9 Narrative Medicine

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> Interrogation generates defensiveness, narration encourages intimacy.
>
> George Engel (1997: 526)

Abstract: The following is about the importance of narration in a *biographical-narrative* anamnesis, which must correspond to the paradigm shift to *biopsychosocial* medicine (§ 9.1). First of all, the focus should be on the *concept of anamnesis* itself, according to which it is above all the patient's *remembering of himself* that is important. Remembering oneself extends to all dimensions of *biopsychosocial* anamnesis, which proves to be more effective in a *narrative* approach than the traditional *interrogative* approach (§ 9.2). To this end, the *functions* and *structures of* narrative itself are to be elaborated, which experiences a special institutional manifestation in the medical consultation. In a *dialogical narrative model,* the aspects guiding the study are differentiated, which are to guide the subsequent empirical conversation analyses.

For the theory and practice of a biographical-narrative anamnesis, borrowings can be made from *psychotherapy*, in which patient narration has a long tradition (§ 9.3). The *basic psychoanalytic rule of* stimulating the patient to think, experience and talk *associatively* is not only to be practiced in relevant psychotherapies, but it should be applied in a *moderate* form in everyday medical care practice to promote narrative self-exploration by patients.

Here too, however, one has to expect resistance from the patients, whose willingness to tell their stories often has to be *elicited* with great effort before they finally get into a more or less *associative* narrative flow "under the direction" of the doctor (§ 9.4). During the medical conversation, different developments can be "conditioned" by verbal and nonverbal interventions of the doctor, which tend to *promote* or *inhibit* a *free patient speech.* Overall, a *balance* between *interrogation* and *narration* must be found in medical conversation, where both partners benefit from both forms of communication in their common interest.

When using the *listening privilege,* which patients grant their doctors with a great leap of faith, it must first be assumed that medical *listening takes precedence* over *asking* (for details), without "playing off" both forms of medical intervention against each other (§ 9.5). Rather, listening and questioning must come into play as a unity in the medical "art of midwifery". Thus, the interpretations that physicians make available

in a *questioning* manner following patient's narratives as offers of *meaning* are *aids in verbalisation* that the patient can accept, but also reject, add to or change, to which the physician in turn reacts again, etc. This cooperation in interpretative conversation work is then further concretised in empirical narrative analyses (§ 19-21, 24-25) using anchor examples.

9.1 Biopsychosocial and narrative medicine

With the paradigm shift from traditional *biomedicine* to *biopsychosocial* medicine described above (§ 4), a paradigm shift in medical interviewing is taking place at the same time. Since the early beginnings of empirical-critical research on doctor-patient communication, there has been a plea for a move away from the traditional *integrative* interview style, which can no longer do justice to *patient-oriented* medicine. The pleas for a change "from silent to talking medicine" (Lüth 1986), which gives patients more room for self-exploration in their own words, begin at the latest with Balint (1964/1988) and extend through Engel (1979, 1997) to the more recent empirical studies on doctor-patient communication (§ 2), such as those initiated by the fundamental work of Byrne and Long (1978). This development then led to the approach of *narrative medicine*, which is outlined here in an overview and problem outline and will be further elaborated in the handbook and concretised in empirical conversation analyses.

9.1.1 Anamnesis: Remembering

With the orientation towards a *biopsychosocial* medicine and a corresponding conduct of the conversation, the thematic scope of what should be the subject of the anamnesis has expanded considerably. Beyond the patient's *body,* his or her *body* and *life* also become the subject of the medical consultation, in which not only *physical symptoms* but also the *personal experience* are moved into the focus of conversation (Langenbach, Koerfer 2006). In this way, a broad concept of anamnesis is also pursued in the more recent research on doctor-patient communication, which ties in with traditional understandings as they have been handed down through the meaning of the term and the history of

concepts, to which, for example, attention is drawn by Gadamer (1993) (Box 9.1):

Box 9.1 On the concept of anamnesis: remembering and searching

At least the Pythagoreans already linked 'anamnesis', i.e. the realm of memory and recollection, with the concept of the psyche. The Greeks made a whole series of efforts to master this by thinking (...) We probably say 'mneme', 'memoria', both of which are firmly programmed into the life traits of living beings and their instincts. But anamnesis, remembering, is obviously something else. While it is related to mneme, it seems to be reserved for humans in a specific way. Memory, anamnesis, is a form of thinking, of logos, that is, of seeking. We all know that when one has a word on the lips and yet has to search for it and usually does not find the right one. But the fact that one can search and in the end know when he has found what he is looking for is the distinction of man.

Gadamer 1993: 179f

If this interpretation of the traditional meaning of *anamnesis* is taken as a basis, the question arises as to what the patient should remember in a searching manner and in what communicative form this can best be done. For the medical interview, this also means in concrete terms how the doctor in his specific *midwifery function* can *help* communicatively in remembering and searching (§ 9.5). Since it cannot be clear from the outset, especially in the first interview, what the subject of the recollection and search is, it cannot be asked openly about it, but the relevant topics must first be successively developed conversationally in the communicative exchange between doctor and patient. For this purpose, the free patient narrative can take over an essential function, which, however, must be sufficiently promoted during the biopsychosocial anamnesis collection.

9.1.2 Narrative of biopsychosocial patient stories

As stated in the introduction (§ 1), *clinical* access to the patient is primarily a *linguistic* access, in which the sick person must be sufficiently stimulated by the doctor in the medical consultation in order to be able to open up to him accordingly. The *patient narrative* is seen as a predes-

tined form of linguistic access to the patient, in which personal experiences can be conveyed in a specific way, which would remain closed to the conceptual level of abstraction of a mere question-answer dialogue, especially if the questions are determined by an exclusively doctor-centered interest in information.

The promotion of patient narratives results above all from the necessity of reconstructing patient histories that are as comprehensive as possible, which, in the sense of a biopsychosocial medicine, concern the individual medical history of the patient as a person with a lived biography. Biopsychosocial medicine must be associated with the claim to reconstruct the patient's story as a history of illness and life in the interaction of all three components of the model, as already highlighted by Smith, Hoppe (1991) (Box 9.2), among others, with reference to the early work of Engel (1977).

Box 9.2 Biopsychosocial patient history

According to the biopsychosocial model, every patient has a story that demonstrates the interaction among the biologic, psychologic, and social components of his or her life (...) The patient's story emerges in a meaningful, integrated, and complete way. The physician's task is to elicit and understand this story, for it provides an introduction to who the person is and why he or she is seeing the physician. The story also provides clues to diagnostic and therapeutic issues relevant to the patient's problem.

Smith, Hoppe 1991: 470

If the medical task is seriously pursued to *elicit* and *understand the* patient's *story* under the interaction of all three *biopsychosocial* components, this conversational attitude must manifest itself in the practice of conversation at least under the following two aspects of *content* or *dialogue,* which should also guide our later empirical conversation analyses:

1. On the one hand, from a *content* point of view, the conversational practice must be characterised by a *thematic progression* in which biotic, psychological and social thematic complexes can be alternately initiated, ratified and integrated by both partners into their shared understanding of the reality they jointly produce (Uexküll, Wesiack 1991, 2011).

2. On the other hand, under a dialogical aspect, specific forms of conversation are to be expected, which come close to *storytelling* by one interlocutor and listening by the other interlocutor, as is also common in everyday communication.

The *asymmetry* that one partner essentially *tells* and the other essentially *listens* before asking further questions is by no means to be understood as a disturbing factor of an overall *symmetrical* communication (§ 7, 10). Rather, the patient's narration and the doctor's attentive listening can be used productively to bring to light the relevant biopsychosocial issues in the common interest of action in the first place. Before the advantages of *narrative* over *interrogative* conversation can be illustrated with examples of conversations, the theoretical aspects that should guide the empirical narrative analyses must be worked out.[1]

> Narrative medicine is a recent innovation in clinical training, research, and practice that recognizes the human capacity to tell stories as central to health care. People are storytellers, and patient's stories are key to understanding their health care problems, predicaments and concerns and to negotiating effective treatment.
>
> Kirmayer et al. (2023: 235)

9.2 Functions and structures of narration

The communication form of narrative is receiving increasing attention both in research and in many practical fields of action. The "narrative turn" has currently reached not only the social sciences in general (Mishler 1995, Straub (eds.) 1998, Baroni 2014) and *psychotherapy* in particular (Labov, Fanshel 1977, Schafer 1995, Boothe 2011, Scheidt et al. (eds.) 2015, Lätsch 2017, Deppermann et al. 2020, Habermas, Fesel 2022), but also medicine in the narrower sense: In the meantime, in analogy to *evidence-based medicine* (Lauterbach, Schrappe (eds.) 2001)

1 Empirical narrative analyses can be found in particular in chapters 19, 20, 21, 24, 25. In the following presentations of theoretical foundations, we were guided by preliminary work on narrative analysis in Koerfer et al. 1994, 2000, 2010, Koerfer, Köhle 2007, 2009, Köhle, Koerfer 2017.

(§ 5, 10), there is a corresponding plea for *Narrative-based Medicine,* for which the abbreviation *Narrative Medicine* has also become established (Greenhalgh, Hurwitz (eds.) 1998/2005, Launer 2002, Mehl-Madrona 2007, Lucius-Hoene 2008, Koerfer et al. 2000, Koerfer, Köhle 2009, Arntfield et al. 2013, Charon 2012, 2013, Goyal 2013, Gülich 2017, Birkner 2017, Köhle, Koerfer 2017, Galvagni 2022, Kirmayer et al. 2023).

The current strong interdisciplinary interest in the theory and practice of storytelling is related to the universal function and structure of this form of communication, which we use in all cultures for the most diverse occasions and purposes, both in everyday life and in institutions, in both written and oral forms (Ehlich 1980, Quasthoff 1980, 1999, 2001, Gülich, Hausendorf 2000, Lucius-Hoene, Deppermann 2002, Bamberg 2007, Baroni 2014, Quasthoff, Ohlhus 2017). In his interdisciplinary contribution to the "Historical Dictionary of Philosophy", Stierle (1984) introduces the following definition of *narration* or *narrative* (Box 9.3), which provides a good introduction to the topic.

Box 9.3 Representation scheme of narrativity

The term "narrative" refers to a textual scheme that is fundamental to the ordering of experience and knowledge in all cultures. In the representational schema of narrativity, a context of events and action is transformed into a story ordered according to relevance and under a temporal form of representation. At the same time, this story is concretised and perspectivised in the medium of language (...) Every story stands under the principle of relative closure (...) It is at the same time a temporal interpretation of the difference between the initial and final state and its visualisation in a specific field of experience.

Stierle 1984: 398

This universal form of communication has taken on a specific *institutional* form in the form of patient narratives in medical consultations and rounds, which will be elaborated in the following. First of all, the general "bridging function" of narratives should be emphasised, which can act as a mediator in the communicative exchange between the *life world* of the patient and the *professional world* of the doctor (§ 10.2) (Launer 2002, Hurwitz, Greenhalgh, Skultans 2004, Brody 2005, Heath 2005, Greenhalgh, Hurwitz 2005, Charon 2006). The pleas for a narra-

tive approach in medicine can be justified above all by the *closeness to everyday life* of this form of communication, which proves superior in many respects to a purely *interrogative* interview style. This is because narrative allows not only more, but above all different kinds of information to be *brought up* than would be possible by simply answering a *professional-terminological* catalogue of questions. This difference between *interrogative* and *narrative anamnesis* will be defined in more detail below, as will the difference between *narratives* and *reports*. However, it should be noted in advance that for all the differences, it is not a matter of alternatives in conducting the interview, but rather of finding an appropriate *balance* (§ 9.4) between the different forms of communication.

9.2.1 Conceptual and narrative mode of communication

The specific cognitive functions of narration as opposed to purely conceptual discernment have been highlighted by Ritschl (2004) in the following way (Box 9.4), although he does not thereby suggest any fundamental alternatives, but merely a temporal-logical sequence of communication modes, each of which is deployed in its own way:

Box 9.4	"Closeness to reality" of concept and narrative

Admittedly, the mode of narration offers no substitute for clean concepts and clear distinctions. However, narration has been recognised as a form of speaking (and listening) that still has its function 'below' the concepts, so to speak, at the base, hard up against reality. It is, if you will, closer to reality than the concept. This also applies to a great extent to understanding patients and our dealings with them.

Ritschl 2004: 139

As an everyday form of communication, the narrative provides excellent access to sources of information that cannot be readily conceptualised by the patient and that cannot be readily developed by the doctor through conceptual questioning. If the doctor does not want to give away the typical information that can only be conveyed in the appropriate conversational form of *free narrative*, he must first largely dispense with interrogative interview forms. Here Balint's dictum ("If you ask questions, you get answers to them - but nothing more", 1964/88: 186),

which we will return to shortly under the aspect of the *art of listening* (§ 9.5), acquires its specific conversational-analytical meaning: *stories* can hardly be *asked,* but essentially only *told*.

It is precisely with this specific type of dialogue role distribution, in which one partner narrates and the other listens attentively, that the principle of the *primary speaker* introduced by Wald (1978) and taken up by Quasthoff (1990) also comes into play in doctor-patient communication: the patient is granted a special *speaking privilege* as narrator, without the doctor as listener being condemned to silence. Rather, the doctor is also granted a *listening privilege* in the dialogue role assigned to him (§ 9.5), which, however, also obliges him to engage in specific listening activities (§ 19.3), so that the narrative as an interactive process of speaking and active listening gets underway and remains underway at all.

