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SELF-NARRATIVE ANALYSIS METHODS IN CLINICAL DIAGNOSIS: THE EXAMPLE OF PARANOID PERSONALITY DISORDER

The article is aimed at presenting the usability of some aspects of self-narrative analysis in clinical diagnosis. Clinical diagnosis concerns not only the identification of nosological categories, mechanisms of psychopathology, or etiology, but also familiarity with patients' self-experience. It is assumed that the patient's narrative is a psychological phenomenon in itself; it is a way of construing and re-experiencing his or her disorder. Therefore, self-narrative analysis is expected to lead to an understanding of how psychopathology is construed in language. As the leading theoretical approach, the model of narrative development proposed by Salvatore, Dimaggio, & Semerari (2004) was chosen. In order to illustrate narrative analysis, examples of paranoid personality self-narrative accounts are presented.

Keywords: paranoid personality disorder, clinical diagnosis, self-narrative, analysis of narratives, narrative psychology.

INTRODUCTION

Narrative studies have been common nowadays – opinions can even be found in the Polish literature that the pioneer period of narrative psychology may be regarded as closed and that we are currently witnessing the heyday of this discipline (Dryll & Cierpka, 2011). It is worth stressing that the aim of narrative psychology as a scientific discipline is, most generally speaking, to study the psychological aspects of meaning-making (Laszlo, 2008). An important area in which narrative psychology develops is methodology, mainly connected with the use of narrative analysis methods for both research and diagnostic purposes.

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Narrative analysis should be understood not as a homogeneous method but rather as a set of diverse methods treating a story (a narrative) as a basic unit of analysis (Esin, 2011; Polkinghorne, 2003). It belongs to the broader current of narrative research, also called narrative inquiry, whose aim is understanding as a result of interpretation rather than explanation (Josselson, 2006; Kramp, 2004; Howitt, 2010).

The narrative analysis method has a long tradition in clinical diagnosis (e.g., analysis of stories produced in the course of Thematic Apperception Test) as well as in psychotherapy and psychoanalysis (Ferro, 2006). It is now receiving more and more precise descriptions and is subject to increasingly accurate classifications as one of the qualitative research methods in psychology and social sciences (Frost, 2011; Howitt, 2010; Riessman, 2008). At the same time, it can be observed that the narrative analysis method is less frequently related to clinical practice, even though – as a qualitative research method – it is close to clinical diagnosis, in which deepened and individualized contact with the patient (client) is essential (cf. Zhou & Zhang, 2007).

The aim of the present article is to increase the transfer of knowledge and research experience concerning 1) the methodology of self-narrative analysis as well as 2) the model of narrative development proposed by Salvatore, Dimaggio, and colleagues (Salvatore et al., 2004; Goncalves et al., 2002) to clinical practice, together with examples of how selected aspects of narrative analysis are useful in qualitative clinical diagnosis. The possibilities that self-narrative analysis affords will be shown on the example of paranoid personality disorder (PPD), since that is one of the most severe personality disorders and one that involves a characteristic strongly persuasive self-narrative, influencing the addressee and thus posing considerable diagnostic challenges.

NARRATIVE, SELF-NARRATIVE, AND NARRATIVE STUDIES

In the psychological literature, the concept of narrative is used in a variety of ways (see more in: Trzebiński, 2004; Stemplewska-Żakowicz, 2002; Dryll, 2004). A narrative (a story, a history) is a configuration of events in time, presenting the experiences of characters (protagonists) that take place against the backdrop of the circumstances described (the world presented). If we treat the narrative as a process of communicating the stories produced in social relations (the so-called narrative discourse – Kurcz, 2001), it is possible to identify the structure of the narrative told, distinguishing its abstract, orientation, complicat-

ing action, evaluation, resolution, and coda (Labov, 2009). Elements of the story – that is, episodes – are linked with one another in three main ways: temporally (e.g., events take place consecutively), causally (e.g., a certain event leads to a particular experience), or/and teleologically (e.g., the protagonist has the intention to act in a particular way). The way of arranging and linking events and experiences points to the way in which the events are interpreted by the author, who appears in the story as a narrator.

Some researchers treat self-narrative as an autobiographical statement structured in narrative terms (the textual approach); others emphasize its psychological and dynamic nature, explaining it as a superior cognitive-affective-behavioral structure that organizes the "micro-narratives" of everyday events into a "macro--narrative" of life, improves self-understanding, allows to determine the scope of personal goals, and results in a particular manner of functioning in society (Neimeyer, 2006; cf. also *life story* – McAdams, 2001). Thus understood, self-narrative is strictly connected with the issues of personal identity. Self-narrative as a meaning-making process engages both perception and imagination; self-narrative may therefore be treated as a creation of an individual, containing both references to facts and fictional elements (Hermans & Hermans-Jansen, 2000).

Organizing experience into a narrative yields a certain surplus of information compared to purely descriptive utterances: it provides data that can be analyzed in terms of structure and form (i.e. the manner in which someone has told a story) as well as in terms of the contents and meanings conveyed (i.e. what the story is about and what self-image and view of the world is constructed in it). Various types of narrative analysis are distinguished in the literature (cf. e.g., Riessman, 2008; Laszlo, 2008; Howitt, 2010; Esin, 2011), the most important ones being: formal-structural analysis (how are stories narrated?) thematic analysis (what is the subject of the stories narrated?) interactive analysis (how is the meaning of a story made in the context of the story being told to another person?), and hermeneutic analysis (connected, among other things, with the information that a story as text carries about the teller's identity, enriching the understanding of the teller as a subject). A separate distinction is made between qualitative analyses, focused on detecting meanings and senses irreducible to numbers (cf. Straś-Romanowska, 2000) and quantitative analyses, based on systematic and objective determination of the measurable features of communication (cf. Holsti, 1968, in: Paluchowski, 2000; Berelson, 1952). A significant part of analyses of self-narratives produced by individuals from the clinical population are carried out using qualitative or quantitative content analysis, focused on the formal-structural or content-related aspects of utterances (cf. e.g. Teglasi, 2010).

