



PSYCHOPATHOLOGICAL NARRATIVE FORMS

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During psychotherapy, patients describe their experiences in the form of storytelling. Our goal here is to define the criteria that will allow a therapist to distinguish an effective narrative from a dysfunctional one. On the basis of a number of criteria, we provide a classification of the psychopathological forms that can be taken by the discourse of patients observed during psychotherapy. Two main categories are described: (a) Impoverished narratives, which are divided into the subcategories, Deficit in Narrative Production and Alexithymical Narratives; and (b) Integration deficit which is subdivided into Basic integration deficit, Deficit in integration between multiple representations of self and of others, Overproduction of narratives and deficit in hierarchization, and lastly Deficit in attribution to the correct mental function and deficit in distinction between reality and fantasy (between primary and disconnected representations).

Our interest is in discussing the characteristics that narratives need to have in order to guide an individual's actions in the world. In particular, we shall try to provide an answer to the question: what conditions render a narrative unsuitable for its objective, and what forms do pathological narratives take? We shall try to give a clinical description of the forms taken by these dysfunctions, so that they can be treated correctly by the therapist. Listening to stories related during psychotherapy is both a working method and the field of observation.

Research into psychotherapy has already produced data that show storytelling is very common in sessions (Luborsky, Barber, & Diguier, 1992). These data also show that various types of narrative lead to different outcomes in psychotherapy. For example, patients whose prevailing narrative form is the so-called reflexive one (one in which patients speak in the reflexive mode when they refer to interpretations,

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meaning construction, and subjective aspects of the experience) achieve a better outcome (Angus, Hardtke, 1994; Gonçalves, Korman, & Angus, 2000). Finally, data also show that narrating as an activity has a therapeutic value for both physical and mental health, and that various types of story correspond to different outcomes (Pennebaker, 1993). The present work therefore aims to categorize the various types of narrative produced during psychotherapy and their organization in an individual's cognitive system. This first step could then provide a guide to research on the psychotherapy process. The goal is to evaluate the changes to which the various types of narrative are exposed. Furthermore, once specific forms of narrative dysfunction have been identified, it will be possible to guide the process of constructing and rewriting a patient's meaning system with greater precision. Patients who are incapable of telling stories about themselves can be helped to do so, and patients who tell stories in a confused fashion can be helped to dissect and reorganize their narrative style.

THE EFFECTIVENESS OF NARRATIVES: STORIES RELATED DURING SESSIONS

We shall reply clinically to the question: what characteristics do stories need to have to be effective and to allow an individual an appropriate action in the world? What structure should a patient's narrative have to permit a therapist to be effective and to help him or her? This allows us to get closer to understanding the pathology of the narrative function.

As they try to transmit their knowledge about their selves to the therapist who is listening to them, patients keep to their personal style, they express points of view about the world, theories that are worked out to a greater or lesser extent on how things are going or ought to be going and on how their life is or ought to be. The main tool that they use is storytelling. They tell about events from their present and past lives, or how they imagine them to be, with the selves, significant others, or the bizarre characters that inhabit their dreams as protagonists. Therapists gather information from their narratives, and this guides them in their requests for further narratives or details about stories that have already been related, thus increasing understanding of the persons with whom the therapists are talking.

Not all stories are equally effective in promoting understanding and clear statement of problems and in increasing shared knowledge. A depressed patient during a session in the second month of psychotherapy relates the following episode:

P.: It's always the same problem that I don't know how to tackle. I had to sit for the exam, I mean the test before the exam. Before I got up I was terribly anxious. I knew it was my turn and I was thinking: "This is it; I'll go in and they'll find I haven't prepared properly and that I'm unable to explain well what I know, and they'll consider me incapable." I also think that I don't know how to explain things well and don't understand them. Then I got up and went in.

T.: How did the oral go?

P.: As I expected, I got embarrassed, I blushed and I thought, "Now they'll notice that I'm embarrassed," and this blocked me even more.

This is, in our opinion, a good narrative. The patient is capable of putting events in a space-time sequence, of supplying information relevant to the problem, of describing clearly his inner states, of finding access to his own thoughts and emotions and of giving the listener the means to get to know them. There is a clear description of the problem: overcoming the feelings of anxiety and shame and the negative opinion that others have of him and that he has of himself. The patient is not very confident that things can change and his appraisal of himself is doggedly negative: "I also think that I don't know how to explain things well and don't understand them." But both persons taking part in the dialogue have easy access to the problem. Moreover, the story has defined time and space boundaries and does not get mixed up and confused with other stories, and the information given is relevant. Without doubt the speaker adheres to Grice's (1975) cooperative principle of conversation (quality, quantity, manner, and relevance) and knows that, when one asks another person for help, it is necessary to grant the other access to one's emotions.

A good narrative during therapy should therefore have the following structure.