The distinction made by Ritschl (2004) (Box 9.4), according to which the narrative is "closer to reality" than the concept, can be applied in particular to the emotional reality of the patient. This is not only about *events* of the external world, but about the *experiences* of the patient's inner world, which in their *subjective meanings* can also often be better conveyed in narratives than in answers to concept-based questions.[2] The fact that these have their justification in the *interpretation work* is another matter, which is only filled in in a later phase of the conversation, when the feelings conveyed in narratives have to be "brought to the concept", because *understanding* is ultimately dependent on *concepts* (§ 20.6-9, 21.3). Once relevant terms have been developed in the interpretive work, their function as "cues" can also trigger further narratives, which can entail further interpretations at a higher level of abstraction, etc.

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2 However, enough examples can be cited in which the conceptual questioning forces the joint conversation work. In these cases, at least direct or indirect, often non-verbal patient *cues* have preceded, which are then rightly questioned by the doctors, to which we will return with many empirical examples, especially on *empathic communication* (§ 20). In contrast, merely asking conceptual questions about emotions is often not very effective if these questions cannot be linked to developed stories of interaction with the corresponding patient cues (§ 19.6).

9.2.2 Intimacy and empathy

In all conversation phases of telling and interpreting, the dialogue role of the doctor as an active listener is essentially determined by an *empathetic* attitude to the conversation, through which the *intimate* rapport of the patient can only be made possible at all (§ 20). For the doctor's conduct of the conversation this means: Intimacy will often fall by the wayside in a mere question-answer scheme, especially if the doctor orients himself exclusively to a biomedical catalogue of questions. The difference between an *interrogative* and a *narrative* interview style has been summed up by Engel as follows, which served us as a motto at the beginning: "*Interrogation* generates defensiveness, *narration* encourages intimacy" (1997: 526). As will be shown later in examples of conversations (§ 19-21), patients who use an extremely interrogative style of interviewing soon resort to silence or respond only with monosyllabic answers in order to maintain a minimally cooperative communication.

In order to be able to achieve intimacy *qua* narratives, on the other hand, the change from an interrogative to a narrative interview style, according to Engel, must at the same time be accompanied by a fundamental change in the *understanding of the roles* of doctor and patient: In a narrative approach to medicine, the role of the patient is no longer that of a mere object of the doctor's action, but rather that of an *initiator* and *collaborator,* while the role of the doctor as a *participating observer* is determined with recourse to the following terminological distinctions (Box 9.5), which can be used to describe the interactive mediation of doctor-patient knowledge resources and competences.

Box 9.5 Observation, introspection, dialogue

The physician in turn is a participant observer who in the process of attending to the patient's reporting of inner world data taps into his own personal inner viewing system for comparison and clarification. The medium is dialogue, which at various levels includes *communing* (sharing experiences) as well as *communicating* (exchanging information). Hence, *observation* (outer viewing), *introspection* (inner viewing), and *dialogue* (interviewing) are the basic methodologic triad for clinical study and for rendering patient data scientific.

G. Engel 1997: 525

In this "methodological triad", it is precisely the interactions between *observation*, *introspection* and *dialogue* that are important. As Engel further explains with the help of recalled or reported examples, the doctor cannot limit himself to a purely external observation (*outer viewing),* especially with a *biopsychosocial* approach to the patient, but must look at his own personal inner world (*inner viewing)* in the dialogue with the patient (*interviewing*). According to this, the doctor can only muster the necessary *empathy for the patient* by allowing himself to be sufficiently stimulated by his own life experience through the patient's stories.

In *empathy,* however, the difference must be preserved, which von Uexküll (1997: 451) pointedly expressed from a *semiotic* point of view: Empathic communication with the patient is not about personal transformation, but about transposition into the subjective world of signs of another person. This distinction corresponds to the definition of empathy as already marked by Rogers (1962/90) with his *as-if attitude* (§ 20.3), which is to be adopted in a distancing manner towards the client in *non-directive* conversation.

Moreover, the relationship between *communing* (sharing experiences) and *communicating* (exchanging information) specifically thematised by Engel in his methodological triad must certainly be thought in circular terms. In order for the exchange of information between the interlocutors to succeed in dialogue at all, they must always be able to refer back to a minimum of socially shared knowledge, as has been worked out in particular in the tradition of *understanding sociology* (Schütz 1932/74, Berger, Luckmann 1966/80). This shared knowledge is differentiated in detail into knowledge of the world, language and action, knowledge about institutions (such as the doctor's consultation) as well as about illness and health and about morality and a good way of life, etc.

The shared common knowledge is often explicitly expressed in narration in *metaphors* relevant to the life world (§ 11) ("getting the first crack", "thrown off track", § 19.8) or even only vaguely presupposed, so that its effectiveness is then implicitly brought to bear as "silent knowledge" (Ehlich, Rehbein 1977, Lakoff, Johnson 1980/98, Buchholz 1996, Koerfer 2013). This shared knowledge as general knowledge is the basis for efficient and problem-free communication, also in the medical consultation, in which it then only takes "a few words" to further promote conversation. Thus, in an example that will be analysed in detail (§ 19.8, 21.3), only brief verbal interventions are necessary, for example, when the doctor, interpreting his patient's dramatic narrative about his professional development, sums up that the patient is "selling himself

short" or that "work seems to be getting on his nerves", which in turn stimulates the patient to further *narrative self-exploration,* with which he can (in Engels' sense) increasingly perceive the role as "collaborator".

9.2.3 Narrative versus report

A further distinction, made essentially according to the extent of possible *intimacy*, is that between *narrative* and *report* (chronicle, etc.), both of which may have their justification, but with which different objectives can also be pursued in the consultation. These objectives also involve the traditional distinctions between *disease* and *illness* (Uexküll 1981, Kleinman 1988, Levenstein et al. 1989, Kirmayer et al. 2023), which are to be abolished in a *biopsychosocial* medicine anyway (Uexküll, Wesiack 1991), because patients are to be treated under both aspects.

With a strongly interrogative interview style, the doctor will at best be able to obtain a *report* on an *objective history of the illness*, which mainly covers somatic complaints (*disease*), if a "surplus" of information beyond the questions can be expected at all (§ 21.2). In contrast, the doctor will be able to persuade the patient with a narrative interview style to *tell* his *subjective history of illness*, which concerns the patient's individual experience of illness as a sick person (*illness*). In his dialogue role as an active listener, the doctor will pay attention to the distinctions the patient can make with words (Tab. 9.1), namely, for example, between *event* and *experience*, *outer* and *inner* world, *objective* and *subjective* meaning, *historical* and *narrative* truth, *calendrical* and *biographical* time, *anonymity and intimacy, rationality* and *emotionality*, etc.

We will take up and concretise these differences between report and narrative in empirical narrative analyses.[3] In advance, we will only point out the relevance of the simple distinction between "objective" and "subjective" time data of patients. For example, the dates in narratives often do not refer to calendar time (date: day, month, year) but to lived time, as in the case of a patient who chooses her own biographically relevant

3 The feature differences between *report* (or *chronicle*) and *narrative* compiled in Table (9.1) represent modifications of the overviews in Koerfer et al. (2000), Koerfer, Köhle (2009) Köhle, Koerfer (2017), whereby individual differences can be derived from results of both discourse linguistic and psychotherapeutic conversation research (e.g. Rehbein 1980, 1984, Becker-Mrotzeck 1989, Meares 1998).

"dates" ("Communion Sunday" of her grandchild), to which we return in detail with a dramatic narrative (§ 19.7). The subjective time details are given by the patient only gradually and in a non-chronological way in the communication with the doctor.

		Chronicle/Report	Narrative
1	Subject	Events	Experiences
2	Area	Outer world	Inner World
3	Validity	Historical truth	Narrative truth
4	Time	Calendar	Biographical
5	Perspective	Past	Visualisation
6	Room	Everyday reality	Scenic performance
7	Form of presentation	Logical-linear	Sequential
8	Dialogue form	Question-Answer	"Free" narrative
9	Language	Impersonal ("man") Abstracts Indirect speech	Personal ("I") Richness of metaphors Direct speech
10	Evaluation	Rational	Emotional
11	Orientation	Listener-neutral	Listener-specific
12	Relationship	Anonymity	Intimacy
13	Medical focus	Disease history	Illness history
14	Topics	Biomedical	Biopsychosocial
15	Relationship model	Paternalism /Service	Cooperation (SDM)

Tab. 9.1: Report/chronicle versus Narrative

As Morgan and Engel (1977: 45) recommend for tempor*al detail exploration* (§ 21.4), patients' memory gaps in calendrical date recall can be compensated for precisely by following the biographically relevant events and experiences that patients are good at remembering because of their subjective relevance, so that one can then often reconstruct the 'objective' dates together by asking ('When was communication Sunday/moving house/school enrolment/wedding etc.?').

Overall, the patient will also prefer different *relationship models* depending on the predominant form of communication (*report* vs. *narra-*

tive) (§ 10). With a "factual" report, the patient will tend to choose an *anonymous* relationship vis-à-vis the doctor as a *service provider to* whom he/she will primarily offer biomedical topics. With a "dramatic" narrative, the patient will tend to seek an intimate relationship with the doctor as a *helper,* to whom he will also confide with his psychosocial problems in a narrative way. However, patients' offers of a relationship often remain ambivalent if they are not answered by corresponding complementary counter-offers from the doctor, who can more or less "condition" the patient's conversational behaviour to a certain extent through his way of conducting the conversation (§ 9.4).

As will be shown in the empirical example (§ 20.9), a patient can report on the death of his mother as a mere *event* and want to leave it at that, or he can talk about his *experience* of a lack of mourning work, which, however, requires a special invitation from the doctor. Because of a restrictive idea of the meaning and purpose of the medical consultation, patients often assume a different order of relevance of what can be "said", with which they initially limit themselves to purely somatic patient offers in a kind of self-censorship. Here, the doctor must counteract in time through intervention techniques of *active listening* in order to achieve a change of direction from mere report to narration and thereby increase the possible spectrum of the "tellable" for the patient.

The problem of *narratability*, which is generally captured by terms such as *tellability* or *reportability* (Labov 1997, 2001, Ochs, Capps 2001, Baroni 2014, Martinez 2017, Weixler 2017), does not only exist in everyday communication, but is even more acute in the consultation, because patients, as (mostly) medical laypersons, find it difficult to assess the relevance of their topics for their medical interlocutor.

Under the more or less explicit question "What is worth telling?", the relevance of patients is occasionally tested, to which the doctor should respond with a *relevance upgrade if* necessary (Koerfer et al. 2000, 2010, Koerfer, Köhle 2007, 2009, Köhle, Koerfer 2017). However, doctors often behave reservedly or even ignorantly towards narrative-emotional patient offers - for whatever reason, which points to deficits in empathic competence (§ 20.2). We will deal with the problem of *upgrading* or *downgrading the relevance* of narrative or emotional patient offers systematically (§ 17.4) as well as in detail in empirical conversation analyses (§ 19-21). Before this, the meaning functions and types of narratives must be differentiated, which must be taken into account in medical conversation practice.

9.2.4 Meaning functions and narrative types

Just as in everyday life, general functions of narration are also perceived in the medical consultation, which have to do with the *meaning*- and *identity-forming function* of (biographical) narratives in general (Schafer 1995, Stern 1998, Bruner 1998, Gergen 1998, 2002, Lucius-Hoene, Deppermann 2002, 2004, Habermas 2006, Goyal 2013, Römer 2017, Habermas 2019, Deppermann et al. 2020). Who we are can hardly be *summed up* in a word, but it can be in a *narrative* in which we can illustrate our course of life with all its designs, realisations and dislocations for ourselves and an interested listener.
The role of narrative has been used in psychotherapy in particular, where various self-presentations of patients are to be promoted via the patient's *associations* (§ 9.4). Before we go into the interactive framework of narrative in more detail, the general function of patients' *self-narratives*, as formulated by Schafer (1995) (Box 9.6), for example, from a specifically psychoanalytic perspective, should be prefaced here.

Box 9.6	Narratives of the Self

My theoretical argument is that the so-called self-concepts, self-images, self-presentations or, more generally, the so-called self, can be seen as a set of narrative strategies or storylines that each person follows in an attempt to develop an emotionally coherent representation of his or her life among other people. We organise our past and present experiences in narrative ways.

Schafer 1992/1995: 62

Although a narrator strives to develop "an emotionally coherent account", this "attempt" often remains provisional. In patient narration, it is by no means possible to assume constant stories that would be told in the same way in all situations and to different people. Rather, according to Schafer (Box 9.7), depending on the occasion and conditions of the telling, different versions of self-narratives can be expected, in which the narrator can position himself in several roles from different perspectives.

Box 9.7 Versions of self-narratives

Or the person may tell of more than one self, as the case may be. The so-called self exists in versions, only in versions, and usually in several at the same time. For example, to say, "I told myself to get started now" is to tell the story of a self with two roles, an admonishing self and an exhorted self, or perhaps even three roles if we include the implied author who tells of the exhortation.

Schafer 1992/1995: 52

Without being able to go into psychoanalytical *concepts of the self* here,[4] later in the empirical narrative analyses, attention will also be drawn to *paradoxes* that patients more or less consciously see themselves exposed to in their narratives, which is expressed precisely in their *evaluations.* For example, one patient continues to take herself into the obligation of a grandmother role, which she at the same time no longer feels up to for reasons of her own illness ("such dizziness") ("it's so bad, I can't take my daughter's children any more, and that's saying something"). Immediately before, the patient had described her personal situation as a "fight" against herself ("Doctor, I'm going against myself in a monstrous way") (*me against myself*), combined with an appeal for understanding to the doctor, whom she addresses here personally with the direct form of address ("Doctor").

The life narrative of a "stomach" patient develops in a similarly (self-) contradictory way. When asked by his doctor, he begins to tell why he is "actually not the type of civil servant" that he has unfortunately become, which he regrets expressis verbis ("unfortunately") in the final evaluation (§ 19.8). As doctor and patient together reconstruct the discrepancy between the life plan and the course of life, an alternative narrative gradually gets underway in which the patient begins to reflect on the consequences of his illness that could be drawn beyond his profession as a civil servant.

