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Paradoxical nature of narrative in analytical psychotherapy

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This study explored the changes, obstacles for changes and the sharing of narratives in psychotherapeutic case studies. Study 1 developed an index for analyzing the process of narratives in psychotherapy, based on 101 cases. In Study 2, 203 cases were evaluated using the index generated from Study 1. As a result, three paradoxical natures of narrative became evident. Narrative in psychotherapy is thought to include (1) recognizing the beginning of a narrative, which can also signify the completion of the narrative, (2) negative movements that hinder the development of the narrative while at the same time move it forward and (3) an individual's narrative that is uniquely one's own, but easily influences and is influenced by the narratives of others.

Keywords: narrative; analytical psychology; paradox; psychotherapy; psychological change; negative movement as a driving force; sharing

Introduction

Psychotherapy through narrative and its criticism: This study explores the functions of narrative based on the analysis of clinical psychotherapy data. Most of the cases in this research are based on analytical (Jungian) psychology. In Jungian psychotherapy, the client's narrative is not considered to be intentionally created by the client, but has an autonomous function. When Jung (1963) emphasizes the power of the story by saying, 'Clinical diagnoses … do not help the patients. The crucial thing is the story', it gives importance to spontaneous remarks and expressions, and focuses on images such as in/from dreams. Through dialogue in therapy, the client touches and changes the healing power of narrative. In this sense, the Jungian psychotherapist views narrative not only by the words and stories told by the client, but also the images of dreams, drawings and sandplay. The client talks freely about things that seemingly have nothing to do with the chief complaint, yet it leads them to change, even for problems that they are unaware of or treat with great resistance. In other words, it can be said that the client

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This study was approved by the Ethical Review Board for Clinical Psychology Research, Kyoto University (Permission number: 17030).

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speaks not only for the purpose of obtaining advice on problem solving or training to correct a cognitive distortion, but also for the autonomous effect of the narrative itself. It is a mysterious phenomenon that the human psyche can change through narrative. In this research, we focused on the following three research questions to address the essential question of why people can transform, even when the narrative does not directly solve the client's symptoms and problems: (1) How do people change, and what kinds of changes occur through narrative? (2) If there are obstacles to change in narrative, what are the factors that prevent change? (3) How are personal stories shared with others, and how do they interact with others?

Evidence emphasis versus narrative emphasis: The power of narrative has subsequently been empirically supported through numerous case studies. However, analytical psychotherapy methods are sometimes criticized because, as Spence (1982) pointed out, Jungian psychotherapy emphasizes narrative truth over historical truth, so scientific facts are not always the first priority. Behind this criticism lies the rise of evidence-based medicine (EBM). EBM was proposed by Guyatt et al. in the early 1990s and advocated that genuine methods must be statistically proven to be effective (Guyatt 1991; Guyatt et al. 1992). This line of thinking went directly against therapies that have relied on the experience and intuition of doctors. As EBM's empirical view was strong, the methods that emphasized subjective and individual stories started to be seen as unscientific. There is a growing belief that empirical research should be conducted in psychotherapy as well, and some challenging research has been conducted (Cooper and Conklin 2015; Faramarzi, Yazdani, and Barat 2015; Hamilton et al. 2000; Stamm et al. 2020). However, in reality, if we try to conduct experiments using controlled conditions, it cannot be applied verbatim in clinical practice. Because Jungian psychotherapy does not have a manual for treatment methodology or processes, there are various framework settings for treatment. Moreover, the analytical psychotherapy that takes a more holistic view aims to change the person as a whole, rather than simply aiming to eliminate the symptom. This makes it next to impossible to predict the therapy process and outcomes in advance. It is inevitable that individual outcomes range widely, which makes it difficult to adapt a strict experimental design into the framework of analytical psychotherapy.

We adopted the viewpoint of narrative-based medicine (NBM) for our study, while keeping in mind the quantitative aspects of EBM. NBM was advocated for in the latter half of the 1990s and was a response to the overemphasis on evidence. NBM is defined as 'a fundamental tool to acquire, comprehend, and integrate the different points of view of all the participants that have a role in the illness experience' (Fioretti et al. 2016). This movement was initiated by clinicians who believed that scientific evidence alone cannot be used for individual clinical practice, and it follows the flow of the British Balint group of the 1950s. In other words, NBM was not a completely new way of thinking, but rather an attempt to reassess the value of individual narratives; a belief that was originally emphasized in psychiatry. EBM and NBM are originally two sides of a coin, and it is considered insufficient to be biased toward only one of them.