1. It should be set out in a well-ordered space-time sequence, so that the chronological order and potential relationships of cause and effect can be identified;
2. It should make explicit reference to inner states, in particular emotional experiences;
3. It should include a description of the problem that is clear or at least easy to construct;
4. It should be put together with, as a reference point, a developed theory of mind of the listener, taking account of the knowledge

- available, the concerns and information the listener possesses and of the listener's psychological skills and intelligence;
5. It should be relevant to the interpersonal context (that of treatment in the case of narrative during therapy);
 6. It should be endowed with an adequate thematic coherence and merge only partially with other narratives (i.e., there is a limit to the number of brackets and parentheses that can be opened without the listener losing the thread of a talk);
 7. It should provide relevant knowledge, of well-defined areas in the world of relationships;
 8. It should integrate inner states and reflect at least in part somatic states and emotions felt and expressed in coherent meaning themes. This operation, as indicated by Guidano (1987), is by definition unending and incomplete, as it is not possible to give a meaning to everything we experience, and there is always an uncanny element that stays left out.
 9. An individual needs to have the ability to imagine multiple stories. The world of relationships is complicated and each individual has to interpret numerous roles. People therefore have to have enough scripts at hand to guide them on how to behave as inner and interpersonal contexts change.

These are the conditions necessary for a narrative to operate well. A narrative that does not adhere to them is problematic and it is possible to describe the pathological forms it takes—the forms of narrative disruption, to use the words of Neimeyer (2000).

In what ways can storytelling during therapy fail in its objectives of communicating knowledge to another person or constructing an agreed text as a basis for building meanings and resolving problems?

Let's summarize schematically the various categories of narrative dysfunction.

1. Impoverished Narrative.
 - a. Deficit in Narrative Production,
 - b. Alexithymical Narratives.
2. Deficit in Narrative Integration.
 - a. Basic Integration Deficit.
 - b. Deficit in Integration Between Multiple Self-Other Representations.
 - c. Overproduction of Narratives and Deficit in Hierarchization.
 - d. Deficit in Attribution to the Correct Mental Function and Deficit in Distinction Between Reality and Fantasy (Between Primary and Disconnected Representation).

INEFFECTIVE NARRATIVES: CLINICAL EXAMPLES. IMPOVERISHED NARRATIVE

Let's subdivide impoverished narratives into two categories: Deficit in Narrative Production and Alexithymical Narratives. With impoverished narrative, the problem is not in the internal structure of the story, which can be coherent and clear. The problem is that the patient does not have a set of stories sufficient to cope with the world of relationships. Often these patients also suffer from alexithymia and other deficits in the higher mental functions, but the crucial point is their impoverished cognitive system. Alexithymical narratives do not refer to emotional states and do not contain comprehensible descriptions of problems that the therapist should be tackling. In general, they do not take much account of the listener's perspective. Lastly, somatic experience is not integrated with emotions and with the meaning of events.

Marcello provides a good example of impoverished narrative. It can be seen in the texts reproduced below how he brings up almost only one theme: the scenario is monotonous, emotions are few, the communication of meanings is weak, one does not understand from them the complexity of the world in which he lives. He is a young man, 28 years old, with a defect in his intellectual development that is probably due to emotional traumas at an early age. There were abduction and shooting incidents between his parents at the time they were separating, when he was three and a half years old. Custody of Marcello was granted to his father, who then asked the aunts on the mother's side for assistance. Marcello lived with them until he was 11 years old and then went back to live with his father, switching between Southern and Central Italy. Not since he was three and a half years old had he seen his mother. Marcello was extremely sensitive with regard to the negative judgment of others. He had a tendency to feel threatened and therefore reacted with anxiety and anger. His proneness to shame prevented him from verbally narrating stories that included problematic emotions. Initial efforts were to encourage Marcello to write freely on the themes of his choice during a group workshop whose aim was to foster self-exploration. His earliest texts were concise and comprehensible, but scanty. He showed few emotions but related that he experienced strong feelings when he was asked to narrate for the first time. After establishing a good relationship with the female workshop leader, Marcello was also asked to write about unpleasant emotions and daily events that he felt to be important. The average number of texts written per week was about one. The numbering that follows indicates their chronological order.

No. 2: What I've drawn here is the sea, which stands for the beach, there's the sand with beach umbrellas and bed-chairs to have a lie down by the water's edge, there's a boat and just beyond the sand there's the land with a little cottage. In the boat there's a man.

In this text there is no narrative development, Marcello is simply describing a scene. There is no development of the action. It lacks any reference to emotional states, and one does not grasp the purpose of the story. Why should the reader (in the first place the workshop instructor) be interested? However, the scene takes place by the sea, which is an element to be noted.

No. 5: What a lovely color, it's yellowish, I really like it, I can't remember if it was in the Carioca paint-box. It moved me, I was feeling very gloomy that day and after that I got over it. That day I was feeling moved because I had been struck by . . . , because it seemed to me that there wasn't that color in the box, and I was annoyed. I can remember a long time ago in a boat a landscape of that color with houses in a place called Tarquinia, on a beach by the sea where I was walking and going a bit far away. In the boat there was a man fishing. This was a long time ago. Daddy was there and me and three men.

In this new text, written three weeks after the previous one, there are references to emotional states, both of a nonspecific nature ("I was feeling moved."), and of a precise one ("I was feeling very gloomy."). It should be said that this is the sole negative emotion that Marcello referred to explicitly in his first three months of writing. This is a first attempt at combining various mental scenarios in a single text. There is a reference to a color being used at that moment, which recalls a memory of the past in a treatment environment and which Marcello associates with a personal recollection. Note that the scene that is recalled is the same as in the previous text but with greater detail, the place is named, the man becomes his father and other characters make their appearance. A reference to intentional actions appears: "I was walking and going a bit far away." In this scene the treatment context and the personal story are close to each other. It is still difficult, however, to make conjectures about the personal meaning of what is written.

