Metaphor in
Cognitive Behaviour Therapy

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Abstract

Metaphors are common in psychotherapy. Over the last decade, there has been increasing interest in the use of metaphor in cognitive behaviour therapy (CBT), with attention to client metaphors being asserted as a way of CBT. However, to date there has been very little research on the use of metaphor in CBT sessions, and no studies which have examined how to train therapists in this skill. Empirical study of metaphors in cognitive behaviour therapy has tended to be put in the ‘too hard basket’, confined to being part of the art rather than the science of therapy. The lack of research is largely due to problems with definition, lack of a consistent, reliable approach to metaphor identification and the challenges of finding appropriate methodology to study this language-based activity.

This thesis will describe four studies exploring metaphor use in CBT. The first study used the discourse dynamics approach to assess the frequency of metaphors in CBT in a large sample of therapy sessions and to evaluate the reliability and utility of the discourse dynamics approach. The second study explored metaphor co-construction in early therapy sessions. It looked at what responses therapists and clients make to each other’s metaphors during bursts of metaphoric exchange and whether these were initiated by the therapist or the client. An iterative process led to the identification of a range of therapist and client responses to each other’s metaphors, and identification of whether therapists or clients initiated metaphoric exchanges. The third study explored the effect on therapy alliance of training CBT therapists to intentionally bring client metaphors into case conceptualisations, using video-recorded pre and post-training role played therapy sessions. Significant increases were found in some ratings of alliance, based on role play ‘client’ ratings and external ratings of role plays of therapy sessions before and after training. This study also explored whether working metaphorically suited some therapists and clients better than others. Correlations between ratings of preference for metaphoric language and alliance ratings suggested that working metaphorically may be most effective when the therapist and client have a similar degree of preference for speaking metaphorically. The fourth study describes the metaphor training provided and explores therapist ratings of the content and delivery of the workshops and the impact of the training provided, based on self-report ratings and reflections on their ongoing application of learning over a three-month period. These were compared to pre-training ratings. Therapists rated the workshops positively. They also reported significantly increased awareness of metaphors; increased confidence in responding intentionally to client metaphors and bringing them into shared conceptualisations; significant increases in reported time spent
elaborating on client metaphors, and significantly increased use of metaphors when conceptualising with clients. Barriers and solutions to application of learning were identified.
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First and foremost, I would like to express my deep gratitude to my supervisors. Dr Maria Stubbe as on-site primary supervisor has been a central person in this process. She has brought a wealth of linguistic and research expertise, a different perspective, an eye for detail and unflagging encouragement. I am also deeply indebted to Dr Jennifer Jordan, my second supervisor, who has been always supportive, given prompt feedback, helpful, consistent expert advice and encouragement and a clinical psychology perspective.

Dr Paul Merrick has kindly acted as an advisor for this thesis. His breadth of knowledge of methodology has been extremely helpful, particularly in guiding me regarding the design and data analysis of the third of the four studies that comprise the heart of this thesis.

I am grateful to Dr Louise Signal, who was my academic mentor as I talked through starting this PhD and has taken a continued interest, giving me useful tips and encouragement. Dr Janet Carter provided ‘fresh eyes’ when reviewing our first article for submission.

Many thanks to the Christchurch CBT/IPT study team, for allowing me access to the CBT session transcripts, which the first phase of the study was based on. Thanks also to the patient participants in the CBT/IPT study for their participation in that study. Thanks to Jo Hilder for conducting the reliability check and to Jayden MacRae for developing the Discombobulator programme.

I am also grateful to the clinicians and students who generously agreed to participate in the metaphor training workshops conducted for this study, and to Dr Susan Watson, who was the external rater of the therapy sessions recorded during this second phase. Dalice Sim was a great help with the statistical analysis, walking alongside me through the SPSS process.

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project. I also appreciate the ongoing annual PhD student funding from the Department of Primary Health Care and General Practice, which supported my research and conference costs.

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Publications and presentations arising from this thesis

This doctoral thesis is a hybrid thesis and the thesis chapters 4-7 are largely based on four published academic articles listed below. The content of each published paper is substantially the same as that found in chapters 4, 5, 6 and 7, but in this thesis, there is some elaboration as to the choice of method, additional (newer) references and an extra table in chapter 6. As a consequence of the hybrid nature of the thesis, there may be a small amount of repetition between chapters, most notably within the introductions of Chapters 4, 5, 6 and 7. Some summary sections and reading suggestions in the articles have been removed for the thesis. In the interests of clarity, as each of the four main chapters of this thesis uses a different method, I have included each method in the chapter it relates to and have provided an overarching methodology chapter (Chapter 3).

The four papers are outlined below and details are provided on the authors, the contribution of the candidate to the papers and the journals they were published in. Permission has been granted by journal publishers to include these papers in this thesis (see Appendix H). Copies of the articles can be provided on request. A list of conference presentations based on this thesis is also provided below.

Publications


Mathieson F, Jordan J, Carter J.D., Stubbe M. (2016). Nailing down metaphors in CBT: Definition, identification and frequency. *Behavioural and Cognitive Psychotherapy.* 44(02):236-48. [https://doi.org/10.1017/S1352465815000156](https://doi.org/10.1017/S1352465815000156) FM reviewed the literature, led the study design, coded all transcripts, conducted the analysis, wrote the first draft and conducted subsequent editing. This study is described in Chapter 4 of this thesis.

Mathieson F, Jordan J, Carter J, Stubbe M. (2015). The metaphoric dance: Co-construction of metaphor in cognitive behaviour therapy. *The Cognitive Behaviour Therapist* 8. [https://doi:10.1017/S1754470X150000628](https://doi:10.1017/S1754470X150000628) FM reviewed the literature, led the study design, coded all transcripts, conducted the analysis, wrote the first draft and conducted subsequent editing. This study is described in Chapter 5 of this thesis.
Mathieson F, Jordan J, Merrick P, Stubbe M. (2017). Juicy conceptualizations: Increasing alliance through attending to client metaphoric language. *Behavioural and Cognitive Psychotherapy*. 45(6):577-89. [https://doi.org/10.1017/S1352465817000339](https://doi.org/10.1017/S1352465817000339) FM reviewed the literature, led the study design, developed and ran the training workshops, completed the data analysis, wrote the first and edited subsequent drafts of the article. This study is described in Chapter 6 of this thesis.

Mathieson F, Jordan J, Bennett-Levy J, Stubbe M. (2018). Keeping metaphor in mind: Training therapists in metaphor-enhanced cognitive behaviour therapy. The Cognitive Behaviour Therapist 8;11(E8). [https://doi:10.1017/S1754470X18000077](https://doi:10.1017/S1754470X18000077) FM led the study design, designed the measures, completed the data analysis, reviewed the literature, wrote the first draft and edited subsequent drafts of the paper. This study is described in Chapter 7 of this thesis.

**Presentations**

*All were oral paper presentations by Fiona Mathieson, unless specified*


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Glossary of terms and abbreviations

ACT  Acceptance and commitment therapy

Alliance  The therapeutic alliance (or working alliance) refers to the quality of the therapy relationship.

Analogy  A comparison between one thing and another typically used for the purpose of explanation or clarification. Often used as a synonym for ‘metaphor’, but also sometimes regarded as a broader linguistic phenomenon, of which metaphor is a sub-category e.g. ‘an analogy between the workings of nature and those of human societies’.

Apostrophe  A type of personification, when an absent person or personified abstraction is addressed such as ‘Death: where is your sting?’

CBT  Cognitive behaviour therapy

CCC-RS  Collaborative case conceptualization rating scale

CMT  Conceptual metaphor theory

CPR  Change process research

Change process research  Study of the process by which change occurs in psychotherapy

Co-construction  Both therapist and client contributing to the development of a shared metaphoric understanding, rather than this being primarily therapist or client-led.

Cognitive linguistics  An interdisciplinary branch of linguistics, combining knowledge and research from both psychology and linguistics. It describes how language interacts with cognition.

Cognitive Load theory  The idea that chunking of information reduces cognitive effort

Constructivism  The idea that people construct knowledge out of how they actively make sense of their experiences.

Conceptualisation  A way of making sense of a client’s problems and how they are maintained, often in the form of a diagram.

Conceptual Metaphor Theory  The idea that metaphor arises from pre-existing patterns of thought which are shared across speech communities

Conventional metaphors  Words or phrases in common usage, often to the extent we may not consider them metaphorical, such as ‘I see your point’.

Conversation Analysis  A qualitative approach to the study of talk during naturally occurring social interactions.

Corpus linguistics  The study of linguistic phenomena through large computerised databases of machine-readable samples of real life language use.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>CTS-R</td>
<td>Revised cognitive therapy scale</td>
</tr>
<tr>
<td>DBT</td>
<td>Dialectical behaviour therapy</td>
</tr>
<tr>
<td>Dependent</td>
<td>A dependent variable is what you measure in the experiment and what is affected during the experiment. The dependent variable responds to the independent variable. It is called dependent because it &quot;depends&quot; on the independent variable.</td>
</tr>
<tr>
<td>Discourse</td>
<td>Written or spoken communication.</td>
</tr>
<tr>
<td>Discourse Dynamics</td>
<td>Method of analysing conversational interactions, based on Dynamic Systems theory.</td>
</tr>
<tr>
<td>Discursive</td>
<td>Relating to discourse or modes of discourse.</td>
</tr>
<tr>
<td>Discursis</td>
<td>Computer software which is used to analyse large amounts of written text and identify concepts within it.</td>
</tr>
<tr>
<td>Dynamic Systems</td>
<td>Theory that spoken interactions are complex, fluid, self-organising systems.</td>
</tr>
<tr>
<td>Embodied cognition</td>
<td>Embodied cognition, a theory that many aspects of cognition are shaped by the body.</td>
</tr>
<tr>
<td>Eriksonian</td>
<td>Erik Erikson developed an eight-stage theory of psychosocial development from infancy to adulthood.</td>
</tr>
<tr>
<td>Framing device</td>
<td>Relatively stable metaphorical mappings that function as key ways of communicating about more abstract therapeutic processes, conceptualisations and constructs.</td>
</tr>
<tr>
<td>Guided discovery</td>
<td>A collaborative approach used in CBT to utilise a client’s natural curiosity, using Socratic questioning and experimentation to find out what the world is really like.</td>
</tr>
<tr>
<td>Hedging device</td>
<td>A mitigating word used to lessen/soften the impact of an utterance due to constraints on the interaction between the speaker and addressee, such as politeness, softening the blow, avoiding the appearance of bragging or cautiousness.</td>
</tr>
<tr>
<td>Hyperbole</td>
<td>Exaggerated statements or claims not meant to be taken literally. E.g. ‘I completely died out there during the marathon’.</td>
</tr>
<tr>
<td>Iatrogenic</td>
<td>Medical disorder caused by diagnosis process or treatment.</td>
</tr>
<tr>
<td>ICS</td>
<td>Interacting Cognitive Subsystems</td>
</tr>
<tr>
<td>Idioms</td>
<td>Idioms are expressions that often include aspects of metaphor (can also have metonymy, irony, hyperbole e.g. ‘it’s raining cats &amp; dogs’ Idioms and metaphor are not separate, mutually exclusive categories (Gibbs &amp; Colston, 2012, p. 51).</td>
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<tr>
<td>Term</td>
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<tr>
<td>Interacting Cognitive Subsystems</td>
<td>A comprehensive model of how we process meaning and emotions.</td>
</tr>
<tr>
<td>Irony</td>
<td>The expression of one's meaning by using language that normally signifies the opposite, typically for humorous or emphatic effect.</td>
</tr>
<tr>
<td>Kinaesthetic</td>
<td>Relates to a person’s sensory awareness of the position and parts of the body.</td>
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<tr>
<td>Likert scale</td>
<td>A type of rating <em>scale</em> used to measure attitudes or opinions. With this <em>scale</em>, respondents are asked to rate items on a level of agreement. For example: Strongly agree.</td>
</tr>
<tr>
<td>Literalisation</td>
<td>Extended real-world analogy</td>
</tr>
<tr>
<td>LPR</td>
<td>Language Preference Report</td>
</tr>
<tr>
<td>Metaphor topic (or ‘target’)</td>
<td>The actual issue under discussion.</td>
</tr>
<tr>
<td>Metaphor vehicle (or source)</td>
<td>The word or phrase used metaphorically, with some meaning other than its basic sense and transfer of meaning to the metaphor topic.</td>
</tr>
<tr>
<td>Metonym</td>
<td>A substitution of a descriptive word for what is meant (a part stand for a whole or a whole for a part) e.g. head count; green (for money); wheels (meaning car) or a football player describing fans who lacked spirit as ‘prawn sandwiches’.</td>
</tr>
<tr>
<td>Mindfulness</td>
<td>A mental state achieved by focusing one's awareness on the present moment, while non-judgementally acknowledging and accepting one's feelings, thoughts, and bodily sensations.</td>
</tr>
<tr>
<td>MIP</td>
<td>Metaphor identification procedure</td>
</tr>
<tr>
<td>Multimodal therapy</td>
<td>An approach to psychotherapy devised by psychologist Arnold Lazarus, based on the assumption that <em>therapy</em> must assess seven discrete but interactive modalities (Behaviour, Affect, Sensation, Imagery, Cognition, Interpersonal factors, and Drug/Biological considerations).</td>
</tr>
<tr>
<td>Neuro-linguistic programming</td>
<td>Neuro-linguistic programming (NLP) is an approach to communication, personal development, and psychotherapy created by Richard Bandler and John Grinder in the 1970s. NLP claims there claim there is a connection between neurological processes, language and behavioural patterns learned through experience and that these can be changed to achieve specific goals in life.</td>
</tr>
<tr>
<td>Object Relations</td>
<td><em>Object relations theory</em> in psychoanalytic psychology is the process of developing a psyche in <em>relation</em> to others in the environment during childhood. The first &quot;<em>object</em>&quot; in someone is usually an internalized image of one's mother.</td>
</tr>
<tr>
<td><strong>Oxymoron</strong></td>
<td>Linking of two terms that are ordinarily contradictory such as ‘love is such sweet pain’.</td>
</tr>
<tr>
<td><strong>Periphrasis</strong></td>
<td>Substitution of a descriptive word or phrase for a proper name, or a proper name for a quality associated with a name: ‘He is a real ‘Judas’’ or ‘You might as well wear a white sheet’.</td>
</tr>
<tr>
<td><strong>Personification</strong></td>
<td>Investing abstraction or inanimate objects with human qualities as in: ‘the sea beckoned me’.</td>
</tr>
<tr>
<td><strong>Process based therapy</strong></td>
<td>The contextually specific use of evidence-based therapeutic processes linked to evidence-based therapeutic procedures to help solve the problems and promote the wellbeing of an individual.</td>
</tr>
<tr>
<td><strong>Proverbs</strong></td>
<td>Some have obvious metaphorical motivations, e.g. ‘Don’t put all your eggs in one basket’. Yet other proverbs are not metaphorical, such as ‘Where there’s a will, there’s a way’ (Gibbs &amp; Colston, 2012, p. 54); they are effective because they draw on common wisdom e.g. unwise to put them all in one basket in case you drop it. This enhances the validity of the advice and decreases the speaker’s personal responsibility for what is being urged. They can work well as ‘off the record’ communication, enabling speakers to deny their covert communication intentions if questioned (Gibbs &amp; Colston, 2012, p. 240)</td>
</tr>
<tr>
<td><strong>Psychodynamic therapy</strong></td>
<td><em>Psychodynamic therapy</em>, also known as insight-oriented therapy, focuses on unconscious processes as they are manifested in a person’s present behaviour. The goals of <em>psychodynamic therapy</em> are a client’s self-awareness and understanding of the influence of the past on present behaviour.</td>
</tr>
<tr>
<td><strong>Qualitative analysis</strong></td>
<td><em>Qualitative research</em> is a scientific method of observation to gather non-numerical data. It is a process of naturalistic inquiry that seeks in-depth understanding of social phenomena within their natural setting. It focuses on the direct experiences of human beings as meaning-making agents in their everyday lives.</td>
</tr>
<tr>
<td><strong>Relational frame theory</strong></td>
<td>A complex theory of human cognition and language that underpins ACT.</td>
</tr>
<tr>
<td><strong>Signalling device</strong></td>
<td>A linguistic device (or ‘tuning device’) such as ‘It’s like...’ or, ‘metaphorically speaking’ that might indicate metaphoricity.</td>
</tr>
<tr>
<td><strong>Socratic questioning</strong></td>
<td>The Socratic approach was used by Socrates and is also used in CBT. It involves asking questions the listener has the knowledge to answer in order to assist them to challenge their current thinking.</td>
</tr>
<tr>
<td><strong>SRS</strong></td>
<td>Session rating scale</td>
</tr>
<tr>
<td><strong>Stem Sentences Test</strong></td>
<td>A method of prompting metaphoric comparison using stem sentences</td>
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<td>Term</td>
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<tr>
<td>Synecdoche</td>
<td>A figure of speech in which a part is made to represent the whole or vice versa, as in ‘England lost by six wickets’ (meaning ‘the English cricket team’). It is sometimes considered a sub-class of metonymy.</td>
</tr>
<tr>
<td>Synonym</td>
<td>A word or phrase that means exactly or nearly the same as another word or phrase in the same language.</td>
</tr>
<tr>
<td>Thematic analysis</td>
<td>Widely used qualitative analytic method for identifying, analysing and reporting patterns (themes) within written data.</td>
</tr>
<tr>
<td>Third wave</td>
<td>This term refers to cognitive therapies developed after CBT was developed by Dr Aaron Beck</td>
</tr>
<tr>
<td>Unconventional metaphors</td>
<td>Novel metaphorical words or phrases.</td>
</tr>
<tr>
<td>WAI-SR</td>
<td>Working Alliance Inventory (short form, revised)</td>
</tr>
<tr>
<td>Working alliance</td>
<td>The quality of the therapy relationship</td>
</tr>
<tr>
<td>Working memory</td>
<td>The part of short-term memory which is concerned with immediate conscious perceptual and linguistic processing.</td>
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Chapter 1
A Broad Metaphorical Landscape

1.1 Introduction and personal statement

My background is as a clinical psychologist. I was trained in cognitive behaviour therapy (CBT) as my primary treatment modality, qualifying in 1991. CBT is an evidence-based form of psychotherapy. Over my career I have watched CBT evolve in terms of the range of conditions it has been applied to and the ongoing application of new findings in basic science to the clinical setting. This has been accompanied by a very strong research tradition, continually seeking to enhance the therapy we offer to people so as to improve outcomes. For the past sixteen years I have taught a postgraduate course in CBT. Like CBT, my own teaching practice and research has evolved, with ongoing integration of the latest evidence-based approaches to treatment and of ways to effectively develop competence in CBT. My early research was mainly focused on methods of developing competence in CBT.

I built on this background for my PhD topic, also drawing on my love of writing and literature (as I also have an English degree), to look at metaphoric language in CBT. In CBT, the primary focus is on transforming meaning and belief about self, the world and other people, so as to reduce distress. It made sense to me that working with metaphors may be one way to achieve this, given that they can have a great deal of associated meaning and may provide a ‘bridge’ from a problematic perspective to a more helpful perspective. What particularly inspired my interest in the topic was the observation that there seemed to be growing interest in metaphor within the CBT field, with many assertions being made about the benefits of metaphors in therapy. What particularly caught me interest was the encouragement to therapists to bring client metaphors into shared case conceptualisations (Kuyken, Padesky, & Dudley, 2009). However, there was very little empirical research in the area specific to CBT. There also seemed to be a tendency to put metaphors in the ‘too hard’ basket, due to the methodological challenges of empirical research in this area. The CBT approach involves curiosity and taking an empirical approach I was curious to discover whether I could find a way through the methodological challenges, so as to, at least in part, establish an empirical basis for the use of metaphor in CBT.

In particular, I was curious about how often clients and therapists use metaphors in CBT and how these metaphors are elaborated upon or otherwise harnessed to transform meaning. Based on this investigation, I became interested in how specific training in identifying and
transforming client metaphors, within a CBT framework, might be experienced by therapists and clients and what impact this might have clinically.

### 1.1.1 Thesis Statement

As already noted, while there are enthusiastic claims within psychotherapy about the benefits of metaphor, there is little empirical literature on metaphor in psychotherapy, and virtually none in the area of CBT. This thesis aims to begin the process of building an empirical literature around the use of metaphor in CBT.

First, I will outline the broad landscape of the literature and relevant theory on metaphor in general (Chapter 1) and the current literature on metaphor in psychotherapy, including CBT, outlining the gaps in the literature and methodological challenges (Chapter 2). Next I will outline the available approaches to investigating metaphor empirically and justify the overall research design used in this thesis (Chapter 3).

I will then lay some groundwork in the area with my first study, which explores a method of metaphor identification and looking at frequency of metaphor use in CBT sessions (Chapter 4). I build on this with my second study, which explores the types of verbal responses that occur during co-construction of shared metaphors between therapists and clients in CBT (Chapter 5).

Based on this groundwork, at the heart of this thesis, I will describe in my third study how I applied what I had learnt clinically, by evaluating the effect of training a group of CBT therapists to bring metaphor into shared case conceptualisations. I focussed on conceptualisations because this is both a cornerstone of CBT and a specific area that CBT experts have advocated bringing metaphor into. I looked at the impact of this training on ratings of alliance and collaboration, as these areas are fundamental to a productive working relationship in CBT (Chapter 6).

I go on to describe my fourth study which explores the impact of this training from the perspective of the therapists who attended the workshops, in terms of awareness of metaphors occurring, confidence in intentional responding to metaphor and the degree to which they continued to apply the training over time (Chapter 7).
Finally, I draw together the threads of my foray into empirical study of metaphors in CBT and discuss the implications for future research (Chapter 8)¹.

1.1.2 Search Strategy

A search of the University of Otago’s PsycINFO and EBSCO Psychology and Behavioural Sciences databases using T1 metaphor* AND TX (cognitive AND therap*) was conducted. Further hand searching of references and targeted searches of databases and google scholar was conducted, based on authors and references in articles found in this search. Resources drawn on were limited to those in the English language. Loan services of other New Zealand, Australian and United States libraries were used for resources not available within University of Otago. The microfiche copy of the ‘Training manual for identifying figurative language’ (Barlow, Kerlin, & Pollio, 1971), was accessed by using the Wellington City Council’s microfiche readers². Literature searches were completed in two main stages. The first was a preliminary broad reading of the available metaphor literature in order to understand the key theories and debates in the area; summarise the state of the literature on metaphor in psychotherapy, particularly in cognitive behaviour therapy (CBT) and identify the gaps in the literature. The second stage involved revisiting the metaphor literature and extending the search to look in more depth at potential qualitative and quantitative methodologies within psychology and linguistics for addressing the research questions.

Ongoing email alerts proved to be productive as further studies on metaphor in psychotherapy were published. These were integrated into the literature review as part of the final write-up.

1.2 Chapter Overview

This first chapter aims to bring together and distil the key broad theoretical concepts, debates and research findings relevant to the study of metaphor. It is hoped that this will provide a helpful landscape both for this thesis and for future scholars in the area. The next chapter (Chapter 2) will focus on the existing literature on metaphor in psychotherapy (and in CBT in particular).

Key points made in this chapter are that metaphors are pervasive in language, and rather than being simply linguistic ornamentation, they are fundamental building blocks of language and

¹ As noted in ‘Publications and presentations arising from this thesis’, this thesis is a hybrid thesis and chapters 4-7 are largely based on four published academic articles.
² Microfiche is a flat piece of film containing microphotographs of the pages of a newspaper, catalogue, or other document. A microfiche reader is a device that magnifies microfiche images to readable proportions.
thought. Metaphors are not easy to categorically identify or define, but all share the fundamental characteristic of talking about one thing in terms of another.