THE CLINICAL MODEL OF NARRATIVE DEVELOPMENT: THE PERSPECTIVE OF SALVATORE, DIMAGGIO, AND COLLEAGUES

In the literature on human narrative activity, there appear numerous models of self-narrative production: from social models, stressing the co-construction of the narrative in dialog (Gergen, 1998), to clinical approaches, setting the criteria of health and pathology (Salvatore et al., 2004; Goncalves et al., 2002; Angus et al. 2004). In the latter it is suggested that, before a self-narrative assumes a particular linguistic form and materializes as the narrator's speech, it can take certain primal and intermediate forms, deeply rooted in somatic experience. Narrative tendencies are observed to be present as early as the perception stage and to develop until an advanced level, on which experience can be comprehensively processed and consciously reflected on (cf. Stemplewska-Żakowicz & Zalewski, 2010; Damasio, 2000; Trzebiński, 2002).

Salvatore and colleagues (2004; Goncalves et al., 2002) propose a conceptualization of the process of narrative construction (development) that enables the examination of various narrative forms, from those more primal and nonverbal to more complex verbal ones (cf. Table 1). This model is based, for example, on the work of Damasio (2000) and on the assumption that discontinuous neuronal processes make up mental images, combined with affect, and that those in turn form up a more complex narrative (cf. also Tomkins, as cited in: Oleś, 2003; cf. also Kernberg, 2005). Primal pre-verbal narrative processes take place on two levels: pre-narrative and proto-narrative. On the pre-narrative level, a causal connection emerges between the presence of an object and a bodily state (the brain produces representations of itself in a particular changing environment), which can be called micro-episodes (cf. Stemplewska-Żakowicz & Zalewski, 2010). On the proto-narrative level, pre-narrative representations make up affectively marked micro-sequences of mental images, accessible to consciousness. Certain mental images have a common affective theme, so they link up with one another and can be retrieved from memory and experienced by a person as consecutive mental images.

Table 1
Levels of Narrative Development and Their Characterization. Based on: Salvatore and colleagues (2004)

Level of narrative development		Brief characterization
Pre-verbal levels	pre-narrative	causal connection between the presence of an object and bodily state
	proto-narrative	micro-sequences of mental images, affectively marked and accessible to consciousness
Extended narrative levels (verbalizable)	procedural unconscious narrative	more complex sequences of affectively linked mental images, object-related, triggering particular automatic reactions in interpersonal relations
	propositional narrative	complex conscious verbal representations integrated into a narrative structure
	interactive narratives	diverse narratives produced in complex internal dialog or in social interactions

In the case of pre-verbal narrative levels, the problem of psychopathology most probably concerns the missing, excessively weak, or erroneous affective marking of mental images, which makes it impossible for different components of experience to link up into a coherent whole (a fragmentation of experience occurs). As a result, narrativizing one's own experience proceeds in a chaotic and unreliable way (cf. Stemplewska-Żakowicz & Zalewski, 2010). The process of synthesizing a proto-narrative (creating micro-sequences of mental images) does not take place in isolation in the mind (Salvatore et al., 2004). At the early stages of development, the caregiver helps the child identify emotional states, select images and significant memories, as well as exclude from consciousness whatever is insignificant, thus supplementing the child's emotional regulation (de Roten et al., 2003; Salvatore et al., 2004). At the subsequent stages of development, a person continues to form further self-narratives starting from these levels, but that may proceed in a more or less satisfactory manner, depending on earlier experiences (cf. Angus et al., 2004).

Salvatore and colleagues (2004; Goncalves et al., 2002) go on to distinguish levels of more complex narratives, the so-called extended narratives, in which the past, the present, and the future are interconnected. The first of these levels is the procedural unconscious narrative, whose formation begins in the relationship with the caregiver. It comprises organized intrapsychic mental representations of relations with significant others. In other words, these representations are more complex sequences of object-related, affectively connected mental images. In clinical psychology, those representations are referred to as object relations representations (Kernberg, 2005), internal working models (Bowlby, 2007), relational episodes (Luborsky & Crits-Christoph, 1990), or scripts (Tomkins, as cited in: Oleś, 2003). Their main function is to trigger automatic reactions in specific situations, which may lead to misunderstandings and interpersonal conflicts. Procedural narrative can be said to be acted out rather than told, and it would be difficult for a person to account for why they behaved the way they did. Procedural unconscious narrative may vary in the extent to which it does involve consciousness, even approaching verbalization – this is because it may involve different levels of the capacity to think about oneself in the context of knowledge about the psyche of other people as well as different levels of mentalization capacity (cf. e.g., Fonagy & Target, 1997). In the case of this narrative level, the signs of mental health are the prevalence of fulfilling object relations representations (over frustrating object relations representations) as well as the ability to treat the object as different from the self and as possessing his or her own inner life (cf. Kernberg, 2005; Fonagy & Bateman, 2005). Despite the automatism of reactions and the presence of conflicts in relations with significant others, this enables a certain flexibility of behavior, resulting from an understanding of the other person's mind, and does not exclude satisfaction in these relations (cf. Cierpka et al., 1998).