Method of this research: Since this study deals with a highly individualized narrative process, we adopted a methodology that combines an empirical perspective with a perspective that emphasizes individuality. Namely, our methodology emphasizes both a quantitative and qualitative analysis of data. To extract the narrative function without discarding the uniqueness of the process, this paper is divided into two studies. Study 1 generated an index to inform our hypotheses for Study 2. Since psychotherapy is a record of narratives that can sometimes span years, the task of creating indicators to capture features common to vast amounts of data has, in itself, led to an understanding of the process of

narrative transformation. By creating indicators in a data-driven manner, it is possible to discuss the function of narrative in clinical data. In Study 2, meta-data were collected from the psychotherapists and evaluated in great detail using the index created in Study 1. Due to space limitations, this study did not use inference statistics and instead used descriptive statistics in order to deepen the discussion on our three research questions. We attempt to avoid subjective discussions by focusing on features that are common to many cases.

Study 1

Purpose

Study 1 aimed to develop an index for analyzing the process of narratives in psychotherapy, using clinical data from open conferences. In order to address our research questions, we provisionally created three categories (Change, Resistance and Sharing), which we then modified, added and deleted indicators during the collection process. The category 'Change' is related to RQ1 by clarifying the types of changes to the narrative that occur through psychotherapy. We set two dimensions of change: 'changes in reality' and 'changes in psychological problems'. 'Changes in reality' refers to objective changes in the clients' real life such as getting a job, getting married, and so on. Although reality adaptation is rarely the direct goal of analytical psychotherapy, there are many empirical cases of reality adaptation. The second dimension, 'changes in psychological problems', evaluates whether there was an improvement in the client's psychological problems, as identified by the research team. It can be said that this type of change is the goal of therapy. Our research team judged whether or not changes had occurred in both dimensions; not the therapist or the client's subjective evaluation. This decision was made in order to avoid evaluation distortions caused by the subjective reflection of the persons concerned, as it is generally difficult to grasp one's own condition or change in it. The second category, 'Resistance', relates to RQ2 by identifying the obstacles for change. It can be assumed that there are cases where changes do not occur smoothly, therefore we included this category to explore cases in which changes are hindered. The third category, 'Sharing', addresses RQ3 by determining how changes in the client relate to others.

Method

Three researchers (over 15 years of clinical experience) recorded the outline of 101 random cases presented at public case study meetings. Individual data were abstracted to the extent that personal information was not specified. We then created a list of indicators after evaluating the meta-data of these cases based on the following three categories: Change, Resistance and Sharing. Regarding 'change', we abstracted the triggers that are considered to be the factors of the change until they became indexes according to the SCAT method (steps for coding and theorization) (Otani 2011). SCAT is a qualitative research method that extracts the latent meaning of the text by emphasizing the context, regardless of the existing concept.

Our research was conducted from April 2016 to March 2017. To focus dialogue-centered therapy, we decided to collect data of junior high school students and older. As Study 1 was a preliminary study to create an index, we collected a wide range of data without controlling the therapist's experience and case condition. Therefore, the collected data include ongoing cases in addition to finished ones.

Results and discussion

While collecting data using the above procedure, indicators were added and corrected as appropriate. Table 1 shows the generated indexes and their definitions.

(a) Basic information: There were 101 cases (35 males and 66 females). Because the exact age was redacted due to privacy protection, only age group data were collected. The distribution of the age groups included 25 cases aged 10–19, 31 aged 20–29, 14 aged 30–39, 18 aged 40–49, 5 aged 50–59 and 7 aged 60 or over. The period of therapy ranged from 2 months to 25 years (average = 3.8 years, *SD* = 5.0), and the number of sessions ranged from 3 to 400 (average = 83.5, *SD* = 93.8). At the time of collection, the statuses of the cases were as follows: 75 cases ongoing, 19 cases terminated and 7 cases suspended.