Last but not least, illnesses often represent breaks in the previous self-image, through which previous lifestyles are called into question. In the face of the crises of meaning and identity that increasingly arise in

4 At this point, reference can only be made to the traditional psychoanalytic discussion of the *True Self* (Winnicott) or the *Core Self* (Kohut), to which Schafer (1995: 44ff) himself also refers in advance.

the case of illness, narratives in medical consultations must increasingly take on the function of narrative self-assurance, in which the narrator hopes to find the professional resonance of a medico-therapeutically competent listener in whom he can personally confide with his problems.

In building a trusting relationship, narratives in the medical consultation have a special function that has to do with the concrete reason for the consultation itself, which Brody says patients often associate with the general appeal to the doctor: "My story is broken; can you help me fix it?" (1994: 85). Such "broken" stories, whose narration addresses the doctor as *helper,* can be told in various ways through which the narrators can present themselves (*ego*) or others (*alter)* in a particular perspective, in which several people may be involved.

The prototype is the *story of suffering,* in which patients can portray themselves as "sufferers" in different roles as *victims*, *failures*, *culprits*, etc. The narrators can make themselves (self-narratives) or others (other-narratives) the protagonists of a story. In this process, narrators can make themselves (*self-narratives)* or others (*other-narratives)* the protagonists of a narrative, under whose story the narrators (as partner, child or parent) can suffer (with) just as much as those directly affected (§ 19.7). The suffering of others then becomes one's own suffering, under which one's own illness with one's own medical history can eventually develop, which then becomes of particular relevance for the social and family anamnesis.

However, the protagonist of a narrative can initially also be portrayed contrastingly as a lucky devil, adventurer or hero who, for example, initially coped well with a serious illness or family or professional strain before he was nevertheless "struck by fate" or "completely failed" and was "thrown off course", which is then often narrated as a development contrary to expectations in an *anti-climax* (§ 19.7-8).

In addition, *mixed types* of narratives can also be differentiated, which are not characterised by an "either-or", but linguistically-communicatively by a "one-sided-other-sided" or "both-as-well" or "yes-but", i.e. are determined by a complex type of evaluation, which will be further differentiated in the exemplary narrative analysis. In doing so, we first follow Gergen's (1998 and 1999/2002) typology on the evaluation function of narratives, according to which general types of *progressive* and *regressive*, *tragic* and *comedic* narratives can be distinguished, which we reproduce here as *prototypical* representations (Fig. 9.1-4).

In narration, events can be arranged in a two-dimensional evaluative space in which the narrator either moves in a positive direction with successes more or less rapidly approaching his goals, or moves in a negative direction (disappointments, failures) when, for example, failures and disasters follow one another.

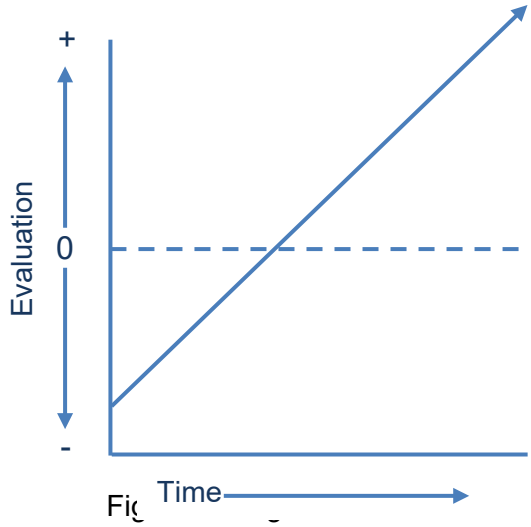


Fig. 9.3: Tragic narrative

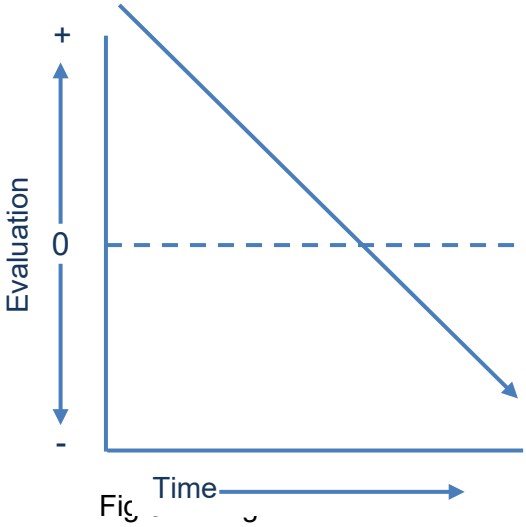
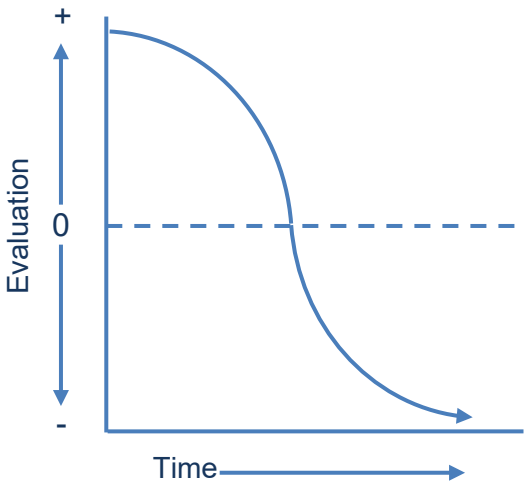
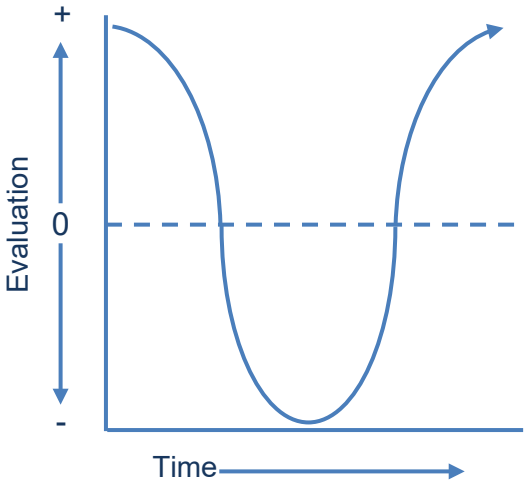


Fig.9.4: Comedic narrative





(mod. after Gergen 1998: 179ff and 1999/2002: 94ff)

Further complex (and potentially infinite) variants result from a mixture of positive and negative events or developments, so that upward and downward tendencies occur. Further subtypes are the *stability narratives*, where the line of development remains essentially (horizontally) unchanged: "Life just goes on like this, neither better nor worse, at least with respect to the conclusion of the story" (1998: 178). Development

then stagnates either above or below the (dashed) zero line without further swings.

Following this typology by Gergen (1998, 2002), the empirical conversation analyses will focus on typical case narratives, but at the same time specific in their *individual* characteristics, in which the individual life courses can be mapped on the time axis of *real* patient biographies as *evaluation curves* with specific *upward and downward trends* (Koerfer et al. 2000, 2005, 2010, Köhle, Koerfer 2017). In this context, the corresponding narrative analyses (§ 19, 20, 24, 25) should not only take into account the patient narratives themselves, but also their interactive pre- and post-narratives, in which the physicians' constructive participations of narratives and evaluations should be reconstructed.

As *co-constructors,* doctors are actively involved in the development of patient narratives, which can also lead to the reconstruction of stories (*new story*) (Brody 1994, Stern 2004/2010, Stern et al. 2010/2012, Vickers et al. 2012).[5] In joint conversation work, the narrative can have a *catharsis effect* on the patient and, in addition, often have an *explanatory function* for both partners ('Why did it all happen the way it did (unfortunately)?'). Once again, what cannot be *summed up* in a few words or sentences can be illustrated in *stories.* In this way, both interlocutors gain a better understanding of the medical history as well as of the need for help of patients, who can become increasingly aware of this need for help during the narration.

Through active listening and narration, both interlocutors can alternately "pull themselves deeper and deeper into a conversation". In their respective dialogue roles (as speaker and listener), doctor and patient initially use the same basic patterns of communication and the same linguistic means as in everyday life, which will be illustrated with specific institutional characteristics in a *dialogical narrative model for* doctor-patient communication.

9.2.5 Narrative model of doctor-patient communication

As explained in the introduction (§ Box 9.3), narrative is a *universal* form of communication that we use frequently and in a variety of situa-

5 To avoid a possible misunderstanding that *co-construc*tions might presuppose planning, Stern (2004/2010: 163ff) and Stern et al. (2010/2012: 130ff) prefer the term *co-creativity* to account for the spontaneous activities in micro-processes.

tions with many variants. This "large form of speech obviously has a reproductive capacity in different contexts of action" (Rehbein 1980: 70). General narrative models can ultimately only prove their worth in these different contexts of action. In linguistically oriented narrative research, attempts have been made to transfer text grammatical approaches to oral forms of communication and, in this sense, to develop specific narrative grammars conceived on both micro- and macro-structural levels (van Dijk 1980, Prince 1982, 1999). A particular impetus for the further development of empirical narrative analyses was given by the pioneering work of Labov and Waletzky (1967/73), which applied to "oral narratives of personal experience". Their general narrative model will be reproduced here in its main features in a figure (Fig. 9.5) together with the explanations (Box 9.8) given by Labov, Waletzky (1967/73) directly following this figure itself.

Fig. 9.5 Normal form of narration

The normal form of storytelling can be represented by the following diagram:

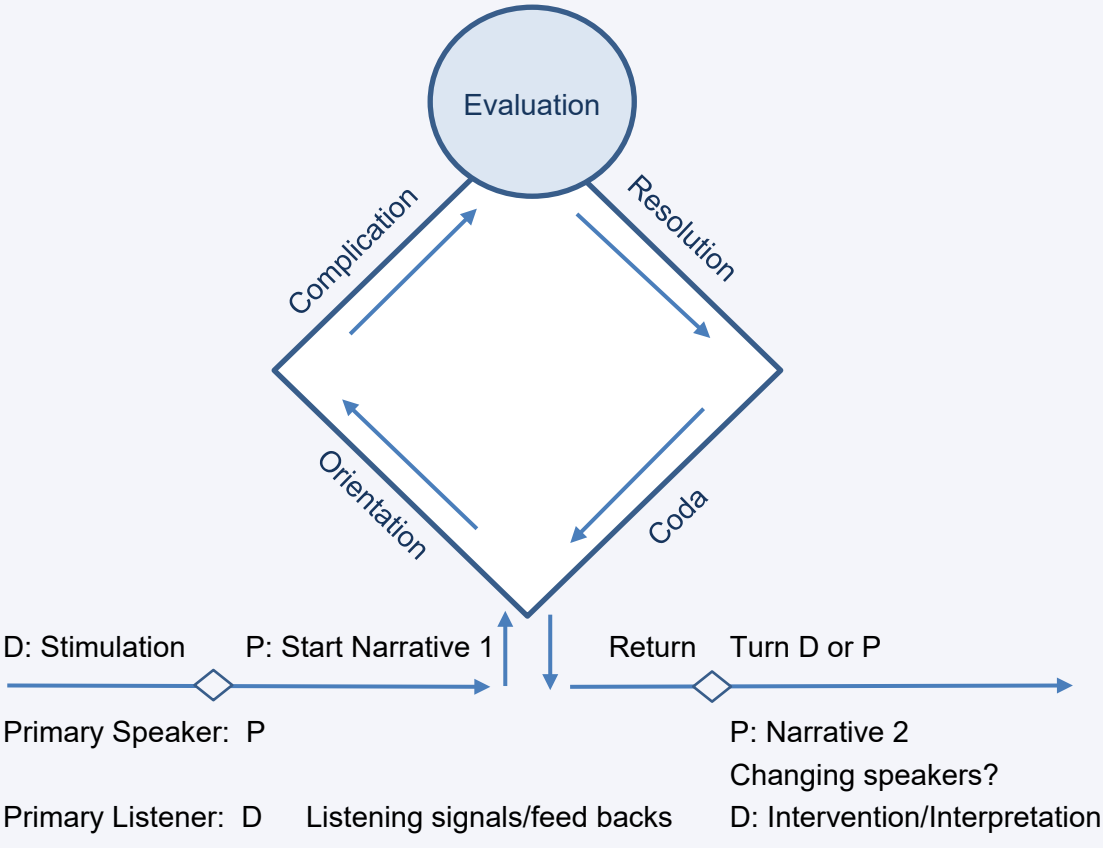


Fig. 9.5: Mod. on Labov, Waletzky 1967/73: 124 and on Koerfer, Albus 2018: 425

Box 9.8 Explanations of the narrative model (cf. Fig. 9.5)

The development function of the narrative starts at the base of the square, followed by the orientation part at the top left, then the complication part towards the top. Often, though not always, the evaluation stops the plot at this apex, which is expressed by the circle. The resolution takes place downwards to the right, and the coda appears as the line that returns to the situation (the point in time) in which the narrative was originally stimulated.

Labov, Waletzky 1967/73: 124

Labov and Waletzky's narrative model has been commented on, modified, specified or revised many times, including by Labov himself (Quasthoff 1980, 1999, Flader, Giesecke 1980, Prince 1982, 1988, 1999, Rehbein 1980, 1984, Eisenmann 1995, Mishler 1995, Labov 2001, 2007, Koerfer et al. 2000, Delbene 2011, Quasthoff, Ohlhus 2017, Hoffmann 2018). Following this text- and discourse-linguistic research, we tested a dialogic narrative model for doctor-patient communication (Tab. 9.2), which is tailor-made for our purposes of empirical analysis of narratives in the doctor's consultation.