The second level of extended narratives is the conscious propositional narrative, comprising the verbal representation of self, object, and self-object relation. Such a narrative may be produced consciously, intentionally modified, and directed by the narrator towards his or her goals. It contains personal elements, such as expectations concerning the relation, a self-schema, and the expected reaction of the other (cf. also Luborsky & Crits-Christoph, 1990) as well as sociocultural values and ideals present in social discourse, myths, or other external stories (narrative patterns, Gergen, 1998; cf. also Neimeyer, 2006; Norrick, 2008). The condition of mental health is the correspondence between conscious propositional narrative and somatic experience – that is, harmony with the

preceding levels of narrative organization of experience (cf. also Angus et al., 2004).

The third level of extended narratives is verbal interactive narratives, realized in complex internal dialog or in social interactions (cf. polyphonic, discursive model of mind – cf. e.g., Hermans & Jermans-Jansen, 2000; Stemplewska-Żakowicz, 2002). The self is composed of many parts (characters, I-positions, voices – hence polyphony) that address one another (addressability) and may enter into interactions with one another (dialogicity). Thus, a person may produce many different narratives and self-narratives from different perspectives, even opposing ones, though referring to the same experiences and facts (cf. Oleś, 2011, 2008). At this level, the indicator of mental health is the capacity to maintain dialog between I-positions, which implies the possibility of negotiating interpretations of experiences rather than coherence in this area. What plays important positive functions as regards coherence is the assumption of the observing position (metaposition) and, consequently, taking up reflection on one's own interpretative tendencies (cf. Stemplewska-Żakowicz, 2002).

Propositional and interactive narratives are connected with a sense of continuity in one's life story thanks to integrating experiences as well as understanding oneself and the world. The main functions of elaborate narratives are considered to be the stabilization and integration of personal identity (e.g., McAdams et al., 2004) as well as the harmonization of personal experience with socio-cultural meanings (cf. Chaitin, 2004; Hardin, 2003). The observation that these functions are poorly performed in personality disorders is reflected in the new criteria for personality disorders, set out in the draft diagnostic textbook DSM-V, where adaptation problems of individuals with personality disorders are ascribed to a disturbed sense of identity or/and the inability to form satisfactory relationships with people (Kring et al., 2012). Self-narrative analysis carried out from the perspective of the interactive level and propositional narrative is a promising source of access to information about identity disorders and interpersonal relations in personality disorders.

The described model of narrative development has a hierarchical structure: the organization of experience proceeds from basic to more complex narrative levels, reflecting the extent to which a given emotional experience can be processed and consciously reflected upon. This hierarchy appears to refer to both individual development and the formation of each particular experience. It is possible to describe and examine each level separately, but it is also possible to describe the functioning of the same person on different levels simultaneously. This model may be useful for observing the phenomenon of psychological

regression as well as the issues of partial or overall character of disorders (a patient may function on a lower level in certain content areas of experience and on a higher level in others).

A disturbance in the narrative organization of experience (i.e., in narrative development) on the pre-verbal levels will lead to the production of the so-called impoverished narratives, whose surface textual layer will not meet the definitive criteria for narrative or is devoid of references to inner subjective states (feelings, intentions, motives). By contrast, difficulties on higher levels tend to result in deficits in narrative integration, which manifest themselves on the verbal level in the narrative being present but not performing the integrative function or in the narrative being produced excessively but with no order in it (Salvatore et al., 2004; Dimaggio & Semerari, 2001; Dimaggio, 2010; Dimaggio et al., 2003).

THE USE OF SELF-NARRATIVE ANALYSIS IN CLINICAL DIAGNOSIS AS SHOWN ON THE EXAMPLE OF PARANOID PERSONALITY DISORDER

In clinical diagnosis, apart from describing the clinical picture of a disorder, its salutogenic and pathogenic mechanisms, and its etiology (Cierpiałkowska, 2008), it is also important to examine the manner in which patients experience themselves – that is, what the disease (or suffering) looks like from their individual perspective. A patient's personal point of view is not mere enumeration of oppressive symptoms but rather an attempt to make symptoms meaningful, to link these problems with his or her own life story, and to present themselves in a world marked by certain characteristics. In the narrative approach we assume that a patient's speech is a psychological phenomenon in itself – a manner of constructing (and experiencing) a disorder (Goncalves et al., 2000). Therefore, self-narrative analysis allows to understand how the patient experiences their disorder. From the perspective of narrative psychology, psychopathology may be regarded as a science of meaning-making disorders – disorders of making events and experiences meaningful (Goncalves et al., 2002).

In order to demonstrate the usefulness of selected categories of narrative analysis in clinical diagnosis, Paranoid Personality Disorder (PPD) was chosen, being a disorder that poses certain special challenges to clinicians. This is because clinicians deal with patients who attribute meanings to facts and experiences in a biased manner (detecting danger coming from the world), patients barely responsive to psychotherapy since their bias is activated in the relation-

ship with the clinician, too. A PPD patient is also one with a rigid self-image, one whose inner world is difficult to understand because he or she may evoke aversion or anxiety in the clinician or provoke confrontation (cf. Beck et al., 2005; Millon et al., 2005; McWilliams, 2009). The narrative approach, which puts emphasis precisely on understanding and on attempting to capture the patient's psyche from within, will be particularly useful here.