Up to that moment, Marcello made only one reference to negative emotions. His narratives not only were thematically impoverished, they were also alexithymical.

No. 14: This sea reminds me of when I used to go in the boat with Daddy. We went out on the sea for a bit, and we got near to the

cottages. The sea was like a millpond. When I saw the sea it struck me deeply, and I strongly recall the color of it, which is really lovely. The sea is for swimming in and also for fishing (Here, the workshop instructor suggests to him that he can also write about unpleasant things). Sometimes there are certain things that I don't like—going on a ship and also there's a thing I don't like eating, and that's carrots, and honey too. There are also certain objects I don't like. Wax crayons. The emotion of when, as sometimes happens, a drawing doesn't come right or a painting, that agitates me a lot. Also, when you make a mistake, and also making pottery, because I remember that when I was at the other center I didn't like making pottery.

In this written text, too, the same elements make their appearance. The scenario is the sea, the other main character is his father, the time is in the past, and the mental sphere is that of personal memories. The emotions continue to be nonspecifically positive, there continues to be a reference to actions and goals: "We went out on the sea for a bit;" "The sea is for swimming in and also for fishing." We begin to see an ability to describe internal states: "The emotion of when, as sometimes happens, a drawing doesn't come right or a painting, that agitates me a lot."

The patient's mind is lacking in stories that speak about self-in-the-world. He deals with only a few themes; he expresses himself with repetitive and limited scenarios. Marcello, left to himself, has difficulty in constructing integrated mental scenarios by means of which he can connect the past to the present. It is not impossible for him, but he has difficulty. A deficit in production can have an organic component, but the fact that he started to enrich his narratives after the instructor intervened makes us tend towards the conjecture that relationship factors cause a deficit in storytelling.

Marcello's texts are therefore scanty and unsuitable for engaging the complex world of relationships, the multiple problems that it raises and the emotions it evokes. Furthermore they allow only limited access to his inner states and do not indicate which points the listener might share or what help the latter might be able to give. The meaning of one of the last texts was easier to understand and fulfils that function of relating, described by Mancuso and Sarbin (1983) and by Neimeyer (1995, 2000), which is the linking together of life events in such a way as to guarantee a continuity of meaning.

No. 12: Last summer I went to stay by the sea and Luca, Davide, Micaela and Sofia were there. I was lying on a bed-chair on the beach (. . .) I was in the shade on the beach and I was looking at a magazine, there was the water that I was so fond of (. . .) This year

I'm going to stay by the sea with some new friends and some new health assistants—Lisa, Barbara, Andy and Marc—and then there are the other guys—Giulio, Stefy, Ivan and Federico—we'll have a really good time, the place will be lovely (. . .).

Marcello is leaving for his first summer holiday with the patients of the new rehabilitation center that he has joined. In his narrative, he recalls the names of his old nurses and the situations he shared with them. Our hypothesis is that Marcello could have used this narrative as a new map for forecasting his near future, a month to be spent with persons whom he still does not know well and who frequently provoke in him feelings of humiliation, anger, shame, and fear. The summer holidays were very positive, contradicting some fears of the staff. Marcello passed most of the time with the group, declaring that he felt fine. The avoidance of social relations and the anger were present only in a few moments.

We shall now demonstrate an example of alexithymical narrative. A patient with a narcissistic personality, Carmen, a good-looking girl of 25 years of age, in therapy because she is chronically indecisive, relates stories that are devoid of feelings. In the part of a session that we reproduce here, the patient describes her relations with men in such a way that it is not possible to understand what she wants to communicate to the listener.

P.: "When I split up with this guy I'd been dating for five years, there was a certain situation, certain things, but then the very day I split up with him, I hadn't gone there for that reason, that is, but then, when I was there, I just said to him, "Look, no, that's it." So it was like, let's say, a leap in the dark, although I don't know how to express it (smiling).

(. . .) Thursday I went to the cinema with a girlfriend and, as I said, she brought this guy she knows along, well we saw the film and nothing particular happened. Then we all went home. Then the next day she telephoned to ask, "Listen, can I give your telephone number to this person?" I said to her to give it to him. I'd nothing against him; he hadn't done me any harm, and then Friday, I went to do this course at the university, where they gave me back a composition I'd done, and there I was straight away thinking: all right, mine was certainly rubbish, because it wasn't balanced, there was too much of this, too little of that. But then on Friday they gave it back to me, and all in all, it had gone okay, and I was satisfied. Friday evening I went home. I'd been there from two until eight. At eight o'clock I got home. I got a telephone

call, this girlfriend of mine had meant to be coming to dinner, but then she felt ill and didn't come. I got a telephone call to tell me, "All right, come out to dinner with us." I went out to dinner with these people that I'd already met the previous week (. . .), then we went to a discotheque (. . .), then we went to this guy's place (. . .), Alex who is the type that . . . that is, it's the things I notice that, I don't know, I put up a load of barriers in the sense that I notice. Yes, but this one has had big family problems, and he's too rich (. . .). Friday, during the five minutes that I was at home before going out to dinner, another friend of mine called me, let's call him a wooer, how else do you want to call him. . . .