As the literature review presented here shows, there is growing interest in metaphor and recognition of the important cognitive functions it has, particularly as an organiser of experience. There are a number of theories of metaphors, including Conceptual Metaphor Theory, constructivism and Dynamic Systems theory. I will argue that in the case of analysing conversations such as therapy conversations, they need to be analysed in context. There are also several theories of metaphor comprehension and other theories with potential relevance to metaphor research.

1.3 Literature Review

Metaphor is widely studied and used across a wide range of disciplines, such as literature, politics, philosophy, marketing, linguistics, psychology and medicine. Interest in metaphor can be dated back to Aristotle (384BC – 322BC), who claimed that “by far the most important is to be good at metaphor […] it is a sign of natural genius” (Aristotle, as cited in Russell & Winterbottom, 1972, p. 122).

There has been longstanding debate, since the time of Aristotle, regarding whether metaphor is merely an ornamental form of speech or is a fundamental and creative form of thought, having basic epistemological functions (Crystal, 2008; Leary, 1990b). Metaphor was dismissed by the British philosopher John Locke in 1690 as ‘linguistic frills’ and not in the domain of the serious rational thinker (Locke, 1894, p. 20). The widely held view became that metaphor, unlike literal language (the language of facts), has a secondary, peripheral, artistic or poetical function (Törneke, 2017).

In the past thirty years, however, much research in cognitive linguistics has demonstrated that metaphor is not merely a figure of speech, but that metaphors characterise human thought and language in a fundamental way, create new realities, have many different communicative functions and convey a great deal of meaning (Leary, 1990b; Ricoeur, 1981).

Rather than being merely a linguistic device, metaphor is thought to reflect people’s figurative conceptualisations of experience in many instances (Gibbs & Colston, 2012). This potential link between language and conceptualisation has led some therapists to consider how metaphors could be used to explore and change client’s feelings, attitudes, values and behaviours (Wickman, Daniels, White, & Fesmire, 1999).
There has been increasing recognition of the important cognitive function of metaphor in the acquisition of new knowledge, through enabling transfer of understanding and learning from what is well known to what is less well known, in a memorable and vivid way (Petrie & Oshlag, 1993). In 1975, the first empirical investigations of metaphoric language in psychotherapy began (Pollio & Barlow, 1975).

Growing interest in metaphor is reflected in the fact that since 1986 there has been an academic journal called *Metaphor and Symbol* (Originally called *Metaphor and Symbolic Activity*). In 2006 an Association for Researching and Applying Metaphor (RaAM) was formed and began holding regular international conferences. More recently, an overview of metaphor research was published (Gibbs, 2008). In addition, Steen et al. (2010a) and Cameron and Maslen (2010) have addressed methodological aspects of metaphor identification, attempting to bridge the gap between linguists and cognitive scientists, with an emphasis on metaphor in real world contexts. More recently, linguist Dennis Tay has conducted research looking at metaphor use in therapy conversations (Tay, 2013).

Within science, metaphor has increasingly been recognised as having a place. Albert Einstein noted that combinatory play (playing with one idea as another through metaphor) seems to be an essential feature in productive thought (Singer, 2013). It has been argued that art and science, while fundamentally different in their objectives and methods, are at heart just different ways of looking at the world. However, while scientific hypotheses can be empirically supported (or not supported), a picture, a poem or a piece of music cannot (Banville, 1998). Accordingly, scientists may use metaphors in order to assist understanding of abstract scientific concepts. For example: the heart as a pump; the brain as a computer; the eye as a camera (Stewart, 2015).

There is growing evidence that metaphorical language can act as an organiser of experience, often reflecting people’s metaphorical conceptualisations of experience and many empirical findings on both the prominence of figurative language in written and spoken discourse and the ease that people often have with interpreting and using metaphorical meanings. Empirical studies have demonstrated that metaphors convey a wide range of complex cognitive, social and affective messages (Gibbs & Colston, 2012).

### 1.3.1 Defining metaphors

In order to explore metaphor in this thesis, it was necessary to define what a metaphor is. This proved to be a challenging task. Nevertheless, for the purposes of this thesis, a working
definition was necessary. This section will summarise the literature on defining metaphors and provide the definition selected for this thesis.

1.3.2 Terminology

Before proceeding to the topic of defining metaphor, it will aid clarity to explain key aspects of terminology used in the literature on metaphor.

**Vehicle, Source, Topic and Target**

In the literature on metaphor, the terms *vehicle* and *source* are used to mean words or phrases with some meaning other than their basic sense, while the *topic* or *target* is the surrounding, ongoing topic of talk (see ‘Glossary of terms and abbreviations, p. xvi). For example, in the phrase ‘my house is a tip’, the vehicle (or source) is the ‘tip’ (meaning a rubbish dump), while the house is the *topic or target*. In line with the Dynamic Systems approach (explained in section 1.4.5), and in order to avoid confusion, this thesis will use the terms *vehicle* and *topic*.

1.3.3 Conventional and unconventional metaphors

Conventional metaphors are technically metaphorical, but their metaphoricity has faded over time, such as ‘the *legs* of a chair’ or ‘the *neck* of a bottle’. These are part of everyday vernacular. Such expressions are sometimes called ‘frozen’ or ‘dead’ metaphors or clichés, ‘as if the words themselves undergo some process of dying or maintaining life’ (Gibbs & Colston, 2012, p. 47). Some common conventional metaphorical expressions may have stronger metaphorical associations, such as ‘I’m *wrestling with* this illness’ (ILLNESS IS A BATTLE).

Unconventional metaphors tend to be more novel and idiosyncratic such as ‘I have gone into prison and thrown the keys out of the window’ (FM example). Unconventional metaphors are viewed as more likely to be used intentionally and as a way of influencing people; although more conventional metaphors can still be ‘*woken*’ by deliberate use or development (Törneke, 2017, p. 31).

1.3.4 Definitions

A metaphor creates a deliberate resemblance between two different things. The word ‘metaphor’ comes from the Greek *metapherein*, which means ‘to carry over’ (Kopp & Craw, 1998). The transfer or sharing of meaning is from a secondary subject, usually called the *vehicle*. As the poet and novelist James Dickey has noted, metaphor is:
‘not so much a way of understanding the world but a perpetually exciting way of recreating it from its own parts … It is a way of causing the items of the real world to act upon each other, to recombine…It is a way of putting the world together according to rules which one never fully understands, but which are as powerfully compelling in the whole human makeup’ (Dickey, 1968, p. 2).

Metaphors do not only operate as comparisons, but also as connections between that which is understood well (body, earth, common experiences, sensory information), and those that are hard to understand (abstractions, non-sensory phenomena, uncommon experiences): in this way, the unfamiliar is illuminated by the familiar (Maasen & Weingart, 2000).

There is a huge number of definitions in the literature, as reflected in the following comment that “anyone who has grappled with the problem of metaphor will appreciate the pragmatism of those who proceed to discuss it without giving any definition at all” (Soskice, 1985, p. 15). Researchers from different disciplines have used different definitions (Tay, 2013) and this makes it hard to construct a knowledge base and replicate findings (Törneke, 2017). A definition that is useful for one discipline is often unsatisfactory for another: the interests of a poet differ from those of a theologian or psychologist. Literal language is the language of definition and perhaps it is not possible to define metaphor through literal language (Watzlawick, 1978), or not necessary or possible to devise a substantial definition of metaphor that is satisfactory to all (Soskice, 1985). However, it is useful to have a minimal definition adequate across disciplines, which can be elaborated in ways suited to the particular discipline, and which makes clear that metaphor, as a figure of speech, is a form of language use (Soskice, 1985).

Aristotle described a good metaphor as implying an intuitive perception of the similarity in dissimilars (Aristotle, as cited in Russell & Winterbottom, 1972). Similarly inclusive definitions were used by Soskice who wrote that “metaphor is a figure of speech whereby we speak about one thing in terms which are seen to be suggestive of another” (1985, p. 15) and by Lakoff and Johnson: “The understanding of one thing in terms of another” (1980, p. 3).

1.3.5 Definitions in the cognitive behaviour therapy literature

A recent CBT based book on metaphor defined metaphors as comparing seemingly unrelated subjects; they describe the first subject as being or equal to a second subject in some way. They are a figure of speech that implies a comparison between two different entities. This suggests that metaphors act as a bridge between a more familiar or concrete metaphor vehicle and a topic, which is less familiar or more abstract (Stott, Mansell, Salkovskis, Lavender, & Cartwright-Hatton, 2010). Specifically, Stott et al. (2010, p. 3) define metaphor as “a figure of
speech in which an expression is used to refer to something that it does not literally denote in order to suggest a similarity”. This broad definition is in line with many other authors in the area in suggesting that similarity (or analogy) is included in the definition of metaphor, often along with stories, parables and similes (see Hill and Regan (1991); Shibles (1974); (Tay, 2013)).

Most experimental research in this area is based on simple ‘A is B’ forms of metaphor (e.g. Juliet is the sun), however the term is also used more widely to include analogies, idioms, allegories, short anecdotes and figurative stories. This inclusive terminology is a source of confusion when comparing psycholinguistic research on metaphor (which deals with specific types of utterance) with the applied literature (where metaphors tend to be in the form of stories suggesting solutions to clients’ problems) (McCurry & Hayes, 1992).

Taking the literature into account, the broad working definition of metaphor selected for the purposes of this PhD study, is the definition used in the Discourse Dynamics approach (Cameron & Maslen, 2010, pp. 101-104) (see section 1.4.5). This defines metaphor as “a device for seeing something in terms of something else” (Burke, 1945, p. 503). This definition was selected because it is consistent with the idea put forward by psychologists and linguists in recent decades, which sees metaphor as not merely language play for rhetorical effect, but as a fundamental cognitive tendency to understand one concept in terms of another (Gibbs, 2013). When used intentionally, metaphor (using this definition) seems especially relevant to CBT, which has an emphasis on different ways of ‘seeing’ one’s situation. In addition, given that this thesis uses a metaphor identification process developed by Cameron, it was logical to use the same definition. The metaphor identification process is described in chapter 4.

Similes, in which a comparison is made between one thing and another using the words ‘like’ or ‘as’ are included in this definition of metaphor (for example: ‘my flat is like a fridge’).

There are various sub-types of figurative language, such as metonyms, irony, synecdoche, proverbs, idioms, oxymora, personification, analogy and irony. These are defined in the Glossary of terms and abbreviations (p. xvi). These are often referred to in philosophical and linguistic texts but they play no major role in the metaphor research I am interested in in this thesis, which uses the definitions described above. Furthermore, the boundaries between these categories are not well-defined. For example, ‘analogy’ is often used as a synonym for ‘metaphor’, but also sometimes regarded as a broader linguistic phenomenon, of which metaphor is a sub-category (Törneke, 2017). There is further reference to sub-types of figurative language in section 1.4.1.
1.3.6 Identifying metaphors

As well as defining metaphors, identifying them in written or oral communication can be challenging. Research on metaphor use in psychotherapy has been hampered by the lack of rigorous and explicit methods of metaphor identification, particularly with naturally occurring conversational data as opposed to de-contextualised sentences or indisputably figurative examples made up by the experimenters (Semino, Heywood, & Short, 2004).

The analogy of walking down the street and trying to pick which people have a cold has been used to describe how challenging it can be to identify metaphorical language in real life discourse. Several people with varying symptoms might all be described as having a cold, but with no single symptoms that is common across all instances. Metaphors may be like colds in that they have symptomatic, but not defining features. In this view, it may not be possible to devise a set of criteria that determine for certain whether a word or phrase is metaphorical, but there may be a variety of clues that are symptomatic of a word having metaphorical meaning, including that it expresses indirect meaning in context, and has other, more concrete, embodied, imageable or historically older meanings from which metaphorical meaning may be created (Gibbs & Colston, 2012, p. 55). The idea of embodiment is described in section 1.7.1 and the importance of imagery in metaphors, is covered in section 2.10.

Fortunately, in recent years, linguists such as Steen et al. (2010a) and Cameron and Maslen (2010) have made progress in this area, developing a detailed method of metaphor identification, which is appropriate to the conversational context of therapy used in the current thesis. Details of this will be provided in section 4.6.

1.4 Metaphor theory

Not surprisingly, given the wide range of disciplines with an interest in metaphor, there are numerous theories in the literature as to the role of metaphors and how they are understood. I have summarised the main theories relevant to metaphor in psychotherapy in this section.

1.4.1 Constructivist view

In contrast to Locke’s idea that metaphors are mere linguistic frills, the constructivist approach views individuals as actively participating in the construction of perceived reality (Mahoney, 1988). Many of the philosophical roots of CBT are evident in this constructivist approach which views reality as a socially constructed phenomenon that occurs as a function of the observer who creates it (Martin & Sugarman, 1997; Meichenbaum, 1993). Metaphors
serve as a good example of active meaning making in that they organise, communicate and negotiate understanding (Tay, 2017).

In constructivism, all knowledge is seen as fundamentally based in metaphorical (or analogical) modes of thought and perception. For example, if confronted with an unknown word, you might either ask someone else what it means, or look it up in a dictionary (or online). You are likely to keep searching until you find a definition that uses words that are more familiar to you. This process may serve as a model for how people come to understand new experience in that we search for similar instances to assist understanding. These instances are either implicitly or explicitly metaphorical in nature. We look for analogues of things we wish to comprehend (Craik, 1943; Leary, 1990b). If this is true, metaphor plays a fundamental role in psychotherapy, as it does in any other domain. As noted earlier, arguably this role is even more important in CBT given the emphasis in CBT on changing dysfunctional cognitions.

Metaphorical and literal language have been viewed by some as qualitatively different forms of language, with metaphorical language suited to the expression of intuitive truths and literal language as suited to empirical truths (Watzlawick, 1978). However, constructivists challenge this sharp division, regarding all language as creative to some extent and as active in constructing meaning. The constructivist view is that literal and overtly metaphorical language lie along a continuum, varying only in the degree and explicitness of their generation of new meaning (Leary, 1990a). The idea here is that with repeated usage, terms such as the ‘leg’ of a chair are transformed over time by shared usage among a speech community into literal terms with widely understood meaning (Leary, 1990b). Conversely, literal terms can be used metaphorically in a new way, such as describing a key idea as the ‘third pillar of the building’ (FM example).  

Recent developments in empirical metaphor research support the idea that there may not be a fundamental distinction between figurative and literal language (Gibbs & Colston, 2012). Problems with this distinction include: the lack of a single common feature that unites all the variety of sub-types of ‘figurative’ language (as mentioned in section 1.3.5, these include idiom, metonymy, irony, proverbs and oxymora) (Gibbs, 1994), with metaphor and metonymy, for example, reflecting very different kind of mappings: Metaphor involves the mapping of information between different conceptual domains. Metonymy involves

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3 I have noted ‘FM example’ at various points of this thesis so as to indicate that these examples are not given by other authors. All examples given are drawn from those used in FM’s clinical practice.
highlighting a salient part of a single domain, such as ‘The White House’. No single mental process or strategy can account for the production and processing of figurative language. Further, there is a great variety of forms of literal utterances. We do not completely understand how people process literal language either, with no sole agreed upon position amongst linguists as to what people do when they encounter each word they encounter in speech and written text. Therefore, it is not correct to assume that models of figurative language processing models stand in contrast to some well-understood idea of how literal language is processed (Gibbs, Wilson, & Bryant, 2012).

While the constructivist position that clear distinctions cannot be made has considerable merit, the study described in Chapter 4 did attempt to identify and count instances of metaphoric language occurring naturally in CBT sessions. This was in order to explore the frequency of metaphor in CBT and evaluate the reliability of a recently developed method of identifying metaphors (Discourse Dynamics), while bearing the constructivist position in mind. The hope was that there would be valuable learning through the process of attempting to identify metaphors in therapy conversations.

The Discourse Dynamics identification method is based on Dynamic Systems theory (described below in section 1.4.5). It was developed as a way of analysing evolving patterns of metaphor within conversations, with the aim of investigating metaphor as a way of understanding people’s values, ideas and attitudes, in context (Cameron et al., 2009). It therefore appeared to be highly relevant to exploring metaphor in the CBT context, given the importance of values, ideas and attitudes in CBT (explained further in section 2.4).

1.4.2 Interactive view

The interactive view is a radical constructivist view of metaphor that originated with Richards (1936) and is elaborated on by Black (1993). This approach to metaphor emphasises the unique nature of metaphor and its effect on cognition and language. It views metaphor as a basic component of language use with epistemic value (i.e. value in understanding new schemata of knowledge) and heuristic value (i.e. value in learning), both of which have been acknowledged by many psychologists and linguists (Muran & DiGiuseppe, 1990). The interactive view is that metaphor creates similarities, thus providing a bridge between old and new conceptual and representations. The interaction between the meaning of one object and that of another is thought to result in a new meaning that transcends both. Metaphor is seen as a way of bridging the epistemological chasm between new and old knowledge and enabling different ways of organising and perceiving the world (Petrie & Oshlag, 1993), creating a
“new perspective or frame, a way of looking at things” (Schon, 1993, p. 137). Similarly, metaphor is described as an additive instrument of knowledge, rather than as a substitutive one (Eco, 1984).

1.4.3 Conceptual Metaphor theory

This theory is the dominant theory in metaphor research (Gibbs, 2011b). Conceptual Metaphor Theory (CMT) was introduced thirty years ago through the highly influential work of Lakoff and Johnson (1980) in their book *Metaphors We Live By*. CMT views metaphor is not just a decorative aspect of language but as a specific neural and mental mapping, a fundamental part of human thinking, reasoning and imagining in everyday life (Lakoff & Johnson, 1999). Most metaphorical language is considered to originate from pre-existing patterns of thought, or underlying conceptual metaphors, which are thought to reflect the different ways that particular concepts are represented in people’s long-term memories (Gibbs, 1994, 2011b).

Lakoff and Johnson demonstrated that everyday language is full of metaphors we may not always notice. They collected and classified a huge number of conceptual metaphors, in which more abstract ideas (such as relationships, life, love, anger and the nature of the mind) are understood through accessing our knowledge of more concrete and familiar experiences, (such as warmth, buildings, machines, plants, hot and cold, light and darkness) (Gibbs, 1999; Kovecses, 2002). Some go so far as to argue that metaphors are more basic than literal language: “All knowledge is ultimately rooted in metaphorical (or analogical) modes of perception and thought” (Leary, 1990a, p. 2).

Conceptual metaphors are enduring conceptual mappings from vehicle to topics that provoke a broad range of linguistic expressions and tend to be shared across a speech community. For example, a common conceptual metaphor is ARGUMENT IS WAR⁴. This reflects a view that argument (the topic) is like a battle or a war to be won (the vehicle). It is commonplace to hear someone say ‘I attacked the weak point in her argument’ or ‘She won that argument’. Argument can be viewed in many other ways other than as a battle, but this concept may shape the way we think about or conduct arguments. Another commonly used conceptual metaphor is LOVE IS A JOURNEY, reflected in phrases such as: our relationship is off track.

⁴ Labelling of metaphors: Conceptual metaphors are conventionally written with SMALL CAPITALS; Larger groupings of metaphors found in discourse data (called ‘systematic metaphors’) are labelled in SMALL CAPITALS AND ITALICS (Cameron & Maslen, 2010). For the purposes of consistency with the identification approach used in Chapter 4, I have underlined all specific examples of metaphoric words and phrases used in this chapter but used CMT conventions to indicate conceptual metaphors.
and look how far we have come. These phrases, according to Lakoff, serve as mnemonics for sets of cross-domain mappings, such as those between lovers and travellers (Lakoff, 1993, pp. 206-207).

According to CMT, people can draw metaphorically on well-known bodily experiences in order to understand more abstract ideas and solve problems, even when they are not currently experiencing these bodily states. The term embodied is used to refer to this. For example, LOVE IS A JOURNEY draws on the embodied experience of travelling along a path towards a destination (Gibbs & Franks, 2002). Embodied cognition is discussed further in section 1.7.1.

Since 1980, a large body of empirical evidence from cognitive linguistics and related disciplines has detailed how conceptual metaphors underpin significant aspects of thought, language, cultural and expressive action (Gibbs, 2017). Many cognitive scientists agree that we make predictions by forming mental models, which are internal structures that represent external reality. Cognitive scientists have analysed the ways people think systematically about a broad range of human experiences (e.g. emotions, time) and experimental research has shown the presence of underlying conceptual metaphors in people’s use and understandings of a broad range of figurative language (Gibbs, 1992; Gibbs & Nascimento, 1996; Pfaff, Gibbs, & Johnson, 1997).

1.4.4 Criticisms of CMT

Despite the popularity and influence of CMT, there are major criticisms of CMT research, with arguments on both sides of the ‘war’ for and against CMT (Gibbs, 2017).

Linguistic analyses from a CMT perspective have been criticised for being based heavily on reliance on intuition (Murphy, 1996), and for typically not providing explicit criteria for identifying what comprises a metaphor (at either the word or phrase level) or for inferring the existence of specific conceptual metaphors (Gibbs, 2011b). CMT is not falsifiable if the only data supporting it is the systematic grouping of metaphors linked by a common theme, such as ARGUMENT IS WAR (Vervaeke & Kennedy, 1996). There is a danger of reductionism: we risk reading too much into a figure of speech that might be expressing something different from what we want to hear (Törneke, 2017). It has been suggested that the alleged correspondences should be subjected to more rigorous empirical test rather than being inferred from surface level idioms found in everyday discourse (McGlone, 2007).
Another major criticism of CMT research concerns how representative of real discourse the examples used are (Gibbs, 2011b). By contrast with constructivist approaches or approaches based on analysis in the context of natural conversational interaction such as Discourse Dynamics (discussed in section 1.4.5), most assertions about the existence of particular conceptual metaphors are based on lists of de-contextualised sentences. These purportedly reflect the same underlying conceptual mapping in the minds of the language speakers. Such lists of de-contextualised expressions can in some instances lead to a single interpretation where others are possible. For example, Lakoff’s (1993) claim regarding A PURPOSEFUL LIFE IS A BUSINESS was based on: He has a rich life. I want to get a lot out of life. It’s an enriching experience. He’s going about the business of everyday life. It’s time to take stock of life (Lakoff, 1993). While some of the examples fairly indisputably relate to A PURPOSEFUL LIFE IS A BUSINESS (e.g. He’s going about the business of everyday life), others, such as: I want to get a lot out of life are less clear, and the rationale for making the connection is not spelled out (Semino et al., 2004).

A further criticism is that generalisations about conceptual metaphors used by linguistic communities may not reflect the minds of single individuals. The exact meanings an individual may infer in real world discourse depend on many individual, linguistic and situational factors (Cameron et al., 2009; Gibbs, 1999; Gibbs & Colston, 2012). Even when individuals have developed conceptual metaphors, each individual will have developed a slightly different version since they have had different experiences (Cameron, 2008a). In real discourse events, the vehicle domains are

‘..everything that is activated in memory by the use of that item. This will include images, words, meanings, concepts, personal episodic memories. There will be a certain commonality across speakers with similar cultural experiences and from our shared physical interactions with the world, but there will also be many individual differences’ (Cameron, 2008b, p. 46).

There is further elaboration on Cameron’s views in section 1.4.5.

In addition, it has been argued that CMT is based on analysis of written language and assumes spoken and written language come from the same conceptual system. Spoken language differs because it is a joint process, and a lot of feedback is received during the process: it co-evolves, so may be a fundamentally different phenomenon. Therefore, spoken language may enact a different mode of cognition, involving emergent experiencing within a dynamic social interaction (Jensen & Cuffari, 2014). This point is relevant to the psychotherapy setting, given that therapy is an evolving interactional process.
Some authors question whether there is even a need for postulating conceptual metaphors, arguing that metaphorical expressions may have nothing to do with thought, but rather are to do with word meanings and can be explained historically (McGlone, 2007; Murphy, 1997).

Other writers, coming from a behaviour analytic approach, repudiate the idea of inner structures (such as conceptual metaphors) as an explanatory model for human action, arguing that we must focus on what we can observe, because that is all we have direct access to (Ramnero & Törneke, 2008; Skinner, 1974). Even behaviour analysts concede, however, that metaphors are pervasive in human communication, whether oral or otherwise and that therapy-relevant topics such as talking about emotions and other ‘inner’ phenomena often involve metaphoric language (Törneke, 2017).

