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**Supplementary material to accompany video 1:**

 **‘clinical narratives’**

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This is the supplementary material that accompanies my first video ‘Clinical narratives’, which touches on key components of our clinical prose – narrative summaries, vignettes, and immediate scenes. All material quoted below is used with the kind permission of each author. I am grateful to these authors for agreeing to share their work and also to John Wiley & Sons Ltd, publishers of the *Journal of Analytical Psychology,* for their permission regarding the journal.

**Narrative summaries and vignettes**

Narrative summaries — condensed stories of what happened — are one of the essential building blocks of clinical writing. They cover and compress a sweep of history, the course of a treatment, a set of themes or relational patterns (See Naiburg 2015, pp. 3-5, 15-19, 81-84). A vignette is a brief description or illustration used to make a point. It is usually an interweave of select clinical material and a teaching point. (See Naiburg 2015, pp. 174-176, 179-180). Like a snapshot or portrait, a vignette captures a moment in time and often includes — either implicitly or explicitly — an interpretation or commentary on that moment. Reading the examples of narrative summaries and vignettes below, what similarities and differences do you notice?

In my first video entitled ‘Clinical Narratives’, I quote the following narrative summary from Susanna Wright’s (2009) *JAP* article ‘Going home: migration as enactment and symbol’.

*During the years I had known Ana she had struggled with poverty, poor housing, back-breaking physical work, a strange language, strange culture and social isolation. She would visit me in my consulting room and have to battle not only with her envy of what appeared to be my comfortable circumstances, but also with a lonely conviction that I could never understand how hard it was for her. Nonetheless, her determined “fighting” as she would say, led her to years of study and finally, only a few months before that day, to work that began to open up opportunities more like those she had left behind in her country of origin.*

*Perhaps her progress in establishing a place in the new country reflected some use Ana had been able to make of me, but she felt both angry and guilty towards me, saying ‘immigrants should be grateful for what they get, and not be angry when things are difficult’. She described me as her “tour guide”, a native who helped her with the ways of the foreign country.*

*And, following the years of work that I felt were beginning to pay off in new possibilities for her, she was beginning to form a different point of view. She was thinking of migrating again to be closer to her family. She wanted a better life. Rather in the way that when we met in the street Ana was walking away from our appointment, going home, this felt to me to be a statement by Ana that she did not see her analysis as providing hope of change from her internal experience of being alienated, apart. She was thinking of giving up on the dreams and ambitions that brought her to London and proposed her old solution, an external repetition—another migration in search of a better place.*

 (Wright 2009, pp. 480-81)

***Writing exercise 1: narrative summary***

Think of a patient you would like to write about. Take a few minutes to visualize this patient and sense how it feels to be with this person. Use your senses to register what it’s like to be with this person **and yourself** when you are together. Now from this embodied place and with Wright’s excerpt as inspiration, write a brief narrative summary of the challenges your patient faces. Include a comment about your relation with your patient as it developed over time, adding a note, perhaps, about the progress this patient has made.

In the same video, I also quote the following vignette from Favero and Candellieri’s (2017) *JAP* article ‘Analytical practice: do the new technologies have an impact?’.

*Jason is a highly intelligent 16-year-old boy who in the early years of secondary school begins to manifest the first symptoms of school refusal. Following an improvement in the situation when he was 15, the following year he stops going to school altogether. With his family left feeling powerless, the boy, shut up in his room, inverts the patterns of sleep and wakefulness, remaining awake at night playing his favourite online video game, Minecraft, and sleeping during the day. His virtual friends help him to feel gratified and competent, and so this alternative reality acts as a substitute and a valid refuge against the anxiety and shame associated with the idea of presenting himself in an authentic social context. Conversely, relationships with friends in actual flesh and blood and with his parents become impoverished, or even actively avoided. Furthermore, whereas at school Jason was often ignored by his classmates, in the online video game world he has acquired the status of a ‘lamer’ (someone who is willfully ignorant of how things work and whose main aim is to try to do as much damage as possible), earning a certain prestige and notoriety among his peer group.*

(Favero &Candellier, 2017, p. 358)

The following portrait of a patient called Daniel is from Monica Luici’s (2017) *JAP* article ‘Disintegration of the Self and the Regulation of “Psychic Skin” in the Treatment of Traumatized Refugees’.

