, E. (1995). *Constructing panic: The discourse of agoraphobia*. Cambridge, MA: Harvard University Press.

Chafe, W. (1994). *Discourse, consciousness, and time: The flow and displacement of conscious experience in speaking and writing*. Chicago: University Press.

Civitarese, G. (2013). Spettri del transfert. In A. Ferro (Ed.). *Psicanalisi oggi* (pp. 77-121). Roma: Carrocci.

Dimaggio, G. (2011). Impoverished self-narrative and impaired self-reflection s targets for the psychotherapy of personality disorders. *Journal of Contemporary Psychotherapy, 41*, 165-174.

Doan, S., & Wang, Q. (2010). Maternal discussions of mental states and behaviors: Relations to emotion knowledge in European American and immigrant Chinese children. *Child Development, 81*, 1490-1503.

Eisenberg, N., Cumberland, A., & Spinrad, T. L. (1998). Parental socialization of emotion. *Psychological Science, 9*, 241-273.

Ferro, A. (1999). *La psicanalisi come letteratura e terapia*. Milano: Raffaele Cortina.

Fiehler, R. (1995). *Kommunikation und Emotion*. Berlin: deGruyter.

Fivush, R., Haden, C. A., & Reese, E. (2006). Elaborating on elaborations: Role of maternal style in cognitive and socio-emotional development. *Child Development, 77*, 1568-1588.

Freud S (1905). Fragment of an analysis of a case of hysteria. *Standard Edition*, Vol. 7 (pp. 7–122). London: Hogarth.

Habermas, T. (2007). How to tell a life: The development of the cultural concept of biography across the lifespan. *Journal of Cognition and Development, 8,* 1-31.

Habermas, T. (2011). Autobiographical reasoning: Mechanisms and functions. In T. Habermas (Ed.), *The development of autobiographical reasoning in adolescence and beyond*. New Directions in Child and Adolescent Development, 131, 1-17. San Francisco: Jossey-Bass.

Habermas, T. (in press). A model of psychopathological distortions of autobiographical memory narratives: An emotion narrative view. In L. Watson & D. Berntsen (Eds.), *Clinical perspectives on autobiographical memory*. Cambridge, UK: Cambridge University Press.

Habermas, T., & Bluck, S. (2000). Getting a life: The development of the life story in adolescence. *Psychological Bulletin, 126,* 748-769.

Habermas, T., & de Silveira, C. (2008). The development of global coherence in life narratives across

adolescence: Temporal, causal, and thematic aspects. *Developmental Psychology, 44*, 707-721.

Habermas, T., Negele, A., & Brenneisen Mayer, F. (2010). „Honey, you're jumping about" – Mothers' scaffolding of their children's and adolescents' life narration. *Cognitive Development, 25,*339-351.

Habermas, T., Ott, L. M., Schubert, M., Schneider, B., & Pate, A. (2008). Stuck in the past: Negative bias, explanatory style, temporal order, and evaluative perspectives in life narratives of clinically depressed individuals. *Depression and Anxiety, 25, E121-E132.*

Habermas, T.,& Köber, C. (in press). Autobiographical reasoning is constitutive for narrative identity: The role of the life story for personal continuity. In K. C. McLean & M. Syed (Eds.), *The Oxford handbook of identity development*. Oxford, UK: Oxford University Press.

Hauser, S. T., Allen, J. P., & Golden, E. (2006). *Out of the woods: Tales of resilient teens*. Cambridge, MA: Harvard University Press-.

Holodynski, M., & Friedlmeier, W. (2006). *Development of emotions and emotion regulation*. New York: Springer.

Kächele, H., & Albani, C. (2001) Die Arbeit an einem zentralen Beziehungsmuster als Musterbeispiel klinisch relevanter Empirie. In M. Cierpka & P. Buchheim (Eds.). *Psychodynamische Konzepte* (pp. 169-190). Berlin: Springer.

Kernberg, O. F. (1984). *Severe personality disorders*. New Haven, CT: Yale University Press.

Labov, W., &Waletzky, J. (1967). Narrative analysis: Oral versions of personal experience. In I. Helm (Ed.), *Essays on the verbal and visual arts. Proceedings of the 1966 Annual Spring Meeting of the American Ethnological Society* (pp. 12-44). Seattle, WA: University of Washington Press.

Laub, D., & Auerhahn, N. (1993). Knowing and not knowing massive psychic trauma: Forms of traumatic memory. *International Journal of Psychoanalysis, 74*, 287-299.

Lothane, H. Z. (2011). Dramatology vs. narratology: A new synthesis for psychiatry, psychoanalysis, and interpersonal drama therapy. *Archives of Psychiatry and Psychotherapy, 4*, 29-43.

Rubin, D. C., & Berntsen, D. (2003). Life scripts help to maintain autobiographical memories of highly positive, but not highly negative events. *Memory & Cognition, 31*, 1-14.

Schafer, R. (1983). *The analytic attitude*. New York: Basic Books.

Williams, J. M. G., Barnhofer, T., Crane, C., Hermans, D., Raes, F., Watkins, E., & Dalgleish, T. (2007). Autobiographical memory specificity and emotional disorder. *Psychological Bulletin, 133*, 122-148.