A review of contemporary psycholinguistic research on CMT found that conceptual metaphors seem to play some, but not necessarily an exclusive role in the processing and interpretation of many types of verbal metaphors (Gibbs, 2011b).

In sum, Lakoff and Johnson’s identification of many clusters of consistent mappings between concrete and abstract concepts and the realisation that much of our language and thought about abstract ideas is metaphorical was an important contribution to metaphor research. In the therapy context, however, a primary focus on conceptual metaphors runs the risk of overlooking important factors regarding the metaphorical expressions that are actually used, what contextual factors influence their use (and how they are received), and the effects this has on the therapy interaction (Törneke, 2017).

The next section discusses an alternative approach and argues that this is better suited to the empirical examination of metaphors in psychotherapy.

1.4.5 The Dynamic Systems approach

The Dynamic Systems approach to metaphoric language sits within the constructivist view and comes out of the complex systems theory in the physical sciences literature, which studies processes that unfold over time (Aihara & Suzuki, 2010). Biological and physical scientists recognise that nature is composed of many interacting subsystems that exhibit a strong propensity to self-organise (Bak, 1996; Kauffman, 1993). For example, in nature, clouds emerge from the interaction of humidity, wind and temperature (Cameron et al., 2009). Cognitive scientists have applied self-organisation principles to explain how simple and complex human behaviours can emerge as higher-order products of self-organisational processes (Kelso, 1995; Spivey, 2007).
Dynamic Systems sees spoken language interactions (including metaphorical language) as a complex, fluid, self-organising system in which irregularities unfold over time according to particular dynamics. Many dynamic factors contribute to the interpretation of figurative meaning, (including bodily; cognitive, cultural, linguistic, present cultural conditions, social context, knowledge of language, individual cognitions and motivations, present bodily states, immediate linguistic processing and neural processes). As with traffic flows, each of these may operate at different speeds: as speakers co-ordinate in diverse ways to address adaptive needs in discourse, structured patterns emerge (Cameron, 2003, 2008a; Gibbs & Cameron, 2008; Gibbs & Colston, 2012, p. 337). People’s interpretation and use of language is a higher order product of self-organising processes. Self-organisation can occur within people’s minds, with coherent knowledge structures emerging from dynamic activation and inhibition of lower level cognitions (Gibbs & Colston, 2012, pp. 122-126).

The Dynamic Systems approach contrasts with CMT in that it takes into account the complex, dynamic nature of the discourse context, with metaphor not seen as a fixed, static mapping, but as a temporary stability that emerges from interconnecting systems of cognitive activity and socially-situated language use. Through self-organisation and emergence, metaphors and systems of metaphors can stabilise. This emergent stability is dynamic and open to further change (Cameron et al., 2009). Each metaphor is thought to arise from the particular communicative needs of the discourse participants in that moment. As speakers build on their own or each other’s ideas, offer alternatives or disagree, the dynamic system of the discourse flows and adapts. Conversations are therefore dynamic, with speakers not simply expressing their own thoughts, but also taking the listener’s perspective into account. Metaphors, like any other use of language, can bring to a discourse event traces of previous uses and of previous discourse events: What happens metaphorically at a particular moment in a conversation is influenced by what has already happened in the conversation and influences what happens afterwards (Cameron, 2003).

The emphasis on the dynamic nature of conversations makes Dynamic Systems theory particularly relevant to the therapy situation, where there is constant interaction and feedback between therapist and client perspectives. According to the Dynamic Systems approach, metaphor may contribute to cognitive change. People can learn through analogical transfer from vehicle to topic, or through collapse of existing conceptual structures and rebuilding of more ‘scientific’ conceptual structure. Metaphor may also assist with recall of information, problem-solving and bring an alternative conceptualisation, perhaps generating conflicts with
aspects of the topic domain that may prompt noticing of gaps in understanding, restructuring of concepts or new explanations (Cameron, 2003).

The Dynamic Systems perspective on how people comprehend metaphors is that most figures of speech are so complex and have so many forms that even individual figures of speech will have complicated theoretical explanations for how they are used and understood. People appear to have great conceptual and linguistic flexibility in terms of knowing what interpretation mechanisms or strategies to use when faced with varying figures of speech. While figurative language may have special rhetorical functions, this does not necessarily require that people engage in special figurative-language-only processes to determine the meaning of the figures of speech and to communicate in discourse. People do not comprehend language and think ‘now it’s time to switch on the metaphor processing mode’. People are adaptive and may do slightly different things depending on: who they are; the context they are in; the type and form of language encountered and the tasks they are undertaking. In this view, there is no single figurative processing mode. Instead there is a general propensity to engage in adaptive, relevant behaviours depending on the varying constraints in the communicative situation (Gibbs & Colston, 2012, p. 191).

Empirical findings from a Dynamic Systems perspective give a rather complicated picture of metaphor use: Metaphor can contribute to learning by ‘complexifying’ concepts through analogy and through prompting restructuring; Metaphor can help people recall information and apply what is known to new contexts (Cameron, 2003). The content and nature of specific instances of metaphor and the discourse context, including the previous knowledge of discourse participants, will affect whether learning opportunities are opened up or limited. However, metaphor is not necessarily helpful: for example, initially helpful analogies can also seriously impede fuller and more accurate understandings, particularly if there is reliance on just one metaphor. Further, metaphor may provide a false sense of understanding thus preventing access to alternative knowledge structures; provide concept domain structuring that is partial, too simple or lead to inappropriate transfers of attributes or relations (Cameron, 2003; Spiro, Feltovich, Coulson, & Anderson, 1989).

Dynamic Systems is an overarching theory which can accommodate the many ways that metaphorical language is produced and interpreted by different people in different situations. It explains both the regularity and context-specific variation in human performance, acknowledging that adaptive behaviours are self-organising. Rather than assuming inherent top-down conceptual structures, dynamic systems as in the CMT approach, the Dynamic Systems approach is bottom-up which makes it suitable for the therapy context where novel,
idiosyncratic client (and co-constructed or therapist-initiated) metaphors may emerge and change.

A recent comprehensive discussion of the diversity of experimental findings and models of figurative language comprehension concluded that the dynamic system perspective was the best way to account for the diverse experimental findings and has the flexibility to account contextual influences (Gibbs & Colston, 2012). It should be borne in mind, however, that Dynamic Systems models differ from traditional statistical models used in psychology: the same variables serve as both independent and dependent variables, i.e. they are feedback models. Researchers need to clearly distinguish between dynamic and non-dynamic models and between influences on the variables from the proposed model and other influences; and need to include a time series plot from the empirical data and the model. If both of these are available, then these should be shown together. It is unclear whether Dynamic Systems approaches are really a useful approach for psychological research. However, it has been suggested that if researchers provide clear information about the role of Dynamic Systems models in their work and regarding the fit of their models to their data, the usefulness may become clearer (Gelfand & Engelhart, 2012).

The Discourse Dynamics method, based on Dynamic Systems theory, was developed for analysing conversational interactions (Cameron, 2007, 2008a). Much of the Discourse Dynamics approach was developed during an analysis of ‘reconciliation talk’: a discussion between an Irish Republican army bomber, and the daughter of a victim of a bomb he planted (Cameron, 2007). This method is described in more detail and used in the study described in Chapter 4.

Discourse Dynamics analyses evolving patterns of metaphor within a conversation, and across different conversations between the same speech partners over a period of time. Speakers may negotiate metaphors or develop them by repeating, re- phrasing, clarifying or contrasting them. Throughout conversations, speakers may use recurring or ‘systematic’ metaphors. Using Discourse Dynamics, Cameron et al. (2009) aim to investigate metaphor as a way of understanding people’s values, ideas and attitudes. Thus, metaphor analysis from the Discourse Dynamics perspective looks for the development of systems of connected metaphors that frame and re-frame key ideas. They identify clusters of metaphors that indicate intense bursts of interactional activity and the co-construction of metaphors across the discourse (Cameron & Stelma, 2004).
Cameron (2003) describes the idea of ‘alterity’ or ‘otherness’. This is the idea that there are inevitably differences in understanding and perspective that need to be understood and worked with, rather than lamented. The discourse goal is the mediation of alterity between participants. Cameron argues that metaphor works through alterity, through importing an incongruous vehicle term into the discourse, thereby opening up alternative meanings and interpretations around the topic term (although this also opens up the possibility of misinterpretation). She also emphasises the delicate interplay of language and thought in the ongoing processes in constructing and expanding the ‘sense’ of words and concepts, where ‘sense’ is the ‘overall, cultural, psychological and personal significance’ of a word for an individual. Understanding metaphor is the process of making sense, of topic and vehicle words in their discourse context: The relation of thought to word is not a thing but a process, an ongoing movement back and forth from thought to word and from word to thought. In that process the relations between thoughts and words undergo changes which themselves may be viewed as development.

In sum, these characteristics of the Discourse Dynamics approach make it highly relevant to examining metaphor in the therapy situation, (particularly CBT), because it is a conversational interaction, where reframing of ideas and attitudes may prove therapeutic.

1.5 How do people comprehend metaphors?

Experimental research by psycholinguists on figurative language has led to us knowing a good deal about how people comprehend metaphoric words and phrases. While early psycholinguistic studies were based on the idea that figurative language must be more difficult to comprehend, subsequent studies demonstrated that people can mostly understand metaphors just as quickly and easily as we understand literal meanings (Gibbs, 1994, 2001). The general consensus is that comprehension of ‘ordinary language’ and metaphor involves common cognitive and linguistic processes (Paivio & Walsh, 1993). There is likely to be some variability in comprehension ability for example with people on the autistic spectrum, although there is minimal research in this area (Gibbs et al., 2012).

Numerous studies by experimental psycholinguists have examined the ways in which the vehicle and topic interact to produce metaphorical meaning for expressions like ‘my job is a jail’. The assumption is that the listener works out the properties of jails and jobs that are similar (Gibbs et al., 2012). However, metaphor comprehension does not require the topic and vehicle to share associations or properties (Glucksberg, 2001). Support for this claim comes from studies that show metaphors to have directional meaning: if metaphorical meaning
comes from the shared properties of the vehicle and topic, the ‘The surgeon is a butcher’ and ‘The butcher is a surgeon’ would have identical meanings, when this is not so. Rather, similarity is created as an emergent property of metaphor understanding (i.e. as an interaction between the vehicle and topic), with many studies demonstrating that the novel features that emerge from metaphor comprehension are not salient in a person’s separate understanding of the vehicle or topic (Gineste, Indurkhya, & Scart, 2000; Utsumi, 2005).

There is disagreement, however, about what cognitive mechanisms are involved in metaphor comprehension. There are two main schools of thought, comparison and class inclusion, both with supporting experimental studies.

### 1.5.1 Comparison theory

Traditional comparison theories view mappings between topic and vehicle as occurring simply through implicit comparison of features from the vehicle with features of the topic. A more recent variant on this is the idea that listeners begin processing a metaphor by first aligning features of the vehicle and topic then directionally projecting inferences from the vehicle to the topic, with new inferences arising that are relational but not feature-specific (Gentner & Bowdle, 2001; Gentner, Bowdle, Wolff, & Boronat, 2001). For example, ‘plant stems are drinking straws’ infers that both plants and straws transmit liquid to nourish living things, not just that they are both long and thin (Gibbs et al., 2012, pp. 474-475).

### 1.5.2 Class Inclusion theory

The class inclusion view (also called the interactive property attribution model) is that metaphors are comprehended through categorisation processes, as class inclusions not comparisons (Glucksberg, 2001). For example, ‘Trump is a walking time bomb’ suggests this American president belongs to a category exemplified by time bombs (things that explode unpredictably, causing a lot of damage). The class inclusion is a constructivist view implies that vehicles and topics interact and create a new meaning that transcends both (Glucksberg, McGlone, & Manfredi, 1997). For example, in the phrases ‘My lawyer is a snake’ and ‘the road was a snake’, ‘snake’ has a different meaning: The metaphor vehicle provides attributes that are attributed to the different topics and irrelevant information is suppressed during comprehension (Gibbs et al., 2012). The idea that metaphor provides a bridge or interplay between the meaning of one thing and another has been discussed in the therapy context as a way of assisting learning and understanding (Muran & DiGiuseppe, 1990).
1.5.3 Career of Metaphor theory

Some argue that the difference between categorisation and class inclusion is more apparent than real and that whether metaphorical mappings are more akin to comparisons or class inclusions and whether they are computed indirectly or directly depends on the type of representation invoked by the base term and the linguistic form of the metaphor (Gentner & Bowdle, 2001). Career of Metaphor theory is a more recent view that incorporates aspects of both the comparison and categorisation views (Bowdle & Gentner, 2005). This theory asserts that there is a shift in the mode of mappings from comparison to categorisation processes as metaphors become more conventionalised. For example, the phrase ‘Science is a glacier’ might initially be comprehended through comparison between science and a large body of frozen water, but then come to be understood through class inclusion as something that moves slowly but steadily (Gibbs et al., 2012).

According to Gibbs (2013), psychologists and linguists should not surmise that a single theoretical model will make sense of complex empirical findings, because metaphoric behaviours in the moment emerge from the interaction of multiple factors as part of human self-organising processes.

1.6 Recent developments in metaphor research

In recent years, metaphor research has begun exploring resistance to metaphor and deliberate use of metaphor. Both of these could have relevance to the therapy context.

1.6.1 Resistance to metaphor

Gerard Steen and colleagues (see: https://www.researchgate.net/project/Resistance-to-Metaphor) are currently studying resistance to metaphor: when, why and how language users might resist metaphoric conceptualisations such as the ‘tsunami of islamization’. Resistance requires specific conceptual, linguistic and communicative skills and special argumentative and analytical effort. This research has social importance when you consider the impact of such metaphors as ‘immigrants are like viruses’ on how immigrants might be responded to by others. It may also have relevance to the therapy environment, particularly when therapists use metaphors to explain concepts. Resistance to metaphor may be relevant to understanding why and how clients might resist therapist-delivered metaphors.
1.6.2 Deliberate metaphor

There is some controversy as to whether there is a distinction between deliberate (i.e. pre-prepared and deliberately deployed as opposed to spontaneously popping into one’s mind) and non-deliberate use of metaphor (see Gibbs (2011a)). However, there is a growing literature exploring ways to assess the ‘deliberateness’ of metaphor and what the effects of this might be (Reijnierse, Burgers, Krennmayr, & Steen, 2018; Steen, 2016). Steen and colleagues provide the following compelling excerpt from Time Magazine of what appears to be deliberate use of metaphor in support of ‘deliberate metaphor theory’:

‘Imagine your brain as a house filled with lights. Now imagine someone turning off the lights one by one. That’s what Alzheimer’s disease does.’ (Nash, 2000). Non-deliberate use, in contrast, could be someone in the midst of a therapy conversation spontaneously saying ‘I’ll just try and gather my thoughts’.

Deliberateness of metaphor may have relevance clinically to intentional (or non-intentional) metaphor use by therapists and clients.

1.7 Other theories with potential relevance to metaphor research

1.7.1 Embodied cognition

Embodied cognition is the idea that cognition is embedded in and influenced by the body (Hauke & Pietrzak, 2016). The idea of embodied cognition is an emerging trend in psychology, with a wide range of implications for psychotherapy, including CBT (Tschacher & Pfammatter, 2017).

Embodied cognition is relevant to the study of metaphor because it sees higher order cognitive processes, such as the understanding of abstract concepts though metaphor, as rooted in bodily experiences, such as journeys. We all know, for example, that journeys involve moving towards destinations, they usually involve some effort and we need to rest along the way. From this perspective, cognition occurs when the body engages the physical and cultural world, and it must be studied in terms of the dynamic interactions between people and their environment. The body is thought to have direct influence on cognitive, emotional and motivational processes, e.g. through posture, facial expression, gestures, and direction of motion. While cognitive states are well established as producing corresponding physical states, physical states can also influence cognitive and affective processes (Gibbs, 2006). For example, studies have found when people experience physical warmth they feel socially included (Fay & Maner, 2014); adoption of an upright (rather than slumped) posture increases
the feeling of pride when given positive feedback (Stepper & Strack, 1993); Previous bodily experience of hunger predicts people’s understanding and use of statements such as ‘I hunger for fame’, or ‘I craved her affection’ (Gibbs, Lima, & Francozo, 2004) and having people make or imagine making relevant body movements, such as grasping, facilitates their processing of related metaphorical expressions, such as ‘grasping the concept’ (Wilson & Gibbs, 2007).

In the psychotherapy field, there is some evidence that where there is a good metaphoric ‘fit’ (or mental mapping between presenting problem and familiar bodily experience), embodied cognition can influence problem solving (Keefer & Landau, 2016). For example, when depression is metaphorically framed as being ‘darkened’ or ‘down’, this increases the perceived effectiveness of medications that have been metaphorically framed as solving these problems by ‘lifting’ or ‘illuminating’ (Keefer, Landau, Sullivan, & Rothschild, 2014). There is even a form of psychotherapy called Emotional Activation Therapy that bases its theory of emotion on embodiment (i.e. that emotions follow body activities such as postures, gestures and movements (Flies & Schmidt, 2016)).

Within CBT, the body receives some attention in terms of assessing and understanding the body sensations that accompany emotions. When affect is high, clients will often experience what has been termed a ‘felt sense’ in which they experience a combination of verbal thoughts, imagery, emotions and other bodily sensations (Butler, Fennell, & Hackmann, 2008). For example, clients with post-traumatic stress disorder often re-experience bodily sensations they had at the time of the trauma, such as hyper-arousal (Rothschild, 2000). However, there is growing recognition of the role embodied cognition may play in therapy in terms of understanding the body’s influence on cognitive, motivational and emotional processes. Embodiment can be applied in areas of alliance-building, motivational clarification, problem activation, developing mastery, drawing on values (Hauke & Pietrzak, 2016).

### 1.7.2 Interacting Cognitive Subsystems

Recent cognitive behavioural theory also places significance on the body, along with increased attention to the importance of emotional activation in order for change to occur e.g. Safran and Muran (2000). The Interacting Cognitive Subsystems (ICS) model (Barnard & Teasdale, 2008; Teasdale, 1993) is a comprehensive model of how we process meaning and emotions. Sensory input, and in particular bodily experience is seen as directly contributing to the development of emotional disorder. ICS posits two information-processing systems: a
propositional system and an implicational system. Propositional knowledge explicitly conveys specific information and is not directly linked with bodily experience, emotion, or sensory input. In contrast, the implicational system is holistic, with input from the body, emotions and sensory information contributing to implicit schemas that are not easy to verbalise or to test using standard CBT thought-challenging techniques. Teasdale and Barnard suggest that deeper change cannot happen without a change at the implicational level.

Teasdale's insight into the affective disorders has been a major driver of the cognitive revolution in clinical research (Siegle & Ingram, 1996). In therapy, ICS targets the holistic implicit meaning (rather than specific propositional meaning) using experientially-oriented approaches (such as behavioural experiments), body state, and the wider semantic context. The therapeutic focus is on changing the attitude towards inner experience, using techniques such as mindfulness exercises in which mindful awareness of the body is developed as an important information source for self-regulation.

The ICS model is relevant to metaphor in that metaphors have potential to draw on bodily experience and to capture more holistic, implicational level meaning. Further, working metaphorically may prove to be an option for working therapeutically with implicational level meaning, in that changing a metaphor may assist in developing a more adaptive frame of reference for processing the impact of experiential strategies.

### 1.7.3 Brewin’s retrieval competition approach

The retrieval competition approach (Brewin, 2006) accounts for CBT in terms of the relationship between old and new memory representations (similar to what Teasdale would call alternative schematic models). Brewin’s proposes that clients with emotional disorders have highly accessible negative memory representations, with intrusive memories, self-critical interpretations, and high levels of rumination (e.g. ‘I’m incompetent’ memories). These negative memory representations are seen as being in ‘retrieval competition’ with more positive/adaptive memory representations. Brewin proposes that CBT does not directly modify negative information in memory, but instead changes the relative activation of positive and negative representations, strengthening and enhancing the positive representations so that they are activated across a wide range of situations and win the retrieval competition.
The relevance of Brewin’s theory to metaphor in therapy is that metaphor may be associated with both negative and positive memory representations. Adaptive metaphors have potential to be a memorable way of assisting clients to access more positive memory representations.

### 1.7.4 Cognitive Load theory

*Cognitive load* refers to the total amount of effort being used in the working memory. It builds on earlier work in the cognitive sciences that established the limitations of working memory capacity as seven plus or minus two units of information, (assisted by strategies such as chunking of information to increase capacity such as what people tend to do when learning phone numbers) (Miller, 1956). There is evidence that individuals vary in their processing capacity (Voorhies & Scandura, 1977). The theory was developed by Sweller (1988), with the idea that how information is presented can reduce the cognitive load for learners. It is considered one of the main cognitive educational theories in medical education (Sandars, Patel, Goh, Kokatailo, & Lafferty, 2015). Cognitive load theory asserts that learning is impaired when the limited working memory capacity is exceeded (Chandler & Sweller, 1991).

Cognitive load can comprise three types which can have positive or negative effects on learning: intrinsic, extraneous and germane loads. Intrinsic cognitive load is the effort associated with the inherent difficulty of the particular topic. Extraneous cognitive load refers to how tasks or information are presented to the learner (e.g. redundant information would add to the load), and germane cognitive load refers the work put into creating a permanent store of knowledge. Ideally, negative loads should be minimised while optimising positive loads to optimise learning.

Cognitive load theory may prove relevant to the study of metaphors, given that metaphors are often described by clinicians as being used as a *shorthand* method of organising information or communicating a great deal of meaning in an efficient way (Kuyken et al., 2009).

There is some limited evidence that use of metaphors can reduce cognitive load for learners (Cheon & Grant, 2012; Henderson, 2014) and that chunking of information reduces the load on working memory (Thalmann, Souza, & Oberauer, 2019), but there does not appear to be any literature to date investigating the use of metaphor to reduce cognitive load in psychotherapy. It is possible that fully explored and developed metaphors may operate at a meta-level, like the label on the spine of a book and both therapist and client know what’s inside.
1.8 Summary of key theoretical approaches

Conceptual Metaphor Theory is a dominant theory and sees metaphors as reflecting people’s underlying concepts but has been criticised methodologically and may not necessarily hold for an individual language user in a conversational context such as psychotherapy. Dynamic systems theory is a constructivist approach which takes the context and interactive nature of the conversation into account when analysing the use of metaphor. While there are clearly a number of theoretical approaches to understanding metaphor comprehension, it is unlikely that a single theory can account for how all aspects of figurative language are understood or processed (Gibbs & Colston, 2012).

Embodied cognition theory emphasises that our understanding of abstract concepts is rooted in bodily experiences. ICS contributes the idea of the holistic implicational (schema) system. Brewin’s retrieval competition approach suggests that people have competing memory representations and cognitive load theory may point to the use of metaphor as a shorthand.

1.9 Primary theoretical framework for this thesis

This thesis takes a Dynamic Systems approach within a broader constructivist framework. This was taken because Dynamic Systems has a well-articulated theoretical position, has been developed for spoken interactions in context and has a well-operationalised method for investigating this, namely by identifying metaphoric words and phrases of an individual without forcing them into pre-existing abstract categories as in the CMT approach. Cognitive behavioural theory drives the choice of the constructivist approach because purposeful construction of meaning is a fundamental assumption in CBT. Further, constructivism is the shared lens through which researchers and therapists make sense of empirical findings. The approach taken in this thesis is also consistent with the Interacting Cognitive Subsystems model in that (as noted in section 1.7.2) metaphors draw on bodily experience as part of meaning-making. The discussion section of this thesis will reflect on the findings, taking these and other relevant theories into account.