In the DSM-IV-TR classification (2000/2008), paranoid personality disorder (PPD) is placed, together with schizotypal and schizoid personality disorders, in cluster A (referred to as the odd or eccentric disorders group) and characterized by a long-standing attitude of mistrust and suspicion that the motives of others are full of evil intentions as well as by an expectation of being deceived and taken advantage of. More precisely, PPD is defined by a set of six maladaptively heightened traits: suspicion, antagonism, autonomy, hypersensitivity, hypervigilance, and rigidity, which should be distinguished from both transitory suspicious states and regular psychotic delusions (Miller et al., 2002; see also Figure 1). It is regarded as one of the most severe personality disorders due to a high level of interpersonal dysfunctions, a projective defensive style (Millon et al., 2005), as well as a low maturity of self-object relations and intrapersonal functioning (Kernberg & Caligor, 2005). It may involve periodic psychotic states, particularly during heavy stress. Individuals with PPD usually begin psychotherapy between the age of 30 and 40, and the reported causes include depression, a stay in a mental hospital, or the family's concern over their alienation; these individuals experience fears, addictions, or problems at work (Nicolo & Nobile, 2007).

Apart from complex theories explicating the mechanism and genesis of PPD in a variety of paradigms (cf. e.g., Soroko, 2004, 2013), it is worth stressing the clinical significance of models describing the dynamics of the picture of this disorder, examples being the model proposed by Akhtar (1990) and the narrative models of paranoid personality disorder presented further, where clinical illustrations are discussed.

Figure 1
Paranoid Personality Disorder Diagnostic Criteria According to DSM-IV-TR (2000/2008)

DSM-IV (Axis II: Personality disorders)
A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
1. suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her
2. is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or -associates
3. is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her
4. reads hidden demeaning or threatening meanings into benign remarks or events
5. persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights
6. perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack
7. has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner
B. Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, or another Psychotic Disorder and is not due to the direct physiological effects of a general medical condition.

Trying to combine the phenomenological approach with the psychoanalytic one and striving to show the complexity of the disorder, Akhtar (1990) proposed a division of the clinical features of PPD into six areas of functioning. Each area has an overt dimension – behaviors shown to other people – and a covert dimension, which an individual wrestles with in their internal experience (Table 2). The overt dimension can also be understood as the picture of PPD during the compensation period and the covert dimension as the picture during the period of decompensation, caused by increased stress, which deprives a person of defense mechanisms typical for disorder. A person can, then, move from functioning based on overt features to functioning based on covert features under the influence of stress-related trigger factors or experience both overt and covert states simultaneously, though partially. Akhtar's proposal points to the dynamics of the picture in PPD and encourages clinicians to look at various aspects of mental functioning, suggesting that behind the changes in the patient's experience and the changes in the clinical picture there are complex psychological mechanisms. A similar extension of the descriptive perspective to include an understanding of mental processes is afforded by the narrative approach, both theoretical and methodological.

Table 2
Areas of Psychosocial Functioning in Individuals With Paranoid Personality Disorder and Selected Examples of Overt and Covert Traits (Based on Akhtar, 1990, pp. 15-19)

Areas	Overt traits	Covert traits
1. Self-image	arrogance, overconfidence	diffidence, self-doubt
2. Interpersonal relations	accusations, requirements	sense of guilt
3. Social adaptation	industriousness, preference for dry facts	inability to be natural and enjoy e.g. music or poetry
4. Love and sexuality	lack of romanticism	anxiety about sexual performance
5. Ethics, standards, ideals	religiousness	occasional sociopathic tendencies
6. Cognitive style	hyper attention	loss of proportion and meaning of context

Based on the already mentioned ways of analyzing narrative material, it is possible to distinguish several methods of self-narrative analysis, taking into account the general characteristics of narrative development described by Dimaggio, Salvatore, and colleagues. Each of those methods of analysis shall be illustrated further on with clinical material and related to the level of narrative development.

Illustration I
– Proto-narrative and propositional narrative in PPD

In order to illustrate selected features of proto-narrative and propositional narrative in individuals with PPD, analysis drawing on the tradition of thematic narrative analysis was applied (cf. selected categories of speech analysis in TAT – Suchańska, 1994; Teglasi, 2010; cf. life story analysis system as proposed by McAdams, 2001). The following were analyzed: 1) emotional tone, 2) the protagonist and her actions, 3) other characters and their actions, and 4) conclusion. The categories were selected to serve as examples only, in an arbitrary manner, but with reference to theoretical knowledge, indicating that interpersonal relations as well as the processes of biased interpretation of events and behaviors would be important for the understanding of experience in PPD. The unit of analysis is a fragment of text that refers to a particular category and carries

a specific meaning (a unit of sense). The material analyzed was the words of a patient, a 59-year-old woman suffering from paranoid personality disorder, recorded during a psychotherapeutic session[1].

Figure 2
A Speech of a Woman With Paranoid Personality Disorder About Her Neighbors (Please note that non-standard transcription rules have been applied: there is no grammatical division into sentences, and a period "." indicates a pause shorter than one second)

actually let me tell you I can't sleep all night because . the people next door I don't know maybe they want us out of this apartment . there are sounds a kind of noises and they get louder from time to time . and you know at the beginning my daughter didn't hear there were any sounds at all . but later when I woke her up at night and said listen then she said there were those sounds . and I'm not making it up it is like metal bars hitting against one another, so scary .
they always . they were bad people . they always . you know a car draws up there and I think I've phoned the administration already and my daughter called the police about that car drawing up but you know they just ignore us . they didn't take an interest or anything . one of them told me that I was to ignore it . and how can I ignore it if there's that sound, day and night, when I sit or listen to the radio there's that sound . well then . but it's the kind of sound that sends shivers up and down your spine you know .
if you ask me I'm convinced that they would like to expand their apartment [... – a digression follows, amounting to a separate episode]
I wonder sometimes if all this makes sense . my daughter called specialists because someone said this had to do with the radiators, that sound . but, you know, radiators don't make that kind of sound . and they checked and went down to the basement and said many times that wasn't true . no it must be that . their family got larger because their son moved back in there, he moved back in with some girl a wife they say and a baby is on its way and they have an apartment the same size as ours two rooms an a kitchen those two rooms are kind of small .
I'm sure . I don't want to say things because if you do then people say that you . well, I'm a Catholic so I'm not gonna say this sort of thing but still I'm convinced that's what it is about because it turned out there was nothing in the basement . specialists went there and saw everything and you know they even left a noise meter in that basement for two days to measure it all that time and you see they proved there was nothing there . so it was them after all