T.: And the third one? (The patient had mentioned in advance that there were three persons courting her).

P.: The third one, yes. Well, this Friday (laugh), he asked me if I'd go out with him the following day, if we could go to the sea to have something to eat, and I said "yes," but in the morning I had to go to the university, so it could only be after that or else not at all, and that's how it went. Anyway, nothing special, we had a lovely day together, we had a really good time. We chatted and we went for a walk on the beach.

Unlike the previous narratives, it is difficult to grasp from the patient's talk what her significant inner states are. There are a few sporadic emotions, although with reference to an item that is not part of the main story, i.e., the outcome of the homework ("I was satisfied"). What one doesn't understand is why the patient is relating these episodes, in what way the information transmitted ought to be important for the therapist, and which are the problematic emotions to be tackled. The patient's narratives are almost all like this, lengthy descriptions of facts and ways of behaving, with minimal references to mental states and emotions, both her own inner ones and those of others, the existence of which are in any case denied when the therapist points them out.

T.: I remember you saying that you were happy to get attention.

P.: Yes, but not especially so. Everyone likes to get attention. I mean it's nothing important. Happy for want of a better word, but it's not as if I felt, heaven knows what.

Or alternatively:

T.: It would appear that you were satisfied about passing the exam.

P.: Not particularly. Why? Wouldn't you be?

There is a lack of consistency between the emotions reported and the action taken or the general mental context. When the therapist asks her if she is interested in the man with whom she spent a "lovely day by the sea." Stirred by the fact that her nonverbal language, tone of voice, and posture do not reveal the least sign of pleasure, the reply is, "No, not at all, he's a nice guy and no more than that."

At the end of almost every session during the first six months of therapy the therapist felt disorientated, incapable and useless. Why was Carmen relating these episodes to him? What was the help she was looking for? What were the problems that had to be tackled?

Carmen has difficulty in gaining access to her inner states and in understanding the mental states of others. She barely manages to understand others, although it helps a little if she refers to social principles and culturally shared values when she cannot manage consciously to decipher those physical and emotional signals that are fundamental to the choice of what action to take. Her narratives suffer from a deficit in what Damasio (1994) calls "somatic marking," which allows individuals to move between the various possible futures with the guidance of emotionally loaded anticipatory images.

INEFFECTIVE NARRATIVES: CLINICAL EXAMPLES. INTEGRATION DEFICIT

Integrating the elements of a narrative or various narratives has a clear functional meaning. As a result of such integration, one's consciousness is provided with coherent texts, maps, and scripts of the state of self and of its relations with others. Similarly, it allows the subjects to relate their experiences in a comprehensible way, such that they can get replies from another person that are consistent with their programs. Lastly, it permits the building of models on models, stories in which a consistency can be found among many discordant aspects of experience.

There are four forms of integration. First, basic integration blends together the elements of mental activity in a coherent narrative. Second, there is integration between multiple aspects of self, of the other, and of the world. Here it is a question of metarepresentations that allow a subject to state that multiple representations are various facets of the same phenomenon. For example, a hated father is the same person that a little while ago helped us, a partner irritates us, whereas a short while ago we were feeling affection for the same person, or a street full of rubbish leads to a beautiful park just beyond it in the same town. A third form of integration involves creation of internal hierarchies between the stories of which we could be conscious and

selection of the narratives to exclude from one's story. There needs to be an identifiable and recognizable dominant theme which predominates over the others in a discourse. Attribution of narratives to the correct mental sphere is the fourth form of integration. This form treats memories as exactly that, possible futures as not yet real, dreams as inner images, and current relationships as something with which to settle accounts here and now. The principal alteration that takes place at this level is the break in the operating distinction between reality and fantasy. We shall now describe the different forms that pervade borderline personalities and dissociative disorders.

Basic Integration Deficit

The narrating of stories is not a once-and-for-all action. There is never an end to the synthesis of them. This synthesis starts from rhythmic interactions, which are then repeated with caregivers and represented in the form of interactive procedures and working models (Bowlby, 1969/1982, 1979; Stern, 1985).

To be useful a self-narrative has to integrate various levels. It has to make reference to the emotional states that have really been experienced, so that it is consistent with physical experience and with choices that have been made. It has to link these emotional states to conscious valuations of current relationships, as when a child is able to say, "I'm sad because my friends have already left for their holidays." Self-narratives therefore need to be continuously rewritten, at least in part, in line with experience. The consistency of a text thus obtained permits critical operations such as the following.

1. **Self-recognition.** "I tell myself I'm sad and I really am sad."
2. **Coherent Physical Retroactions.** "I tell myself I'm angry, and my body has a tendency towards angry gestures – such as eliminating obstacles and fighting antagonists while making strategic plans consistent with the type of action taken at the present moment."
3. **Clear Signals Listener.** This allows them to give appropriate replies such as "You tell me you're sad, your physically-communicated signals tell me you are sad, you ask me for comfort or to listen to what has been happening to you, and I comfort you or talk with you about your sad experiences."
4. **Mastery of Experience.** "My body is communicating sadness to me, and I feel sad. I know that when I'm sad I need to go out more often."

5. **Minimization of Signal Contrasts and Interferences.** Conflicting Internal signals are reduced to a minimum. Cognitive-emotional cerebral feedbacks are appropriate to the basic emotion, and the organism's action readiness is focused, so that there is not an activation of multiple and contradictory patterns of experience that disorganize the subject.