We recorded the 'chief complaint' stated by the client themselves, and the 'psychological problem' as judged by the research team. If there were multiple problems, only the main problem was included. The distribution of 'chief complaint' was as follows: [problem of adaptation] 27 cases, [interpersonal problems] 15 cases, [physical symptoms] 13 cases, [developmental problems] 11 cases, [mental symptoms (depression, anxiety and dissociation)] 9 cases, [trauma] 6 cases and [other] 29 cases. Different from the client's viewpoint, our research team evaluated 'psychological problem' as follows: [problems

Table 1. Index made based on preliminary research.

Category	Index	Definitions
Basic information	Age	The client's age group at the start of psychotherapy
	Gender	The client's gender
	Status of cases	Whether the psychotherapy case is 'ongoing' or 'suspended' or 'terminated'
	Therapy period	The duration of the therapy and the number of sessions
Task	Chief complaint	The client's main problem, as stated by the client themselves. If there are many complaints, a main one is selected
	Psychological task	The client's main problem, from a clinical psychological viewpoint, that is determined by our research team's discussions about the case
	Gap between chief complaint and psychological task	Whether there is a gap between the client's chief complaint and the psychological task
Change	Changes in reality	Whether the client has any changes in real life. The changes are objectively obvious, such as getting a job, returning to work or getting married
	Changes in image	Whether or not there is a change in the structure of the sandplay, drawings or dreams
	Changes in psychological problems	Whether there are any changes in the client's psychological theme
Resistance	Refusal of change	Whether the client is resisting their own change, even though the opportunity to change is apparent
	Complicity with anyone around clients	Whether anyone around the client causes the client to resist change, even though the opportunity to change is apparent
Sharing	Share problems with others	Whether the client shares their problem with others

of self (agency)] 39 cases, [psychological problems (dissociation, aggression, neurotic problem)] 34 cases, [developmental problems] 11 cases, [avoiding tasks] 11 cases and [other] 6 cases.

It is evident that there is a gap between the client's 'chief complaint' and the research team's categorization of a 'psychological task'. After counting the cases containing a gap, we discovered that 84 out of the 101 cases (83.2%) had a gap. Since the client's complaint is not based on psychological knowledge, it is inevitable that there will be a gap, but this means that the client may not be treating the genuine issue. Since gaps may hinder the progress of psychotherapy, we used the difference between the chief complaint and the psychological problem as an index. For example, in the case that a client complains about a 'developmental disorder' but the psychological problem is actually a 'problem of agency', if the problem of the agency has a direct effect on the developmental problem, then the case was rated as 'without a gap'. On the other hand, if the client's complaint was about a 'developmental disorder', but the growth of agency was hindered by their mother's over-interference, developmental delay itself would not be classified as the main problem, and therefore separation from the family in such case would be rated 'with a gap'.

(b) Change: 'Changes in reality' were seen in 39 cases (38.6%), while 'changes in psychological problems' were seen in 38 cases (37.6%). The slightly low percentage might be due to the fact that the data collected here contained many ongoing cases. On the other hand, there were several cases that were rated 'without change' that in reality contained negative change. These negative changes included troubles with others, or worsening social adaptation, but they often lead to subsequent positive changes. This finding suggests that negative changes are more than just deterioration when viewed as a long-term, multi-layered process. Therefore, we added an index of 'Negative Movements' in the [Trigger for Change] category. Originally, 'Changes in Reality' included changes of physical symptoms, but these kinds of changes behave differently to other changes. Therefore, it was considered appropriate to provide an independent index called 'Somatic Symptoms'.

Using SCAT, we extracted constructs for the elements that trigger positive changes. The following five perspectives were generated and added as indicators in the [Trigger for Change]; 'Change in Image', 'Significant Others', 'Contact with the Therapist', 'Emerging/Expressing' and 'Act on their Initiative'.

'Change in Image' is a change in dreams, sandplay or drawings; a unique viewpoint for the Jungian who believes that changes in the degree of differentiation or structure of image (narratives, sandplay, dreams, and so on) rather than the expressed content, correspond to more fundamental changes. 'Significant Others' includes cases where meeting a new person or parting from a previously important person is the trigger point for change. There were examples like meeting a good teacher, breaking up with a lover and the death of a client's dog.