While this introductory chapter has briefly mentioned therapy in relation to metaphor, the next chapter will focus much more fully on the literature on metaphor in therapy, and in CBT in particular.
Chapter 2
Metaphor in Therapy

2.1 Introduction

While the previous chapter established a broad landscape for the study of metaphor and touched on how this might be relevant to psychotherapy, this next chapter outlines literature where there is an explicit focus on metaphor in psychotherapy, and specifically in CBT. This review shows that there is interest in metaphor from a wide range of psychotherapeutic traditions, with many claims as to the potential functions of metaphor use, although the degree of empirical evidence for these functions varies. In the next part of the chapter, CBT is described, along with the central importance of conceptualisation in CBT; there is no prior empirical research supporting metaphor as beneficial in CBT. Related cognitive behavioural therapies (so-called third wave) are also described, along with their various approaches to metaphor. Finally, a rationale is provided for the series of studies that were conducted for this thesis.

2.2 Overview of the empirical research on metaphor in therapy

There has been a moderate amount of research that has advanced practical and theoretical knowledge of the forms, processes and effects of metaphor use in psychotherapy in general. These areas include: definition; identification and classification; models of how metaphor may trigger therapeutic change; potential functions of metaphor; structured protocols on developing metaphoric conceptualisations and cultural variations in metaphor use. The rather fragmented empirical research includes qualitative analyses of metaphor themes identified in actual therapist-client interaction while quantitative studies have investigated associations between aspects of metaphor use and treatment outcome (Tay, 2016a).

Studies generally focus on either the client’s use of metaphor or the joint use by client and therapist, with broad questions about how the content and use of metaphor facilitate the process of psychotherapy and/or are related to the outcome of therapy (McMullen, 2008).

A summary by Tay (2013) found that the bulk of empirical research into metaphors has investigated their functions and their impact as process variables, with common questions being: how metaphors contribute to diagnosis, prognosis and recovery of patients (Goncalves, 1994; Goncalves & Craine, 1990), how metaphors help build a stimulating collaborative relationship (Angus, 1996; Lenrow, 1966; Stine, 2005), how metaphors instigate
therapeutically crucial shifts in patients’ emotional attitudes (Muran & DiGiuseppe, 1990; Rasmussen & Angus, 1996), and how metaphors facilitate recall of key therapeutic moments (Martin, Cummings, & Halberg, 1992).

2.2.1 Methodological challenges

Empirical investigation into metaphor in therapy is fraught with methodological challenges. As noted in Chapter 1, the broader landscape of metaphor research has been hampered by the use of different definitions and lack of rigorous methods of identification of metaphors. The same challenges are noted in the CBT field along with the risk of asking overly narrow questions and ignoring the context in which the metaphors are used (Stott et al., 2010). Fuller description of the methodological challenges in this area will be provided in Chapter 3.

2.3 Metaphor in different schools of therapy

Metaphor has been widely used in various schools of psychotherapy. Erickson viewed much of human communication as a metaphor, and he deliberately embedded metaphor within stories in an attempt to bypass client consciousness (O’Hanlon & Hexum, 1990). Metaphor is often used in Ericksonian therapy (Pearce, 1996) and psychodynamic psychotherapy (Arlow, 1979). The object relations theorist, Winnicott, used metaphors to change embedded and entrenched thought patterns (Winnicott, 1965). In narrative therapy, metaphors are often used to assist clients to become ‘unstuck’ from (inflexible and unhelpful) stories of their own lives (White & Epston, 1990). Metaphor has also been used in couples and family therapy (Barker, 1985; Fox, 1989; Lankton & Lankton, 1989). These theorists view metaphor as a tool of creation and innovation. By using metaphor, the patient is thought to create new understanding of their world and new perceptual frameworks (i.e. different perspectives) with regard to possible solutions to the challenges they face.

Within cognitive approaches to psychotherapy there is an increasing constructivist orientation, with growing emphasis on client’s deep, tacit or unconscious levels and on knowledge as represented in metaphorical ways (Goncalves & Craine, 1990; Ronen, 2011). In the psychotherapy context, the constructivist position is that the objective of therapist use of metaphor is to “create an opportunity to restructure the client’s deep conceptualizations and tacit paradigms” (Goncalves & Craine, 1990, p. 139). A metaphor-based treatment approach, called ‘metaphor therapy’ was developed in the late 1990’s (Kopp & Craw, 1998). This approach is based on the theory that metaphors involve a distinct mental process: metaphorical cognition, which combines both imaginal cognition (relatively unconscious
form of cognition, with its own principles, rules and characteristics, which functions as a weak form of perception) (Pearson, Naselaris, Holmes, & Kosslyn, 2015) and propositional cognition (relatively conscious logical processes, which tend to form the main focus of current cognitive therapy). Constructivist approaches and metaphor therapy both emphasise a view of cognition that incorporates metaphorical, analogical and imaginal processes along with verbal and logical forms (Ronen, 2011). These ideas are consistent with the Interacting Cognitive Subsystems approach (Teasdale, 1993) (described in section 1.7.2), which distinguishes between a specific and more holistic level of meaning, suggesting that holistic level meanings are of primary importance in emotion production.

2.4 An overview of CBT

This section will provide a brief overview of CBT. The aim is to provide a solid theoretical and conceptual basis. Later in the chapter I will discuss the context for exploring metaphor use in CBT.

CBT was initially developed by Dr Aaron Beck (1976), based on his observation that clients interpreted aspects of their experiences through distorted lenses and that working together with patients to help them identify and evaluate unrealistic or unhelpful thoughts helped reduce symptoms. Beck developed a system of psychotherapy based on these principles that has been empirically validated for a range of mental health problems and populations (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). While Beck was the most prominent person in the CBT field (and has remained so), there have been many others who have contributed along the way, such as Drs Paul Salkovskis and Christine Padesky. CBT has evolved over the years to become a family of therapies, all with a focus on the importance of cognition and behaviour in creating and maintaining distress.

CBT is a relatively brief form of therapy (generally twelve to twenty hour-long sessions) that aims to help clients learn to solve current problems and change unhelpful or unrealistic thinking patterns that contribute to distress or maladaptive behaviour. The central idea in CBT is that cognitions (how people appraise a situation) profoundly influence emotions and behaviours. It is usually undertaken in a face to face interaction between the therapist and client, in a private room in a clinic setting. In this setting the therapist and client share the goals of enhancing client wellbeing, developing coping skills and preventing relapse. Sessions are structured, with a typical session covering: catch up and mood check; review of homework; agenda setting; working through agenda items (such as skills training, problem solving or evaluating cognitions); homework setting and feedback. CBT is also collaborative,
using a guided discovery approach to find out how the world really works. This involves Socratic questioning\(^5\) to explore and test thoughts and beliefs. A collaborative, working together, approach is taken, with plenty of feedback sought from the client by the therapist (Kuyken, Padesky, & Dudley, 2009).

### 2.4.1 Conceptualisation: the cornerstone of CBT

Case conceptualisation is regarded as an important foundation for the competent practice of CBT (Easden & Kazantzis, 2018; Kuyken et al., 2009; Kuyken et al., 2016). In CBT, clients’ conceptual systems (their concepts of self, world and others) play a central role in defining their everyday realities. Case conceptualisation draws together a client’s important early life experiences with key cognitions and behaviours, often in diagrammatic form. A common, relatively simple way of conceptualising is to use what is commonly referred to as the ‘five part model’. This breaks down a client’s response into the situation, thoughts, feelings, bodily sensations and behaviours as depicted in Figure 2.1 below (based on Greenberger and Padesky, 2015).

![Figure 2.1. CBT Five-part Model](image)

The conceptualisation serves as a basis for developing and testing hypotheses about the aetiology and maintenance of the client’s presenting problems, along with identifying client strengths. Case conceptualisations are ever-evolving hypotheses, based on new information.

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\(^5\) Socratic questioning involves asking questions to assist clients to draw on existing knowledge in order to challenge beliefs and solve problems.
generated during the therapy process. An idiosyncratic conceptualisation that describes and explains the client’s presentation is developed in collaboration with the client and is used to inform intervention.

A review of existing studies on case conceptualisation in CBT suggests that therapists can reliably construct some elements of case conceptualisations, but evidence for the efficacy of CBT case conceptualisation in terms of specifically contributing to outcomes has yet to be demonstrated. The direct observation of therapist competence in case conceptualisation as a predictor of outcomes is recommended as a focus for future research (Easden & Kazantzis, 2018).

2.4.2 Working alliance and CBT

CBT (along with most other therapeutic approaches) emphasises the importance of the working alliance (J. Beck, 1995). Working alliance refers to the development and maintenance of a collaborative relationship that focuses on modifying psychological experiences that are having a negative impact on the client (Henry & Strupp, 1994; Horvath & Luborsky, 1993). This section will outline the literature on working alliance because the effect of metaphor as potentially contributing positively to the working alliance is studied in chapter 6.

Although definitions of alliance have varied across studies, there appears to be a convergence theoretically and empirically that the central aspects of the therapeutic alliance construct involve the bond between the client and therapist as well as agreement about the therapeutic tasks and goals (Del Re, Fluckiger, Horvath, Symonds, & Wampold, 2012).

The working alliance construct is well supported empirically (Constantino, Castonguay, Zack, & DeGeorge, 2010) and is a moderate predictor of psychotherapy outcome, regardless of disorder (Fluckiger, Del Re, Wampold, Symonds, & Horvath, 2012; Horvath, Del Re, Fluckiger, & Symonds, 2011). Establishing a strong alliance in the early sessions of psychotherapy, in which collaboration and trust are established, is crucial to the therapeutic process (Horvath & Luborsky, 1993), and might safely be described as the most robust change mechanism (Constantino et al., 2010). Early alliance has been demonstrated to be a stronger predictor of outcome than middle and late alliance (Constantino, Castonguay, & Schut, 2002; Hersoug, Monsen, Havik, & Hoglund, 2002; Horvath, 1994; Kokotovic & Tracey, 1990; Strauss et al., 2006). Initial alliance development is thought to occur during the
first five therapy sessions, peaking most often by the third session (Eaton, Abeles, & Gutfreund, 1988; Horvath, 1994; Horvath & Luborsky, 1993).

Therapist variability has been found to be more important than patient variability for improved patient outcomes: some therapists develop stronger alliances with their patients than others (irrespective of diagnosis) and the clients of these therapists do better at the conclusion of therapy (Del Re et al., 2012).

Some researchers view client changes in therapy as being predominantly due to the therapeutic alliance (e.g. Bordin, 1979), while others have investigated the therapy alliance as a product of change due to specific treatment techniques rather than as a causal agent (Norcross, 2002). Some research supports the idea that specific techniques and the therapeutic alliance mutually interact with each other to produce positive outcomes (Burns et al., 2015; Castonguay & Beutler, 2006; Watson, Schein, & McMullen, 2010).

The working alliance research also applies to working alliance in CBT (Castonguay, Constantino, McAleavey, & Goldfried, 2010). However, there is little research on specific actions that therapists can use to develop or maintain the relationship (Horvath & Symonds, 1991; Kozart, 2002). Attention to and co-construction of metaphor may prove to be one way to build and maintain working alliance.

### 2.5 Practice oriented literature on the functions of metaphor in psychotherapy

Metaphoric language has long been recognised by therapists as a tool for understanding clients’ experience of the world and many therapists have published articles describing their experiences with metaphor clinically. This practice-oriented literature has developed over the past forty years and spans a range of therapeutic perspectives. The bulk of the writings are based on psychoanalytic (Freud, 1963; Jung, 1963; Stine, 2005) and Ericksonian principles (Rosen, 1991), with a few from the CBT perspective (detailed in section 2.5). They assert multiple benefits of metaphor to promote client change, generally without a clearly articulated theory as to how working metaphorically might lead to change or any empirical evidence beyond observation. They provide detailed instructions on how to construct and use metaphors (Barker, 1985; Gordon, 1978; Hammond, 1990; Lankton & Lankton, 1989). Case examples of metaphors are provided, with problem-targeted metaphors embedded in sections of narrative (for example Burns (2007); Pearce (1996)).
The many asserted benefits of metaphor in therapy include associated imagery; accessing deep knowledge structures; enhancing conceptualisation; allowing indirect expression; expressing emotion; building alliance and collaboration; transforming meaning and finding solutions; maximising memory cues and interest; compact communication; perceived helpfulness; assisting the development of a stable theme; function as an explanatory device; playfulness; and enhanced outcome. These are outlined in more detail in the following sections, along with any supporting experimental or other empirical evidence, with explicit reference to any evidence from within the CBT approach.

2.5.1 Imagery

Metaphors often have associated imagery. People may use specific metaphors because they create vivid images for listeners or readers (Gibbs & Bogdonavich, 1999). Images are described as a way of accessing affect for clients who intellectualise, have problems with emotional expression or find it hard to bring up negative or unpleasant emotions. Images enable direct access to emotions because they are usually accompanied naturally by emotions (Ronen, 2011). The symbolism and imagery of metaphor may enable the imagination to be put into action (Tilley, 1999). The recent flourishing of research on imagery in CBT is discussed in section 2.10.

2.5.2 Accessing deep knowledge structures

Metaphors have been recommended as a promising therapeutic tool for accessing and changing structures of meaning that clients may struggle to verbalise in other ways and that therefore remain resistant to traditional therapeutic efforts in cognitive therapy. Such deep knowledge processes are thought to be represented in the form of analogies and metaphors. These capture the fundamental essence of a client’s knowledge and reality (Goncalves & Craine, 1990). For example, a client with a sexual abuse history might describe herself as ‘black inside’ (FM example), conveying a deep sense of shame.

2.5.3 Enhancing conceptualisation

Metaphors may enhance shared conceptualisations, functioning as “potent conveyors of information through which the patient reveals questions, fears, hopes, struggles, and style of coping that pertain to their lives, to their therapy, and their therapist” (Brooks, 1985, p. 762). They may become a key that unlocks new opportunities for learning about clients’ inner self and internal life (Mahoney, 1995). For example, an anxious client who describes the ‘cutlery
in her stomach’ (FM example) may be conveying a great deal about how her body feels when she is stressed, along with the sharpness of her associated emotions. As metaphors can highlight previously unspoken, unexplored meaning, they may assist in uncovering and challenging tacit assumptions. Metaphors may also facilitate client awareness of previously unknown aspects of the self or the self’s relationships to others and create new possibilities for action (Lyddon, Clay, & Sparks, 2001). There may be idiosyncratic ‘key’ metaphors for clients, which are introduced by the client and capture the client’s concept of self and his or her psychological situation, which are repeated and elaborated, and sometimes accompanied by changes in affective state (Siegelman, 1990). These have been described as metaphoric kernel statements (Witztum, van der Hart, & Friedman, 1988).

In CBT, client metaphor may provide therapists with important information about client’s views of reality. For example, a client might view her marriage as a ‘pressure cooker’ (FM example). Such expressions, if explored, may enhance the conceptualisation of client problems in terms of deepened understanding of the rich interplay of beliefs emotions, physical states and strategies (Ronen, 2011). Within CBT conceptualisation, Kuyken et al. suggest that therapists

use the client’s own words, metaphors and images when reflecting and summarising the issues discussed. Use of client language in a case conceptualization personalises the model and increases the likelihood that clients will understand and apply the model outside of therapy sessions (2009, p. 83).

Kuyken et al. encourage therapists to be alert to client images and metaphors, collaboratively integrating them into conceptualisations wherever possible, because they are packed with information, offer sources of creative ideas to facilitate change, easy to remember, and fit well with client experience and strengths.

There is also some empirical support for the idea that metaphors of the self, others and of interpersonal relationships are a fundamental part of psychotherapeutic talk, based on qualitative analysis of small numbers of cases of client and therapist interactions and recollections of metaphoric events in therapy (Angus & Rennie, 1989; McMullen, 1989).

2.5.4 Indirect expression and playfulness

Metaphors may enable clients to access new information about themselves in indirect ways and thereby help clients to examine and express painful feelings and experiences (Lyddon et al., 2001). Therapists and clients often “struggle to find words” to convey “difficult-to-describe sensations, emotions, psychological states and views of self” (McMullen, 1996, p.
In particular, it is claimed that emotions and metaphor are closely connected and that clients often use metaphors when they want to convey strong affect that cannot be communicated easily in other ways, or to reveal things which they cannot talk about more directly (Gibbs, 1994; Nadeau, 2006; Siegelman, 1990). As Bayne and Thompson (2000, p. 48) put it: “Metaphors can be used to describe experiences and emotions for which, at least at that time, there are no words; they are too abstract, intense, complex or ethereal”. Exploring metaphorically represented concerns may be a safe way to explore new realities (Nadeau, 2006). Similarly, metaphor has been described as enabling clients to express what has previously been inexpressible, filling the gap between what they are able to communicate about how they feel and what they may be actually experiencing (Fine, Pollio, & Simpkinson, 1973). For example, a client may describe themselves as feeling ‘trapped’ (FM example). This metaphor can be unpacked in therapy in order to clarify the associated imagery, emotion, physical sensations and behaviour.

Metaphors have been described as having playful qualities that permit the therapist to communicate about intimate information without appearing intrusive (Babits, 2001; Barlow, Pollio, & Fine, 1977). They may work well in the ‘potential space’ (an intermediate area of experiencing that lies between reality and fantasy within which all therapeutic interventions occur (Winnicott, 1989)). This space provides opportunity to play with, or mull over potential versions of the self, in a spirit of playfulness (Bollas, 1983). Any example of this would be a therapist asking the aforementioned stressed client: ‘How’s the ‘cutlery’ today? What is it doing in your stomach at the moment?’ (FM example).

Strategic use of therapist-generated metaphors may avoid much of the awkwardness and defensiveness that may occur when information about sensitive issues is asked for directly, allowing therapists to embed new ideas and suggestions for future action in a way that allows clients to try new patterns of thinking, feeling and behaving without having to commit consciously or openly to them (Combs & Freedman, 1990). In this way, therapist-delivered metaphors may have a stealth capacity, making an indirect form of treatment possible, without evoking the resistance to considering new ideas that can occur with direct suggestions (Way, 2006, p. 28). This indirectness may prove particularly useful in therapeutic work with particular groups. For example, given that men tend to be less likely than women to be able to identify and describe their emotional responses to situations (Dindia & Canary, 2006), familiar topics can be used metaphorically in therapy with men, to help them to describe vulnerable emotions and connect with emotional experience (Rabinowitz & Cochran, 2002). For example, an extended football metaphor was used as part of a mental health intervention.
with a group of men keen on football, metaphorically using ideas such as ‘goals’, the importance of ‘team support’ (i.e. support from the group), having a ‘good solid defence’ (i.e. coping strategies) (Spandler, Roy, & McKeown, 2014).

2.5.5 Expressing Emotion

Metaphors may have unique utility for communicating emotions and other sensori-motor states (McMullen, 2008). It is well established that emotion language is highly figurative, to the extent that metaphor has been described as the language of emotion rather than of cognition (Kovecses, 2008). Kovecses further suggests that each strong emotion has metaphors that are used in everyday language to convey its meaning, especially fear, anger, happiness, sadness, lust, love, shame, pride and surprise. For example, anger is often described as fire ‘I am burning up with rage’ and absence of love is seen as hunger ‘I am starved of love’.

Writing from a CBT perspective, Stott et al. (2010) note that emotions can be difficult to express without the use of metaphor, for example ‘his blood is boiling’ or ‘I wanted the ground to swallow me up’. When we describe the emotions of others we may use terms such as ‘chicken’, having ‘cold feet’ or being ‘faint-hearted’ when they are fearful; we use colours such as ‘blue’ for sadness and ‘red’ for anger. We use visual images to talk about how love can ‘blind’ you, hope can ‘cloud your vision’ and anger can ‘prevent you from seeing straight’ (Averill, 1990). As working with emotions is a central part of CBT, it follows that working with such metaphors may be helpful.

In addition, it may be the case that such metaphorical depictions of emotion are central to a more complete understanding of the complex experience of emotion, from a cognitive, bodily, social and cultural perspective (Kovecses, 2000). Experimental studies show that speakers can convey more emotional intensity and induce stronger emotional reactions in listeners when they describe their emotions using metaphorical language (Gibbs, Leggitt, & Turner, 2002). Metaphorical language may convey more emotional intensity due to its ability to convey a wide variety of meanings. For example, ‘My job is a jail’ arguably expresses a wider range of meanings and images about one’s job than does a non-metaphorical expression such as ‘my job is terrible’ (Gibbs & Colston, 2012, p. 230).

Consistent with this, (Fainsilber & Ortony, 1987) found in an experimental task (examining the function of metaphor production in participants’ descriptions of events and emotional states), that descriptions of emotional states contained more metaphorical language than did
descriptions of behaviours and that unconventional (novel) metaphors appeared to be especially effective at conveying emotional intensity. Strong emotional states led to greater metaphor use than did mild emotional states. The results of two neuroscientific studies support the link between metaphoric language and emotional arousal: Functional magnetic resonance imaging was used to measure brain activity and metaphoric language was found to be more emotionally arousing than literal language (Citron, Cacciari, Funcke, Hsu, & Jacobs, 2019; Citron & Goldberg, 2014).

2.5.6 Building alliance and collaboration

As noted in section 2.4.2 above, the therapeutic alliance refers to the quality of the therapeutic relationship.

Metaphor use may increase alliance, possibly due to the emotional communication mentioned in the previous section. This may establish a sense of intimacy and understanding between speakers and listeners: Philosopher Ted Cohen (1978) argues that one of the unexamined consequences of poetic metaphor is the achievement of intimacy. He argues that the speaker of a metaphor and the listener are brought into a deeper relationship with each other because the speaker gives a concealed invitation to be understood, the hearer tries hard to understand, and this exchange acknowledges a community. Although these three aspects occur in any communication, Cohen argues that the use of metaphor throws them into relief (Cohen, 1978). In therapy, the therapist’s ability to comprehend and respond to client metaphors may convey empathy and nurture the therapeutic alliance (Brooks, 1985), due to the shared use of mutually understood language (McMullen, 1985). Metaphoric language may also enhance collaboration through requiring active involvement, instigating an interactive process between clients and therapists (Kovecses, 2000). As noted in section 2.5.4 above, metaphorical language may assist clients to discuss painful material in a way that reduces anxiety in the session to a manageable level. This may protect the therapeutic alliance and the client from the full impact of such material until the alliance has formed sufficiently for it to be safe and appropriate to discuss it more directly (Guinjoan & Ross, 1999). By being responsive to client metaphors, the therapist may convey understanding of the client’s way of knowing and can contribute to the development of a shared language and collaborative relationship (Lyddon et al., 2001).

Practitioners writing from the CBT perspective have traditionally assumed that the therapy relationship alone is not sufficient to produce change (Beck, Rush, Shaw, & Emery, 1979). Clinicians assert that where metaphors are explored and developed, they can become an
important shared reference point, allowing therapist and client to ‘speak the same language’. This may enhance the feeling of being understood in the client, thus strengthening the therapeutic bond (Stott et al., 2010). Writing from the ACT perspective, Hayes, Strosahl, and Wilson (1999) also emphasise the benefits of metaphor use for developing empathy and rapport.

Sensitivity to culturally specific and salient metaphors can also be a way for therapists to demonstrate empathy for clients’ world views and values, potentially assisting alliance. For example, metaphors from the Qur’an were found to evoke positive responses in Muslim clients (Ahrammed, 2010; Dwairy, 2009).