*Daniel, 31 years old, was referred to me at the psychological service of a large reception center for refugees in Rome by a social worker worried about his severe insomnia and suicidal thoughts. At our first meeting, Daniel looked upset, agitated and exhausted, like someone who had been struggling for a long time. He was suffering from a range of severe post-traumatic symptoms: insomnia, nightmares, recurrent flashbacks, distressing memories of war events, emotional distress and physical reactions to anything reminding him of past events, a persistent deep state of sadness and marked social withdrawal. The most disturbing symptoms were his suicidal thoughts, which were coloured by a chronic sense of guilt, intense shame, helplessness and a sense of being completely different from other human beings, with no future and no possibility of recovering.*

 (Luci 2017, p. 229)

In an example below, Jody Messler Davies (1999) takes a different approach to describing her new patient:

*Daniel was twenty-seven years old when he first came seeking psychotherapy with the vague sense that he needed some help* *‘putting things together’. Indeed, my first impression of him was of a young man for whom nothing quite went together: clothes somewhat wrinkled and mismatched, long arms and legs that didn't quite work together in coordinated motion, thoughts that seemed scattered and undirected. He came for the first time on a bitterly cold day, and some of the first things that struck me were the thin socks and sandals he wore on his feet. Though I asked him about this, he simply replied offhandedly, ‘Oh, I never, ever get cold’. Daniel was exceedingly bright, remarkably well read, and potentially attractive under his somewhat rumpled, ragged, and disorganized exterior: an interesting combination of creative genius and neglected little boy. I entertained both fantasies.*

 (Davis 1999, pp. 188-89)

***Writing exercise 2: portraits and vignettes***

Once again, take a few moments to visualize the person you want to write about and let your experience of being with this person come into your mind and body. Following the examples provided in the portraits of Jason and the two Daniels, write from this embodied state a brief description of this patient’s character, challenges, appearance — whatever you think will serve as an introduction. If you like, include a bit of commentary as Davies does at the end of the passage I quoted above. When you begin writing, don’t disguise anything so that you won’t confuse your unconscious or intuition, which can infuse your writing with deeper meaning than meets your more conscious observing eye. The time to instigate disguise to protect your patient’s identity comes near the end of your writing process (see Naiburg 2015, chapter 18).

**Immediate scenes**

In an excerpt I quote on my first video, Joan and Neville Symington (1996) illustrate Bion’s concept of the container/contained by *showing us* what happens between the man in the shelter workshop and the analyst who moves beside him to look at the pain with the patient that he can’t bear to see alone. You will find my fuller commentary on how this passage is written in my (2015) book (pp. 174-75). While this excerpt is a snapshot used to make a point and hence is a vignette, it is also an ‘immediate scene’ (Stein 1995; Naiburg 2015, pp. 15-19, 21), something that is filmable, that we can picture because of the way it is presented — with dialogue, the use of the present tense, visual details, like ‘words would sometimes dribble out from the corner of his mouth’ (Symington & Symington 1996, p. 51), and action. Putting a scene before the reader’s eyes brings the clinical illustration to life, lets the reader see what the analyst/writer sees. But in this example, we don’t have access to the analyst’s subjective experience, which is essential to the analyst’s understanding of the meaning of what happens.

When I use Stein’s (1997) term ‘immediate scene’ in the context of our clinical writing, I mean a scene that is filmable **and also** gives us access to the analyst’s subjectivity. In the example of an immediate scene that follows and that I also quote in my first video, Sylvia Brinton Perera (2009) gives us access to her internal experience:

*As Judith sits on the couch, I repeat her nod, looking at her, feeling my facial expression is both calm and welcoming. She does not respond. I sense I need to sit as quietly as she does, and I begin to feel into the increasingly charged atmosphere between us. I am trying to be present to all my perceptions. They form into an initial impression of someone who is depressed, vigilant, and in disguise, knowing all the social rituals that form an appropriate persona, and dutifully, slightly defensively, accommodating them. So after a silence, I try another greeting and a question: ‘Hello. (pause) Did you get here OK?’. (A kind of Zen opening, but yielding only another pause and another question.) ‘Do you want to tell me what brings you today?’. Judith gives me a quick, wordless look and returns her gaze to the window. I feel a pull to engage her in social greeting behavior, but sense that would violate some process already in operation. So I wait, trying to stay present to the feel of space that is not really between us, and yet she is already compelled by her role, and I am trying to observe and discover the roles I am to serve in what may become our mutual performance.[[1]](#footnote-1)*

***Writing exercise 3: immediate Scene***

Let a scene of intense engagement with a patient come to mind. Take a few minutes to recreate the memory of that experience in all its rich emotional complexity and let the feel of it re-enter your body. Writing from that embodied state, give your readers as rich a sense of what it is like to be in relationship with your patient **and yourself** in that charged moment. Writing in the present tense will create a sense of immediacy. Provide some vivid sensory details to bring the scene to life as if it’s being played out on the stage of your readers’ mind.

As you read clinical papers, begin to read as a writer, noticing how writers pull their readers in, convey affect, create suspense, provide vivid detail. Then follow the examples of writers you find effective and practice writing narrative summaries, vignettes, and immediate scenes to deepen your understanding of yourself, your patients, and the clinical process. Write on!

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**Additional resources**

<https://thejap.org/resources/submit-an-article>

<https://thejap.org/resources/step-by-step-guide>

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