'Active action' is an opportunity for the client to take some assertive action prior to the change, such as 'starting a new hobby' or 'refuting their parent who has never rebelled'. 'Emerging/Expressing' occurs when something is expressed or appears from within the client, such as revealing something that could not be said before, or a client with a flat affect who sheds tears for the first time. 'Contact with the Therapist' is a direct contact between the client and the therapist, such as an accidental encounter outside the session. It is a principle in the usual psychotherapy framework that the client and the therapist keep an appropriate distance and do not have a personal relationship, but when this

principle is broken by chance, the client sometimes changes. To summarize, we added these five perspectives as indicators in the 'Trigger for Change' category.

(c) Resistance: [Resistance] includes cases in which changes were hindered during the process despite positive changes previously occurring. Two indexes were generated; 'Refusal of Change' for when the client themselves refused to change, and 'Complicity' for when a person involved with the client disturbs their change. In the former index, there were cases where the client had the anxiety to change due to difficulty of the task itself, or because there was some benefit to subsuming the role of 'a patient who suffers with symptoms'. For the latter index, example cases include a mother who stopped the client from returning to work by saying it's 'You're not ready to go to work yet'.

(d) Sharing: 'Sharing' was originally set as an index to see if the client's problem was shared by the people around them, however, it was difficult to judge the degree of sharing, even for the therapist, so this index was deleted from the indicators. On the other hand, a different form of 'sharing' that was not initially hypothesized was extracted and labeled as the 'Spread of Change'. This type of change is that change in people around the client occurs in synchronization with the change in the client. For example, a client who was once subjective (overly introverted?), changes in response to the change of his over-interfering mother's attitude. On the contrary, there were cases in which the person interacting with the client moved in opposite directions to the client's improvement. There is a concept of Jung's psychology called 'compensation' which functions unconsciously balancing or supplementing the conscious orientation to keep the whole of the psyche in harmony. In the above case, it can be said that compensation is functioning, not only within a person, but between the individuals as a system. This is the essence of shared narrative. In our index, we named this element, 'Compensatory Spread of Change'. Furthermore, there were cases where the overlap of accidental events contributed to the development of therapy, although it is difficult to understand the direct causal relationship. This is more difficult to understand than the 'Spread of Change', but it can be grasped by Jung's concept of 'constellation', where seemingly unrelated events overlap and correspond to changes in the client. To summarize, three indexes, 'Spread of Change', 'Compensatory Spread of Change' and 'Constellation' were added to the indicators. The indices discussed thus far were combined into one, titled the 'case analysis index' and are shown in Table 2.

It should be noted that this study does not attempt to comprehensively clarify the elements of the changes that occur during psychotherapy. Psychotherapy follows a highly individualized process, making it difficult to find points that are applicable to every case. However, it is beneficial to extract some of the therapeutic effects, difficulties and possibilities of the narrative that are common to many cases. Since Study 1 included ongoing cases, we wanted to use our finalized index to analyze finished cases, as we believe that they might show a whole new form of personal story that adds to the function of narrative.

Study 2

Purpose

In Study 2, we collected completed psychotherapy cases and evaluated them using the case analysis index generated in Study 1. The data include recordings of psychotherapy sessions, the client's narrative, as well as images taken from dreams, sandplay and drawings. Though images are not traditionally seen as narratives, we regarded media in

Table 2. Index for analyzing psychotherapy cases.

Category	Index	Definitions
Basic information	Age	The client's age group at the start of psychotherapy
	Gender	The client's gender
	Therapy period	The duration of therapy and the number of sessions
	Chief complaint	The client's main problem, as stated by the client themself. If there are many complaints, a main one is selected
	Psychological task	The client's main problem, from a clinical psychological viewpoint, that is determined by our research team's discussions about the case
	Gap between chief complaint and psychological task	Whether there is a gap between the client's chief complaint and the psychological task
Change	Changes in reality	Whether the client has any changes in real life. The changes are objectively obvious, such as getting a job, returning to work or getting married
	Changes in psychological problems	Whether there are any changes in the client's psychological theme
Trigger for change	Negative movements	Whether there are any objectively negative movements or changes in the process of therapy
	Somatic symptoms	Whether somatic symptoms 'have developed' or 'are changing' or 'has improvement' during the process of therapy
	Changes in image	Whether or not there is a change in the structure of the sandplay, drawings, or dreams
	Significant others	Whether the person who has influenced the client's change 'has appeared', 'has changed the dynamics of the relationship' or 'has departed'
	Contact with the therapist	Whether there is accidental contact between the therapist and client outside of therapy. Ex. Meet by chance outside
	Emerging/expressing	Whether something emerges or something is expressed that has not been expressed until now
	Active action	Whether there is opportunity for the client to take some assertive action prior to the change
Resistance	Refusal of change	Whether the client is resisting their own change, even though the opportunity to change is apparent
	Complicity	Whether anyone around the client causes the client to resist change, even though the opportunity to change is apparent
Sharing	Spread of change	Whether someone around the client is changing in a positive direction in connection with the client's own changes
	Compensatory spread of change	Whether someone around the client is changing in a negative direction in connection with the client's own changes
	Constellation	Whether coincidences associated with client changes, although there is no clear causal link