### 2.5.7 Transforming meaning and finding solutions

Metaphors may facilitate new ways of thinking, talking and understanding (McMullen, 2008). They can accommodate multiple meanings, such as describing a relationship as a ‘tennis match’ as a way of capturing its competitive nature and opportunities for achievement and mastery (Cirillo & Crider, 1995). Use of metaphor may assist in reframing or suggesting solutions: Unfolding and clarifying the meaning of a client metaphor (particularly unconventional metaphors) may result in a wide variety of associations, which may lead to the client becoming aware of new relationships between phenomena, and new ways of dealing with a problem situation (Barlow et al., 1977). Metaphors may allow clients to integrate new information within their existing beliefs, create new mental models and set new goals (Pennebaker, 2000). Similarly, Lenrow (1966) describes metaphor as providing a model of trying out new ways of understanding that can be applied to future situations. Building on this idea, Fine et al. (1973) describe employing novel metaphors to describe problems in a new and unusual way so as to assist problem description and resolution. Similarly, by symbolising emotions that have previously been unexpressed, unexplored or unrecognised, the use of metaphors may assist clients in constructing new personal meanings of their experience (Lyddon et al., 2001).

Writing from a CBT perspective, Abbatiello (2006) gives the example of using the metaphor of a kaleidoscope to assist people to understand the concept of altering one’s perspective: ‘turning the lens’ in order to look differently at an event. Stott et al. (2010) describe metaphors as a powerful tool to transform meaning to further client goals and assist them to develop more helpful, adaptive and realistic views of themselves, the world and other people. They note that clients’ distorted thinking does not apply universally across all areas of cognition. Clients generally maintain a robust grip on most of their fundamental conceptual
world, including day and night, up and down, the fact that journeys have a beginning and an end, that buildings need foundations and so on. Helping distressed clients to use metaphor to bring their knowledge of experiences of the physical world to bear on areas of distorted thinking, enables new understandings to be firmly founded in concrete reality. An example of this is an anxious client who described himself as being ‘stuck halfway up a cliff-face’.

Working socratically with this metaphor, the client came up with some different ideas: that he did have a solid grip on the cliff-face; that he already had some coping skills that had got him halfway up; that he could see some things to hold onto further up (i.e. applying new CBT skills) and that the therapist was up on the cliff-face with him to guide him (FM example).

One meta-analytic study (though not in the therapy context) found that metaphors are more effective than literal language in changing people’s attitudes, although the effect tends to be relatively small (Sopory & Dillard, 2002). This needs further research within the therapy context, but it suggests that metaphors may have potential to be used to good effect in therapy to assist with changing unhelpful or unrealistic attitudes or beliefs, where they are causing distress or affecting client functioning.

2.5.8 Maximising memorability

Weekly therapy sessions account for less than 1% of clients’ waking hours, so it is important that therapeutic information be retained in order to be applied. The possible therapeutic value of using metaphoric language to aid clients’ memory of important therapy events has been emphasised, based on the assumption that such memory is essential to therapeutic effectiveness (Bonanno, 1990; Edwards, 1990). Within the CBT literature, Otto (2000) also describes the goal of metaphor use as being to transform therapeutic information into a form that is easily memorable. There are a number of ways that metaphors may assist memory:

1) Metaphor may facilitate efficient memorable communication between a therapist and a client because sensations and feeling are described as external, mutually observed phenomena, drawing on existing knowledge structures (McMullen, 1985).

2) Metaphors may assist memorability through providing information in a more vivid, interesting and engaging way than straight instruction (Fox, 1989; Kopp, 1995; Linehan, 1993; Stott et al., 2010). Vividness may increase due to the changes in vocal tone and tempo and theatrical gestures and pauses that can occur with metaphors and stories (Otto, 2000). There is some experimental research supports the idea that people may use metaphors because they are vivid (Ortony, 1993).
3) A third way metaphors may assist memorability for important aspects of therapy sessions is through the associated imagery (Stott et al., 2010) (further discussed in section 2.10). Empirical research on the therapeutic use of imagery supports the claim that information is more easily remembered if the imagery is interesting, organised and mildly but not intensely emotionally evocative, and draws on a number of sensory modalities (Baddeley, 1990; Cahill, Prins, Weber, & McGaugh, 1994). 

4) In line with Cognitive Load Theory (see section 1.7.4), memory may also be aided by the capacity of metaphors to operate as a method of chunking information in an organised form (Otto, 2000). Metaphors may function as a compact, shorthand form of mnemonic in that are both concise and rich with meaning (Ortony, 1975; Pearce, 1996). For example, ‘love is a journey’ includes a set of related mappings that: the relationship is a vehicle, relationship partners are travellers, relationship problems are barriers to motion and so on (Wickman, Daniels, White, & Fesmire, 1999). Within CBT, the compact nature of client metaphors has been described as capturing packets of emotion, behaviour and beliefs (Padesky & Mooney, 2012). Experimental research supports the idea that people may use metaphors because they are compact (Ortony, 1993).

There is some evidence which supports the benefit of metaphor as a memory aid that assists clients to encode and recall significant therapeutic material. One study found that clients could recall intentional therapist metaphor use in 66% of experiential therapy sessions, especially when these metaphors were developed collaboratively and repetitively (Martin et al., 1992). Episodes of expressive communication in therapy (including metaphor use) were found to be viewed as important by both clients and therapists and were recalled with high level of accuracy up to six months after therapy ended (Martin & Stelmaczonek, 1988).

The experimental literature on metaphor memorability has found it to be associated with multiple factors, including the number of interpretations that can be derived from a metaphor and the degree of associated visual images (Marschark & Hunt, 1985). However experimental studies of memory for metaphors typically use brief phrases, without context. Subjects’ memory for these could be very different from what is recalled by a client who hears a therapeutically relevant metaphor. In the broader literature on the effect of analogies on learning, laboratory studies have yielded mixed results, with some finding a generally positive effect (Gentner, Bowdle, Wolff, & Boronat, 2001). If the goal is to enable learners to memorise and retrieve factual information, analogies may hinder learning, but if the aim is to challenge them to make inference and go beyond the information given, analogies may help
significantly, especially with learners who are unfamiliar with the subject area (Donnelly, 1993).

2.5.9 Perceived helpfulness

Metaphors may increase the extent to which clients perceive therapy as helpful. Therapist interventions involving metaphors were found in two studies to be rated as more helpful by the participants than other interventions (Hill & Regan, 1991; Martin et al., 1992).

A study of four therapist-client dyads of experiential psychotherapy and clients rated sessions in which they recalled therapists’ intentional metaphor use as more helpful than sessions in which they recalled other therapeutic events (Martin et al., 1992). Another study had a client view a video after her therapy session and she rated each intervention sequence for helpfulness. The client rated therapist metaphor sequences as more helpful than non-metaphor parts of the interaction (Hill & Regan, 1991).

2.5.10 Assisting the development of a stable theme

A shared central metaphor that has been developed and elaborated on by the therapist and the client may help the development of therapy themes and may be an important marker of a productive therapeutic relationship (McMullen, 1989; Rasmussen & Angus, 1996), fostering collaboration (McMullen, 2008). Metaphors which have a positive effect on clients can then be ‘recalled as touchstones when the going gets rough’ in the future (Nadeau, 2006, p. 219).

A qualitative study by Shell (1986) of one successful case of psychotherapy concluded that unconventional metaphors did gather themes together and made central issues manifest, encapsulating the patient’s experience.

2.5.11 An explanatory device/ providing a rationale

Metaphor, particularly when it is the form of a direct analogy, has been described by CBT authors as being a helpful explanatory device that therapists often use to explain concepts and facilitate client understanding (Abbatello, 2006; Alford & Beck, 1997). Similarly, developmentally appropriate metaphors were described as making CBT much more accessible to children, making explanations fun and engaging (Friedberg & Wilt, 2010).

In CBT, metaphors have been used increasingly in shared conceptualisations with clients, so as to provide a rationale for interventions that may not be easy to sell. For example in post-traumatic stress disorder, the metaphor of the oversized duvet (the traumatic memory) stuffed
in the linen cupboard, and the door keeping popping open and being slammed shut again, is used to explain involuntary re-experiencing of symptoms, with the implication that the solution is through removing the duvet, spending some time folding it (processing it) and then putting it away (Stott et al., 2010).

2.5.12 Enhanced outcome

As already noted, enhancing clinical outcome through particular techniques (such as use of metaphor) tends to be the primary focus of mental health researchers and psychologists. However as mentioned in Chapter 1, metaphor research has been hampered by the lack of rigorous and explicit methods of metaphor identification and identification methods vary between studies. Chapter 3 will elaborate on the many outstanding methodological questions relating to the empirical investigation of metaphors. Whether or how metaphor use enhances patient outcomes is therefore an open question at this stage.

The number of metaphors used in therapy sessions does not seem to be an important marker of efficacy (Angus, 1996). Rather, several small qualitative studies suggest that the degree of co-operation between therapist and client in co-creating a few core metaphors may correlate with positive outcomes, and it does not seem to matter whether these are initiated by the therapist or the client (Angus, 1996; Angus & Rennie, 1988, 1989). Some studies have investigated frequency of metaphor use and/or the distinction between conventional/unconventional metaphors, with an assumption that unconventional metaphors are of particular therapeutic value (McMullen, 2008). These studies suggest that metaphor frequency varies across therapists, clients and sessions and is not consistently related to outcome (e.g. Hill and Regan (1991); Pollio and Barlow (1975)). Further details of frequency studies are summarised in Chapter 4. It is possible that the degree of therapist-client match in preference for using metaphors may be more important than the number of metaphors used per se. This will be explored further in Chapter 6.

Previous studies have generally recorded metaphor use in therapy interactions and attempted to find correlations between aspects of metaphor use and outcome or process variables. In addition to the problems around consistent and accurate metaphor identification already noted, such studies have a number of other limitations: Most include only a small number of cases (three to six) and conclusions are thus unreliable, although some findings accrue validity by their recurrence (Törneke, 2017).
Secondly, the existence of so many therapeutic approaches makes it hard to compare findings across studies and raises the question whether metaphor is effective only within that particular therapeutic approach, or is effective across therapeutic approaches (Tay, 2016a). For example, metaphor could prove effective within a CBT approach when used by a therapist as a way of providing a rationale but be ineffective or unhelpful in a psychoanalytic approach where a therapist might assume meaning of a client’s metaphor without unpacking it, and possibly interpreting it in a way that is not helpful or meaningful to the client.

Finally, although some (mainly qualitative) studies report correlations between aspects of metaphor use and therapeutic change (Angus & Korman, 2002; Gelo & Mergenthaler, 2012; Sarpavaara & Koski-Jannes, 2013), it is not clear whether and/or how metaphor causes such changes (McMullen, 2008). This is mostly due to the difficulty of disentangling metaphor use from other co-variates such as the intensity of the intervention and the degree of therapist interest (McMullen, 1996). As a result, metaphor research has moved away from investigating global mechanisms linking metaphor use and therapy outcome. The focus recently is more on specific metaphor functions and metaphor use in particular contexts, even though this may be at the expense of generalisability (McMullen, 2008; Tay, 2013).

In sum, cause and effect has not yet been established. The strongest claim one could make about the therapeutic efficacy of metaphor is correlational, in that certain patterns of metaphor use appear to be more typical of successful than unsuccessful cases (McMullen, 1996).

2.6 Critique of claims about metaphor functions

The ideas above about the functions of metaphor in psychotherapy are in line with the common view of language and its power: “what language does is to refer, represent, communicate, or express…the power of language to do these things is somehow contained in the words themselves” (Guerin, 2003, p. 251). Language is central to psychotherapy, which is often described as a talking cure: client change is seen as occurring both through what is said and how it is said (Shpancer, 2017).

At the extreme end of the practice-oriented literature on the power of metaphor in psychotherapy are statements that metaphor serves to “enrich virtually any communication process” (Barker, 1996, p. 23). There is an assumption in this literature that the functions of metaphor are isomorphic with the goals of psychotherapy when used appropriately and strategically, but evidence to support these claims is patchy and often based on anecdotal evidence or no evidence at all.
While many claims have clearly been made about the power of metaphor in therapy, the writers have not categorically extolled the use of metaphor. The potential rhetorical benefits or functions of metaphor can depend on many factors, including the context, the speaker’s motivation and what alternative ways of speaking are most readily available in the discourse situation. Just because metaphor is used, does not necessarily mean it is used well or that it suits the client. Any strategy use can be clumsy or misjudged, including metaphor. The possible pitfalls in using metaphors in therapy are described in section 2.13 later in this chapter.

One of the main problems with the claims made about the power and function of metaphor in the practice literature is that they have often not adequately taken into account the context of the client-therapist interaction: Metaphors have tended to be isolated for special consideration rather than considered in the context of conversational exchanges where a particular metaphor might be further shaped by its effects on the listener, leading to continued co-construction and elaboration over time. This can result in claims about metaphors that are not adequately grounded in evidence. Evidence to support claims about the power of metaphor often consists of summaries of client’s and therapist’s use of a particular metaphor, along with brief fragments of actual interchanges or metaphorical stories used. However, the contexts in which metaphor is used are rarely, if ever analysed (McMullen, 2008). Without an understanding of metaphor in context, study of metaphor is at risk of the tautological argument that metaphor is important in psychotherapy because it promotes the goals of therapy (Guerin, 2003; McMullen, 2008).

Counter-examples of some asserted benefits of metaphors can be found. For example, ‘time is a physician’ may not necessarily have rich associated imagery for the listener and saying ‘you are an asshole’ lacks any sense of indirectness (Gibbs & Colston, 2012, pp. 223-224).

Unfortunately, in the empirical literature, little has been learned because different questions are asked in different studies, different definitions and methods are used across studies and typically the findings are not particularly convincing or are contrary to expectation. As studies are not replicated and there is a lack of common research strategies between studies, claims can be contradictory or tied too specifically to the study to be of great value (McMullen, 2008). There has been a critical lack of definitional consistency among researchers of metaphor in therapy (Tay, 2013), with the absence of sustained consensus about what counts as metaphorical being described as a main reason for the contradictory results found in studies (Long & Lepper, 2008). In addition, researchers have tended to draw theoretical implications from their studies as if their experimental findings are representative of what always occurs.
when people encounter metaphorical language. This results in a tangled web of empirical findings and theories. In experimental tasks there is a fair degree of individual difference in interpreting figurative meaning that is often not acknowledged or explained by traditional psycholinguistic theories (Gibbs & Colston, 2012). Further detail on the methodological shortcomings and challenges in this area is provided in Chapter 3 (sections 3.2-3.4).

Most of the limited empirical research to date involves analysis of metaphors used in actual therapy sessions (mainly psychoanalytic, psychodynamic and process-oriented psychotherapy sessions). There are also a few studies in which post-session inquiry interviews of therapists and/or clients were analysed (Angus & Rennie, 1988; Rasmussen, 2000; Rasmussen & Angus, 1996). The accumulated findings of this research underscore the highly contextualised nature of metaphor use and the need for more therapy-specific research using robust definition and methods.

2.7 Therapist, client and co-constructed metaphors

As well as literature on the functions of metaphor in therapy, various authors describe how metaphors used in therapy can be constructed by the therapist, by the client or co-constructed during therapy. This section will review this literature.

2.7.1 Therapist-generated

Therapist-generated metaphors aim to use metaphors as a resource to enhance clients’ understanding or coping with issues currently addressed in therapy. Often these are in the form of a teaching analogy, such as teaching an anxious client about the effect of focussing attention by drawing an analogy to the effect of focussing on an itchy bite (which increases the perceived intensity of the sensation). Therapists who advocate the use of therapist-generated metaphors tend to provide collections of readymade analogies or ‘stock’ metaphors which can be used with appropriate clients (Blenkiron, 2010; Stoddard & Afari, 2014; Stott et al., 2010).

The metaphor of being on a bus is an example of a sustained shared metaphor which can be presented by the therapist as a way of conceptualising the vicious cycle of pain. The client is on the bus of life, and pain has got on as a passenger. The red wheels of the bus describe the vicious pain cycle in which pain is driving the bus. When the client drives the bus towards their important values, (changing behaviours that keep them locked in the vicious cycle, such
as avoidance and inactivity), they get into a ‘virtuous’ pain cycle in which the bus has green wheels (Stones & Cole, 2014).

Writing from an Ericksonian tradition, Barker (1996) suggests that when therapists are considering the selection of a metaphor it is important to consider the cultural and vocational background, language style, vocabulary and primary sensory channels used by the client (i.e. visual (‘I see what you mean’), auditory (‘That sounds pretty bad’) or kinaesthetic language (‘that feels just right’)). Confident delivery of the metaphor, along with good timing and pacing, are also viewed as important.

One author suggests that clinicians should not hesitate to introduce appropriate metaphors if a client has not spontaneously generated metaphors and the clinician has a good understanding of the therapeutic issues that could be addressed through metaphors. A metaphor that is on target will resonate with the client’s inner world and clients will typically use and modify the therapist’s metaphors, increasingly experiencing them as their own (Brooks, 1985). Possible pitfalls in therapist use of metaphors are elaborated on in section 2.13.

2.7.2 Client-generated

As noted above, much of the clinical literature on metaphor in psychotherapy relies on therapist-delivered metaphors and views client-generated metaphor as a form of communication requiring therapist interpretation (Sims & Whynot, 1997). This is not true of the CBT approach, however, as ‘interpretation’ (in the psychodynamic sense of therapist ‘interpretation’ of client utterances, as reflecting repressed or unconscious impulses, anxieties, and internal conflicts) is not a CBT strategy. CBT is more focussed on how clients interpret situations and therefore explores the idiosyncratic meaning for the client of client metaphors.

Research into metaphor in psychotherapy tends to begin from the assumption that the therapist should generate the metaphor, but often concludes that exploration of the client’s own metaphors provides the most therapeutic potential (Angus & Rennie, 1988; Martin et al., 1992). Client-generated metaphors are those spontaneously generated by clients, which can be explored and transformed to contribute to treatment. Client metaphors can reveal a considerable amount about clients’ major concerns, interpersonal relationships, emotional experiences and views of self and others (McMullen, 1985, 1989). They often contain themes that are central to the client’s problem (Angus & Korman, 2002; Levitt, Korman, & Angus, 2000).

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6 The terms vicious cycle and virtuous circle and vicious circle refer to complex chains of events that reinforce themselves through a feedback loop. A virtuous circle has favourable results, while a vicious circle has detrimental results.
Client metaphors may have profound personal significance: ‘It is undeniable that no one could construct for another individual a metaphor as meaningful as the one which that person constructed for himself’ (Gordon, 1978, p. 166). Similarly, from a CBT perspective, it has been claimed that ‘metaphors, stories and images need to come from the individual to have personal meaning and resonance’ (Kuyken et al., 2009, p. 109).

This suggests that it may be most helpful for the therapist to use metaphors first generated by clients (Brooks, 1985) and that therapists should assist clients to explore and transform these metaphors and to use this material in the continuing dialogue (Törneke, 2017), even with more conventional metaphors (McMullen, 1989; Rasmussen & Angus, 1996).

Exploration of client-generated metaphors may increase understanding of the client’s belief system and tap into their imagination, like Alice going through the looking glass, journeying beyond the mirror’s image into the creative realm (Kopp, 1995). It may be that in the generation of such metaphors, clients are more active in their development, engaging in a creative process to contribute to their own treatment. Working within the client’s metaphors, the therapist is thought to discover, with the client, new possibilities and new interpretations (Nadeau, 2006), with client metaphors serving as ‘points of entry’ in to a client’s subjective experiencing, if therapists are attuned to them (McMullen & Conway, 1996, p. 59).

Examples of client-generated metaphors are as follows: On returning to his wife after ending an affair, a depressed client said, ‘I have gone into prison and thrown the keys out the window’ or when explaining his sense of his mind being a threat to him, an anxious client said, ‘my mind is a loaded weapon’ (FM examples).

2.7.3 Co-constructed

The distinction between therapist-generated and client-generated metaphors may be an oversimplification, not reflecting the full complexity of metaphor use in actual client-therapist interactions. There appears to be a middle ground, in which metaphors are seen to be negotiated and co-constructed in a collaborative manner. According to this view, metaphors become the product of the unfolding interaction between client and therapist, rather than a method of intervention or a mirror of clients’ thoughts (Tay, 2016a). In addition, intentional co-construction of metaphors may have benefits, through creating a shared language within which successful change conversations can occur (McMullen, 2008). Based on a study of themes in therapy transcripts (Angus & Korman, 2002) conclude that “it appears that the reuse and co-creation of metaphoric themes creates a mutually understandable terminology.
and context of meaning between the therapist and client” (p. 160). Co-construction is consistent with the approach taken by Kopp (1995) who suggests that working with metaphors should ideally be a collaborative venture, with client and therapist actively incorporating, altering and extending each other’s metaphors to establish a shared therapeutic vocabulary that serves to link and organise large amounts of experience and knowledge. This is concordant with the Cameron’s dynamics systems approach outlined in Chapter 1. Co-construction of metaphors may also have the advantage of reducing the risk of unintended misinterpretations (due to divergent vocabularies, cultural backgrounds, histories and contextual dissimilarities) (Stewart, 2014).

In practice, there may be considerable variability in metaphor use and (co)-construction, with speakers switching rapidly from one vehicle to another and basing their selection of metaphor vehicles on how well they are able to express their point (Tay, 2013). Metaphor variability can include re-use of vehicles with different topics, several vehicles being used in a discussion of a topic, or arbitrarily switching between different topics and vehicles (which is less desirable as it may reduce coherence and require strategic management by therapists when clients switch in this way) (Goatly, 1997; Tay, 2013). It is suggested that therapists keep a keen awareness of how metaphors can be deployed in both a consistent and varying fashion, as circumstances dictate. Consistent themes are thought to be beneficial; however, this does not mean interweaving threads of ideas necessarily have negative impacts (Tay, 2013).

Little is known about how the metaphorical language of clients and therapists evolves in therapy conversations. An early article by Barlow et al. (1977) described how a client and therapist repeatedly used, responded to and built on each other’s metaphors. A few studies found varied results regarding whether and how clients and therapists made use of each other’s metaphors. Co-construction of metaphor was not very common (Hill & Regan, 1991). In terms of outcomes, comparisons of successful and unsuccessful cases were similar in that the clients consistently used many more of their own metaphors. These studies found no differences in the extent of therapist metaphor use in relation to therapy outcome: therapists were found to use their own and the clients’ metaphors to roughly the same extent or to repeat and elaborate their own metaphors (McMullen, 1985, 1989).

Co-construction does not necessarily indicate that a collaborative, productive process is occurring. Although extended bursts of metaphoric language by clients were found to relate to problem solving (Pollio & Barlow, 1975), other studies suggest a more complex picture with two different patterns of metaphoric communication emerging: attuned, collaborative and associated with the development of a mutually shared understanding, and non-collaborative
and frequently associated with a joint misunderstanding of the meaning of a metaphor (Angus & Rennie, 1988; Rasmussen, 2000).

2.8 Other aspects of metaphor in therapy

2.8.1 Bursts of metaphoric exchange

Metaphors in therapy tend to occur in bursts. Elaboration via bursts of metaphoric language or development of a metaphor over time may be more consistently present in successful cases of therapy (McMullen, 1989). This pattern of bursts of metaphorical exchange will be explored in Chapter 5.

2.8.2 Behavioural responses to metaphors during conversations

Various rhetorical devices may be used in conversation by the client or therapist in the service of endorsing a metaphor, rejecting it or negotiating its interpretation (McMullen, 2008). Most of the empirical literature tends to focus on therapist responses.

Descriptions of potential therapist responses to client metaphors in the literature tend to overlap, but include: misunderstanding, comprehending without comment; not comprehending or getting the point; repetition, ratification by comment or use of an associated word in later discourse; or joint construction and extension of the metaphor: weaving a web of correspondences that tease out further ramifications and add new dimensions (Ferrara, 1994). Therapists may: ignore or miss the occurrence of metaphor; assume meaning; express curiosity about the metaphor; explore the imagery associated with the metaphor; praise the metaphor’s expressive power; or explore associated feelings (Sims & Whynot, 1997).