The failure to achieve such internal consistency can produce incompatible physical feedback, as when one is sad at a basic emotional level, angry at a conscious level, defensively closed at an expressive level, and calmly narrating the experience at a social level. In such a case, the emotion will lead towards the shutting out of relationships, the mind will ask the body to react to an aggression, the face will seek the suspension of relationships and current relationships will give feedbacks of the type, "prepare to open up to relationships." A seriously affected borderline patient of 30 years of age, Serena, illustrates this pattern. The victim of sexual abuse, both in her family and during a relationship with a man, she relates her story without links between the verbal text, emotional signals, posture, or relationship context.

P.: Since I underwent. . . . As well as being raped by my father, when I was 23 . . . 22 years old, I was also raped another time, by one of the group of friends I used to go out with, who then turned out to be mentally unstable. [. . .] We ended up in court. (With a fatuous laugh, she stretches out crossways on the therapist's armchair, which is uncomfortable in the best of circumstances.) What a pity there wasn't an armchair like this I could snuggle into. . . . Do you mind if I stay like this?

T.: mm, mmm.

P.: No? Just another five minutes, I always adopt this position when I'm talking. They look nice; the design's nice.

T.: Sorry. This episode. . . . Do you feel up to recalling it or would you rather. . . ?

P.: Oh, yes. On the contrary, I want to speak about it, because now I connect everything to that. Because that's where all the problems started from. That is, I had. . . . Yes, well, wait a moment. Well, I need to locate it in my mind, because, well . . . I, so Vittorio and me split up. Vittorio was my boy-friend (Sigh), I had. . . . Oh God, I can't remember. Well, hang on. . . . So it was in '88 or 89. Well, in 1987 my father had anemia. Was I there or not? [. . .] In 1990 I was really plump. I weighed 73 kilos. [. . .] I'd got arms like Popeye (She laughs and feels her arms), huge legs. I would measure my

skirts, one time I went to buy one. Oh, it was size 50. You really should have seen it. I'm not feeling too well today because my blood pressure's low, I can't manage to eat, I've had some coffee, and I've bought some cakes. I'm going to buy some potassium.

The narrative is only weakly stitched together. The subject, being raped by her boyfriend and previously by her father, clashes with the emotional tone, which is jolly and superficial. The patient's bodily posture is artificially relaxed, but at the same time, she is uncomfortable about what her body was like in the past (i.e., too fat), and about the unpleasant signals she is getting from it at the moment. Her father is described first as being violent and then as being ill. The therapist is trying to reconstruct a rape story that he imagines he ought to be helping her to overcome, but he finds it impossible to concentrate on a discomfort that the patient is unable to feel. It is difficult even to create a treatment environment. The patient behaves as if she was just having an idle chat on topics that barely concern her.

Deficit in Integration between Multiple Self-other Representations

At this level, the stories that a clinician listens to are well-conceived, with coherent links and goals and intentions that are easy to decipher. But there is a deficit in integration between multiple narratives. In other words there is a lack of metanarratives that endow the relationship with the other with continuity and coherence. For example, suppose a male patient tells of an episode with the other as the main character—a relative, a friend or a partner—and, in one life episode, he describes the person as tender, affectionate, loving, and loved. Then only a few minutes later, in the same session, he relates another episode involving the same person, who is now seen as being intrusive, violent, lacking in respect, and detested. If the patient is faced too early on with a comment of the type, "But a few minutes ago you described another side to this person," the patient could reveal his lack of integration. He might reply, "Who, me? I have never thought that worm to be worthy of anything. She's just a worm, and I want to get rid of her." Such replies can have a paranoid streak to them. He might say, "You're poking fun at me, Doctor, just like all of them. You're against me. You take her side. You don't respect me either. You couldn't care less about what I'm saying."

We reproduce here a part of a session that was tape-recorded and transcribed. In it, the patient succeeds in one of her first attempts at

integration during her sessions. In moments when she had been feeling particularly bad, the patient would telephone her partner, who was in another town. She would regularly finish the telephone call with a paroxysm of rage, which she would express with violent scenes. When she managed to reconstruct sequences, she described them, as reproduced here, in an adequately integrated way. But this operation does not work out in her everyday life where, in different moments in a relationship, she reacts as if she were dealing with completely different people.

P.: I feel so terribly lonely. I wish he'd call me, and I feel the need to call him.

T.: What would you like him to say to you in such moments? What image do you have in your mind?

P.: It's not a precise image. I fancy a feeling of . . . like warmth, of . . . support.

T.: Support against what? Do you feel very sad?

P.: Sad, yes, and a bit . . . as it were frightened . . . , too.

T.: I see, those are the moments in which we feel the greatest need for someone to give us support.

P.: Yes! I imagine, I don't know . . . , that he'll tell me that he will deal with everything and that I don't need to worry.

T.: When does this image get modified? How is it that you always end up getting angry?

P.: As soon as I hear his voice. But what am I saying? As soon as I've dialed the number, I suppose I'm bothering him. I imagine him detached. As soon as he answers, I get angry and I start to tell him off for never phoning me. Then I'm angry with myself too for getting into this situation, for always choosing the wrong type of man. And then . . . then, I think I must be mad, too, and that I'm making his life unbearable.