psychotherapy (dreams, sandplay, drawings, etc.) as such. The objective of Study 2 was to discuss common functions of narratives in psychotherapy without compromising individuality. We accomplished this by having the therapist in charge and research team members jointly examine the therapy process in more detail.

Method

We asked 26 (10 males and 16 females) certified clinical psychologists with Jungian orientation to provide data on their cases. The therapists had an average of 17 years of clinical experience (7–30 years, $SD = 5.8$). Our target was dialogue-based cases whose clients were junior high school students or older. To best examine the progress of the entire therapy, we limited cases to those that were labeled as ‘finished’ and those that contained more than five sessions in a row. To avoid arbitrary selection of cases, we asked that therapists select no more than eight of their most recently ‘finished’ cases. In this case, ‘finished’ included cases that were interrupted in the middle of the process. This means that not only ‘successful’ cases were included. We asked the therapists to summarize each case (one page each) and rate the cases based on the indicators from Study 1: Change, Triggers for change, Resistance and Sharing. In order to unify the rating criteria and make it objective, we then invited the therapists to participate in a conference with our research team, where the index rating for each case was jointly finalized between the research team and the leading therapist.

Results

Table 3 shows the evaluation results for each case.

(a) Basic information: There were 203 cases (74 males and 129 females) with 71 clients aged 12–19 years, 57 aged 20–29, 28 aged 30–39, 10 aged 50–59 and 5 aged 60 or older. The average therapy period was 2.3 years (range: 2 months to 18 years, $SD = 2.8$), and the average number of sessions was 44.1 (range: 5–358, $SD = 50.8$). If there were multiple problems, we selected the main one. The distribution of these complaints,

Table 3. The appearance of each feature in the process of psychotherapy cases.

Category	Index	Yes (%)	No (%)
Task	Gap between chief complaint and psychological problems	158 (77.8%)	45 (22.2%)
Change	Changes in reality	175 (86.2%)	28 (13.8%)
	Changes in image	113 (55.7%)	90 (44.3%)
	Changes in psychological problems	170 (83.7%)	33 (16.3%)
Trigger for change	Negative movements or changes	118 (58.1%)	85 (41.9%)
	Somatic symptom	97 (47.8%)	106 (52.2%)
	Significant other	80 (39.4%)	123 (60.6%)
	Contact with therapist	35 (17.2%)	168 (82.8%)
	Emerging/expressing	137 (67.5%)	66 (32.5%)
	Active action	124 (61.1%)	79 (38.9%)
Resistance	Refusal of change	64 (31.5%)	139 (68.5%)
	Complicity	55 (27.1%)	148 (72.9%)
Sharing	Spread of change	50 (24.6%)	153 (75.4%)
	Compensatory spread of change	30 (14.8%)	173 (85.2%)
	Constellation	49 (24.1%)	154 (75.9%)

as identified by the client, was as follows: [problems about oneself (personality, way of life, etc.)] 39 cases, [interpersonal/communication problems] 24, [family relationship problems] 23, [depression/mood disorders] 22, [problem with adaptation] 22, [anxiety] 16, [physical symptoms] 13, [consultations about others] 10, [developmental problems] 10, [eating disorders] 5 and [other] 19.

On the other hand, the distribution of psychological problems, as assessed by the therapist and research team, was as follows: [psychological problems] 72 cases (excess or suppression of aggression in 34 cases, neurotic problems in 23 cases, dissociation in 6 cases, attachment problems in 4 cases), [problem of the self/agency] 52, [interpersonal relationship problems] 40, [development problems] 20, [physical symptoms/somatization] 8, [past obsession/trauma] 6 and [problem avoidance] 5. There were 158 cases (77.8%) in which there was a discrepancy between the client's 'chief complaint' and 'psychological problem', as agreed upon by the therapist and research team. For example, a case where the client complains that his parents are causing his symptoms, but from the perspective of the therapist and research team, the client himself is considered to be obsessed with his family.