Similarly, another study found that therapists may respond to client metaphors by: exploring the idiosyncratic meaning of the metaphor meaning to creating a shared understanding; therapeutically extending or modifying the metaphor (modifying metaphoric conceptualisations of problems, experiences or situations) and responding to a client metaphor with a metaphor of their own which is isomorphic (i.e. corresponds in form and in the relations between the elements) to the client’s metaphor so as to reframe the problem (Strong, 1989). The frequency of these potential responses were studied by Bayne and Thompson (2000), who found frequent use of the first two responses (exploring personal meaning and extending or modifying the metaphor) but low frequency use of the therapist-delivered therapeutic metaphor. They found a further therapist response: recognising and remembering
a client’s metaphor for possible use in the future. Many of these responses could presumably also be used by clients and a study by Hill and Regan (1991) did look for repetition and elaboration by clients as well as therapists. The range of behavioural responses that may occur in co-constructing a metaphor in therapy is further investigated in Chapter 5.

2.8.3 Common metaphor themes in therapy

While exhaustive coverage of the literature on metaphor themes is beyond the scope of this review, the literature on themes in the talk of depressed clients warrants inclusion because the second stage of this thesis involves using metaphors with (role played) depressed clients. Metaphors of depression were derived from 471 therapy sessions of twenty-one clients in psychodynamic therapy (McMullen & Conway, 2002). Clients’ metaphorical descriptions fell into four categories: Depression is ‘descent’, ‘darkness’, ‘weight’ and ‘captor’, with ‘descent’ being by far the most commonly used (over 90%). They state that the ‘dominant conventional metaphor of DEPRESSION IS DESCENT is so much a part of the fabric of our culture that it is simultaneously trite (and virtually inaudible) and associatively rich’ (p.167). The authors noted that therapists virtually ignored client’s use of the descent metaphor and suggest that opening up this metaphor by asking clients to elaborate might have assisted productive therapeutic discourse.

A second example of themes in the talk of depressed clients involved the selection from a pool of transcripts of two clients (one undergoing process-experiential therapy and one undergoing client centred therapy). A predominant metaphor of RELATIONSHIP IS CONFLICT was found in both transcripts. Both clients initially experienced their marital relationships as ‘fighting but losing’. Over the course of therapy, however, these evolved: one became ‘fighting and winning’ and the other became ‘negotiating’ (Angus & Korman, 2002).

It is not clear whether metaphors of recovery, such as a RETURN TO THE LIGHT emerge spontaneously as clients recover from depression, or whether therapists use such metaphors strategically in fostering hope (Schoeneman, Schoeneman, & Stallings, 2004).

2.8.4 Conventional and unconventional metaphors in therapy: Dead or alive?

Conventional metaphors are sometimes described as ‘dead’, while unconventional ones are described as ‘alive’ (Törneke, 2017). The assumption in much of the empirical literature is that it is unconventional metaphors that do the work in psychotherapy, helping conceptualise and elucidate new ideas (Fine et al., 1973; Pollio & Barlow, 1975). However, researchers have not found the distinction between conventional versus unconventional metaphors to be
particularly clear or useful: some unconventional metaphors do not seem to be important in the work of therapy while some conventional metaphors do seem to be useful and hold unique import for clients (McMullen, 1985, 1989; Rasmussen & Angus, 1996). ‘Many of these worn out metaphors are unconsciously determined figurative expressions that may have a vivid sensory connection and the potential for affective charge’ (Siegelman, 1990, p. 45). For example, a client might talk about the ‘barriers’ to change. While this is (arguably) a conventional metaphor, exploring the meaning, emotions, sensations, behaviours and images associated with this with the client could prove as fruitful therapeutically as exploring the more unconventional metaphor of the mind’s ‘border security’ (FM example).

According to Törneke (2017), the classification into dead versus alive is unviable: instead metaphors exist on a continuum from completely novel expressions (such as awaking being described by a poet as a ‘parachute jump from a dream’ (p. 27)) to terms that are unrecognised as metaphors by most users, such as ‘emotion’, the etymology of which is ‘out of something that moves’ (p. 29). Further, unconventional metaphors can become conventional through overuse, while conventional expressions may seem fresh and unconventional in certain contexts (McCurry & Hayes, 1992).

Empirical research has explored whether conventional metaphors are necessarily ‘dead’ or whether they can remain productive. Some evidence does suggest that they are productive in assisting comprehension (Thibodeau & Durgin, 2008). Given that even conventional metaphors can be productive, and that determining the degree to which any metaphor is ‘dead’ depends on assessing the person’s communicative actions at a particular moment, there has been a shift in the empirical literature away from distinctions between conventional and unconventional metaphors (McMullen, 2008). The degree to which a metaphor is alive is really may be a matter of associated meanings for specific individuals in particular moments of speaking and listening (Mueller, 2007).

Conventional and unconventional metaphors are mostly described in the literature as conceptually distinct and requiring different processes to interpret. However, across different studies, different stimuli items are used that are assumed to be representative of ‘conventional’ and ‘unconventional’ metaphors. The two terms are rarely defined, and the distinction is typically based on intuitive ratings, which are highly variable (Gibbs & Colston, 2012). Further, corpus linguistics (which analyses large amounts of text) has established that

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7 Corpus linguistics is the study of linguistic phenomena, through large computerised databases of machine-readable samples of real life language use
people’s intuitions about whether a metaphor is conventional or unconventional may differ from how words are actually employed in real discourse (Gibbs, Wilson, & Bryant, 2012, pp. 472-473). In sum, attempting to differentiate conventional versus unconventional metaphors does not appear to be a particularly helpful way forward.

### 2.8.5 Cultural and individual differences

A potential concern with metaphor use is that meaning may be ‘lost in translation’ between different cultures. As conceptual systems vary, metaphors in one culture (or generation) may be meaningless in another. For example, several ‘stock’ metaphors described by Blenkiron (2005) are highly culture specific: clients from other cultures may take offence at their health problems being compared to a ‘car’. There are differences in conceptual metaphors used by different cultures: For example, in western cultures, since the term ‘painkiller’ was first used in 1845, pain has been seen as an ENEMY TO DEFEAT (e.g. headaches being described as: ‘shooting’ or ‘stabbing’). By contrast, in Japan, metaphors of pain draw on the animal world: ‘bear’ headaches (resemble heavy steps of a bear); ‘deer’ headaches (like the galloping of running deer; ‘octopus’ headaches (sucking) & ‘crab’ headaches (prickling)(Bourke, 2014).

A series of studies explores people’s metaphorical conceptualisations of time: westerners tend to understand time as going ‘forward’ or ‘backward’, while fluent Mandarin speakers are more likely to place time on a vertical axis (time moving ‘up’ and ‘down’) (Fuhrman et al., 2011).

However, Kovecses (2000, 2010) found similarities between different cultures in the popular metaphors they used to describe emotion and suggested that utilisation of metaphors enables people to conceptualise emotion and transfer its meaning to another culture. However, he suggests that as with any language use in a therapy setting, it is prudent for therapists to attempt to ensure that the meaning of a metaphor is fully understood by both parties, rather than being assumed. The importance of explicitly ensuring shared understanding of metaphor in order to reduce the potential for harm is also emphasised by Muran and DiGiuseppe (1990).

It has also been argued that all therapy involves the client and therapist coming from different ‘cultures’ (Dwairy, 1999) and metaphor may provide an interface on which biological, psychological and social factors interact for non-western patients (Dwairy, 1997). Dwairy’s ideas have been critiqued, however, for assuming that non-western language is inherently more metaphoric in the absence of extensive linguistic or anthropological evidence (Tay, 2013, p. 67).
2.8.6 Metaphor in the therapy context

Metaphoric content may have multiple functions or meanings and is embedded in an ongoing and highly complex clinical process (Cirillo & Crider, 1995; Rasmussen, 2000). As emphasised in section 1.4.5, context is important to metaphor use and understanding (Cameron et al., 2009). In therapy, context (such as the people involved, their relationship, their motivations and the tasks they are undertaking) helps shape whether a word or phrase is interpreted as having a metaphoric meaning (McMullen, 2008). In order to add to conceptual and empirical understanding of metaphor in psychotherapy, we also need to bear in mind the conversations that surround and subsume metaphors (Eubanks, 2000).

The importance of context in therapy is elaborated on by McMullen (2008, p. 409) who states that the largely de-contextualised approaches used to date (with metaphors isolated from the surrounding therapy talk) have led to claims in the empirical literature that are ‘over-reaching or banal’. She argues that we should see language in terms of its strategic use, focussing on what the conversation in the context is accomplishing. In this approach, metaphors are one of many discursive devices that are used by a speaker to attempt to meet communication goals. As such, any metaphor is seen as having multiple potential meanings and can perform a variety of functions, depending on the situation and how it is employed. Researchers working from this perspective would need to explore how the meanings of any particular metaphor are understood and jointly developed (perhaps over several therapy sessions) and analyse how the metaphor functions to achieve certain goals, and how other discursive devices contribute. This analysis would then need to be placed within the broader social, economic and cultural context of the psychotherapy discourse. This would include explicit specification of the asymmetrical social influence process of the psychotherapy (in which the client is expected to disclose personal problems to the therapist, who is expected to provide expert guidance with respect to these problems) as practiced at that time and place, the circumstances under which psychotherapy has been sought and the therapist’s understanding of his/her role.

The following layers of context in psychotherapeutic discourse are based on those proposed by Tay (2013):

1. **The individual patient’s life history and subjective experiences.** The patient’s idiosyncratic personal ‘schemas’ and ‘narratives’ which are developed in making sense of life experience, may be drawn on as source materials for metaphor vehicles (Ritchie, 2009). Such vehicles are as likely to be drawn from highly personalised experiences as they are from conventional metaphors (Kovecses, 2001).
2. The socio-cultural context of therapy and its participants (shared cultural understandings and conventional conceptual metaphors in interaction with individual minds and cognitive processes).

3. The therapeutic approach used has implications for whether and/or how metaphors are used. Metaphors can potentially become ‘framing devices’ of therapy, where more abstract therapeutic processes, conceptualisations and constructs are communicated via relatively stable metaphorical mappings (Zinken, Hellstenm, & Nerlich, 2008). These may differ for different therapeutic orientations and may be subscribed to by both therapist and client. For example, the brain as a ‘computer that processes information’ has been widely used in CBT in the past (Meichenbaum, 1993), with associated meanings of ‘running programmes’, having ‘faulty software’ and so on.

4. The interactional context between therapist and patient. This refers to the strategic, interactional aspects of metaphor, in which meaning is often spontaneously and collaboratively constructed (Ferrara, 1994) in accordance with speaker’s discourse objectives (Wee, 2005).

5. The co-text of therapeutic talk (i.e. other linguistic features that often co-occur with metaphors, such signalling devices that a metaphor is about to occur (e.g. “you know…” (Tay, 2011a)).

In short, the many layers of context of metaphoric language use clearly need to be taken into account in the study of metaphor in therapy.

2.9 Practice-based metaphor literature from CBT and ‘third wave’ cognitive therapies

This section will summarise the small but growing practice-based literature on metaphor in CBT and ‘third wave’ cognitive behavioural therapies that have evolved from CBT, such as Acceptance and Commitment Therapy and Dialectical Behaviour Therapy both of which strongly advocate metaphor use (particularly therapist use of metaphor).

Early in the development of CBT, Beck noted that metaphor could be a powerful way to generate and sustain helpful alternative ways of thinking, often starting from the patient’s own use of metaphor (A. Beck et al., 1979). On the surface, given its emphasis on logic and rationality, CBT may seem unsuited to metaphors. However, CBT does employ metaphors (Ronen, 2011). CBT aims to transform meaning and metaphors can achieve this by providing a conceptual bridge from a problematic interpretation to a new perspective on experiences (Stott et al., 2010). Further, metaphors in CBT may transform therapeutic information into a
form that is easy to remember. This can provide useful guidance and can be applied at relevant moments in clients’ lives (Otto, 2000). One could argue that CBT, almost by definition, encompasses a metaphorical or analogical view of thought and cognition, treating something internal that we can’t physically see, hear or touch as concrete, observable (and hence changeable). CBT also has metaphors for the therapy process itself, such as ‘two scientists working together’ (A. Beck & Weishaar, 1989).

Writing about specific content and process variables that may contribute to the differential effectiveness of CBT, Elliott, Adams, and Hodge (1992) suggest that appropriate and well-designed metaphors may be particularly effective as a way of changing clients’ distorted views. Metaphors are further described as a way to go ‘beyond competence’ in CBT delivery, going beyond the required elements (Newman, 2015). Further details on how Newman proposes this can be achieved are provided in Chapter 6.

The many assertions about the beneficial function of metaphors have already been described including assertions from the CBT practice literature (see section 2.5).

In a recent practice-oriented book on metaphors in CBT, therapist use of metaphoric language is broadly described as way of building cognitive bridges, making it easier for patients to process, make sense of, and take control of their problems (Stott et al., 2010). Recently CBT experts have advocated a collaborative approach to developing client metaphors on the basis that if the metaphor comes from the client it is thought to have personal meaning and resonance, be easier to remember and link to deeper emotions (Kuyken et al., 2009).

CBT has recently also seen increased focus on therapists explicitly using metaphors to teach ideas to clients (Blenkiron, 2005; Otto, 2000; Stott et al., 2010). More recently still, there has been some focus on transforming client metaphors (Kuyken et al., 2009; Padesky & Mooney, 2012; Stott et al., 2010), using a similar approach to that developed by Kopp (1995) (see Appendix F).

A distinction has been made between the application of metaphor in CBT versus other psychotherapies, where it is often assumed that the therapist and client will automatically have a shared understanding. In CBT the meaning of the metaphor is made more explicit and is usually “deconstructed to ensure that the point has been made” (Blenkiron, 2005, p. 47).

A number of examples of working with metaphors within a CBT framework can be found in the literature: The therapeutic metaphors of critical self-talk as being like a ‘gargoyle on your shoulder’ and helpful self-talk as being like a ‘good sporting coach’ are outlined by (Otto,
The analogy of ‘lighting a fire’ is has been used as part of psycho-education about motivation. It takes a certain amount of energy to collect firewood and arrange the firewood in preparation for lighting, but little energy to light it and throw on the occasional log once it gets going. Likewise, it takes some physical or mental energy to start a task but less once one gets started (J. Beck, 2005, pp. 179-180).

Multiple therapist-generated metaphors in the form of teaching analogies are described and reviewed by Blenkiron (2005) and added to by Stott et al. (2010), who describe the ‘Pushing the wall’ metaphor, which is used to explain the purpose of behavioural experiments in CBT: A naïve apprentice is left holding up a brick wall while his colleagues take a break. In order to test his belief that he needs to keep holding up the wall, he will have to do the uncomfortable experiment of risking not holding up the wall.

Many of these are therapist-initiated metaphors, rather than examples of working with the client’s metaphors. However, several collaboratively developed strengths-based metaphors are described in a recent book on CBT conceptualisation, such as a client ‘Learning to live in the light’ and ‘Hiking on an unknown trail’ (Kuyken et al., 2009, pp. 109-110). Each was unpacked in therapy sessions to understand the client’s resilient core beliefs, underlying assumptions, emotional responses and behavioural strategies.

2.9.1 Third wave cognitive therapies

Metaphors are often used in third-wave cognitive therapies, particularly in Acceptance and Commitment Therapy (ACT) and Dialectical Behaviour Therapy (DBT).

2.9.2 Acceptance and Commitment Therapy

ACT is a recent branch of cognitive therapy developed by Dr Stephen Hayes and colleagues that uses therapist-generated metaphor extensively (Hayes, Strosahl, & Wilson, 2012). ACT is a contextual behavioural approach that views metaphor as a way to connect with clients and deepen understanding (Hayes et al., 1999). ACT differs from traditional CBT in that rather than trying to teach clients to evaluate their thoughts so as to reduce distress and dysfunctional behaviour, it teaches clients to observe, accept, and embrace their thoughts and feelings, while clarifying values and taking concrete steps towards living by one’s values. ACT’s theoretical framework is a complex theory of human language and cognition called
‘relational frame theory’ (RFT), based in radical behaviourism (Barnes-Holmes, Hayes, Barnes-Holmes, & Roche, 2001; Hayes & Toarmino, 1999). RFT attempts to bring verbal behaviour back within the realm of behaviour analysis. In other words, ACT tries to change the impact of thinking rather than the specific content. ACT sees human verbal abilities as a double-edged sword, which helps us solve everyday problems while at the same time bringing painful aspects of the past to the present so that we view historically-based emotional echoes as a problem to be solved, projecting fearful futures and comparing ourselves to unrealistic ideals. Cognitions and emotions are thought to become barriers in life when they are taken literally, as static objects. They can lead to avoidance, alteration or termination of unwanted feelings, thoughts or memories, which is often futile or counter-productive (Varra, Drossel, & Hayes, 2009). In RFT, metaphor is seen as helping transform the ‘functions’ (i.e. effects) of the stimuli in question. For example, describing cats as ‘dictators’ establishes a ‘framework of co-ordination’ between cats and dictators, with the shared feature of being demanding. The relational framework is thus elaborated and the function of ‘cats’ has been transformed (Hayes et al., 1999). From an ACT perspective, when we use metaphors, we use language to frame relationally: we ‘relate relations’ (Törneke, 2017, p. 70).

ACT sees metaphors as particularly powerful in highlighting what would otherwise be an abstract philosophical idea. For example, the metaphor of a ‘bad cup’ is used to explain the difference between descriptions and evaluations. Adjectives such as ‘bad’ can fool us into thinking they are descriptions, when in reality a cup is just a cup: ‘Bad cup’ only has meaning in relation to a person with opinions, who evaluates it. In contrast, a ‘ceramic cup’ would maintain its validity even if there was no-one to evaluate it. Metaphors are also seen by ACT as memorable and applicable across many settings (Hayes et al., 1999). One particularly rich ACT metaphor describes the patient as being like to someone who has ‘fallen into a hole and is desperately trying to dig themselves out by using the available tool, which is a shovel’ (Flaxman, Blackledge, & Bond, 2010). ACT advocates that a better approach than using a stock therapist-generated metaphor (which may for instance refer to quicksand, which the client has not directly experienced) is ‘to build metaphors on the personal history and cultural background of individual clients. This ensures that clients will have direct, concrete knowledge of what happens after they execute a given action’ (Stoddard & Afari, 2014, p. 20). A recent book by Törneke (2017) moves from the previous ACT emphasis on therapist-delivered metaphors and clearly outlines how to use collaboratively developed metaphors within the ACT approach. This is described and discussed further in Appendix F. In sum, while attention to client-generated metaphors is emphasised within the CBT approach, ACT
primarily used therapist-generated metaphors though Törneke’s recent book advocates a more client-centred, co-constructed approach.

2.9.3 Dialectical Behaviour Therapy

Another third wave cognitive behavioural therapy that makes extensive use of therapist metaphors is Dialectical Behaviour Therapy (DBT). This was developed by Dr Marsha Linehan (Linehan, 1993) for working with clients with borderline personality disorder and focuses on assisting clients to develop skills to regulate emotional states. DBT uses a large number of metaphors, generally taking something the patient understands and comparing it to something the patient does not understand. For example, therapy-interfering behaviour is compared to a ‘mountain climber who refuses to wear winter clothing when climbing a mountain’ as a way of inviting discussion about unhelpful or dangerous behavioural strategies. Passive behaviour is compared to ‘cringing in the corner of a flaming room when the only way out is to wrap oneself in wet sheets and run through the flames’. Learning acceptance is compared to a ‘gardener accepting that weeds will come back up in the garden, month after month’ (Linehan, 1993, pp. 209-210).

2.10 Related Research: Imagery in CBT

This section will summarise and discuss the research on the role of imagery in CBT, having first distinguished between imagery and metaphor.

Before discussing the imagery research, the difference between imagery and metaphor warrants clarification, given that metaphor can have a great deal of associated imagery. Imagery and metaphor can be described as kindred spirits (Ronen, 2011). Considerable work is being done currently in the area of working with imagery in CBT (Hackmann, 2011; Holmes, Crane, Fennell, & Williams, 2007; Renner & Holmes, 2018; Stopa, 2009; Wheatley & Hackmann, 2011) and this literature will be summarised in this section.

Mental imagery is a perceptual-like experience in the absence of sensory input, which is often described as “seeing with the mind’s eye; hearing with the mind’s ear and so on” (Kosslyn, Ganis, & Thompson, 2001, p. 635). When we think or fantasise about the future, or when we remember the past, much of this is in imagery form. As Beck (1976) suggested, it is not the event itself that causes distress, but what the thoughts or images our mind generates in relation to it. For example, when a friend is late for a social event, we may think they have been in an accident, or we may imagine the scene of an accident. Both would lead to distress. Ronen (2011) elaborates on this theme, asserting that imagery is a major part of human
experience. Human distress, she says, derives from negative self-images, such as viewing oneself as failing, helpless, hopeless and alone. Therapy can end when a client can adopt a positive image of themselves coping successfully and being happy despite challenges in their lives.

Imagery is not necessarily metaphorical, however: some images, such as traumatic memories, are of actual events, such as during flashbacks (Holmes & Hackmann, 2004). In order for images to be metaphorical, representation of something else is required. Metaphors resemble images in many ways and sometimes it is difficult to draw the line between them. According to Ronen (2011), the simplest way to differentiate the imagery and metaphor is by saying that the speaker talks about metaphors while staying ‘outside’ them (e.g. ‘I feel like a rag that my husband steps on’) whereas in imagery we jump inside, becoming the image itself and acting as though we were there (e.g. the therapist saying: ‘could you please become a doormat and explain what it feels like being down there while everyone steps on you?’).

In the CBT field, despite the emphasis that Aaron Beck placed on imagery when he founded CBT, there was initially little research on imagery in CBT. Imagery was conceptualised as functionally equivalent to thoughts (and tackled using similar cognitive techniques as thoughts, such as thought challenging (A. Beck et al., 1979)). In the past 15 years, however, there has been an explosion of interest within CBT in imagery across many disorders, including social phobia, depression, schizophrenia and post-traumatic stress disorder (D. Pearson, Deeprose, Wallace-Hadrill, Heyes, & Holmes, 2013). Much of this interest has arisen from the work of Holmes and Hackmann (2004). Experimental studies have demonstrated the strong relationship that imagery has with both memory and emotion: For example, imagery was found to have a more powerful effect on emotion than verbal processing of the same material (Holmes & Mathews, 2005; Holmes, Mathews, Mackintosh, & Dalgleish, 2008). This finding has led to the development of CBT interventions that target imagery (for example ‘imagery re-scripting’: (Hackmann, 2011)) and the publication of a guide to imagery in CBT (Hackmann, Bennett-Levy, & Holmes, 2011).

2.11 Conceptual frameworks for metaphor in CBT

In studying metaphor, as well as having a precise definition, there is a need for a rigorous theoretical framework regarding how metaphor functions.

There is only one conceptual framework in the CBT literature that suggests how metaphor may trigger therapeutic change. The framework shown in figure 2.2 was developed by Stott et
al. (2010) and builds on Lakoff and Johnson’s work as well as more recent work in psychology, cognitive neuroscience and artificial intelligence. The key premise is that metaphors allow us to use familiar sensory and motor experiences to understand, utilise and modify more abstract concepts.

This model involves a four-fold process of activation, elaboration, synthesis and reframe. It attempts to capture both the cognitive phenomena and interpersonal process of metaphor in therapy. According to Stott et al. (2010), by invoking a metaphor, two cognitive structures are
activated, the vehicle domain and the topic domain (which Stott calls Source and Target). The topic domain is the problematic cognitive structure or process – which may originate from the client or therapist, will typically have a concrete, experiential basis and be easily pictured in imagery. It will often be shared between the client and therapist. The therapist may elaborate either of these domains. Then a process of cognitive synthesis occurs in which the two domains are bridged and meaning elements are integrated. This process is thought likely to involve some sustained attention to both imaginal and verbal components of each domain, switching between them and allowing both to be held in conscious awareness. According to this model, a new ‘cross-fertilised’ structure is created, which may have both verbal and imaginal components. This may stimulate further consideration and/ or elaboration of each of the domains in a cyclical process. The degree to which the therapist is explicitly involved is thought to vary hugely. If successful, the client will attain a reframed, alternative perspective on the target domain and a distinctive image will be stored for easy recall in the client’s mind.