Figure 2 presents an episode concerning the patient's complaints against her neighbors and her attempts to cope with their alleged hostility. A fragment considered to be a digression has been removed from the episode for the sake of clarity. Table 3 illustrates the assignment of specific fragments of the patient's speech to particular categories of analysis.

[1] I wish to thank Professor Lidia Cierpiałkowska for making the material available for analysis.

Table 3
Selected Categories of Analysis and Sample Fragments of Speech

Category of analysis	Sample fragment of speech
Emotional tone	so scary sends shivers up and down your spine
The protagonist (self)	actually (...) I can't sleep all night when I woke her up at night and said listen and I'm not making it up I think I've phoned the administration already that I was to ignore it how can I ignore it if there's that sound, day and night, when I sit or listen to the radio there's that sound if you ask me I'm convinced that I wonder sometimes I don't want to say things well, I'm a Catholic so I'm not gonna say this sort of thing but still I'm convinced
Other characters: neighbors	the people next door I don't know maybe they want us out of this apartment they always . they were bad people . they always they would like to expand their apartment their family got larger because their son moved back in there, he moved back in with some girl a wife they say and a baby is on its way and they have an apartment the same size as ours
Other characters: apartment administrators	they just ignore us . they didn't take an interest or anything one of them told me that I was to ignore it someone said this had to do with the radiators, that sound and they checked and went down to the basement and said many times that wasn't true specialists went there and saw everything and you know they even left a noise meter in that basement they proved there was nothing there
Other characters: daughter	at the beginning my daughter didn't hear there were any sounds at all but later [...] she said there were those sounds my daughter called the police my daughter called specialists
Conclusion	so it was them

The emotional tone of this speech may be regarded as negative (complaint, dissatisfaction, irritation), but the patient did not use words describing emotions. One reference to emotions ("so scary") names an emotion but at the same time remains a rhetorical set phrase (revealing little about personal experience), while

the other reference to emotions ("sends shivers up and down you spine") amounts to a description of a physiological reaction connected with fear, anxiety, or unrest. The patient refers to her own emotions rather unclearly and it is possible here to speak of a dominant, undiversified negative affect as well as advance a preliminary hypothesis about the expected difficulties in the verbal control of emotions. The disorder in this area, then, most probably concerns the pre-verbal levels of narrative development and the inability to form proper connection between mental image and affect (the proto-narrative level).

The protagonist's activity in the self-narrative concerns the reduction of symptoms (e.g., "I can't sleep"), actions aimed at getting her out of trouble (e.g., "I've phoned the administration already"), references to religious principles regulating her morality ("well I'm a Catholic so"), and various kinds of inner doubts that she actively struggles against ("and I'm not making it up"). This activity may be understood as an expression of the patient's need for control of her fear of passive submission to external forces.

Other characters are presented either unambiguously (neighbors) or ambiguously (the daughter and the building's administrators) by the narrator. The neighbors have evil intentions and the protagonist is trying to defend herself against them, involving her daughter and administration staff. There is, then, an object in the patient's mental image that she expects harm and scorn from (a persecutory object), and other characters are supposed to act as intermediaries in her contact with that object. The image of the daughter's actions changes from no involvement to taking the protagonist's side ("my daughter didn't hear there were any sounds at all . but later [...] she said there were those sounds"), which may indicate attempts to test loyalty by means of behaviors provoking anger or submission ("when I woke her up at night and said listen"). Building administrators are perceived as having ignored the reported problem at first (e.g., "one of them told me that I was to ignore it") but later it turns out that, paradoxically, they take the protagonist's side ("they proved there was nothing there"). With the situation thus presented, the protagonist concludes her story by confirming the thesis that she assumed to be true already at the beginning of her speech: it is the neighbors who are guilty and she is right in defending herself against them ("so it was them after all"). This illustrates the lack of flexibility regarding self-image as well as hypervigilance and rigidly fixed attention, characteristic for the cognitive style of individuals with PPD (Shapiro, 1999; cf. also signal detection theory, Millon et al., 2005). Moreover, the statement "so it was them after all" is a surprising example of the patient's feeling that the truth, previously hidden from her, has been revealed; from the perspective of the narrative structure it is

a conclusion, difficult to challenge rationally. According to Horowitz (2004), a paranoid person has a sense of mission: to detect evidence of deception, falsification, persecution, betrayal, and other forms of antagonism. The person searches through data in a biased manner: rational data contradicting the thesis that a threat exists are ignored and the data that fit the thesis are picked up hypervigilantly. The interpretation of the data as fitting confirms the initial thesis and further increases vigilance at the cost of effecting a loss of proportion (Akhtar, 1990). Gabbard (2005, pp. 401-404) stresses, by contrast, that patients with PPD perceive their environment accurately but misunderstand the meaning of their observations.