(b) Change: There were 175 cases (86.2%) in which some kind of 'Change in Reality' was observed during the course of therapy. For the purposes of our study, 'change' included anything that was considered a large change for the client, even if it was an objectively small change. For example, we evaluated the case of a client who had been withdrawn in his room for many years and went on to clean up his room for the first time.

There were 170 cases (83.7%) with 'Change in psychological problems'. Psychological problems tend to be life-long, so cases where it was determined that some progress had been made were included in this index, even if it was not completely achieved. Psychological problems are very diverse and individual, with varying degrees of change, but we have endeavored to assess changes that are of great significance to the individual. There were various examples such as increasing self-efficacy, recognizing and expressing emotions, and separating from family members.

(c) Triggers for change: First of all, we describe two indicators that can be classified as negative changes [Triggers of Change]. In 97 cases (47.8%), 'Somatic Symptoms' appeared during the course of therapy. 'Somatic Symptoms' included a variety of symptoms such as colds, fever, herpes outbreaks, exacerbation of allergies and low back pain. Moreover, 156 cases (77.8%) showed some kind of 'Negative Movement' in the process. 'Negative Movement' included worsening truancy, trying to interrupt the therapy, self-harming, increased suicide ideation, and so on. Of the 170 cases with 'Changes in Psychological Problems', 126 cases (74.1%) had 'Somatic Symptoms' or 'Negative Movements'. In other words, it can be inferred that in the process of improving one's own problems, there was a period of worsening negative aspects in nearly 70% of cases.

Continuing on, we will describe the four positive indicators. 'Changes in Image' were observed in 113 cases (55.7%). Changes that can be evaluated as 'progress' from an analytical-psychological viewpoint were included, such as a client who started drawing colored pictures after only drawing monochrome pictures, or a client who was actively involved in a dream after usually dreaming passively. Eighty cases (39.4%) that were classified as 'Important Other' experienced an important encounter or farewell related to their change. Examples include a client who was not interested in her family but met an old man who cared about her and came to celebrate her graduation, leading to a big change in the client. There were 35 cases (17.2%) who had 'Contact with the Therapist'. This included an accidental encounter with a client while the therapy was paused but later resumed. There were 137 clients (67.5%) who experienced 'Emerging/Expressing'. This

index included an emotionless client shedding tears in the session, and a doting client who usually saved face for others being self-assertive for the first time. There were 124 cases (61.1%) in which 'Active Action' was observed. Examples included deciding to change jobs, joining a new group and beginning to live away from an over-interfering family.

(d) Resistance: There were 64 cases (31.5%) of 'Refusal to Change' in which the client gave up the chance to change. Fifty-five cases (27.1%) featured 'Complicity', in which a person close to the client disrupted their improvement. One specific example includes a client who, once cured of the nausea he would experience while studying, continued to be truant from school by making some other excuse, or when a client wanted to return to work, but his mother stopped him by saying, 'It is too soon for you'.

(e) Sharing: There were 50 cases (24.6%) involving a 'Spread of Change', which means that while the client was changing in a positive direction, the person(s) around them also began to change. In one example, as a client began to think about and change her lifestyle, her daughter's trichotillomania was cured, the relationship with her husband improved and her son also showed progress. On the other hand, 'Compensatory Spread of Change' was identified in 31 cases (15.3%). This index means that the people around the client change badly, as if in response to the client's improvement. For example, when a client's interpersonal relationships improved, her sister's interpersonal relationships deteriorated. Finally, 48 cases (23.6%) featured 'Constellations' related to change. Examples include a client who broke his classmate's bone, then at a later time accidentally broke the same bone himself, or when a client purchased a cursed item for an opponent who ended up dying in an accident.