There have been no studies to date which have explored or refined this model. As Stott et al. (2010) note, this model is useful only if it makes valuable predictions, such as predicting the type and process of application of such metaphors which are likely to be useful in therapy. The model is consistent with Dynamic Systems theory in its description of a cyclical process of meaning making and also with Barnard and Teasdale’s ICS model model of how we process meaning and emotions (Barnard & Teasdale, 2008) (see section 1.7.2). It could apply during case conceptualisation, during which a cognitive bridge can be formed if exploration of client metaphor occurs. However, investigating this will be challenging methodologically in terms of finding ways to know or measure whether a new image has been generated or stored for recall in a client’s mind.

2.12 Protocols for working with metaphor in therapy

Several similar protocols have been proposed, along with clinical examples of their use for exploring, co-constructing and transforming client-generated metaphors, although none of these have been empirically evaluated. These outline specific steps starting with noticing and affirming client metaphors, seeking elaboration on these, and then exploring their relevance to the client’s presenting issues. There have also been recommendations as to how to do this (although without specific steps (Bayne & Thompson, 2000)). The step by step protocols have been written from a range of psychotherapeutic orientations (Kopp, 1995; Sims, 2003), from a CBT perspective (Butler et al, 2008; Ronen, 2011) and from a linguist’s perspective (Tay,
2016b). Such protocols and recommendations guide therapists to use prompts such as ‘what does [the metaphor] look like?’ and ‘What connections do you see between the [metaphoric image] and the original situation?’

A further approach to working with metaphors was described by Törneke (2017), which post-dated the final empirical study for this thesis. This approach is firmly grounded in ACT theory and is outside the scope of this thesis so will not been discussed here in detail. This approach is clearly articulated, with examples of metaphors that fit with the principles provided. It is based on a clear therapeutic model and while many of the examples provided are therapist-initiated, it emphasises the importance of co-creation of metaphors. The approach taken by Törneke (2017) is consistent with a CBT approach in that there is a focus on functional analysis of the client’s problems (akin to CBT conceptualisation but with a different theoretical framework). The approach provides some clear guidance as to how a metaphor might be selected that corresponds to essential features of an important therapy topic and which contains a property or function that is more salient than the metaphor topic. But salience is subjective, varying between individuals. This quality may not therefore be a particularly reliable guide.

These protocols and recommendations are included as Appendix F.

**2.12.1 Critique and discussion of protocols**

The protocols have many similarities in terms of the steps involved and tend to emphasise the inherent validity of the client’s conceptualisations by attending to them, collaboratively exploring associated feelings, images and meaning, and inviting transformation of the metaphor. One has a stronger emphasis on deliberately evoking the metaphor (Butler et al., 2008) and all but Ronen (2011) explicitly invite the client to bridge back to the therapy topic. The overarching objective of the process is to develop a metaphoric scenario that is conceptually rich enough to be used as a frame for relevant therapy topics, with inferences that can be drawn from the vehicle and applied to the therapy topic in an adaptive way (Tay, 2013).

Some guidance is provided as to which metaphors to explore. It is possible that patient’s metaphors may relate to overly narrow or overly general aspects of the topic, in which the therapist will need to help the client to focus in a way that better aligns with the topic (Tay, 2011b). One author recommends that therapists select from among the aspects of the metaphor’s expanded significance those that promote the current treatment goals, especially those bearing on the client’s management of the problem under discussion (Sims, 2003).
The protocols also lack clarity as to how the connection between the metaphoric scenario and the therapy topic is to be made, although providing such specific guidance may not be possible. Instead, therapists are left to decide how explicit they wish to be in connecting the imagery and associations generated with the goals of therapy (Sims & Whynot, 1997).

One proposal to help therapists with this lack of clarity is for them to develop a working knowledge of metaphor types (i.e. how metaphor vehicles and topics relate to each other in terms of correspondence or class inclusion, (as outlined in section 1.5). This would guide therapists as they work towards therapy goals (Tay, 2011b). In clinical practice, however, this may be too cognitively challenging for therapists who are already trying to maintain engagement, keep therapy goals in mind and work to explore and transform a metaphor simultaneously.

The step-in which clients are encouraged to seek parallels between their metaphoric image and real life situations has a number of advantages. It affirms clients’ ideas and conceptualisations, helping clients compose fuller, more coherent metaphoric images and can provide an underlying consistency which can become a theme across later sessions (Tay, 2011b).

Taken together, while there are some issues with these protocols, they do provide a structure for therapists to use as a starting point for metaphor work.

2.13 Pitfalls in metaphor use

Many have urged therapists against an overly zealous or rigid approach to working with client metaphors or using their own metaphors. They emphasise that metaphors are just one form of communication, not to be overused (see Burns (2001); Siegelman (1990)). Metaphors have the potential to be iatrogenic both in broader usage and in therapy: there is some evidence that coercive, didactic styles of metaphoric communication in therapy can have negative consequences for treatment outcome (Angus & Rennie, 1988). This section will outline the literature on possible pitfalls and problems with metaphor use.

2.13.1 Potential to mislead: Unhelpful framing

While metaphors are widespread in therapy, they are also common in healthcare and public discourse, with potential to influence both positively and negatively (Burgers, Konjin, & Steen, 2016; Schon, 1993). Such metaphors have been described as generative metaphors in that they become a frame that is implicit, semi-conscious and can shape how problems are
tackled, not necessarily in helpful ways (Schon, 1993). Because mapping between vehicle and topic selectively highlights consistent aspects of topic and vehicle, it may downplay other critical aspects (Keefer & Landau, 2016). Research with learners shows that a single metaphor for a particularly complex concept can lead to errors in judgement due to oversimplification: While simple analogies can help novice learners to gain a preliminary grasp of difficult, complex concepts, these may later obstruct fuller and more accurate understandings (Spiro, Feltovich, Coulson, & Anderson, 1989). The assumptions that flow from such framing metaphors can obstruct cognitive reappraisals and problem-solving (Sontag, 1978). For example, a common example of a metaphor that can constrain thinking and problem solving is the BATTLE metaphor reflected in descriptions of BACTERIA AS THE ENEMY and THE WAR AGAINST CANCER). This metaphor implies we have to ‘attack’ (or escalate intervention), rather than work to understand and accept problems, taking account of multiple factors such as the context in which they occur (Wiggins, 2012).

The effect of metaphorical framing was explored in a series of experiments which found that even the most subtle instantiation of a metaphor (via a single word such as ‘virus’ or ‘beast’) had a powerful influence on how people tried to solve social problems like crime. The influence of the metaphorical framing was covert: people did not recognise that metaphors were influencing their thinking (Thibodeau & Boroditsky, 2011). This suggests that metaphors have potential to be used to deliberately mislead or manipulate people.

In therapy, it is recommended that therapists critically examine what kind of meanings and values are hidden in a therapist-delivered metaphor and whether there may be any costs to using it before employing it as an intervention (Cederborg, 2000). For example, the commonly used metaphor of the BATTLE against anorexia construes anorexia nervosa in entirely negative terms, omitting the ego syntonic aspects of the experience, thereby risking alienating the client and reducing the ability to explore ambivalence between values and behaviours, which is a key motivational intervention (Conti, Rhodes, & Adams, 2016).

Further potential to mislead or confuse arises in other compelling evidence that therapists and clients may speak using different metaphoric vehicles. In a study by Skelton, Wearn, and Hobbs (2002) corpus linguistic research was used to analyse the difference between GPs’ and patients’ metaphors to explain symptoms. GPs tended to liken the body to a ‘machine’; while patients tended to use more evocative expressions, such as ‘cotton wool’, and the authors suggest that clinician-generated ‘machine’ metaphors with pain clients may unhelpfully reinforce a body-mind partition. Therapists need to recognise this communication gap and be careful in their metaphor use.
2.13.2 Not for everyone

Metaphors may not be suitable for everyone and are only one form of communication available to therapists. Some clients (and therapists) may have difficulty with imagination (Siegelman, 1990). Some clients may see metaphors and stories as condescending, evasive or demeaning. Metaphors may also not suit clients with more concrete thinking styles and depressed clients may have difficulty engaging in the active and interactive process required by metaphors. In any case, if direct communication works with a client, constructing an elaborate metaphor may be unnecessary. It has been suggested that therapists should not be overly zealous or rigid in their metaphor use: if a metaphor is not working, therapists should give up and try something different (Burns, 2007).

In line with suitability concerns, Loftus (2011, p. 217) suggests that “a powerful and enabling metaphor for one patient might be meaningless or even threatening to another” and notes that “there is a degree of fuzziness and openness in metaphor, and their boundaries are not always clearly defined”. Conversely, as noted earlier, the ability for metaphors to blur more literal linguistic boundaries may provide an opportunity to reframe experiences (Stewart, 2014). As (Nerlich, 2017, para.10) puts it: “metaphor… can illuminate but also inflame”. We must therefore remain mindful of our eagerness to “impose our brushstrokes onto the canvases of others” (Stewart, 2015, p. 12). Therapists are further advised to remember that metaphors can have multiple meanings. We should not ‘literalise’ them in an A=B manner but bear in mind that although metaphors may be apt, they are likely to be partial. We need to remain flexible and open to other possibilities (Siegelman, 1990).

When clients consistently cannot collaborate with metaphors and continually correct therapists, changing metaphor’s meanings or arguing about accuracy, this means either that therapist’s understandings of clients was incorrect or that using metaphors (or particular metaphors) may not suit these clients, according to Ronen (2011).

2.13.3 Not inherently useful

Therapeutic metaphors are not inherently useful. For example, in a group therapy programme based around a football metaphor (Spandler et al., 2014), football can have associations of competitiveness and aggression, or winners and losers, that may not be helpful for everyone. A football metaphor may well make some feel anxious and unsafe. The value of the metaphor will depend on the flexibility, skilfulness and sensitivity of the clinician who introduces and uses it and the personal resonance for the person (for example if someone had a non-sporty childhood, a football metaphor may be unhelpful). The similarities and differences between
people’s experiences and the metaphor can be explored rather than assuming all aspects are helpful.

2.13.4 Not ‘getting’ it

A further drawback is that people may not pick up on the intended meaning of a therapist-generated metaphor, such as a teaching analogy. Cognitive scientists investigating problem-solving have found that problem solvers are not very good at picking up on analogical relationships unless the relationship is pretty obvious (Gick & Holyoak, 1983; Holyoak & Koh, 1987). There is some debate about this finding, however, with one study finding that people in everyday circumstances may be more sensitive to structural similarities between topics and vehicles than had been suggested by earlier research (Blanchette & Dunbar, 2000).

2.13.5 Therapists getting carried away

Therapists have also been cautioned not to go too far with metaphors because they are only metaphors, not reality (Alford & Beck, 1997). Tay (2013) suggests that “the extravagant reliance on metaphors might be criticised for being whimsical, childish, or even irrational” (p. 82), while Blenkiron (2005) cautions that pushing metaphoric comparisons too far runs the risk of trivialising the patient’s problems. Blenkiron further warns that the satisfaction gained from developing metaphors may be greater than the information imparted, while the use of therapist-generated metaphors may risk weakening valuable client-generated expressions (Wiklund, 2010).

Therapists can potentially ‘fall in love’ with their own metaphors, forgetting the client, according to Ronen (2011, p. 135) and should take care not to ramble on with metaphors or metaphor exercises without tailoring them to the clients’ stage and tempo (Hayes et al., 1999). Therapists might also hijack and misuse client metaphors, in a disempowering way, by fixing meaning or imposing interpretations on clients. This was compared to taking the client’s ball (metaphor) and running away with it rather than exploring meanings with the client, resulting in the metaphor taking a meaning not intended by the client. For example, the therapist saying, ‘Can’t you see that real life is not like riding a horse?’ was experienced by the client as unhelpfully obliterating her world view in favour of the therapist’s perspective (Milioni, 2007).

If therapists overuse metaphor, seizing on every metaphoric utterance, no matter how inert or casual, and exploring it or forcing an unready client to create or elaborate on metaphors, this
could implicitly ‘teach’ the client to produce metaphorical material (Siegelman, 1990). It is unclear whether this would necessarily be helpful.

Therapists are advised to ‘hold your agenda lightly’: ensuring that appropriate therapeutic metaphors are chosen, that respond to the client’s experience in the moment, rather than several being packed in, based on an agenda (Stoddard & Afari, 2014, p. 171). Therapists are also advised to learn to back off gracefully if the client does not want to explore the metaphor: “What works for fruit and flowers does not work so well for people…therapeutic growth can be fostered, not forced” (Siegelman, 1990, p. 123). When working with metaphors and imagery, the therapist needs to be like a skilful driver, adapting their driving to the situation at hand, in terms of paying attention to speed, hazards and warning signs (Ronen, 2011).

Finally, Tay (2016a) reminded therapists to exercise a measure of flexibility when using metaphor protocols that require the therapist or client to assume main authorship: even unremarkable metaphors can provide a meaningful avenue into exploring deep-seated assumptions, and therapist and client may need to collaborate in adopting a measured stance towards the use of metaphor itself. One possibility is the use of ‘hedging’ to lessen the impact of an utterance (e.g. prefacing metaphoric utterances with ‘sort of’ ‘sounds like’ or ‘seems to you like’, as a way of ensuring metaphoric comparisons are not ‘pushed too far’) (Blenkiron, 2005, p. 56).

It appears that when making a decision about whether or how to work metaphorically with a client, therapists would be best to conduct a careful assessment and consider the effect of metaphor use with this client, in this situation, given the goal(s) of therapy. Consideration should be given to whether the client is likely to agree to participate and enjoy metaphorical exchanges and where therapist-generated metaphors are used therapist should consider possible interpretations by the client and should take care not to get carried away.

2.14 Chapter summary

While multiple benefits of working with metaphor in psychotherapy have been enthusiastically asserted in the existing literature, not a great deal has been empirically established, particularly within the CBT context. CBT is an evidence-based form of therapy that has conceptualisation as a cornerstone which guides appropriate use of CBT strategies and relies heavily on the working alliance and collaboration for positive outcomes. So far, there is only one conceptual framework for the use of metaphor in CBT, but this requires empirical evaluation. There are a number of quite similar protocols for working with
metaphors in therapy, which provide a useful starting point for therapists wishing to work metaphorically, but there are also potential pitfalls to keep in mind in working in this way.

2.15 Gaps in the literature and research questions

Research into metaphor in CBT is a wide-open field. For this thesis, it was not so much a case of identifying the gaps as making a start on empirical research and establishing a foundation upon which other researchers could build. It is clear that there are many areas that need investigating in this area such as: the functions of metaphor (such as assisting memory) cross-cultural applications of metaphor; whether metaphors can do harm and how metaphors might work differently than literal language. The following gaps were identified as particularly important and of particular relevance:

1) How can metaphors be identified reliably in therapy conversations? Researchers need a commonly agreed identification method with at least adequate reliability in order to progress research into metaphor in therapy and be able to compare findings.

2) How can we describe what is happening during the co-construction of metaphors between therapists and clients? If we can describe what is happening, then we can learn from this and apply it more intentionally.

3) What happens when this learning is intentionally applied clinically? The aim was to make a start on answering this question by focussing on one particular area: metaphor in CBT conceptualisation. This seemed a particularly important area to explore given that conceptualisation is the cornerstone of CBT and metaphors appear to capture such rich information about how people make sense of their experiences.

4) Do metaphors suit some clients and therapists better than others?

5) How might we go about training CBT therapists to intentionally use metaphors to enhance their CBT? What would the effect of such training be on the therapists?

Detailed research questions and hypotheses are provided in each of the four studies that comprise this thesis.

There are many other possible areas of research into metaphors in therapy that are ripe for future investigation. These are covered in the discussion chapter (Section 8.5).

2.16 Rationale for this thesis

After a broad reading of the literature, as summarised in the preceding chapters and consideration of the potential research avenues, it was decided that this thesis would begin by
establishing some building blocks for future research on the use of metaphor within CBT. A degree of pragmatism was used in selecting methods, with a philosophy of ‘what can I do?’ given the methodological challenges in the area (as discussed in chapter 3).

The first study (Chapter 4) looked at frequency of metaphor in CBT sessions, and evaluated the reliability and utility of the Discourse Dynamics identification method used (Cameron & Maslen, 2010).

The second study (Chapter 5) built on this, looking at how metaphors were co-constructed in early therapy sessions, including an analysis of whether the metaphor was introduced by the therapist or the client.

This initial work highlighted the importance of conceptualisation in CBT (see section 2.4.1) and the importance of working alliance and collaboration for therapy outcomes (see section 2.4.2). Therefore, the third study (Chapter 6) looked at the effect of training therapists to attend to and co-construct metaphors and bring them into shared CBT conceptualisations. This included some exploration of whether metaphors suit some clients (and therapists) better than others.

The final study (Chapter 7) followed on from the therapist training study, exploring the impact of the training on the therapists, as there are no previous studies on training CBT therapists in intentional metaphor use. The study looked at the impact of this training over time on therapist (self-reported) awareness of metaphors, confidence in metaphor use and time spent elaborating on client metaphors and use of metaphors when conceptualising with clients.

The next chapter will provide a broad methodological framework for this thesis and overview of the methodologies available to study metaphor empirically, along with the challenges of empirical research in this area.
Chapter 3
Review of available methodologies and justification of overall research design

3.1 Introduction

This chapter describes some of the many challenges to investigating metaphor empirically. The main current and emerging methodologies for investigating metaphor will be outlined, with a particular focus on methods used in investigating metaphor in psychotherapy. A broad description of the overall methodological framework and rationale for methods used in this thesis will be provided.

3.2 Methodology challenges

Metaphor in psychotherapy is a methodologically challenging area to explore. It is not as simple as comparing therapy sessions with and without metaphor use, because as Lakoff and Johnson (1980) established, metaphors are pervasive in language, so will also occur naturally in therapy. Experimental manipulation of a natural discourse feature like metaphor in spontaneous therapy talk is not amenable to typical randomised controlled trials as contextual features of the interaction are likely to influence outcomes in unknown ways (McMullen, 2008). Metaphor generally occurs in an interpersonal interaction between two individuals with different background experiences, learning styles and preferences regarding metaphor use. In addition, therapists rarely use metaphor alone in a therapeutic intervention. Metaphor, if it occurs, tends to be part of a larger process that can include a range of other techniques. Therefore, determining the efficacy of a specific use of metaphor is very difficult (McMullen, 2008). As McCurry and Hayes point out, on the one hand “trying to disentangle the effects and biases of complicated stories in complex and dynamic contexts may seem overwhelming” to applied researchers into metaphor. On the other hand, for clinicians interested in the overall impact of metaphors (which are only a small portion of the verbal activity in therapy), systematic component analysis of metaphoric language may seem superfluous to the larger clinical undertaking (1992, p. 780).

As noted in Chapter 2 (see critique of claims about metaphor functions), the existing empirical literature is a tangled web of empirical findings and theories (Gibbs & Colston, 2012) which makes findings difficult to interpret and thus inconclusive (Gelo, 2006). There are a number of reasons for this, as follows:
1) The existing empirical literature on metaphor in psychotherapy consists mostly of small studies, which limits the generalisability of results. Often these studies are based on recordings of therapy dyads or descriptive accounts by clinicians in uncontrolled settings with clinical samples (Ingram, 1994; McMullen, 2008). Very few studies are replicated (McMullen, 2008).

2) There is a critical lack of definitional consistency between different researchers as to what constitutes a metaphor (McMullen, 2008; Tay, 2013), which has been described as a main reason for the contradictory results found in studies (Long & Lepper, 2008).

3) Some studies refer generally to metaphors, without giving a definition (McMullen, 1989; McMullen & Conway, 1994), while others, such as Levitt, Korman, and Angus (2000) just provide a brief definition based on Lakoff and colleagues’ conceptual metaphor theory (Lakoff & Johnson, 1980). A manual for the identification of figurative language was developed by Barlow, Kerlin, and Pollio (1971) and used in several studies such as Pollio and Barlow (1975). This manual did not focus exclusively on metaphors but also encompassed identification of different tropes such as metonymy, oxymoron and hyperbole (See Glossary of terms and abbreviations p. xvi for definitions). These may involve different cognitive processes (see for example Kovecses (2002)), making it inappropriate to study them under the same conceptual framework.

4) As well as different definitions, different methods are used. The lack of common research strategies also limits the value of the findings (McMullen, 2008). Previous results relating figurative language use to therapeutic efficacy were inconclusive largely because the methodology was inadequate to the task of identifying and articulating the function of metaphor in psychotherapy (Ingram, 1994).

5) Research often lacks an adequate operational identification procedure (Gelo, 2006) and a range of different identification approaches have been used (McMullen, 2008).

6) Different questions are asked in different studies, which in combination with definitional differences, different methods and lack of replication, means the findings are not particularly convincing (McMullen, 2008).

7) Experimental studies tend to use de-contextualised sentences or made-up examples, which may have little relevance to the interactional context of actual therapy conversation (McMullen, 2008).

8) Theoretical implications are drawn as if the findings of experimental studies represent what always occurs when people encounter metaphorical language (Gibbs & Colston 2012).
9) There has been poor specification of the particular conceptual model of metaphor
underpinning the empirical literature (although generic reference to the constructivist
approach to metaphor is common), with a consequent difficulty in interpreting results.
Most of the studies about psychotherapy and metaphor overlook the importance of a
comprehensive and detailed theoretical view of metaphor, with consequent limitations
in the identification protocols developed (Gelo, 2006).

10) There has been poor specification of which metaphorical language will be included:
early studies distinguished ‘frozen’ and ‘novel’ metaphors (Amira, 1982; Pollio &
Barlow, 1975). However, due to cognitive approaches which recognised that novel
metaphors derive from the transformation of conventional ones, this terminology has
been replaced by the terms ‘conventional’ and ‘unconventional’ metaphors, without
full consideration of the theoretical implications of this change. Gelo (2006) argues
that the distinction between ‘conventional’ and ‘unconventional’ is very important
because (as discussed in section 2.8.4), even conventional metaphors may play an
important role in the psychotherapeutic process (e.g. Siegelman (1990)), and not
distinguishing them makes results hard to interpret.

11) Studies often lack clear specification of the level of analysis at which identified
metaphorical language will be examined, making results difficult to interpret:
Metaphors can be analysed in terms of broad frequency counts which often include
description of the conventionality of the metaphor and investigate process variables
such as therapeutic restructuring and alliance; or at a more detailed level which deals
with phenomena of the therapeutic process such as communication styles and the way
the patient and therapist express themselves (Gelo, 2006).

12) While in some cases researchers have applied structured process measurement
systems, standardised instruments, which would allow a more systematic investigation
of psychotherapy process variables, have rarely been used. In addition, since the
functions of metaphors in psychotherapy could be dependent on the psychotherapeutic
theoretical orientation, one proposed solution is to use therapeutic theory-independent
instruments to evaluate clinically important process variables (Gelo, 2006).

3.3 Psychologists and linguists: talking past each other

There has unfortunately been little collaboration in the past between psychologists and
linguists on the subject of metaphor in psychotherapy. The two literatures have grown without
significant co-ordination (McCurry & Hayes, 1992). The two groups have different
philosophical starting points and objectives.
Linguists tend to focus on describing the characteristics of metaphor in therapist-client talk, without necessarily exploring efficacy (McMullen, 2008; Tay, 2013). They emphasise the contextually modulated nature of metaphor, rather than its therapeutic functions and effects (Tay, 2016a). Linguists do not typically assert that certain ways of using language are better than others, instead focussing on the characteristics of metaphor in therapist-client talk without necessarily evaluating the therapeutic impact on clients (McMullen, 2008; Tay, 2013).