In this narrative model, we take essential elements from the model of Labov, Waletzky (1967/73), which is limited to the narrative as a *monological* large form, and arrange these elements in *dialogical* sequences in which both interlocutors are involved in their own way before, during and after the narrative. Thereby, it remains with the relevant dialogue role distribution in narration in the consultation hour, according to which the patient is the *primary speaker* and the doctor the *primary listener.*

The dialogical narrative model is designed in such a way that optional and obligatory structural and functional elements can be distinguished and, in principle, mental and interactional processes of narration can be recorded, whereby only the mental doctor's side has been differentiated here for reasons of space (Tab. 9.2). Even according to this dialogical narrative model, a "normal form" of the narrative can initially be assumed, against which variants of realisation can be recorded in the first place (Fig. 9.5) (Labov, Waletzky 1967/73, Labov 1997, 2001). Just like everyday narratives, patient narratives are not always realised in "pure culture" according to sequence and completeness. Deviancies or fragmentary forms of realisation may have to do with a number of psychological, cognitive or interactive aspects of narrative.

	Primary speaker	Primary listener	
	Patient	Doctor	
	Actional	Mental	Actional
1	Communication 1	New focusing 1 Speech transition	Narrative stimulus "How did that happen?"
2	Framing Thematisation	Logical Understanding	Issues: "Where was that?" "Who else was there?" "When was that?"
3	Orientation Place, time, people		
4	Personal Perspectivation	Psychological Understanding	Settings: "This was what you wanted (hoped for, feared)?"
5	Complication, Scandalon	Scenic-empathic Understanding	Listener feedback: "hm", "yes", "ah", "oops", "terrible", "great", "gosh", "Oh my goodness", "jeez", etc.
6	Problem solution, -Clarification		
7	Evaluation: Morals, maxims		
8	Coda Speech transition	Willingness to taking the floor and making a statement	Empathic Response, Interpretation: "This must have been a shock for you"
9	Feedback "hm", "yes", "right", "exactly"	Securing understanding	Reconfirmation: "even", "that's how it is"
10A	Communication 2A	Focusing 2A	Narrative stimulus 2
10B	Communication 2B	Focusing 2B	Interpretative Intervention

Tab. 9.2: Dialogic narrative model (DNM) of doctor-patient communication
Modified on Koerfer et al. (2000: 96), Koerfer, Albus (2018: 228)

For example, the deficits in *framing* and *thematisation* may be due to the special interaction context of conversations in medical consultations, whose structural-thematic specifications make special markings unnecessary because, for example, the general reason for the consultation (e.g. "As a sick person, I need your medical help!") or the previous history belong to the mutually available interaction knowledge and can be presupposed accordingly.

Likewise, specific *evaluations* or *resolutions* can be omitted from a narrative because, for example, the corresponding information is already sufficiently known in the context of the previous stories of interaction, which can extend over many consultations. Thus, the stories of suffering with their open, previously unsolvable problems may already have been developed as a basic narrative pattern, so that *fragmentary* narratives suffice here for further communication between patient and doctor.[6]

This is where the consultation meets other everyday as well as institutional conversational situations in which formal "deficits" or "deviancies" compared to a "normal form" are to be expected (Labov, Waletzky 1967/73, Labov 1997, 2001, Gülich 1980, Mishler 1995, Quasthoff 1999, Georgakopoulou 2006, 2007). Furthermore, incoherence in patient narratives has been made a special object of research (McAdams 2006, Dimaggio 2006, Gülich, Schöndienst 2015), where the analysis of, for example, transpositions, omissions, repetitions or discontinuations in narration can serve specific diagnostic purposes.

Such "disturbances" are a phenomenon of oral communication in general, but they are particularly so in medical consultations, because "delicate" topics (§ 21.6) cannot always be communicated in fluid "normal forms" anyway. Nevertheless, especially in initial conversations, in which the interlocutors still meet as relative "strangers", largely complete narratives are often realised (§ 19-21, 24, 25), which then become the basis for further conversation work, in which both conceptual and again narrative communication patterns can come into play.

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6 Labov, Waletzky (1967), for example, allow deviations from the normal form even in complex or minimal narratives, such as altered sequences or omissions. It remains to be seen whether their example of a minimal narrative ("He hit me hard and I hit him back") is a message or a report rather than a narrative (§ 9.2.3).

9.2.6 Psychological and scenic understanding

While the patient is telling the story, *logical understanding* as well as *psychological* or *scenic* understanding is indispensable in medical listening (Argelander 1970, Lorenzer 1970, 2002). After the narrative has been stimulated and set in motion, there are possible hurdles to overcome at every stage of development, first of all in *logical* understanding, which sometimes makes banal queries necessary (*Who? Where? When?*), for example, if the common thread is lost for the doctor already in the *orientation* about places, times and people. In order to avoid misunderstandings between the two interlocutors, which later have to be repaired at greater expense, medical questions should be asked in good time to *ensure understanding* (§ 19.5). This kind of clarification of understanding can usually be well integrated into the narrative without "interrupting" the flow of the narrative in any relevant sense (§ 19.3).

The transition from *logical* to *psychological* understanding is more difficult, for example, when the motives or intentions of the narrator or other characters remain unclear. Here, a conflict of maxims must be solved, in which a decision is made after weighing up the interests. If it is foreseeable that the clarification of motives and intentions will require major digressions that could take the narrator out of his "narrative concept", the clarification should be waited until after the conclusion of the narrative. If the doctor can follow the narration well as a listener anyway, questions of comprehension are obsolete, so that the narration can only be supported by more or less "sparing" listener feedback (*yes, hm*) (§ 19.3), so that the narrator continuously experiences that he has an attentive and interested listener.

Similarly, a doctor will not tend to give strong *empathic* listener feedback ("terrible!") to every narration of a banal "flu" story, as may be the everyday expectation, but he will (have to) react to a dramatically staged "accident" story with appropriate *empathic* feedback. With such feedback, the patient's *stresses* and *attempts to cope* should be adequately *acknowledged* (§ 20.5), so that at the same time the appellative function of narratives towards the *medical assistant* (in the above sense of Brody 1994) can initially be satisfied conversationally.

Psychological understanding and correspondingly empathic reaction is complicated in *scenic* understanding, which is not only a matter for the (psychoanalytic) therapist (Argelander 1970, Lorenzer 1970, 2002). Rather, even in the medical consultation, the overall situation as well as

detailed phenomena of action must be recognised in their significance for the development of the relationship and taken into account in further communication.

This brings us back to the role of the *meta-physician* (§ 3.3) who, according to Uexküll, Wesiack (1991), must observe himself, the patient and their relationship in the "background" with a *self-reflexive meta-competence,* while "in the foreground" he continues the communication with the patient. Because of the relevance of "scenic information" in the medical consultation, which the doctor pursues with an "equal attention" (in the sense of Freud), the remarks of Uexküll and Wesiack are to be reproduced in detail here (as a textual basis for the discussion in teaching) (Box 9.9):

Box 9.9 "Scenic Information" and "Equal Attention"

When the patient enters the doctor's consulting room, he conveys to him a wealth of information of a verbal and non-verbal nature (consciously offered and unconsciously expressed). Not only what he says, but also how he says it, is significant; no less important is all that he conceals, what he does not speak of. Especially significant is everything he expresses involuntarily, what impression he makes, whether he is depressed, anxious, clinging, seducing or defensive, and what he "makes" of the doctor-patient relationship, in short, what "scenic information" he conveys. The doctor allows all this information, which runs through very different channels and emanates from different areas of the patient's personality and organism, to have an effect on him - Freud (1912) spoke of "equally suspended attention" - and initially also reacts quite involuntarily with a certain "affective resonance". He experiences sympathy, interest, helpfulness, but perhaps also antipathy, anger and helplessness - to mention just a few of his emotional reactions (...) The patient receives the information coming to him from the doctor through various verbal and non-verbal channels and reacts to it either with trust or with mistrust and fear. He will behave accordingly and give further information or withhold it. This is how the specific communication process between doctor and patient is formed, which we would like to call the diagnostic-therapeutic circle, because the diagnostic and therapeutic efforts of the doctor are almost inextricably linked from the beginning. Experienced doctors have therefore rightly pointed out time and again that the treatment of the patient already begins with the first welcoming handshake and that the diagnostic process is never completely finished as long as doctor and patient deal with each other. Finally, one must not forget that every reac-

> tion of the patient to the doctor's therapeutic interventions will give the doctor further insights into the patient's psychophysical pathodynamics, i.e. will expand the diagnostic insight, just as conversely every diagnostic intervention has positive or negative therapeutic consequences.
>
> v. Uexküll, Wesiack 1991: 291f

As in this excerpt, Uexküll, Wesiack also emphasise in many other places of their "Theory of Human Medicine" the necessity of a *therapeutic-diagnostic* circle, which in principle is never completed. Even if this process begins with the first greeting, in which the relationship is established (§ 18), it is seldom completed with the first consultation, but extends, especially in *primary care* (§ 15, 25), over long periods of time, in which the alternation of *communicative* and *instrumental* action (surgery, medication) must prove itself (§ 8), so that sustainable *adherence* to therapy (§ 26) can be expected in joint decision-making (§ 10).

On these long journeys, "disturbances" in communication can occur again and again, which not only manifest themselves in *non-adherence* or even in patients staying away for good and changing doctors, but in many conversation situations are initiated and announced beforehand, which should not escape the attentive doctor. The dissatisfaction of patients and their insecurities, doubts, disappointments, reservations, objections, resistance, etc., which manifest themselves in communication, should be noticed in good time and taken into account in communication.[7]

Thus the doctor should also sharpen his perceptions for *non-verbal* interaction (§ 12), in which the "attitudes" of patients can already become clearly "visible" (through gaze behaviour, posture, facial expressions, gestures, etc.) or also "audible" (through tone of voice). As part of *scenic understanding,* this should not escape the attention of the doctor conducting the conversation, just as it should not be missed by "beating around the bush" when verbally formulating concerns, where the information "between the lines" should not be "overheard". This applies, of course, in communicative dealings with patients with *depression* (§ 30)

7 The extent to which the patient's emotions (but also one's own) can or should be made an issue in communication requires a special, *empathic competence* with which, depending on the state of relationship and conversation development, a decision must be made about what is still "reasonable" for this individual patient and, for example, a choice must be made between a more *confrontational* or more *tangential* conduct of the conversation (§ 3, 17, 20, 21).

or *anxiety disorders* (§ 30), who often try to "conceal" their "feelings", but also with the so-called "difficult" patients (§ 34), with whom, for example, "hidden" aggression should be noticed in good time, before it is "too late" for a good relationship development.

The best precaution against setbacks in the doctor-patient relationship, however, remains the taking of anamnesis, which, although hardly complete (§ 21.6), should be conducted so *openly* (7.5) that the patient's problems and concerns, i.e. also their needs, worries, fears, hopes, etc., are adequately *expressed in their own words.* This is best achieved in "free speech", in which the patient has his or her *say*. For this purpose, the necessary conditions for conversation must be created, under which the patient can make use of a specific privilege of speech, at least temporarily, as is similarly granted in psychotherapy. Although long-term psychotherapy cannot be provided in the medical consultation even in the case of basic psychosomatic care (§ 15, 25, 42), moderate applications of the basic rule of *association* can also be used for cooperation between doctor and patient.

9.3 Cooperation and association

In order to create the necessary framework conditions for the patient to speak as "freely" as possible, borrowings can be made from psychotherapy, in which *letting people tell stories* has a long tradition. However, the basic psychoanalytical rule of stimulating patients to make extensive *associations* should be moderately applied in medical conversation practice, where *cooperation* and *association* do not form a contradiction but a unity.

9.3.1 The basic psychoanalytical rule

The problems of cooperation between doctor and patient were already anticipated by Freud early on, at least for the psychoanalytical conversation, and they can be generalised to a certain extent for the medical consultation. In his "Advice to the Physician", Freud (1913) at the same time makes recommendations for the communicative behaviour of patients who might obviously find it difficult - as Freud literally puts it (Box 9.10) - to deviate from an "ordinary conversation":

Box 9.10 Basic psychoanalytical rule

One more thing before you begin. Your narrative should differ from an ordinary conversation in one respect. Whereas otherwise you rightly try to hold on to the thread of the context in your presentation and reject all disturbing ideas and secondary thoughts so as not to get, as they say, out of the hundredth into the thousandth, here you should proceed differently (...) You will be tempted to say to yourself: This or that does not belong here, or it is quite unimportant, or it is nonsensical, therefore it need not be said: Never give in to this criticism and say it anyway (...) So say everything that crosses your mind.

Freud 1913/1970: 194

What is more or less action-guiding in everyday communication is apparently to be negated in psychoanalytic conversation. The Freudian distinctions "from an ordinary conversation" read six decades before Grice (1975/1979) like an early *anti-maxims catalogue*, with which the validity of the everyday rules of communication is precisely to be invalidated: Although the maxims, even after Grice, are not always separable in detail (§ 7.3.3), in retrospect they can easily be assigned to Freud's formulations of psychoanalytic basic rule communication, as this can be contrasted in a tabular overview (Tab. 9.3).

Freud (1913)	Grice (1975)
Whereas otherwise you rightly try to hold the thread of the connection in your presentation,	Be relevant; Be orderly
and reject all disturbing ideas and secondary thoughts,	Be orderly
in order to avoid, as they say, going from the hundredth to the thousandth, you should proceed differently here (...)	Avoid overinformativeness
You will be tempted to say to yourself: this or that does not belong here, or it is quite unimportant (...)	Be relevant
Never give in to this criticism (...) So say everything that crosses your mind.	Make your contribution to the conversation as required by the accepted purpose (...).