The conclusion discussed also reveals the dynamics of the protagonist's actions towards other characters of the narrative. These actions may be regarded as indicators of the patient's defensive reactions and as attempts to retain control over the problematic relationship, whose social consequences include becoming impervious to external influence and rigid insistence on the previously conceived interpretations. Moreover, the sense of security experienced by individuals with PPD increases when there is someone who confirms their fears and worries; such individuals also have a tendency to avoid those who try to reassure or convince them that there is no danger – unlike, for example, in the case of generalized anxiety disorder, in which a person feels better if their catastrophic vision of the future is not confirmed by their family and friends (Nicolo & Nobile, 2007).

A source of additional information on the patient's experience of herself and the surrounding world is the analysis of ways in which events and experiences are linked, referring to the definitive characteristics of the narrative and drawing on the tradition of formal-structural narrative analysis (cf. Table 4). Temporal, causal, and teleological connections have been identified (cf. Soroko, 2009). What could be regarded as temporal linking is the occurrence of events one after another, the way they appear in the plot, but in this case consideration was limited to the temporal aspect emphasized by the narrator. The narrator says that one of the characters (the daughter) changed her attitude towards the danger (not hearing any sounds at first but admitting, after the patient's intervention, that she did hear them). This provoked change ("I woke her up at night and said listen") is used by the patient to confirm the situation of danger and exemplifies an attempt to involve the daughter in the relationship with the neighbors. This may be understood as an attempt to reinforce her own weak self in relations with the threatening persecutory object by finding a supporter and regaining control over the situation.

As regards causal connections, they show the patient's dependence on the neighbors' perceived actions (which is a significant addition to her declaration of being independent of their negative influence) as well as explain, quite indisputably, the psychological reasons of other people's behaviors. The patient's use of teleological linking reveals her perception of neighbors as threatening the protagonist's safety, and the protagonist's perception of herself as helpless and socially isolated.

Table 4
Selected Aspects and Ways of Linking Events/Experiences

Explicit temporal linking (arranging the sequence of events)	at the beginning my daughter didn't hear there were any sounds at all. but later when I woke her up at night and said listen then she said there were those sound
Causal linking (identifying physical and psychological causes)	I can't sleep all night because . the people next door my daughter called specialists because someone said their family got larger because their son moved back in there I don't want to say things because if you do then people say but still I'm convinced that's what it is about because it turned out there was nothing in the basement
Teleological linking (characters' intentions)	they want us out of this apartment they would like to expand their apartment I don't want to say things because if you do then people say

In this illustration, conscious propositional narrative is, on the one hand, the material subjected to analysis (thematic analysis in terms of selected categories and an analysis of how events are linked) and, on the other, a level of narrative development on which it is possible to study the processes of self-image and the vision of the world gaining coherence. In the present example, the greatest contribution was found in such areas of the patient's functioning as cognitive styles, functioning in interpersonal relations, and self-image.

Illustration II
– Verbal interactive narrative in PPD

In the literature of the subject, there have been attempts to analyze utterances of patients with paranoid personality disorder that are inspired by Hermans' dialogical self model (Salvatore et al., 2005; Dimaggio et al., 2006; cf. Hermans & Jermans-Jansen, 2000). In this model, it is assumed that constant interactions

take place in the mind between different aspects of the self (voices, I-positions), reflecting the way a person perceives themselves, others, and the world. Although Hermans' approach concerns internal dialogs carried out from different I-positions and is based on the capability of conscious self-reflection, the idea of interaction between various aspects of the self can also be related to unconscious processes, taking place not only within the mind but also between the individual and his or her significant others (Salvatore et al., 2005). Certain I-positions may be identified with the self while others may be attributed to significant others and narrativized as their states, intentions, or emotions.

Dimaggio and colleagues (2006) stress that four main I-positions dominate in PPD: 1) the "insufficient-inadequate" position, which a person often identifies with and seldom attributes to others; 2) the "diffident-mistrusting" position, usually attributed to oneself and sometimes, reactively, to others; 3) the "dishonest, deceitful, ill-intentioned" position, usually attributed to others, and 4) the "hostile and angry" position, which the self defensively adopts in the face of humiliation, deception, or betrayal. The configuration of these I-positions and the internal interactions that may occur between them often leads to a deterioration of interpersonal life. A person with PPD describes others as angry and domineering and themselves as an unfairly attacked victim, without realizing their own tendencies to put pressure on others or the fact that others may have good intentions as well. This is an example of impaired reflective function (Fonagy & Target, 1997; Fonagy & Bateman, 2005) – of the inability to accurately recognize people's states of mind such as intentions, feelings, or thoughts. Individuals with PPD often attribute their own intrapsychic states to others (primitive projection, being the basis of hypermentalization). It seems understandable that – as Gabbard writes (2005, p. 403) – if patients with PPD come to see a specialist at all, they do so to complain about bad treatment or betrayal experienced from others in their environment. At the same time, the mechanism of splitting that underlies projection does not allow them to recognize, tolerate, or comment on the co-occurrence of two opposing states referring to the self (Kernberg, 2004), which impairs reflection on the complexity of their motives and feelings (expressed by different I-positions).

Salvatore, Dimmaggio, and colleagues (Salvatore et al., 2005; Dimaggio et al., 2006; Dimaggio, 2006) put forward the hypothesis that in PPD we are dealing with an impoverishment of dialogical relations, which they understand, above all, as 1) repetitive internal dialogs and 2) low diversity as well as a highly stereotypical character of the dialogs. Among numerous case studies, they present the words of the 29-year-old Sabrina (Salvatore et al., 2005, p. 247),

which will serve as an example for an analysis of I-positions attributed to oneself and projected onto significant others (Figure 3).