There is a good description here of the about face. The patient is able to integrate different images of the same person and also manages to identify the moment in which the shift occurs in the narrative. Note how, together with the image of the other, the image of self also changes at two points of the episode. At the beginning, self is in need of support, expects to receive it, and then it feels that the expected support will not appear because she does not deserve it. At the same time she feels that she is unjustly mistreated. The emotional state in this case is one of rage at being abandoned. The two contradictory

images of self are present simultaneously. Finally, self is described as insane, dangerous, inept, and guilty of causing harm to the other (for a description of the aspects of emotional dysregulation exhibited by this patient see Semerari, 1999).

There is a sequence of different scenarios here, in each of which the roles are laden with extreme emotions and the representations of the characters are incompatible with each other. But the narrative is clear and the intentions of the characters unequivocal. In the first part, the patient is seeking support; in the second, she is claiming the attention that is lacking and wants the other to admit that he is at fault or pay for the harm caused; in the third, she is searching for a new way of being ("I always choose the wrong type of man") in a style that is by now unsuitable.

Two authors are particularly important for understanding this phenomenon. Kernberg (1975; 1984; 1993) underlines the importance of the defense mechanism that consists of splitting "good" objects from "bad" objects. For him, borderline personalities suffer from an excess of aggressive drives that leads them, via the mechanism of projective identification, to make representations of the other that are terrifying or are, at any rate, negative and depict persecution. To protect the relationship with the other, images of self and of the other are split into "good" and "bad" parts. In Kernberg's view, the lack in integration is the result of an active defense process, the price of which is that it makes the subject swing between some representations of the other and of self that are idealized, and others that are totally negative and depict persecution.

Another perspective is provided by Liotti's developmental cognitivism (Liotti 1994, 1999) in which the nonintegration occurs rather between multiple and incompatible representations than dual and contradictory ones. In Liotti's view, patients with a history of attachment in the D category (Disoriented/Disorganised) place self and the other, when the Attachment Motivational System is active, in the roles of Victim, Rescuer, and Persecutor. Self can be the victim of an evil persecutor, and then the roles change and the other is the victim and self a benevolent rescuer. Or alternatively, both are threatened by a mysterious danger. Kernberg and Liotti's models are not incompatible, even if in the latter the stress is not on intrapsychic defensive processes but on the construction of internalized relationship models that are based on one's childhood history. In fact, patients lacking in this sense often come from families characterized by maltreatment, violence, and incest, or those in which the parents were affected by psychiatric illnesses.

Our interest leads to questions of the type, "What clinical problems do the various forms of integration deficit bring with them, and

what are the consequences of relating the important moments of one's life in this way?" A basic integration deficit is perhaps the most serious form. Patients live in a state of confusion because the flow of experience consists of emotions, thoughts, bodily sensations, postures, and expressions that have few links between them. A happy face can go with a talk about death and an agitated body can be in contradiction with a statement that one is calm. Patients lacking in this sense are unable to organize action plans and desires for themselves or to ask the other for assistance. The help that is requested is often seen as interfering, because it is unable to take account of dissociated elements which are not integrated in the request for help. The patients feel, with a sensation of constraint, that they are living in accordance with desires that are not their own.

In the most developed form of nonintegration, the patients find it less easy to pose themselves the problem of identity in a conscious way. They tend to feel that the aspect of self represented in an emotionally marked narrative is unique, that it corresponds to the whole self. The problem is more of an interpersonal nature. Relationships are put at risk by the lack of metarepresentations of self and of a decentered knowledge of the other's mind, of its various facets, and of the reasons that guide his or her set of actions. Narrative fragmentation and emotional disregulation (Linehan, 1991; Semerari, 1999) render interpersonal relations unstable and ungratifying.

Overproduction of Narratives and Deficit in Hierarchization

When stories are told, hierarchies based on economy and significance are to be observed. A discourse, if it is to be produced within one session, cannot contain too many stories. In a little time, it is possible to communicate a lot of things, it is true. Nevertheless, there is a limit to how much mutual understanding two people can achieve and to the quantity of information that they can master. Certain patients relate a thousand stories in a few minutes and their whole life in the course of one session. They are caught up by an infinite number of things, see everything from an uncontrollable multitude of perspectives, and have thousands of thoughts going on about self, others, and the world. This is what is meant by overproduction of narratives.

Although multiple themes and plots are normal in dialogue, a number of criteria need to be complied with. A story is more comprehensible if there is a dominant theme and some subplots that are less important. The story of a quarrel with my girlfriend is still com-

prehensible if I say, incidentally, that, while the quarrel was going on, I went to the local dry cleaner, and that the shop assistant is the daughter of an old family friend, who, when I was a child, used to make almond cakes for the street kids. I can still succeed in making it understood that the theme of the story is “risk of separation” or “how to manage an argument,” and in directing the listener’s attention to this aspect of the narrative. This is also necessary in intrapsychic coping. The evening after the argument, I can be thinking of a thousand things, but my attention will need to be focused on how to overcome today’s problem, to make peace with my girlfriend, to ask her pardon if I realize that I am in the wrong, to help her to deal with her problems – which, perhaps, I can see now, were making her irritable – or to bring the story to an end. It depends on what my intention is. Both at an intrapsychic level and at an interpersonal one, giving a hierarchical order to the stories being processed is indispensable.