Tab.9.3: Comparison of the conversational maxims of Freud (1913) and Grice (1975)

It is no coincidence that Freud addresses the patient directly with his specially formulated basic rule message, which is condensed into a general maxim ("So say everything that crosses your mind") and passes on this "ideal" model formulation of the message as a recommendation to the attending physician.[8] Obviously Freud has assumed here a correspondingly strong validity of everyday rules of communication when he makes these everyday rules so explicitly the subject and appeals to the patient's willingness to negate in such an insistent way: "Never give in to this criticism and say it anyway" (Box 9.10). This strong resistance of patients to an override of socialised everyday rules of communication can not only be anticipated, but it can be demonstrated in detail in empirical conversation analyses (Koerfer, Neumann 1982). Patients often subject the conversation with the doctor to a *critical acceptance test* and try to restore the rules of communication or maxims of conversation they are used to in everyday life.

9.3.2 The problem of acceptance

The psychoanalytic conversation is an excellent "object of study" from which the validity of everyday rules of communication can be inferred in comparative conversation analyses of related and different types of conversation. An extreme communication situation does not have to be artificially created (in the sense of Garfinkel's *crisis experiments*), but is found as a quasi *natural design in* a concrete conversational practice (Koerfer 2013: 180ff, 242ff). This conversational practice goes back to a

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8 In the practice of conversation, there are of course spontaneous formulation variants of doctors and therapists which are placed appropriately to the development of the conversation and renewed if necessary (Koerfer, Neumann 1982). With regard to the practical application of the psychoanalytical basic rule in the ongoing conversation, reference is made in advance to an empirical example (§ 20.9), in which the patient is to be stimulated to broach the subject of his relationship with his mother, to which he initially reacts with a downgrading of relevance. - The effect of the *psychoanalytic basic rule* unfolds in a "classical" psychoanalysis naturally in interaction with the *abstinence rule* for the analyst (Koerfer, Neumann 1982), the abolition or "loosening" of which is a prerequisite for the unity of cooperation and association in the doctor's consultation, which will be perspectivised below.

tradition of over 100 years in which (not only psychoanalytic) psychotherapies were first reflected and analysed in case reports and later on the basis of audio recordings (e.g. Rogers 1942) (§ 40.2). It is a particular merit of the *Ulm research project* (§ 2.2) (Kächele et al. 1973, 2006, Kächele 2016) to have made psychoanalytic conversations available in the form of a database for empirical conversation analyses, from which linguistic studies (Flader et al. (eds.) 1982) could also benefit.

The patients' problem of accepting and then practising the basic psychoanalytical rule, which is initially "unfamiliar" from their participant perspective, in the practice of conversation can only be illustrated here in rudimentary form. In order to clarify the context of the following examples, Menninger and Holzman's (1977) expert perspective (Box 9.11) professional assessment of the double effect that the "privilege" provided in the psychoanalytic setting can have on patients should be prefaced:

Box 9.11	Effects of the privilege granted: satisfaction and frustration
If a person seeking therapeutic help is allowed the privilege of telling a listener, who refrains from excessive or discouraging insinuations, everything he thinks, he will feel two things at the same time, a certain satisfaction and also a growing frustration.	

Menninger, Holzman 1977: 57

Thus, at the beginning of therapy, patients already enjoy this "privilege" by narrating in a more or less *monologue-like manner,* thus following the basic psychoanalytic rule. In the following example (E 9.1) (from Koerfer, Neuman 1982: 110) the specific listening role of the analyst in the whole setting - as here by a patient in the 4th therapy hour - is then judged *expressis verbis* as "positive".

E 9.1		"positive that there is one person to whom I can tell everything"
01	P2	(...) what I feel . is positive, that there really is a person to whom I can tell everything . or who willy-nilly has to listen and who must not scold me if I say something stupid .

However, the "growing frustrations" expected according to Menninger, Holzman (1977) do not remain absent, especially because the patients

begin to miss the corresponding reactions of their interlocutors after their initial narratives. Thus the same patient, who had just in the 4th hour of therapy still positively assessed the listening role exercised by the analyst, already in the 11th hour complains about the *quasi-monological* structure of a *one-way communication* (E 9.2) (from: Koerfer, Neumann 1982: 111), which she aptly characterises from her experiential perspective with a metaphorical expression ("pneumatic post").

E 9.2		"I can't even get a reply to my pneumatic post"
01	P2	(...) and if I say something . then maybe it goes to you by pneumatic post . in writing maybe . but then I'm not there, and I can never know, and I can never find out what you're thinking at that moment when I say something to you, I don't even get an answer to my pneumatic post.

Of the numerous examples of reflexive acceptance testing and "resistant" application of the psychoanalytical basic rule, a few examples (E 9.3-7) (from: Koerfer, Neumann 1982: 112ff) will be cited here as exemplary excerpts from various therapies. The examples all come from the first 12 therapy sessions, because special problems of *socialisation* were to be expected in the early stages. As expected, the learning process then manifested itself in many *meta-comments* on the "unfamiliar" type of conversation experienced in this way.

E 9.3		"I could try to draw you into the conversation"
01	P4	(...) I could try to draw you into the conversation, but you wouldn't get involved at all ... probably.

E 9.4		"I don't ask a question where I can't get an answer to"
01	P3	(...) yes, precisely because this question that you have raised,/ it is actually,/ because it is not the answer that matters, but because I am interested in the background of the question.
02	P3	It depends on the answer, otherwise I wouldn't have asked . I don't ask a question where I can't get an answer . and it really is a terse question . I don't understand why you have to talk about it so much.

E 9.5		"that everything I tell is basically irrelevant"
01	P4	(...) I have the feeling that everything I tell is basically irrelevant, nech . [=right?]

E 9.6		"other thoughts started, which were completely unimportant"
01	D3	you are silent (...) perhaps you yourself also know something of the background . if you then take a break ... for example now ....
02	P3	yes, I couldn't think of anything more to say about the topic in question, and then there was silence about this . silence of thought/and then some other thoughts started, which were completely unimportant and actually have nothing to do with the whole thing.

E 9.7		"my thoughts are actually quite disorganised"
01	P1	yeah, I don't know, so my thoughts are actually quite disorganised .
02	D1	It doesn't matter, you can share them in an unorganised way.

Without being able to further differentiate the various metacommunicative aspects here (Koerfer, Neumann 1982), the acceptance problems of the patients in the psychoanalytical conversation can be recognised from the few examples, which deviates considerably from an "ordinary conversation" precisely in the above sense of Freud (Box 9.10).

While the patient in example (E 9.4) still insists on his right to ask questions and more or less indignantly demands the answer of his interlocutor in the sense of a normal expectation, the patient in example (E 9.3) already seems to be able to come to terms with the non-responsiveness of the analyst, even if he clearly expresses his preference and resignation. In examples (E 9.5) and (E 9.6), the patients each in their own way doubt the relevance (*Be relevant*) of their contributions, which they have to decide on themselves without communicative agreement with their therapist.

The more or less explicit attempts of the patients to restore what they see as the disturbed "normality" of conversations are more or less

"undermined" by the analysts - if they react at all - in that they in turn seek to "invalidate" the arguments presented by indirect references to the basic psychoanalytical rule. Thus, in example (E 9.7), the analyst "defuses" the patient's problem that his thoughts are "disordered" with the recommendation that these thoughts simply be communicated "disordered". With this instruction, the commitment to the basic rule, which is at the same time a violation of the everyday rule (*be orderly*), is renewed in the ongoing conversation with a minimal dialogical response on a meta-level, with the success that the patient temporarily takes over the conversation work again in the intended "manner" – before he later takes a new meta-communicative attempt to restore the "normality" he is used to from everyday life.

Overall, the patients' criticism of the conversation often culminates in the "lack of structure" and "lack of plan" in psychotherapy conversations, which they ultimately attribute to a *lack of cooperativeness* on the part of the doctor.[9] Especially at the beginning of the conversation, the doctor may hold back on *material* cooperation by hardly giving any feedback on the content, but initially limits himself to *formal* cooperation (in the sense of Ehlich 1987), in which the patient merely finds an attentive listener (Koerfer, Neumann 1982, Koerfer, Köhle 2009, Köhle, Koerfer 2017).

In forms of more or less *active listening,* the patient's *associative narrative flow* is merely kept going and promoted by sparing forms of securing understanding and listening feedback (*yes, hm, aha, ah, oh* etc.) (§ 19). Such conversation phases of merely *formal* cooperation, which can even extend over several therapy hours, may be experienced by a patient as critical because, contrary to his everyday expectations, he is initially essentially left to his own devices in the further development of the conversation: He alone is responsible for the choice of topics, which, in the absence of *material* cooperation by his interlocutor, he must make, as it were, on his own, without being able to assume an "accepted purpose" or even a "mutually accepted direction" (in the sense of Grice 1975/1979) (§ 7.3.3, Tab. 9.3).

For the time being, the patient is left to his own devices in his *associations*, whereby he will only realise the reason for following the psychoanalytic "prescription" later, even according to Freud: "The reason

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9 Once again, the interaction of the basic rule and the abstinence rule should be pointed out here, which should be abolished or at least "relaxed" in favour of cooperation between doctor and patient.

for this prescription - actually the only one - that you are supposed to follow, you will learn later and learn to see" (1913/70: 194). This is the *credit* that the patient must first give to the psychoanalytic conversation in a "wait-and-see" perspective before he can comprehend the meaningfulness of the new conversational order through further conversational experiences and restore the *imaginative unity of conversational order* and *conversational utility.*

9.3.3 Moderate application practice

Conversational maxims are essentially linked to the overall conversational benefit to be achieved. What is meaningful and effective in psychotherapy (Thomä, Kächele 1989, Kächele et al. 2006, Shedler 2010) can be disruptive and unproductive in other contexts. In this context, there are rarely categorical validities of conversational maxims. First of all, not all conversational maxims apply in the same way to all (types of) conversations. Associative thinking and talking is also permitted and even desired in other types of conversations, even if the duration and extent may be regulated more restrictively, so that unrestricted association would cause *alienation* in other contexts.

Tell everything that crosses your mind?

A first traditional but not unproblematic distinction is that between *everyday* and *institutional* communication (Koerfer 2013). A conversation with our neighbour, with whom we chat more or less associatively over the garden fence with constantly changing topics (*plants, weather, holidays, health,* etc.), is something different from the communication of judges and defendants over the "court barriers", and court communication in turn is something different from communication at school or university.

Even in an academic context, *associative* thinking ("brain storming") may occasionally be useful, if it is not too personally coloured. Likewise, in the pedagogical context, "casual" or "playful" learning can be more successful than highly structured learning (e.g. through lectures) (e.g. Oerter 1997). Thus, we ourselves have tried to combine and integrate traditional with problem-oriented and playful forms of learning in the

teaching at our clinic (Koerfer et al. 1999, 2008), which we will report on in more detail (§ 13, 14) in the didactics of medical conversation.

However, it is equally clear that if one were to apply the basic psychoanalytical rule in other contexts, one would quickly come up against limits of acceptance: Where would we end up if people said everything that crossed their mind in court or in a seminar? We would be flooded with irrelevant information and would try to stop any interlocutor who wanted to use the psychoanalytic association rule in these contexts. Perhaps we would consider him to be a "confused person" whom we would listen to tolerantly but with "awkward" silence until he (hopefully) soon came to the "good end". Our motive of tolerant listening may be due to "politeness", but we would not really be able to take our interlocutor seriously (e.g. in a seminar) if he allowed himself to be led from one association to another.

But what can apply specifically to doctor-patient communication? Although, for example, GP communication with the patient is not a psychoanalytic therapy, the following will argue for a moderate application of the association rule also for everyday care practice (with the GP, internist, dermatologist, etc.). However, with Morgan and Engel, the general conflict of maxims must be taken into account (Box 9.12): as a doctor, it is necessary to move appropriately between the two objectives of the conversation, to promote the patient's associations without neglecting the guidance of the anamnesis:

Box 9.12 "Spontaneous" associations and "gentle" steering

[The doctor] must encourage the patient to speak freely, because only the patient can tell him what he has experienced. But the patient often does not know what information the doctor needs. Therefore, the doctor carefully guides the course of the anamnesis (...) *The two goals - to encourage the patient's spontaneous associations and to guide the anamnesis - are achieved when the doctor begins each new topic with open (non-directed) questions, followed by increasingly more specific (directed) questions until the topic is clarified.*

Morgan, Engel 1969/77: 41, emphasis (italics) in original

This conflict of maxims between *association* on the part of the patient and *guidance by the doctor* (§ 17.4), which will occupy us permanently and with examples, can therefore be "solved" in principle by understanding the supposed problem of rank as a problem of sequence. First,

the patient should always "have the floor" and be allowed to follow his own association and relevance criteria without manipulation, before the doctor intervenes in a structuring way. According to this sequence, both partners can benefit equally from their primary dialogue roles as speaker and listener, at least in the initial phases of conversations or topics, in the sense of Morgan and Engel's first maxim ("The doctor must encourage the patient to speak freely, because only the patient can tell him what he has experienced"). As becomes clear again here, the *patient* narrative is a predestined form of conveying and gaining information. This narrative form of communication allows the narrator to integrate his flow of associations and stories into the conversation before the doctor begins to "gently guide" the conversation.

Promoting the specific form of communication of *(free) narrative* has become part of the "gold standard" of a so-called "narrative medicine" (§ 9.1), which could be formulated as a *super maxim* for the medical conversation as follows: A "good" conversation should be conducted by the doctor as everyday as possible and as professionally as necessary. In this context, the very first task of the doctor is to let the patient have his or her say in detail and to gradually "draw him or her into a conversation" and then to promote and direct this in such a way that both conversation partners come into "their" own.