Discussion

Three paradoxical natures of narrative: Regarding the first research question, how people change and what kinds of changes occur to their narratives, our results suggest that all facets of the index (Change, Triggers of Change, Resistance and Sharing) were observed throughout the psychotherapy process, although the proportions of each index differed. One criticism of psychotherapy is that because the process is highly individualized, the factors found in client cases may not be generalizable. Nevertheless, more than 80% of the randomly selected cases showed improvement, indicating that it is worthwhile to evaluate the effects of analytical psychotherapy. It is worth noting that there have been many cases in psychotherapy that feature an increase in practical adaptation; interestingly, reality adaptation is not directly targeted in analytical psychotherapy. It should be noted that in Jungian psychotherapy, which focuses on the person as a whole, there are also cases in which reality adaptation improves. In other words, since the narrative includes the person's 'real life', the narrative as a whole appears to affect the person's reality.

In addition, although not all cases dealt with images, 'Changes in Image' were observed in about half of the cases in our study. The change we are referring to is a change in a direction that is more differentiated and structured. Considering that the Baum Test has long been used in clinical settings for diagnosing pathological levels, there is a lot of trust in images for clinicians. Because relevant, spontaneous images reflect the structure of the world in which the client lives, and reveal information about the client that may not be reached through language alone. Words can be consciously distorted or create lies, but images arising from the unconscious are narratives that do not lie. That is why it is believed that differentiation of image structure indicates a clearer outline and a radical change in the flow of narrative.

These discussions reveal the multi-layered nature of narratives in psychotherapy. In other words, as the client's narrative flows naturally, changes in the image and reality itself become clearly visible on the surface. On the other hand, there is also the potential for psychological tasks such as 'triggers of change' and 'resistance' to arise from the depths as background stories, intersecting sometimes with other people. Our research found that in many cases, negative movements occurred during the therapy process. However, negative events often lead to improvement later on, a paradox which indicates that the client's story does not always go forward smoothly. It is worth noting the paradoxical developments that can be seen within narrative. As such, we would like to consider the paradoxical nature of narratives from three standpoints.

Paradox of Narrative (1): difficulty getting into one's own story: This paradox is related to our second research question, 'If it is difficult to change through narrative, what are the factors that prevent change?' Most clients come to psychotherapy to solve or eliminate their problems. But the gap between the client's complaint and the psychological problems that experts assessed shows how difficult it is to understand your own challenges. For example, a client whose first chief complaint was the harassment from a friend actually talked about her mother through her therapy process, resulting in her working on the relationship with her mother instead of the relationship with her friend. In such cases, the client gives up the original complaint, even though the complaint acts as a gateway to develop the client's original narrative. A different example involves a client who endlessly complained about her mother-in-law, despite that her real psychological task was assessed as needing to establish a relationship with her husband. In such a case, it appears that the client has difficulty understanding the psychological tasks because the tasks are hidden from their conscious awareness. Additionally, people with developmental disorders or other illnesses often have difficulty looking at their own potential or growth because they take everything negatively due to their 'disability' or 'illness'. In our study, we found that more than 70% of the cases had such a deviation. Although understanding one's problems is generally difficult, therapy should not be focused entirely on solving the 'chief complaint', since only a small portion of clients are even consciously aware of their real problem. We can see here the contradictory nature of narrative; finding one's own goal is the beginning of the end of the problem.

Unfortunately, there is a possibility of resistance occurring after finding the problem and starting to tackle it. Despite the progress in treating one's own tasks, a client might stop moving forward or be disrupted by those around them. It may seem counterintuitive that clients who want to improve themselves also try to hinder themselves, but these tendencies have been discussed in the Freudian concepts known as *resistance*, *gain from illness* and *flight into illness*. In the first place, neurosis is created from an irrational self-relation in which the client suffers from the anxiety generated from their own psyche. In addition, if the client's illness benefits others, such as when a household is supported by a disability subsidy, *gain from illness* may extend to others. The client may avoid social responsibility or gain validation by creating symptoms, which both consciously and unconsciously hinders improvement. The paradox of wanting to solve a problem while becoming obsessed with it is a common essence of the psyche. Such self-bondage is likely to occur in the process of narrative development. To breathe new life into the narrative, interaction with others is needed, such as encounters with others, contact with the therapists and an overlapping of chance events. That is why therapists are essential in psychotherapy, even when the focus is on one's personal work of creating their own story. Moreover, the Jungian method of actively focusing on images with a higher degree of freedom can be employed to see beyond the limits of the client's

consciousness. Emphasizing images from the unconscious releases the client from resistance and makes the driving force of narrative more functional, as there is a tendency for human consciousness to stop the development of narrative.