This deficit in maintaining a narrative hierarchy is illustrated by Barbara, a 38-year-old patient who was depressed, disheartened, angry, and without hope after six attempts at therapy. All previous treatments had come to an end, either because Barbara held the therapist in disdain, or because she abruptly interrupted therapy as a result of unbearable subjective distress. Barbara would typically relate her experiences like this.

“I’ve had an interview, but I couldn’t care less about it. The usual shop assistant job. The guy that gave me the interview was the usual slimy type that promises you loads of things. He reminded me of my ex-boyfriend. Perhaps it was the forehead. I thought about him all night. But why does he have to introduce me to his new girlfriend and then show me signs of affection, stroking my cheek? What am I to do? It’s always been like that . . . the other evening too, after the theater rehearsal. It seemed like everything was going well. You see, yesterday I felt energetic and industrious. I invested loads of energy in it. I felt to myself that the spiritual exercise had gone well. My voice was working. It wasn’t the leading part. You know, don’t you, that I always like to be a bit, how shall I say (she adopts jokingly a seductive posture), the protagonist? I don’t get the chance to choose. I don’t know whether I really have a talent for acting. The theatrical world is so competitive. They’ll put a knife in your back as soon as you turn round. You see, perhaps my problem is that I’m not feminine enough. But my feelings are that . . . in short, if I do something I like to do it well. I’m keeping on with the German course, even if after the last lesson I had to really rush to get to an appointment with my gynecologist. I’ve had a pain in my ovaries for the last three weeks that has started to torment me. My body’s beginning to show signs of wearing out. I’ve got fat. I’ve ballooned,

but I can't manage to regulate how much I eat. Sometimes I don't feel well. I'm bored. . . ."

Therapists, when faced with this style of presentation, are generally confused. On what theme should they try to focus with the patient? Working through Barbara's splitting up with her boyfriend, and leaving in the background the problems of career choice and personal pride? Dealing with competition at work? This theme turns up in both the job interview, in which the patient has a dominant role, and in the description of the preparations for the play, in which she talks about competition among the females to get attention. Or is the main theme rather the one at the end, the control of one's impulses, the regulation of one's emotions, difficulty in dealing with a sensation of boredom? And we could find others. None of these takes a consistently leading position in the hierarchy of importance, except briefly. The proof is when the therapist tries to focus on one of the clues provided by the conversation, even if the intention is to do this in agreement with the patient. Barbara's reaction, which is typical of her in such instances, is one of disorientation, distress, and irritation. She sounds more or less like this, "What? We're neglecting that other thing I told you! That's my true problem. Come on, be more serious!" The therapist who tries to follow a new line proposed by such a patient ends up within a few minutes in the same situation, with the patient again having the feeling that the fundamental question is being neglected and ignored.

Unlike in a basic integration deficit, each story told has an inner consistency and emotions, cognitions, and physical signals are congruent with each other. When Barbara speaks about her ex-boyfriend, she is sad and angry, and she feels abandoned. When she speaks about work, she is competitive and doubtful about her choices, and she alternates vigor with weakness. And when she talks about the theater, she is enthusiastic, worried and coquettish. The patient makes numerous leaps in subject, but each narrative environment has an inner congruence, something that does not occur in a basic integration deficit.

How does this type of deficit persist? The operation that these patients do not manage to carry out is that of selecting between stories. They are unable to identify and select which stories not to relate. Their fear appears to be one of not managing to transmit all the indispensable knowledge about self, and there is no facet to their lives that should not be submitted to the attention and approval of the other. They need a listener inside them, a reliable partner for internal dialogue, one who is capable of saying, "This information is not significant for the purpose of survival." In the absence of such a figure, the interpersonal signals that the other gives are not an adequate prompt

for pruning information. This problem, then, is of a recurring nature. Confusion in narratives generates confusion in decisions, which generates confusion in narratives, a chaos that feeds on itself. Another road to follow to explain this type of deficit is that the patients attempt on-line integration during the therapeutic relationship. All the stories need to be narrated—and borderline, dissociative patients are like this—because there is no possibility of a stable identity outside the interpersonal context. Asking the other to establish hierarchies between images of self-with-the-other (even if they are continuously being challenged) is for such patients the most effective and perhaps the only possible means of ordering their interior chaos. A session, therefore, has to be a shared job of on-line integration of conscious images. An explicit summary of a session by the therapist is useful; it provides a mnemonic bridge between the episodes that are related and their integration in overall meaning structures, i.e., models of models. The main consequence of narrative overproduction and deficit in hierarchization is the impossibility of deciding and organizing long-term action plans. Each narrative wants to be the dominant one and to put the others in the shade, and this continuous alternation has the same effects as a change in government every week. Laws do not get drafted, and there is no programming of development plans or coherent actions. Moreover, and this is a problem common to all the forms of integration deficit, relevant others, no matter how much they are sought after, can be of little help only. Furthermore, partners or colleagues will probably show only a limited willingness to provide the care and attention sought after and to take the trouble necessary to decipher the discourse they are listening to.