The analysis that the authors propose comprises three stages: Firstly, it is important to distinguish and, if possible, to name the I-positions that enter into interaction with each other on the "mental scene." Secondly, it is necessary to answer the question of what that relation is like in terms of content: what the I-positions "say" and what they "answer" to each other. Thirdly, it needs to be checked in different samples of the patient's speech whether a given internal dialogical relation is repetitive (similar in different interpersonal relations) and what its broader context is.

Figure 3

A Speech of a Woman (Sabrina, Aged 29) With Paranoid Personality Disorder About Her Previous Therapist (as cited in: Salvatore et al., 2005, p. 247) Divided Into "Self" and "Others"

He wasn't to be trusted. The first thing he asked me, after ["others"]
I said to him that I needed help but didn't know whether I'd manage to pay for the therapy, ["self"]
was 'If you don't mind me asking, how much can you afford?' ["others"]
I realised immediately ["self"]
that he wanted to make me look a fool. ["others"]
I talked for a bit, and then at the end I got up feeling convinced that I wouldn't be going there again. ["self"]

Parts of the above speech are marked as corresponding to the two I-positions, one of them labeled as "self" (the patient consciously identifies with this content) and the other one as "others" (the patient identifies this content in the behavior of her former therapist). In the illustration cited, the positions labeled as "self" are inadequate and diffident-mistrusting, whereas the positions labeled as "others" are hostile, humiliating, and terrifying. Thus, they remain complementary to each other and their relation does not change in the course of the narrative. Analyzing the broader context of the discussed patient's speech as well as analyses of other cases, Salvatore and colleagues (2005) point out that, in PPD, the internal dialogs between I-positions are stereotypical, have the same content, and pursue similar goals: the inadequate part of the self is attacked by the hostile other, and so "self" reacts defensively, creating distance between itself and the "other" and, as a result, experiencing isolation.

An attempt to identify interaction between I-positions in a patient's speech is especially useful for the understanding of how the patient experiences inner

dilemmas and of what psychological content he or she attributes to themselves and to others – which is not the same as what he or she could consciously say about themselves. Admittedly, the recognition of a story about an interpersonal situation to be a carrier of knowledge about internal experience is nothing new (cf. e.g., the psychodynamic approach), but understanding internal dialogs in this way certainly does introduce a new perspective. This is because it makes it possible to treat a narrative as an expression of the process of mental activity oriented towards a constant organization of experience. This process can be observed in the course of interactions taking place in the mind between I-positions.

Illustration III
– Procedural unconscious narrative in PPD

A patient can act out the mental scene of interaction between I-positions only in the mind (in the form of fantasies, imaginary representations, or internal dialog), but he or she can also carry it over into social interactions, for instance using the mechanism of projection of projective identification. With this assumption (about the externalization of internal dialogs, as it were), it is also possible to analyze the procedural unconscious narrative (cf. also the projective techniques of work with subpersonalities, in: Trzebińska, 2011).

The proposed method of narrative analysis from the level of procedural unconscious narrative draws on the tradition of interactive and hermeneutic analysis as well as on classical psychoanalysis, remaining under a considerable influence of the clinician's interpretation, impressions, and introspection (including countertransposition), as well as extraverbal observational indicators resulting from contact with the patient.

Procedural unconscious narrative is a "recipe" for how to act when a certain aspect of experience is not represented in the mind well enough to be evoked (named) in the course of behavior self-regulation (Salvatore et al., 2004). This kind of narrative is composed of a series of consecutive scenes that reflect desirable and undesirable states. The series is activated automatically when meaningful emotional elements are repeated or mentally evoked in a given relation. A good illustration of procedural unconscious narrative in individuals with PPD is the activation of the projective identification process, which frequently occurs in this disorder (Kernberg, 2005; McWilliams, 2009). Gabbard (2005, pp. 406-407) quotes an example conversation between a patient and a therapist, in which projective identification occurs. The conversation is cited in Figure 4.

Figure 4
Projective Identification in Procedural Unconscious Narrative – A Patient-Therapist Dialog (as cited in: Gabbard, 2005, pp. 406-407)

version 1
P: I'm really angry with you because I've been sitting in the waiting room for half an hour. You told me to be here at 9:30 today. *T: No, that's not true. I said 10 a.m.* *P: You said 9:30.* *T (a little louder and more forcefully): I said 10 o'clock. I wrote it down in my book.* *P: You're trying to trick me! You won't admit you're wrong, so you try to make me think that I'm the one who's wrong.* *T (louder still): If I were wrong, I would admit it. On the contrary, I think you are the one who won't admit to being wrong, and you attribute that to me!* *P: I'm not going to take this harassment. I'll find another therapist!*
version 2
P: I'm really angry with you because I've been sitting in the waiting room for half an hour. You told me to be here at 9:30 today. *T: Let me see if I understand you correctly. Your understanding was that you were to see me at 9:30 instead of 10 o'clock?* *P: You said 9:30.* *T: I can certainly see why you might be angry at me then. Having to wait for someone for 30 minutes would make most people angry.* *P: You admit that you told me to come at 9:30?* *T: Frankly, I don't remember saying that, but I'd like to hear more about your recall of that conversation so I can find out what I said to give you that impression.*