As everyday as possible, as professional as necessary!

Even if the patient should be granted a special right to speak "freely" in conversation with the doctor, this *privilege of speaking* must not result in any compulsion to exercise this privilege in a certain way and, above all, ad infinitum. The application of the association rule should be understood moderately by the patient and not as an *imperative* to which there would be no alternative forms of conversation. The doctor's invitations to talk can be accepted by the patient by making the subject of what "moves" him or her, but can also be refused if - for whatever reason - he or she still wants to "hold back".

Although queries or follow-up questions may also be necessary and useful for professional reasons, the doctor should not insist "at all costs" by asking further questions, but should "leave it at that" for the time being. It is no coincidence that Morgan and Engel (1977) warn against the extreme that a doctor-patient conversation could take on the form of "cross-examination" (§ 3.4.1: maxim no. 4). On the other

hand, the other extreme should also be avoided, according to which the conversation could proceed completely "unstructured", with the counterproductive consequence that a patient would be left "powerless" to his or her "associations" without medical assistance and structuring performance on his or her part.

Even in psychoanalytic therapy, there is now a plea not for a strict but for a moderate application of the association rule, according to which even the psychotherapy session should not stray too far from the everyday rules of communication. Following the discourse linguistic research on the Ulm conversation corpus mentioned above (§ 2), Thomä, Kächele (1989) in their "Textbook of Psychoanalytic Therapy" established the general maxim of staying as close as possible to everyday communication with the patient in psychotherapy and deviating from it only as far as professionally necessary. This "philosophy" was summarised by Kächele et al. (2006) (Box 9.13) in review of their psychotherapeutic theory and practice as follows:

Box 9.13 "Philosophy" of psychoanalytic therapy

Systematic investigations on the special conversational nature of psychoanalytic technique have been made using materials from the Ulm specimen case. Koerfer and Neumann (1982) focused on the patient's sometimes painful transition from everyday discourse to psychoanalytic discourse. These and other findings from that field of discourse analysis support the topical formulation of our 'philosophy' of psychoanalytic therapy: provide as much everyday talk as necessary to meet the patient's safety needs, and provide as much psychoanalytic discourse as feasible to stimulate the exploration of unconscious meanings in intrapsychic and interpersonal dimensions.

Kächele et al. 2006: 821

What is right as a "philosophy" for psychoanalytic therapy should be more or less cheap for medical consultations and rounds. Although the similarities and differences are to be considered in detail in the following chapters, some aspects of a comparative analysis should be named in advance. After all, it is not only a question of a general medical philosophy of conversation, but its application in the practice of conversation, for example, under the concrete questions: Which of the two interlocutors

- speaks or keeps silent
- takes or leaves the floor
- withdraws, prevents or refuses to speak
- in which conversation role
- at what time
- on which topic
- for what purpose
- with what (more or less) intended effect?

Many variations are conceivable, e.g. when the doctor or therapist, after finishing his speech, asks himself why the patient 'shrouds himself in silence', which the doctor or therapist in turn may experience as an 'eloquent silence' that could prompt him to speak again with a specific content, etc., which he seems more or less obliged to do qua professional role as doctor or therapist, etc.[10] Already the question of how to deal with silence *('Whose break is it and who has to overcome it?'*) points to elementary differences in the types of conversation: Here the different participation roles of the interlocutors come into play simply because of the time available, which in psychoanalytic psychotherapy usually lasts (almost) a whole hour, while a doctor's consultation usually ranges between 5-15 minutes or perhaps reaches 20 minutes as an initial conversation (§ 25.6). Accordingly, the time budget already has an impact on the way of *talking to each other*. Thus a patient in psychoanalytic therapy can quickly learn that "the whole hour is made available to him" (B 9.8) (from: Koerfer, Neumann 1982: 113) even if this initially seems "astonishing".

B 9.8		"that I can almost do what I want with the hour"
01	P	(...) that is for me/and above all it was very astonishing for me eh . to see that the whole hour is just put at my disposal, that I can do what I want with it . hm . that I am just ... proactive and/ or tell something or whether I tell nothing or whether I tell hm/what I tell . that it is pretty much up to me how and what and how long . and that I can do with the hour . almost what I want .

10 Silence can have both negative and positive effects, for example when it is used for reflection. On specific forms and functions of silence in psychotherapy, see Koerfer, Neumann 1982, Knol et al. 2020, Dimitrijević A, Buchholz (eds.) (2021), Buchholz et al. 2022.

While such a psychotherapeutic consultation, in which the therapist as an attentive listener occasionally - if at all - speaks up with sparse listener feedback (§ 19.3), can initially lie predominantly in the responsibility of the patient, the course of a medical consultation (with the family doctor, internist, dermatologist, orthopaedist, etc.) lies essentially in the overall responsibility of the doctor conducting the consultation. However, the doctor should conduct the conversation in such a way that the patient can still *have his or her say* within a limited time, before the doctor asks his or her typical *doctor's questions*, in order to participate in his or her own way in the *art of filling in gaps* in the detailed exploration and completion of the anamnesis (§ 21). The necessary balance between *narration* and *interrogation*, which we will return to in a moment (§ 9.4), will be an ongoing topic in this handbook, which is to be concretised in the empirical conversation analyses (§ 19, 20, 21, 24, 25) with the help of examples. [11]

Narration between interrogation and association

In an interim conclusion, it can be stated as a consequence for medical conversation practice: Instead of being determined by *association without cooperation,* medical conversation should be determined by *cooperation with association.* The *narrative* type of conversation occupies a middle position between the *interrogative* type of conversation, as it prevails in the traditional taking of medical history (§ 9.5, 19.6), and an *associative* type of conversation, as it has shaped "classical" psychotherapy. In the medical consultation, the patient may and should tell as much as possible, but his narratives do not remain unanswered at first, as in "classical" psychoanalysis, but receive empathic feedback in due course (§ 20), which can also be immediately followed by *concept-based interpretations,* which in turn can be further processed in a cooperative conversation work by both conversation partners.

The joint interpretive work can in turn lead to new patient narratives, which then again become the subject of interpretive work at a

11 With reference to the structures and functions of narratives developed above (§ 9.2), it should be emphasised once again that it is not the narratives themselves that are told associatively, but that the associations refer to themes and stories that patients can "think of" more or less spontaneously during the ongoing conversation because they "remember" them at the appropriate moment during the anamnesis (§ 9.1).

higher level of abstraction, etc. This circular process of cooperation in narrative and interpretation will be reconstructed in detail in empirical conversation analyses (§ 19-21). Before this, the opportunities and problems in promoting "free" *patient talk* will be described, which the patient can use for "free" *narration* if possible.

9.4 Promotion of free patient speech

The need to promote *free patient speech*, which can be used for *free narration, has* already been justified several times in advance with reference to the "classics". Here we should again recall one of Freud's "Advices to the Physician" (1913/77) (Box 9.14), which should apply not only to the psychoanalytic therapy session but to every medical consultation, even if the time frame is certainly more limited.

Box 9.14	Let the patient tell the story

Overall, it does not matter with which material one begins the treatment, whether with the patient's life story, the history of his illness or his childhood memories. In any case, let the patient tell the story and let him choose the starting point.

Freud (1913/1977: 197)

As discussed above, such a conversational maxim of *letting the* patient *tell the story,* especially at the beginning, can be generalised not only for therapeutic but in a moderate form for medical communication as a whole (§ 9.3). With all the differences between a more "psychotherapeutic" and a more "medical" communication, which should more or less converge anyway in *basic psychosomatic care* (§ 15, 25), the principle of *association should be* followed to a greater or lesser extent in medical conversation. The spontaneous *flow of thoughts of* patients should be expressed as a *narrative flow* as unhindered as possible in appropriate forms of communication before it can be "steered into certain channels" in the joint conversation work of doctor and patient, for which not least the professional competence of the doctor is required.

The *principle of association,* which is essentially linked to free patient narratives, owes its origins to the psychoanalytic tradition (Thomä, Kächele 1989, Heenen-Wolff 2014), which goes back to Freud's *basic rule formulation* (§ 9.3). In the meantime, however, the principle has become established in medical communication (in the broad sense), albeit certainly in the weaker variant of a *biographical narrative* anamnesis, with which a biopsychosocial care approach (§ 4) is pursued.

Balint (1964) already assumed the primacy of *listening to the doctor* over traditional medical *questioning* (§ 9.5), whereby not alternative but *complementary* forms of interaction are to be assumed, which can meaningfully complement each other at the "given time". Correspondingly, Morgan and Engel (1969) have also decisively advocated the promotion of the patient's *spontaneous associations* in medical conversation, which should allow a free development of topics before the doctor can sensibly perceive a stronger *steering* of the conversation on this basis (§ 17.4), in order to finally close the gaps in the collection of anamnesis (§ 21.6), which the patient - for whatever reason - has left.

Between mere listener feedback (*yes, hm*) (§ 19.3) and targeted detailed questions (*where, when, how often* and *how strongly* etc.) (§ 21.4), a wide spectrum of *verbal* and *non-verbal* interventions opens up, with which conversation developments can be "conditioned" in quite different directions, in which free patient speech is either *promoted* or *prevented.* These positive and negative functions of verbal and non-verbal *conditioning* in medical conversation will be further elaborated below and then illustrated along the *Cologne Manual of Medical Communication* (C-MMC) (§ 17-23) with empirical cases that can be used as more or less successful, but also as best examples (*best practice)* (§ 13.4) for teaching practice.

9.4.1 Verbal and non-verbal conditioning

The doctor's communicative competence is also to be used in the medical consultation and ward round depending on the anticipated conversational experience and conversational behaviour of the patient, which can itself be subject to change in the interplay of interactions. As will be shown by individual phenomena, doctor and patient are subject to reciprocal verbal and non-verbal *conditioning,* as is also the case in everyday conversations. Thus, in our everyday communication we can usual-

ly assume that *questions* will also be *answered* or that *greetings* will be *returned* accordingly, etc.

These examples, like the answering of questions, have been described in *conversation analysis* under the aspect of the *conditional relevance of* utterances as prototypes of speech action sequences, i.e. as a sequence of adjacency pairs of different speakers structured in such a way that after the first utterance the second can be expected:

Box 9.15 Conditional relevance
By conditional relevance of one item on another we mean: given the first, the second is expectable.

Schegloff 1968/72: 388

In this sense of *expectability,* there is often talk of *everyday conventions,* the violation of which apparently disappoints average expectations. Thus, we are irritated in the short term to permanently frustrated when the answers to our questions do not come or our friendly greetings are not returned, and so on. The validity of conventions is expressed precisely by the fact that their violation is perceived more or less critically by the actors and their compliance is demanded more or less strongly.

However, despite all the expectability (of consequences) of our communicative actions, no communicative *determinism* should be assumed, but only the more or less strong *conventionality of communication* should be taken into account, which can be more or less pronounced even in institutionalised to ritualised communication situations (Luhmann 1983, Paul 1990, Koerfer 1994/2013, Ehlich 2020, 2022). Depending on the situation, it is quite possible to deviate from the general expectations, which, from the point of view of mostly lay people, takes "getting used to".

There are specific types of conversations in which the non-answering of questions is the normal case. This applies, for example, to psychoanalytic therapies (Koerfer, Neumann 1982, Pawelczyk 2011, Scarvaglieri 2013), in which questions (of a certain type) often remain unanswered because answering them would violate the (higher-ranking) *abstinence rule* of psychoanalysis, which the psychoanalytically working therapist/doctor is more or less obliged to observe.

As we will see, however, "violations" of general conventions can also be observed in other medical conversation situations. Thus, patient

questions often remain unanswered even when there are no "deeper" reasons against an appropriate answer, as is often the case in ward round communication (§ 24). Here, patients apparently have to "learn" in the ongoing interaction that their questions, which are often "overheard", are not "announced" and to that extent should be avoided. Ward round practice then unfortunately "teaches" patients in short conversation time to "comply" and "keep their mouths shut" instead of seeking dialogue with the doctors (§ 7), which first and foremost consists of appropriately granting the right to speak, which should entitle one to ask, tell, argue, etc.

9.4.2 Positive and negative conversation developments

Overall, the mutual *conditioning* between doctor and patient can lead to both *positive* and *negative* developments in the conversation. For one or the other direction, the first "switch" can already be "set" in the greeting situation (§ 18). A friendly *greeting* can be gratefully received and reciprocated, just as the open opening question (type 7: "Tell me about it") (§ 19.2) can be spontaneously used as an invitation to talk. The open *gaze* is "usually" perceived as attention and care with gratitude, just as the repeated invitation to talk is willingly accepted, even after initial hesitation. In this way, the good *listener* awakens the good *narrator*, whose narration he/she in turn keeps going with appropriate *listener signals* ("yes", "hm"), etc., as this will also become clear in examples (§ 18-20, 24-25).

However, in accordance with a *dialogical communication*, as is also the case between doctor and patient (§ 7), one should not assume the *communication determinism* already questioned above, according to which the intensive use of forms of active listening would automatically lead to patient narratives or the accumulation of empathic feedback would without further ado open up an emotional self-exploration of the patient. Communication, especially between doctor and patient, depends on such *complex* conditions (institutional, individual, situational, etc.) that medical conversation could not be organised according to a simple *if-then scheme.*

Thus, in the case of a specific defensive behaviour of a patient, a constant alternation between a more *tangential* and a more *confrontational* conduct of the conversation (§ 3, 17, 29, 32) must first be repeatedly tested before the first "successes" gradually begin to emerge in the

direction of an emotional self-exploration of the patient, which rarely enough can be "brought about" by a single key medical intervention.