Deficit in Attribution to the Correct Mental Function and Deficit in Distinction between Reality and Fantasy (between Primary and Disconnected Representation)

This form of deficit recalls the so-called *Quixote principle* (Hermans and Kempen, 1993; Levin, 1970; Sarbin, 1990). The knight of La Mancha uses his fantasy to construct stories, as he reads the adventures of the knights errant. Then he “does more than imaginatively travelling in the story; he takes the step of acting on his imagination” (Hermans and Kempen, 1993, p. 21).

The patients, like the knight of La Mancha, make no distinction between the mental spheres in which stories originate and develop. No distinction is made between a dream and a memory from the day

before. A fantasy is given the same weight as a memory from the past; a project for the future has the same value as a reconstruction of the present. It is not a pathological signal if a story passes through the various types of mental function. The mind is being continuously fed with dreams that become projects for the future, with painful memories that get transformed into manageable fantasies, with projects based on fantasies that pave the way for innovative action plans.

Before describing the pathology of this function, we should like to insert some observations about developmental psychology which demonstrate very clearly the thought process on which it is based. There is a mental function (not the only one, of course) which is indispensable for the process of constructing narrative identity. That function is *pretend play*. It consists of the ability to pretend that something or someone has an identity that is different from their real one, and of the capacity to interact with it in an as if way. This ability develops at around 12 to 18 months of age (Leslie, 1987). Children take a piece of wood and, although recognizing its physical properties (weight and form), pretend that it is a noisy airplane or a telephone. The two decoupled representations, the primary and the disconnected as Leslie terms them, are handled separately. The first is stable, while the imagination is brought to bear on the second. In Leslie's view, pretend play is based on the innate ability, which appears precisely at that age, to distinguish between the content of a statement (e.g., "There is a teddy bear on the carpet") and the attitude of a statement ("I believe there is a teddy bear on the carpet").

Starting from this observation, let us define the psychopathological operations of this function. First, a patient is incapable, either constantly or temporarily, of distinguishing between mental spheres (dream versus memory, fantasy versus reality, and so on). Second, mental operations are carried out outside the correct sphere, with, for example, daydreams that become hallucinatory fantasies. Third, the criteria that determine that one is operating in primary representation are not complied with. If one operates with objects, their physical qualities (weight, dimensions, temperature) should be observed. If one enters into relations with someone, certain firm traits get fixed and these take on the appearance of the "reality" of that person, (i.e., the social operations are carried out on automatic pilot). These traits might include intimacies with one's partner, signs of respect with one's superiors, avoiding the arm of the law if one is a criminal.

Laura was another sufferer from a serious borderline personality disorder, with very strong conversion and somatization symptoms, such as nausea, vomiting, and dizziness. Even after three years of therapy and substantial progress, compared to an initial situation in

which she had been in a hospital several times for her irrepressible psychogenic vomiting, the symptoms are still present. At this point she relates this dream.

"I was in a room that looked like a garden. The atmosphere was strange and ghostly. My mother was there, but only a presence, not physically. In the dream she was alive (her mother died three years before the therapy started). There was a parrot in a cage. It started to speak; it was addressing me. I was trembling. It was saying that I had a brain tumor, and that I would die before getting married. I woke up terrified, and I'm still frightened."

The therapist and the patient both have a detailed knowledge of Laura's history. She has lost both her parents, one sister died before she was born, and her mother always spoke about the sister as being a model impossible to equal. Laura was a brilliant and intelligent medical student; her results were excellent. One year after her mother's death, as the only member of the family alive, Laura started feeling nauseous and desperate and was terrified of having suicidal impulses. Those symptoms led to the interruption of her studies. Just the thought of an exam made her feel unendurable fear. At the moment of the dream-telling, the therapeutic relationship was a firm one. Everything would point to a metaphorical meaning for the dream, allowing the deciphering of the symbols that it contains and the linking of them to a personal history of death and solitude. None of these operations proves possible during the session. Laura's interpretation of the dream is summed up by this remark, "I've got a tumor and I'm frightened I'm going to die. I must get a Magnetic Nuclear Resonance scan done." The therapist asks the patient what it is that persuades her to believe this so firmly, and she replies, "It's what the parrot said in the dream." A piece of information from a dream is accepted as real, and a dream narrative guides her action in waking life as if it were a road map for getting to a museum. It is followed with the same level of trust.

CONCLUDING REMARKS

Storytelling is a basic form of human mental operation. It undertakes a range of functions if it is not hampered by forms of illness. To be good, a story should be expounded with space-time consistency, make explicit reference to inner states, contain a clear statement of the problem, have as a reference point a developed theory of mind of the listener, be relevant to the relationship context, be thematically coherent, provide knowledge that is relevant, integrate inner states and translate somatic

states and emotions felt into coherent meaning themes. The effect of a good narrative is to integrate bodily experience, the construction of meanings, and interpersonal relations. This function can prove insufficient, or it can break down in various ways. Stories can be lacking in, or not make reference to emotions or inner states. They can be disorganized, confused, fragmented, incapable of guiding the actions of a subject and of allowing the listener to understand what he or she is communicating. These dysfunctions make it difficult to decipher subjective experience and to move about in the world of relationships. Starting from this definition, we believe that it is possible to use the trend in narratives as a marker of a change in therapy, to conduct research on the psychotherapeutic process to identify the various forms of narrative deficit, and to adjust treatment for the forms of dysfunction that have been diagnosed. Our work as clinicians and researchers will proceed in these directions.

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