Projective identification is one of the most complicated defense mechanisms (see more e.g. in Ogden, 1979), consisting in a (patient's) fantasy about breaking free from an unwanted part of the self by projecting it on another person (the therapist). The person who is the object of projection is subjected to emotional coercion to behave in keeping with the projection and may, at some point, react to the projection in a manner that confirms the projector's fears. In the case under discussion (Figure 4, version 1), at some point during the conversation (in reaction to projection) the therapist defensively articulates an interpretation ("I think you are the one who won't admit to being wrong, and you attribute that to me") and the patient feels attacked and deceived, thus experiencing what he did not want to but "had to" go through again. For contrast, alternative reactions to projective identification are shown, too (Figure 4, version 2), in which a greater degree of tolerance towards the patient's accusations can be seen and the maintenance of a non-defensive attitude despite another accusation. What is

worth noting is the inevitability of the patient's reenactment of the familiar psychological reality – procedural unconscious narrative develops in a direction defined by the dominant theme, in this case towards specifying the persecutor and the victim of unfair attacks. It is not accidentally that the roles are divided between "physical" persons, since that performs a defensive function by allowing to keep the two opposing images split, not letting them merge (cf. the essence of splitting – Kernberg, in: Cierpiałkowska, 2008).

Procedural unconscious narratives are considered to be very stiff and unchanging, since the narrator does not actually have the possibility of changing the course of the story (Salvatore et al., 2004). In the case of projective identification, a change may occur thanks to containment (cf. Ogden, 1979) – unconscious elements of the narrative enacted in the therapeutic relation are processed by the therapist and returned to the patient in an acceptable form. This seems to be a way to express, in the clinical context, the essence of co-construction of a new narrative in a therapeutic relation.

CONCLUSION

The ideas presented in this study amount to the proposal – demonstrated on the example of paranoid personality disorder – that clinical diagnosis should make use of 1) self-narrative analysis (particularly the selected narrative categories), with reference to 2) the model of narrative development proposed by Dimaggio, Salvatore, and colleagues.

Based on the analyses carried out, four areas of clinical diagnosis emerge whose exploration may be particularly effective in the application of the distinguished types of narrative analysis, corresponding to different narrative levels (see Table 5).

It must be stressed that the presented utterances of patients are only illustrations, and the reconstructed fragments of the patients' inner worlds should be treated as case studies, not even allowing to follow an important principle of diagnosing, namely to relate the results of these analyses to the patients' broader life stories. For this reason, it is difficult here to make generalizations concerning the regularities of psychological functioning in paranoid personality disorder. What it is possible to do is advance certain new hypotheses on the functioning of people with PPD.

Table 5
Selected Categories of Self-Narrative Analysis, the Levels of Narrative Development, and the Proposed Areas of Their Application in Qualitative Clinical Diagnosis. Own Elaboration

Level of narrative development	Selected categories of self-narrative analysis	Areas of clinical diagnosis
Proto-narrative level	Emotional tone	Understanding the relations between mental states and their emotional indicators
Conscious propositional narrative	Selected structural-formal categories: – the protagonist and his/her actions – other characters and their actions – conclusion Ways of linking events: – temporal – teleological – causal	Recognition of cognitive styles. Understanding the experience and construction of interpersonal relations as well as the issues of self-image and identity Understanding the processes of integrating the information received
Verbal interactive narrative	I-positions: – identified with self – attributed to significant others	Understanding the complexity of internal experience in its processual dimension Recognizing positions identified with self and those projected on others
Procedural unconscious narrative	Analysis of the dialog with a clinician/therapist: – patient's verbal and non-verbal observational indicators, – clinician's own introspection and feelings. Interpretation of data from the conversation	The understanding of the dynamics of assistance/psychotherapeutic relationship, including the processes of co-constructing the narrative in therapeutic dialog

Based on the analysis of emotional tone, it can be supposed that in PPD a disorder concerning the pre-verbal levels of narrative development occurs, most probably on the proto-narrative level, where the connections between somatic experience and the evoked memory are distorted. This may result in difficulties with the verbal control of emotions and in undiversified affect. Narrative can be called impoverished in terms of the accuracy of its reference to emotional states – those of the narrator and those of others (cf. Dimaggio et al., 2003).

Individuals with PPD begin their self-narratives on psychological difficulties from a thesis (conveyed explicitly or implicitly) which they later substantiate in the course of the narrative by means of selectively chosen arguments – the result being that, in conclusion, they confirms what they assumed. The analysis of the conclusion of the narrative allows to understand the cognitive style of an individual with PPD. The analysis of connections between events and the actions of the protagonist and other characters reveals a considerable effort put into ordering the received data connected with the patient's object of interest as well as attempts to build a coherent self-image and a coherent vision of the world. Despite this effort, the narrative of patients with PPD shows deficits in integration (cf. Dimaggio & Semerari, 2001) because the coherence accomplished is maladaptive (contributing, for instance, to conflicts and social isolation).

Procedural unconscious narrative in PPD is directed towards forcing a specification of the persecutor and the victim in a social situation, which is supposed to justify the necessity of defensive behaviors, self-protection, and withdrawal from an interpersonal relation. To this end, primal defense mechanisms are probably involved.

Summing up, the main benefit of using the narrative approach in clinical psychology is: 1) a systematization of analyses of patients' utterances, otherwise carried out intuitively, and 2) the recognition of the levels of narrative development that may be useful in diagnosing the extent to which a given emotional experience can be processed and consciously reflected on. Moreover, self-narrative analysis affords access to the processes of constructing the disorder and the ways of experiencing it, with the focus being no longer exclusively on descriptive criteria; this results in an improved understanding of the patient's inner world (for example, the processes of identification and projection) and of the patient's various difficulties in the relationship with the clinician.

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