Rather, we must assume a successive "conditioning" in which diagnostic-therapeutic "successes" only occur in the sum of medical activities that have to be carried out in painstaking "detail work" with the patient (Koerfer et al. 2000, 2005, 2010). In this sense, the "fruits" can often only be "harvested" long after the "seeds" have been sown.

Just as *positive conversational* developments, *negative conversational* developments can also be "conditioned" to a greater or lesser extent.[12] A doctor who constantly asks specific *detailed questions* because he considers this to be "more effective" than the patient's *free narrative* should not be surprised if he gradually falls into an *interrogative* style of conversation, which "conditions" the patient just as "effectively" in the direction of a question-answer pattern, from which soon none of the actors can escape. Once the spiral of questions and answers is set in motion, a reciprocal expectation is created that puts both actors under pressure.

Morgan and Engel (1977: 37, 42, 49) have repeatedly described this constraint on the behaviour of patients who, after an answer, wait in silence for the next doctor's question. We adopt here the vivid description of the problem (Box 9.16) that Morgan and Engel formulate here from the specific training perspective of students, but which they generalise at other points for the doctor's questioning behaviour, so that we may make the corresponding addition "[doctor]" here in brackets for the professional subject of the doctor's conversation.

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12 As will become clear in the following, we use the term *conditioning* in a broader sense that goes beyond the narrower concept of *conditional relevance* (of *American conversation analysis* (Schegloff 1968/72, cf. above Box 19.15).

Box 9.16 "Fruitless questions and answers"

The way the student [doctor] starts the anamnesis determines the patient's behaviour. If the student [doctor] asks for numerous details right at the beginning, the patient often just waits in silence for the next question and no longer tells anything spontaneously. In this way, the student [doctor] puts the whole burden on himself: he frantically thinks about what he should ask the patient next. Such an anamnesis often leads to a fruitless question and answer session. Students [doctors] who make this mistake often characterise their patients as uncooperative or closed. It is rather their way of taking an anamnesis that prevents the patient from expressing himself spontaneously.

Morgan, Engel (1977: 37), addition "[doctor]" by us

While the "self-charged burden" of finally having to ask questions may be difficult to bear individually for those conducting the conversation, the consequences of a purely *interrogative* conduct of the conversation are often fatal for the relationship between the two interlocutors: Not only do they lead to the described loss of the patient's *spontaneity* (he "no longer tells anything spontaneously"), but according to Morgan, Engel this lack is still wrongly attributed to the patient, who is characterised as "uncooperative" and "closed".

9.4.3 Balance between interrogation versus narration

The effects of this fatal confusion of cause and effect in the communicative action between doctor and patient were later (1997) summed up by George Engel in a plea for *narrative medicine* (§ 9.1), which we had already used as an introductory motto before the beginning of the chapter and would like to repeat here as a *guiding idea* for the empirical conversation analyses. In doing so, the quintessence ("*Interrogation* generates defensiveness; *narration* encourages intimacy") is to be placed here in the developed context (Box 9.17), in which Engel begins by reminding his readers of their own experiences with the specific type of medical history taking ("taking ..."):[13]

13 The supplementary mark "[sic]" is thus in the original. In the footnote omitted here in the quotation, Engel refers to the much-noted study by

Box 9.17 *interrogation* vs. *narration - defensiveness vs. intimacy*

Readers need only review their own experiences with doctors "taking" [sic] their histories to appreciate the difference between *encouraging narration* and *requiring reporting*. The latter approach is deliberately interrogative, the doctor assuming the initiative and agenda, the patient an object of study rather than an active participant in his/her own study. Eighteen seconds has been reported to be the mean length of time to elapse before doctors interrupt the patient's first response (...) Small wonder patients complain that doctors don't listen. *Interrogation* generates defensiveness; *narration* encourages intimacy.

Engel 1997: 526 (emphasis and "[sic]" so in the original).

In this conception of *conditioning,* which is described here by related terms (*generates*, *encourages*), the conversationalists, by choosing between a (primarily) *interrogative* and (primarily) *narrative conversational* style, bear the main responsibility for negative as well as positive conversational developments, which can amount to two alternatives (*defensiveness* vs. *intimacy*). For the empirical conversation analyses, it should ideally be demonstrated in each case how these alternative conversational developments came about from case to case, i.e. under which conditions and for which topics and purposes with which participation roles (*object* vs. *active participant*) of the respective conversation partners. The alternative participation roles of the patient as *subject* and *object* had already been described in advance (§ 1, 9.2) with Engel's justification of a *dialogical* communication between doctor and patient, which is derived not least from the functions of a *biopsychosocial* medicine (§ 4), which directs its topic and treatment focus not only to the body, but also to the illness of the patient as subject.

However, not only strict alternatives, but also dominances, tendencies or mixed forms must be taken into account in empirical conversational analysis. Although empirical cases of a purely *interrogative conversational* style can certainly be demonstrated (§ 19.6), mixed forms in conversations are to be expected, in which certain conversational styles can also "predominate" in phases. As in the preceding section (§ 8), the

Beckman, Frankel (1984) on early interruptions in patient speech (after 18s. on average). We will return to this and later studies on the problem of interruption later (§ 19.3).

structuring of the conversation (§ 10, 17) is used to work out the various *focal points* (taking anamnesis, clarification, decision-making, etc.) of initial and follow-up conversations, in the development of which the interlocutors are involved with varying degrees of interactional roles.

Furthermore, "intimacy" and "defence" in communication are often "fleeting" phenomena that can develop a "momentum of their own" that is "conditioned" to a greater or lesser extent by the way the doctor conducts the conversation. Thus, "intimacy" may have been established only temporarily and then be lost again because the doctor has "gambled" it away again in the further interaction with the patient, for example by recognisably "ignoring" an emotion (*shame, fear*) revealed by the patient, or at least by demonstrably not taking it up again in conversation, etc. Because the doctor has *downgraded the relevance* by abruptly changing the topic (§ 17.4, 19.4), the patient may have been "discouraged" (in the "negative" sense of Engel 1997) (Box 9.17) and therefore resign instead of taking up a new topic initiative.

Patients' "resistance" can also come and go as a "fleeting" phenomenon and be more or less pronounced, for example, when dealing with "sensitive" topics (*addiction, violence*, *sexuality*, etc.) (§ 20, 21), which, in addition to standard reactions ("fear of contact"), can also lead to individually pronounced reactions (of *denial*, *rationalisation*, etc.). Such reactions on the part of the patient may be primarily due to the "sensitive" topic itself and less to the way the doctor conducts the conversation. In other words: Not every *defensive behaviour* has to be "conditioned" by an *interrogative* style of conversation.

All in all, medical-therapeutic communication is to be understood as a *multidimensional process* that cannot be analysed *monocausally.* Repeated invitations by doctors to tell stories can just as often be turned down by patients who may turn out to be "difficult" patients anyway (§ 34). Their refusal to tell about themselves in the sense of a *narrative self-interpretation* may have "deeper" reasons that cannot be revealed by repetitive invitations to tell, but only by cautious (follow-up) *questions* about their complaints and expectations (fears, hopes, preferences, etc.). Overall, the criticism of the interrogative style of conversation should not be exaggerated to the point that questions are frowned upon at all. Rather, the relationship between *interrogation* and *narration* should be seen as *complementary* overall, which remains a challenge in practice. As Platt and Gordon (2004) point out (Box 9.18), doctors will not be able to avoid the dilemma of choice ("doctor's inquiry" vs. "patient's narrative") in practice, but only to "work through" it.

Box 9.18 The "dilemma" of "balance" in conversation practice

Throughout the conversation there must be a balance between the doctor's inquiry and the patient's narrative. You can decide in the first few minutes of the interview how much guidance your patient needs to tell his story so it will be useful to you. But even if it gives you little biomedical information, telling his story is therapeutic to the patient. *The dialectic between our need to understand, sort, and recombine data and the patient's need to tell his story always creates tension in the interview.* We cannot avoid the dilemma; we can only work with it.

Platt, Gordan 2004: 39 (emphasis there)

These "tensions" between the two ways of conducting a conversation are not only to be endured in principle, but also to be decided on a case-by-case basis in one direction or the other in the practice of conversation. A *super-maximum* could apply here: In case of doubt, the patient's word should be given preference over the doctor's word. The specific functions of *targeted* questions, which are indispensable for *detailed exploration,* will have to be further differentiated later (§ 21). However, as long as patients can muster a sufficient willingness to talk as a willingness to tell, a certain priority should be given to medical *listening*, as will be further elaborated with Balint's critique of traditional anamnesis (§ 9.5) and further illustrated in empirical conversation analyses. This is in no way to advocate a dichotomy of *questioning* and *listening,* but rather to emphasise their unity in a *dialogical* communication (§ 7). Even patient narratives are not "self-propelling“, but must often be laboriously "*elicited*" by the doctor through appropriate *listening activities and* finally kept going and answered. In this process, the doctor performs a *midwifery function,* which is also expected of him by the patient.

9.5 The medical art of midwifery

As has already been made clear (§ 3, 8) and is to be further elaborated (§ 17, 21), doctors must have a *clinical-communicative double competence.* Only with a specific *clinical* competence, developed from the experience and treatment perspective vis-à-vis concrete disease patterns, do doctors understand how to ask the "right" questions at the "right" time

in a "right" form for this individual person with this individual disease for clinical reasons (sic) in order to explore the necessary details (§ 21). Initially, however, these detailed questions should be withheld, because it can also be justified on clinical grounds (sic) that it is initially "better" to listen to the patient and, given the current state of the conversation, to limit oneself to forms of *active listening* (§ 19), which can at the same time *promote* the patient narrative.

9.5.1 The professional listener privilege

Once the necessary trust between doctor and patient has been sufficiently established, the medical consultation often becomes an original setting for narratives that have never been told before in this or a similar way, which is occasionally also specifically emphasised by patients. The doctor thus becomes a *privileged* listener who is authorised as a witness to "unheard-of" events whose meaningfulness is called into question with a specific need for clarification. As the first "crown witness" for the medical listener privilege, we will call here the patient "Katharina", who told about her story of suffering after a chance encounter with the holiday guest Freud, from whom she learned that he was a "doctor". From this conversation, which we will reproduce in more detail later and recommend as a lesson in conversation management (§ 21.8), we will cite the reaction of Katharina (K 16) to Freud's invitation to tell her story (F 15) (E 9.9), who, as a patient, convincingly announces the medical listener's privilege before, after another invitation to tell her story from Freud (F 17), she continues to tell the story she has already begun in detail (K 18).

E 9.9		"You can tell a doctor anything".
13	F	If you don't know, I will tell you what I think gave you your fits. Once, two years ago, you saw or heard something that embarrassed you, something you would rather not have seen.
14	K	Oh yes, I caught the uncle with the girl, with Franziska, my cousin!
15	F	What's the story with the girl? Don't you want to tell me?
16	K	You can tell a doctor anything. So you know, my uncle, he was my aunt's husband, the one you saw there, used to have the inn on the **kogel with my aunt, now they're divorced, and it's my

		fault that they're divorced, because it came up through me that he's keeping it up with Franziska.
17	F	Yes, how did you come to the discovery??
18	K	It was like this. Two years ago, once ... [longer narrative]

Freud 1895/1952: 185ff

Although the conversation at that time (1895) was of course not yet "documented" with modern technology, but reconstructed from Freud's memory ("The conversation that now occurred between us, I give it as it impressed itself on my memory"), the authenticity of this statement by Katharina cannot be doubted. Her statement ("you can tell a doctor anything") is a self-disclosure of her experience of the meaningful function of a doctor's consultation and at the same time an *appeal* to the doctor's willingness to listen, to whom one is not only allowed to "tell everything" but also to *expect him to do so*. In empirical conversations from "our time", patients also emphasise the *listening privilege*, which they sometimes grant only to their doctor, in marked contrast to other potential trusted interlocutors (e.g. relatives, friends). For example, a patient apparently tells her "unheard" story for the first time in a doctor's consultation. In this example (E 9.10), some of the previously differentiated categories for the narrative analysis are already included in the comment column.

E 9.10		Dramatic narrative: "deadly bad" Exclusive story: "I never told my husband"	Comment
37	D	this dizziness, did it start when you found out about this diagnosis [= daughter has MS]? .	Detail exploration (time, condition) + narrative invitation
38	P	yes, I think so ... once I had something in my head at night, uh ... I never told my husband that, once I had something in my head at night, deadly bad ... I woke up ... I thought: "Oh dear, oh dear, what's wrong now?" ... once I got really sick in bed at night ... I fought it, always did everything at her house, took care of the household a bit . until it was no longer possible, no ...	Framing, theme Orientation Listener privilege Complication "unheard of Event" Direct speech Evaluation: Mastery *versus* failure, coda

Since we will come back to the pre- and post-history of the narrative itself and its functions and structures in a detailed analysis of the conversation (§ 19.7), we will only note here under the aspect of *listener privilege*: Following her (partly reworked) local and temporal *orientation* ("there was me once at night...", "once at night ...", "at night in bed"), the patient lets the doctor in on an "unheard-of event", the relevance of which she marks by the very fact that she specifically emphasises her previous secrecy towards her husband ("uh . I never told my husband that"). This is the implicit message of dramatic patient narratives: What must be withheld from relatives can certainly be entrusted to the doctor. The doctor, addressed in this way as a "privileged" listener, now becomes the first witness to the unheard-of event with which the patient confronts him in a linguistically dramatic form that allows him to participate, as it were, in a near-death experience ("deadly bad"), so that he is altogether transported into her threatening "inner world". At the same time, the patient directs an appeal to her doctor with her final evaluation, in which she depicts her resigned exhaustion ("until it doesn't work anymore, ne" [=right?]) with an "approval-seeking" *tag-question ("*ne"), which can again be characterised as an appeal for help in Brody's sense (above) ("My story is broken; can you help me fix it?", 1994: 85). However, before appropriate help can be offered in the face of a "broken" patient story, a doctor's competence is required, as described by Balint (1964) as the *art of listening,* which deviates considerably from the traditional *interrogative* scheme of taking an anamnesis.