Paradox of Narrative (2): negative movement as a driving force: This paradox is also related to our second research question about obstacles in changing narrative. We found that negative movements were observed in 70% of the cases where psychological problems improved. This is not to be confused with a refusal to change, where the path to recovery is visible, as described in the previous section, but a negative movement seen before the improvement. We found various examples of this phenomenon, such as the appearance of depression, deterioration of physical symptoms and suicide attempts. Negative events can arise as a side effect of the client's process of tackling psychological tasks, such as increased interpersonal troubles as a result of a client's first expression of anger. Kawai's research on post-disaster psychological care work revealed that mental growth is more likely to occur when recovering from negative conditions. In the 2011 Great East Japan Earthquake, there were many cases where one's condition deteriorated after the disaster, but within these cases, the original psychological problems resolved in tandem with the recovery from the disaster. When viewed at an objective-level, disasters such as earthquakes are seen only as tragedies, but when viewed from a subjective narrative, 'Some successful patients can make use of disaster' (Kawai 2015). The common occurrence of negative movement before improvement in narratives could suggest that the reaction from negative movements is needed in order to gain forward momentum in some cases. In this sense, the negative movement may temporarily be seen as a turn for the worse, but it has the potential to be the catalyst for positive change.

Paradox of Narrative (3): Crossover between the story of others and the story of oneself: This paradox is related to our third research question, 'How are personal stories shared with others, and how do they interact with others?' Psychotherapy is a highly individualized process, but the process of this personal work is greatly influenced by others. The results of our study show that encounters with and departures from important others, as well as contact with one's therapist, have the power to significantly change a client's narrative. Furthermore, personal changes can spread and influence positive/negative changes in others. When others are involved, these factors often occur beyond our control, such as by chance, failure or misunderstanding. A typical example is the case where a client hears a story about their therapist's private life, and the client changes as a result. It may even depend on the placement of accidental events, such as 'constellations', where causality is difficult to see, suggesting that narratives are by no means limited to stories containing simplistic plots. If we cannot control our own story and are supported by others or by chance, it's possible for the individual to become totally passive. However, it is essential for the subject to be actively involved, as there are many cases where 'Active Actions' and movements to 'Emerging/Expressing' triggered changes. In other words, an individual's narrative is one in which the person must be actively involved in their story, and at the same time, is open to the movements of others, fortuity, and the world as a whole, which has the paradoxical property of both individuality and wholeness.

Conclusion

In this study, we explored the function of narrative by analyzing the meta-data of actual psychotherapy cases from a quantitative viewpoint and analyzing the flow of these individual cases. Change occurred in regard to the psychological problems that analytical

psychotherapy aims to tackle, thereby confirming the effectiveness of therapy. In addition to the achievement of these direct goals, here were also noted improvements of realistic adaptations that were not intentionally focused on. Moreover, the case analysis index created in Study 1 showed various opportunities for people to change through narrative in psychotherapy. The pattern in which these triggers for change occur depends on the individual process, but the complex movements within each case suggest a paradoxical nature of narrative.

Psychotherapy is believed to be the work of individuals creating their own narratives, which can include (1) recognizing the beginning of a narrative, which can also trigger the completion of the narrative, (2) negative movements that hinder the development of the narrative but at the same time move it forward and (3) the individual's narrative is indeed one's own, but easily influences and is influenced by with the narratives of others. Our conclusions are in line with Jung's theory that narratives have an autonomous nature. It is narrative that heals our psyche, but it is also narrative that disturbs healing, which is the paradoxical nature of narrative.

We evaluated the long-term process of psychotherapy as one single data point, but we also found different patterns of change within the clients. For example, a change in image but no change in the reality or psychological task, or a big change in reality but no change in the psychological task, or even parallel changes in many aspects. These patterns will need to be considered with process analysis in the future. Additionally, although analysis using inference statistics was not performed in this study, statistical verification such as the relationship between client symptoms and narrative development patterns should be conducted in future research. We think it is important to mention that our study was conducted within a Japanese cultural context, based on Japanese cases and analyzed by Japanese therapists. As the boundary between the self and others is more ambiguous in Japanese individuals than Western individuals, there is a possibility that these narratives are specific to Japan (Markus and Kitayama 1991). However, as Jung's perspective is universal and inclusive, examining Japanese cases and clinical practices that are based on European psychology should contribute to a greater understanding of the human psyche across many cultures.

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