9.5.2 The art of listening

Instead of constantly interrupting the patient with other questions and thus distracting him from his initiated topic, the patient's current *narrative flow* should first be *encouraged.* In this way, patients can "freely provide" information that is difficult or impossible to ask for, as Michael Balint (Box 9.19) so pointedly summarised in his well-known dictum criticising traditional anamnesis taking:

Box 9.19 The art of listening

According to our experience, if the doctor asks questions in the style of the usual anamnesis, he receives answers to his questions - but nothing more. If he wants to arrive at a deeper diagnosis, he must first learn to *listen* (...) The ability to listen is absolutely an art and requires an essential, albeit limited, *inner conversion of the doctor*. While the doctor discovers in himself the ability to listen to things in his patients that are hardly expressible because the patient is only vaguely aware of them, he begins to listen to this barely audible language in himself as well. During this process, he will soon realise that there are no direct, unapologetic questions that can bring to light what he wants to know.

Balint (1964/1988: 171), emphasis in original

This "art" of *listening*, as Balint called it, will be illustrated in detail with examples, against which counter-examples of the conversational practices of "listening away" and "overhearing" are to be contrasted, to which we will also return with Balint (§ 10.2, 17.4).[14]

To begin with, despite all the theoretical and practical differences, the common ground between a psychotherapeutic therapy hour and a GP consultation hour, in which *basic psychosomatic care* is provided (§ 15, 25), must be emphasised once again: In both cases, the doctor must have the *competence* to "listen to things that are hardly expressible because the patients are only nebulously aware of them". These "hardly pronounceable things" are a challenge for the professional listener both in the psychotherapy hour and in the medical consultation hour, which can only be mastered in the interplay of active listening and questioning.[15] It is in this interplay that the *art of medical communication* must

14 The "limited inner conversion of the doctor" addressed by Balint is certainly a necessary prerequisite for this competence, which is to be imparted precisely in corresponding further training courses (§ 15, 16, 42), the concepts of which have been stimulated above all by the so-called *Balint group work* itself (cf. e.g. Rosin 1989, Cataldo et al. 2005, Torppa et al. 2008, Tschuschke, Flatten 2017, Yang, Wang 2022).

15 From the long tradition of broader and narrower terms and concepts of "active listening" over a period of several decades, reference is made to Dickson et al. 1991, Dahmer, Dahmer 1992, Koerfer et al. 1996, Hugman 2009, Pawelczyk 2011, Martin et al. 2017, Rodat 2020, Collins 2022, Tustonja et al. 2024. Cf. § 19 and on specific empathic relevance upgrades § 20.

prove itself (§ 17, 21), which will be further concretised below as the *art of medical midwifery.*

9.5.3 The Socratic dialogue

The fact that the "hardly expressible things" can nevertheless be "brought up" with the help of a professional interlocutor has also been described as the "art of midwifery" (*Maieutic*),[16] as it has been handed down in *Socratic dialogue,* which essentially makes use of the technique of questioning, inquiring and questioning, the answers to which always trigger further questions, and so on. (Thomä, Kächele 1989, Hanke 1991, Richter 1991, Uexküll, Wesiack 1991, Begemann 2007, Koerfer et al. 2008, 2010, Deppermann 2009). A more or less critical application of *midwifery* has been advocated especially in *pedagogical* and *therapeutic-medical* fields of action, which are anyway characterised by *dialogical* forms of *understanding* and *communication* (§ 7). In these specific (types of) conversations, it is not only about *gaining (self-)knowledge*, but about individual *further development* of persons with the *pedagogical* or *therapeutic* objective that they, as *acting subjects,* can better *cope with the problems* they recognise as relevant in their everyday forms of life.

Occasionally, concerns are raised about negative uses of *Socratic dialogue* by the doctor, who might find himself exposed to temptations to "instruct" or "dominate" the patient. These concerns cannot be shared by Hans-Georg Gadamer, whose conception of conversation between doctor and patient has already been considered in advance in the justification of *dialogical communication* and *medicine* (§ 7), in his treatise on the connection between "treatment and conversation" (1993) (Box 9.20). Rather, Gadamer emphasises the gain from the *inner activity of the* patient, in whose "participation" the doctor himself must be interested, over against possible dangers.

16 A brief characterisation from the (German) Duden (Vol. 5) will suffice here: "*Mäeutik* [Greek]: the Socratic 'midwifery art', designation of the method of bringing up the important answers and insights slumbering in the partner but unconscious to him through skillful questioning". For the history of the term *metaphor* ("midwifery"), see Begemann (2007), and for theory and technique, the works of Hanke (1991) and Richter (1991).

Box 9.20 The "Socratic dialogue" between doctor and patient

So, it is the conversation that can be helpful in the tense situation between patient and doctor. But this conversation is actually only successful when it is almost exactly like what we know in other ways of living together, namely that one gets into a conversation that no one actually has, but that leads us all. In the end, this also remains true for this kind of conversation between the doctor and the patient. In the Socratic dialogue that Plato writes, Socrates seems to be leading the conversation. (The partner is hardly visible.) But there, too, it is so that through such a conversation the other is to be led to his own seeing. The aporia in which he is placed is such that he no longer knows the answer. But even the enumeration of the defining elements does not have the character of an instruction or an attempt to control, as if one now knows everything exactly. The conversation only puts the other person in a position to awaken his own inner activity, which the doctor calls "taking part", without confusing himself anew.

Gadamer 1993: 172

To "awaken" this "inner activity" of the patient and to win him to "participate" is and remains a challenge for the *art of medical communication* (§ 17). Of course, in the practice of conversation between patient and doctor, there may also be abusive applications that translate into "instruction" and "domination". Criticism, however, must then be directed against practical failures or misapplications of a model of conversation that is not to be rejected in principle simply because of empirical problem cases.[17] This always involves a critical comparison of possible alternatives that are realised to a greater or lesser extent in conversational practice.

As becomes clear in the justification of *dialogical communication and medicine* (§ 7, 10, 17, 19-21), the risk of "coercion" and "manipulation"

17 The criticism of Thomä and Kächele (1989, vol. 2: 285ff), who plead for a specifically "psychoanalytic maieutics" in demarcation from the Socratic "dialogue style", could certainly be followed in the empirical case if doctors or therapists could be "accused of manipulation" (286), because this manipulation could be proven accordingly in empirical conversations by the conversational behaviour (sic) (§ 21). Of course, even a specifically "psychoanalytic maieutics" would not be immune to such empirically based criticism, which could just as easily be subject to misapplication or misappointment.

is more likely to be seen where the opportunities for narrative self-interpretation and dialogical participation of the patient in decision-making are blocked, in favour of a purely *interrogative* and *directive* conduct of the conversation: Through *traditional questioning techniques* as well as *orders* and *prescriptions of* a *paternalistically* acting doctor, *questioning* about details is fundamentally placed above *listening* to the complaints, concerns and preferences of ill persons.

In Balint's sense (Box 9.19), their history of illness and suffering can hardly be *asked,* but can essentially only be *told.* Promoting this narrative process requires good listening as well as good (follow-up) questioning, which, however, must first turn to the "things that can hardly be said" (in Balint's sense above) before further unclear details can be made the subject of further questions in order to close the gaps (§ 21.6) that the patient may have left.

9.5.4 Medical help with verbalisation

The *art of medical conversation*, as it is to be differentiated in detail (§ 17), consists not only in merely "getting the patient to talk", which is often difficult enough, but in animating him to "tell" in such a way that he can turn his "innermost being outwards". In this communicative process of initial self-understanding, the doctor assumes the described function of a *midwife* by helping the patient to *verbalise* his/her suffering and distress, fears and expectations, which he/she harbours not least towards the doctor himself. Only through this *verbalisation* can doctor and patient build a shared knowledge and understanding, which is a very first prerequisite for the creation of a *shared reality* (Uexküll, Wesiack 1991, 2011) in which the best (self-)treatment options for the patient can be *negotiated in* the consensus of shared decision-making (§ 10).

In order to set the necessary processes of *(self-)reflection* in motion, it requires the appropriate *stimulation* by the professional helper, who must sufficiently "disturb" his or her interlocutor, i.e. should neither leave him or her "undisturbed" nor "destroy" him or her (§ 17.3). This is about the *limits of* what is "reasonable", which are to be *successively* expanded, especially in therapeutically oriented conversation (Koerfer 1994/2013: 276ff). Accordingly, the impositions of questions, enquiries and scrutinising should be dosed in the practice of conversation. The questions must not become too "intrusive", but must sufficiently

"stimulate" the interviewee to "challenge" him/her for new possibilities of (re)thinking and acting. These *limits of what is reasonable* are not to be fixed in advance, but are to be tested conversationally and, if necessary, readjusted, in accordance with the responding conversational behaviour of patients, who more or less clearly "audibly" reveal their limits, whereby the doctor's *listening competence* is more or less challenged, on which the *questioning competence* can in turn build, and so on.

This is where the *unity of questioning* and *listening* comes into play: good *questions* presuppose good *listening*, on the basis of which further good questions can be asked or must initially be held back until the boundaries are allowed to be "audibly" extended during the further *trial* of questioning and asking, and so on. Whether in certain conversations it is the asking or the listening that has made the beginning in each case is a question of *punctuation*, which according to Watzlawick et al. (1967) is already often idle (§ 7.4). Insofar as both forms of communication must go hand in hand, one should equally assume an *art* of listening *and* asking.

When evaluating the *fitting* of verbal and non-verbal interventions (§ 3.2, 17.2, 21.2, 21.6), different functions, forms and placements of asking and listening in the course of the conversation must be distinguished. As will be worked out in detail in the following empirical conversation analyses, questions can be used to "prevent" or "awaken" narratives, to change or deepen topics, to gain information or to "question" arguments more or less directly, etc.

With certain *question forms,* which still need to be differentiated (§ 21.2), response expectations can be expressed more or less explicitly, through which the response behaviour of the interlocutor is more or less "conditioned" (§ 9.4). Here the spectrum ranges from the more *open* forms of questions ("How did that come about?"), which can serve as invitations to tell stories, to the more *closed* or even *suggestive* forms of questions ("Appetite is normal, ne?" [=right?]), as they were used several times in one conversation (§ 21.2). Compared to an "unbiased" gathering of information (e.g. about eating behaviour), such *suggestive* questions are of course counterproductive from an evaluative point of view, which we will come back to in detail in the more *interrogative detailed exploration* (§ 21).

A special challenge is posed by *interpretations* in which, for example, the patient's emotions are also *verbalised* following patient narratives (§ 19.8, 20, 21.3). Whereas they were previously only conveyed in indirect

cues, they now have to be expressed *in* the joint interpretation work. Here too, the doctor in his midwifery function should take into account that medical *authority is* always weighed in the balance when accepting interpretations. To avoid the risk of *manipulation* and *suggestion*, interpretations should be placed and designed in such a way that patients can reject them without distress (§ 21.3). At the end of the joint interpretation work, in which the physician's offers of interpretation were only questioningly put up for disposition, there should not be the *persuaded* but the *convinced* patient.

9.6 Further information

In the preceding chapter, the theoretical foundations were outlined to guide the *empirical* narrative analyses (§ 19-21, 24, 25). Theoretical and empirical work on narratives in everyday life and institutions (including medical-therapeutic communication) can be found in the collected editions by Ehlich (ed.) (1980), Straub (ed.) (1998), Bamberg (ed.) (2007). The edition by Martinez (ed.) (2017) includes contributions on the basics (Martinez 2017, Weixler 2017), but also on specific media, fields and functions of (oral) narrative (Quasthoff, Ohlhus 2017). Here, special reference should be made to the thematically relevant contributions on psychotherapy (Lätsch 2017), coping with experiences (Lucius-Hoene, Scheidt 2017) and narrative identity (Römer 2017), and above all to the contribution by Gülich (2017), who also gives a brief outline of the history of the development of a narratology for medicine.

For up-to-date overviews, the e-publications by Baroni (2014) ("Tellability") and Goyal (2013) ("Narration in Medicine") are easily accessible. Both works are taken from Hühn's (ed.) handbook (*the living handbook of narratology)*, which contains (easily accessible) further current references on an ongoing basis.

Further analyses and references to psychotherapeutically oriented narrative research can be found in Boothe (2011) and Scheidt et al. (eds.) (2015). For examples of narratives in medical communication, see the editons by Hurwitz, Greenhalgh, Skultans (eds.) (2006) and Greenhalgh, Hurwitz (eds.) (2005). For individual works, reference is made to the literature listed above in context. Of the more recent works on narration in medical and therapeutic communication, reference should be

made to the following examples: Deppermann et al. 2020, Galvagni, L. 2022, Habermas, Fesel 2022, Kirmayer et al. 2023.

In addition to current works, attention should once again be drawn to the "classics" Balint (1964) and Engel (1977) and (1997) for teaching purposes, who have placed the promotion of patient narratives through attentive listening by the doctor at the centre of medical communication.

Problems of narrative mediation between lifeworld and medicine as well as risks of manipulation are taken up again in the following (§ 10) in medical decision-making. For the practice of narrative in doctor-patient communication, reference is made to relevant chapters on the *Cologne Manual of Medical Communication* (C-MMC) (§ 19, 20) and on ward round communication (§ 24) and GP communication (§ 25).

References

Further references on doctor-patient communication can be found in other topic-specific chapters and in the complete bibliography of the handbook.

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