Psychologists have tended to adopt a more functional approach and attempt to connect metaphor use with therapeutic processes and outcome (Stott et al, 2010). They aim to improve the ‘talking cure’, using metaphor to achieve better treatment outcomes (Stott et al., 2010). Therapists have been described as ‘master conversational artists’ who are simultaneously participants and managers of the therapeutic conversation (Anderson & Goolishian, 1988, p. 1). If therapists are such masters of dialogue, and metaphor bridges language, thought and communication, there is clearly potential for metaphor researchers to contribute to psychotherapy (Stott et al., 2010; Tay, 2013). However, therapists may be unaware of the advances being made in linguistic research and less interested in studies that do not directly address the clinical efficacy of metaphor (Tay, 2013).

Progress in psychotherapy metaphor research risks grinding to a halt if therapists continue to overlook or marginalise research findings in fields closely related to their practice, especially the linguistic and cognitive sciences (Teasdale, 1993). This concern is reiterated by Tay (2016b) who notes that linguists tend to have a more nuanced understanding of contemporary metaphor theory. The relevance of this theory to therapy is under-explored and may provide information about cognitive, discursive, and socio-cultural tendencies and preferences of metaphor use. A collaborative approach between linguists and psychotherapist researchers may therefore be beneficial (Tay, 2013, 2016a).

3.4 Gap between clinical observations and empirical validation

There is also a gap between clinical observations and empirical validation, both basic (laboratory based) and applied (Gelo, 2006). This gap may be especially true for CBT, where the growing theoretical and clinical observation (Goncalves & Craine, 1990; Kopp & Craw, 1998; Muran & DiGiuseppe, 1990) lacks empirical support (as noted in the literature review).

The literatures of basic and applied research into metaphor have developed separately and have relatively little in common. They differ widely in their view of metaphor, lacking
common definitions and underlying theory. Although laboratory studies have established a considerable amount of knowledge about such processes as metaphor comprehension (e.g. Glucksberg (2008)), they are generally based on non-clinical student subjects, responding to de-contextualised lists of simple metaphors, and may therefore lack applicability to practice.

In contrast, the clinical literature is based mainly on case examples from individual or family therapy sessions. Empirical studies with therapy material have mainly used frequency counts and ratios of conventional to unconventional expressions as their primary dependent measures, and only a few studies have involved intensive content analyses of client therapist interactions.

These procedural differences have influenced the type of research conducted. For example: basic experimental researchers have compared speed of recognition and recall for metaphorical and literal statements, whereas in the clinical area, anecdotal case material has been used to promote the use of metaphors in clinical settings (McCurry & Hayes, 1992; McMullen, 2008).

Empirical research to fill this gap could clarify the function that metaphors may have in CBT, as well as the extent to which the functions of metaphor in psychotherapy are dependent on the different psychotherapeutic orientations. The use of therapy specific measures alongside therapy independent measures could allow both specificity and generalisability (Gelo, 2006).

In addition, it is recommended by Stott et al. (2010) that clinical researchers should use theories that bridge both domains such as fundamental theories of cognition (e.g. the Interacting Cognitive Subsystems approach (Teasdale, 1993)) (outlined in section 1.7.2).

3.5 Methodological Options

A number of methodological approaches were identified and considered when exploring options for this thesis, many of which are forms of ‘Change Process Research’ (described below). A summary of these methodological options (and measures) is provided below. While most of these approaches were not ultimately used in this thesis due to not fitting well with my research questions, these have been provided in order build up a rationale for the approach that was used.

3.5.1 Change Process Research

Change Process Research (CPR), studies the process by which change occurs in psychotherapy, including both in-therapy processes and the unfolding sequence of client
change (which changes occur first and lead to what subsequent client changes). It is described as a necessary complement to randomised clinical trials and experimental or interpretive single case designs which focus on establishing the existence of a causal relationship between therapy and client change but do not specify the *nature* of that relationship (Elliott, 2010).

Purported methodological ‘sins’ in change process research (Elliott, 1983) include: use of aggregate methods to answer questions about particular interventions, by averaging process measures across sessions or across groups of clients and therapists; assumption that all therapist responses have an equal weight or significance; over-emphasis on therapist verbal behaviour at the cost of overlooking client behaviour and nonverbal aspects of interaction; and exclusive use of global questionnaire measures to assess client and therapist perceptions of therapy process, thus obscuring the vast amount of information clients and therapists can provide about particular events in therapy.

CPR offers several strategies for identifying and evaluating explanations for client change ranging from sampling key processes from one or more therapy sessions and using these to predict post-therapy outcomes. Strengths and weakness of each of these approaches, along with common measures are outlined by Elliott (2010):

### 3.5.2 Quantitative process-outcome designs

These are the most popular form of CPR and seem logical and intuitively obvious and make sense for measuring good process variables such as therapeutic alliance. In the case of metaphor this would entail therapists intentionally using metaphor in therapy and then looking at the impact on outcomes. However, as already noted in section 3.2, metaphors are pervasive in language, so will occur naturally in therapy, making outcome studies that compare metaphor use versus non-use impossible. Stiles and colleagues have also noted that therapist responsiveness could affect outcomes of such studies. Therapists may be more responsive to clients with fewer internal resources, offering more putative active ingredients (such as metaphor) to such clients than others with more internal resources, which may lead to better outcomes for those clients towards whom the therapist has been more responsive (Stiles, 1988; Stiles & Shapiro, 1994).

### 3.5.3 Microanalytic sequential process design

This involves microanalysis of sequential dependencies among successive client and therapist responses, examining the turn-to-turn in-session interaction between client and therapist. Such research has commonly looked at particular kinds of therapist intervention (e.g. therapist
interpretation, exploratory questions) in relation to a measure of productive or unproductive client process (e.g. client experiencing or insight). Some studies have looked at sequences of client & therapist in session actions so as to construct models of common therapeutic sequences (Elliott, 2010). Elliott notes that this Microanalytic Sequential Process Design has great potential for testing key theoretical claims about fundamental therapeutic processes, with the possibility of detecting and demonstrating strong causal influences because the therapist response is seen to ‘touch’ the client through occurring close in time to the client response and through the widely recognised conversational constraints of speaking turns. However, this methodology is typically low-level quantitative in nature, coding client and therapist responses on a relatively small number of categories or rating scales and examining the influence of therapeutic interventions on within-session client processes and the effect of client actions on the therapist.

3.5.4 Helpful factors design

This involves asking clients what they found helpful or unhelpful in their therapy. This approach is consistent with the mental health consumer movement (“Ask the client”). This approach uses qualitative interviews or post-session client self-report questionnaires, such as the Helpful Aspects of Therapy scale (Llewelyn, 1988) or The Helpfulness Scale (Elliott, 1985). The Helpfulness Scale was used by Hill and Regan (1991) to assess whether therapists and clients gave interventions involving metaphors higher ratings than other interventions. The helpfulness of each therapist response (speaking turn) was rated by both client and therapist after the session (one= extremely hindering to nine= extremely helpful on a Likert scale). Elliott (1986) reported adequate reliability and validity for this measure. Limitations of this approach are that the client may make attribution errors about therapy changes, assuming such changes are due to therapy rather than changes to their situation, or medication. Clients may also have difficulty articulating change processes. This can lead to helpful factors research appearing to be ‘testimonials’ for therapies. Elliott recommends that helpful factors research should be accepted as one line of evidence and could be usefully combined with interpretive single-case methods. In the case of metaphor use as part of an intervention, it might prove difficult to tease out whether the metaphor itself was the helpful ingredient or some other aspect of the intervention, unless the client specified that it was the metaphor that was helpful.
3.5.5 Significant event approach

This uses a combination of the above, more basic, approaches to provide a more comprehensive understanding of how change occurs in therapy. Significant event studies generally include a strategy for identifying important moments in therapy. These might include: Helpfulness ratings or observational methods for reviewing therapy sessions (e.g. Greenberg (2007)), video-assisted client interviews (e.g. brief structured recall (Elliott & Shapiro, 1988)), or ‘interpersonal process recall’ (video recordings of clients and therapists describing their experiences during therapy which are used to assess whether clients and therapists select those times that metaphors are used as being significant events (Elliott, 1983, 1986)). Sometimes a combination of these approaches is used. Once significant events have been identified, a qualitative, sequential description of what happened occurs. This tracks multiple qualitative aspects of clients and therapist interactions within and sometimes across sessions. It also generally tries to tie within-session processes to post-session outcomes and post therapy outcomes.

This approach attempts to overcome the limitations of the three approaches described above by combining them and is particularly good for building and adapting theories, is flexible and due to use of clinical examples and transcripts, stays close to clinical practice. However, it is very time-consuming and technically difficult (Elliott, 2010). Elliott (2010) concludes that the optimal strategy is to use several different CPR designs, within or across studies to build a convincing case for a particular change process.

A review of significant event research by Timulak (2010) noted that this approach often uses transcripts of segments of therapy session as well as therapist and client reflections on the event. There are also studies using retrospective recall of events. However, clients’ perceptions in therapy may differ dramatically from that of the therapist. In addition, relational and emotional aspects of significant moments may be more important for clients than the cognitive aspects of therapy which are frequently stressed by therapists. Several previous studies have investigated use of metaphors in therapy using significant event methods (see: Angus & Rennie, 1989; Cummings, Hallberg, Slemon, & Martin, 1992; Levitt & Piazza-Bonin, 2011; Martin, Cummings, & Halberg, 1992). This approach was not used in this thesis because the thesis was the first in the CBT area it would have been premature to apply this with clients in this thesis, given the limited empirical findings to date. Instead, this thesis focussed on a systematic approach building up evidence to support the subsequent application with real clients.
3.5.6 Single case designs

Although well established as a research method in applied behavioural analysis, Single Case Design approach has been relatively recently applied change process research. Rather than using a randomised parallel group clinical trials, it uses repeated measurements of individual clients, generally beginning with baseline measures then looking at the effect of a therapeutic intervention. The rationale for this approach is that group comparison researchers do not generally draw from the population at large: their samples are drawn for convenience and availability. In addition, group comparison researchers often generalise to a group average, which may not resemble any individual’s performance in the group. If psychology is the study of the individual, as is often touted, in a single case design, no subject’s data is dismissed through the averaging process (Kazdin, 2011). However, single case designs do need to be replicated to have external validity (i.e. to be generalisable to the population at large). Visual analysis of graphed data is the traditional method used in single case research design. However clinical interpretation of this can be inconsistent between raters. Statistical analyses can quantify or strengthen visual findings.

Single case design was not used in this thesis because the thesis is an exploratory study, not an intervention study. There are no studies to date that have used single case design to investigate metaphor use in therapy.

3.5.7 Novel use of video recordings

The effect of metaphor as a process variable was recently explored using a novel video-rating methodology for examining process variables, using client ratings of the Session Rating Scale (also used in Chapter 6 of this thesis) (Duncan et al., 2003) at two-minute intervals during a single recorded session of cognitive therapy. This was found to be a feasible and acceptable measure (Cocklin et al., 2017). This approach could have proved useful for this thesis, but the approach was not published until after this thesis was substantially completed.

Another approach called ‘Metaphoric Foregrounding Analysis’ has been developed that uses a multi-modal analytic programme called ‘Elan’ (Nijmegen, 2018), which is used by many conversation analysts to do micro-analysis, especially if they are interested in non-verbal aspects of interaction. Elan has been used to create annotations of verbal and gestural metaphor in video-recorded conversations on a timeline (Müller & Ladewig, 2014). This approach was not used because I already had access to an existing large collection of transcripts of audio-recorded therapy sessions; this was considerably less resource-intensive.
than collecting therapy videos. The level of analysis with this approach was also more detailed than required for the questions investigated in this thesis.

Video-based approaches are very labour-intensive for larger amounts of data and the analytic aims of this thesis required comparatively large amounts of data. However, such approaches are worth consideration for future studies.

3.5.8 Use of computer software

There are several options available for investigating metaphor in therapy using software. These have the advantage of being able to analyse large amounts of text rather than coding by hand.

Researchers at the University of Queensland have recently developed ‘Discursis’ software for analysis of health conversations (Angus, Smith, & Wiles, 2012). This software identifies concepts in transcripts of spoken conversations, based on collocation and frequency. A concept is defined as a ‘bag of words that travel together in high frequency in the text’ (Gallois & Angus, 2013). Unlike alternative qualitative analysis tools (such as NVivo, which require analysts to design the list of concepts and coding rules themselves, Discursis uses machine learning to generate its own concepts from the input transcript. This has the advantage of being highly reliable because it is generated from the text itself whereas manual lists require checks for coding reliability and validity. It provides a visual conceptual recurrence plot of who is speaking, over time and the extent of shared concept development, allowing researchers to find critical time points and to divide the conversation into regions (e.g. engagement, summary section). Topic use patterns can highlight specific interaction dynamics between speakers such as topic repetition and development. Researchers can zoom in on areas of the conversation that are of interest so as to undertake a finer grained analysis. It is also possible to present concepts in a visual display that shows their inter-connectedness and co-occurrence.

Discursis has a number of limitations: it tends to value quantity over quality; a word could be used in relation to two different things (for example ‘young children’ and ‘when I was young’), but still be included in the same identified concept; it is difficult to identify recurring themes because it is not possible to overlay multiple plots of conversations to look for trends; and it will not use phrases as concepts (which is problematic because metaphors are often phrases). However, if a client and therapist were using a metaphor repeatedly, such as ‘being on the wrong train track’, ‘train’ and ‘track’, the software should note the co-occurrence of
these terms and group them into the same concept. Specific occurrences of metaphor would still need to be coded manually. In sum, this software was not specifically designed for the study of metaphor, and there would be a number of limitations and challenges in adapting it for this purpose.

Quantitative corpus research using software could prove particularly useful for investigating patterns and relative frequencies of metaphor use, and the range and frequency of metaphor vehicles across different client groups. Quantitative analyses such as Mergenthaler’s Therapeutic cycles model computerised text analysis may assist with exploring how patterns of metaphor use might correlate with significant moments in a therapy session (e.g. during shared conceptualisation), or other key moments of perceived therapeutic breakthrough (McCarthy, Caputi, & Grenyer, 2017; Mergenthaler, 1996). However, this is likely to have similar limitations to Discursis.

Considering such corpus-based methods illustrates the complexity of spoken language use. Metaphoric language is complex and varied to and does not lend itself easily to automated identification or analysis. Technology can be a useful aid but cannot replace human interpretation at this stage. Such approaches are beyond the scope of this thesis but there may be potential to explore this avenue further in future.

3.5.9 Qualitative analysis

Qualitative analyses of metaphor in therapy have been conducted, based on recorded sessions and post-session recorded interviews with therapists and clients (Angus & Rennie, 1989; Rasmussen & Angus, 1996).

Thematic Analysis (Boyatzis, 1998; Braun & Clarke, 2006) is a widely used qualitative analytic method used in psychology for identifying, analysing and reporting patterns (themes) within written data. A rigorously conducted thematic analysis can provide a rich and detailed, yet complex, account of data (Braun & Clarke, 2006). Thematic analysis is theoretically flexible and used within a number of qualitative analysis traditions. The exact method varies according to the broad theoretical framework or analytic approach used (e.g. grounded theory Glaser (1992)), interpretive phenomenological analysis (e.g. Smith and Osborn (2003)), discourse analysis (e.g. Potter and Wetherell (1987)) or narrative analysis (Murray, 2003).

Thematic analysis, has been used to explore metaphor in therapy, with one study exploring seven clients’ metaphoric experience of the conceptualisation process in CBT for depression,
with key themes identified such as ‘feeling trapped or restricted by depression’ and ‘a new journey: making a new sense of oneself’ emerging (Kahlon, Neal, & Patterson, 2014).

Conversation analysis (CA) is a qualitative approach to the study of naturally occurring talk during ordinary social interactions embracing both verbal and non-verbal behaviour. It aims to discover how participants understand and respond to one another in their turns at talk, uncovering the often tacit reasoning procedures and sociolinguistic competencies underlying the production and interpretation of talk in organized sequences of interaction. Put more simply, it tries to explain why people act as they do in a conversation (that is: what was said, why it was said and how it was said). This approach has exerted considerable influence in the humanities and social sciences including applied linguistics (ten Have, 2007), and could potentially be used to further explore the use of metaphor in therapy (e.g. Buchholtz, Spiekermann, & Kächele, 2015; Jefferson, 1996). However, as CA involves highly technical expertise and time-intensive micro-analysis of conversation, it was impractical to use this for just one part of a mixed methods thesis. In addition, the data made available for the studies described in Chapters 4 and 5 comprised simple (verbatim) transcripts of therapy sessions; because CA relies on audio or video recordings along with more detailed transcripts this was not suitable data for a conversation analytic approach.

3.5.10 Other tools and measures

A number of small studies into metaphor in therapy have used a range of measures not used in this thesis because they did not fit with the research questions, were infrequently used or not validated. The references for these are provided in Appendix G for the interested reader.

3.6 Comment on methodologies

Often the same methods (e.g. video analysis or thematic analysis) can be used in the service of different methodologies. Researchers need to be aware of the methodological challenges in order to select the most robust method possible for investigating their particular research questions within their overarching theoretical framework.

3.7 Overall methodological framework and rationale for methods used in this thesis

As noted in Chapter 1, this thesis takes a constructivist-Dynamic Systems theoretical approach, because the Dynamic Systems approach has a well-articulated theoretical position, is developed for spoken interactions in context and has a well-operationalised methodology.
for identifying both metaphoric words and phrases. As discussed in section 2.8.4, the distinction between conventional and unconventional metaphors is not particularly clear or useful. It is unclear whether what appears to be a conventional metaphor is actually functioning as conventional for the listener or the speaker. Consequently, the identification method selected for use in Chapter 4 of this thesis does not differentiate conventional and unconventional metaphors.

A mixed methods approach was taken, which fitted broadly with ‘Change process research’ (described above). Each of the four studies comprising this thesis required different methods in order to address the specific research questions. These were selected with consideration of the nature and limitations of available methodologies as detailed above; the hypotheses to be tested; the broader constructivist-Dynamic Systems theoretical framework of the thesis; the importance of context in the therapy conversation; the need to consider metaphoric phrases as well as individual words within a clearly operationalised identification approach and the need to describe both client and therapist behaviours. The method drew on both psychological and linguistic methods in order to build a more integrated evidence base for the use of metaphor in therapy.

The first study (Chapter 4) draws on the Discourse Dynamics method of metaphor identification to assess the frequency of metaphorical words and phrases in transcripts of CBT sessions. The second study (Chapter 5) builds on the identification of metaphors in the first study, coding responses to identified metaphors within three speaking turns. This approach fits with microanalytic sequential process design (described above in section 3.5.3). The third study (Chapter 6) uses quantitative methods commonly used in clinical research to assess the clinical effect of training therapists in metaphor-enhanced CBT on shared conceptualisation in simulated therapy sessions. The final study (Chapter 7) uses bespoke Likert scale ratings along with written comments by therapists to assess the quality and impact of the metaphor-enhanced CBT training course.

In the interests of clarity and ease of reading, the specific research questions and detailed descriptions of methods used along with fuller rationales for their use are therefore provided in the relevant chapters.

### 3.8 Chapter summary and next steps

This chapter has outlined the range of methodological challenges and approaches in empirical investigations of metaphor in therapy, along with outlining a number of existing and emerging
methods that future researchers can consider. The overall methodological framework for this thesis was outlined and a broad rationale was provided for the methods used in this thesis.

Based on this, and with the research questions in mind, the decision was made to start by establishing some basic building blocks for studying metaphor in therapy, firstly using the Discourse Dynamics method of identification (Chapter 4) and building on this by exploring behavioural responses that contribute to co-constructed metaphors (Chapter 5), then working to apply what was discovered in the CBT therapy setting (Chapters 6-7).
Chapter 4
Nailing down metaphors in CBT:
definition, identification and frequency

4.1 Introduction

Metaphors are common in psychotherapy and have potential to enhance therapy in numerous ways. However, the empirical study of metaphors in cognitive behaviour therapy (CBT) has tended to be put in the ‘too hard basket’, confined to being part of the art rather than the science of therapy. As noted in Chapter 3, empirical study of the effects of metaphors in psychotherapy has been based on only a small number of psychotherapy sessions (Barlow, Kerlin, & Pollio, 1971; Pollio & Barlow, 1975) and has been hampered by the lack of agreed upon definitions of metaphor and of explicit and rigorous methods of identification, especially in relation to conversational data in context (Cameron, 1999, 2003).

As discussed in sections 1.3.4 and 1.3.5, metaphor is a figure of speech that implies a comparison between two unlike entities (Stott et al. 2010), describing the first subject as being or equal to a second subject in some way. Metaphors thus act as a bridge between a metaphor vehicle which is more concrete or familiar, and a topic which is more abstract or less familiar. Accordingly, the broad definition of metaphor used for this study is ‘a device for seeing something in terms of something else’ (Burke, 1945).

As noted in Chapter 2, interest in the role of metaphor in cognitive behaviour therapy (CBT) has increased recently, with enthusiastic practice-based examples of how metaphor,particularly therapist-initiated metaphors, can be used in psychotherapy (Blenkiron, 2010; Stott et al., 2010). It has been proposed that client metaphors may: provide therapists with important information about clients’ views of reality (Ronen, 2011); have personal meaning and resonance; contribute to the development of a stable theme and enhance conceptualisation (Kuyken, Padesky, & Dudley, 2009; Padesky & Mooney, 2012); access deep knowledge structures (Goncalves & Craine, 1990); serve as an explanatory device (Alford & Beck, 1997); assist engagement; provide a rationale, express emotion and transform meaning (Stott et al., 2010); and aid memory (Martin, Cummings, & Halberg, 1992; Shell, 1986). Within third wave cognitive therapies, Acceptance and Commitment Therapy emphasises therapist-

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8 Metaphor ‘vehicle’ terms relate to a ‘topic’ term. For example, in the phrase a ‘mountain of debt’, ‘debt’ is the topic term and ‘a mountain’ is the vehicle term (Cameron & Maslen, 2010, p. 79).

9 There is a huge number of definitions of metaphor in the literature. Rather than reviewing all these, the authors have confined themselves to being explicit about the definition used in this study.
initiated metaphors (Stoddard & Afari, 2014), as does Dialectical Behaviour Therapy (Linehan, 1993). However, despite the growing popularity of metaphor in CBT and third wave cognitive behavioural therapies, the extent and manner of metaphor use is not known.

A review of studies of metaphor frequency found that the number of linguistic metaphors used in talk of different types varied from around twenty metaphors per thousand words for college lectures to around 50 in ordinary spoken conversation and sixty in teacher talk, although what is found in the data depends heavily on what is categorised as ‘metaphor’ by the researchers (Cameron, 2003, p. 57). While frequency counts provide only limited information and do not clarify anything about elements of usage such as the function or helpfulness of the metaphor, the CBT literature lacks even such basic information.

In this first study of my thesis I aimed to establish some basic descriptive groundwork by assessing the frequency of metaphors in CBT in a large sample of therapy sessions and to evaluate the reliability and utility of the discourse dynamics approach to metaphor identification (Cameron & Maslen, 2010).

4.2 Approaches to identifying metaphor in therapy

This section will outline and critique the available methods for identifying metaphor within psychotherapy and give a rationale for the selection of the Discourse Dynamics approach taken by Cameron and Maslen (2010) and used in this study.

The earliest attempt to define metaphor within psychotherapy was by Pollio and Barlow (1975), who analysed one session of gestalt psychotherapy using a training manual developed by Barlow et al. (1971), designed to teach raters to recognise instances of figurative language in spoken and written discourse. The manual described fourteen different figures, with brief definitions and with examples of how this can be used by researchers in different genres of speech and written text. Raters are asked to judge both whether an instance represents specific type of figurative meaning and whether it is a frozen (clichéd) meaning or novel meaning. Final classification was determined by a majority vote between raters after discussion. The reliability of their approach has been found to be sufficiently high for it to be used to examine figurative language in a number of different therapeutic contexts (Pollio, 1973). However, the manual focused primarily on figurative meaning at the phrasal level and did not provide criteria for identifying figuratively used words. Further many of the types of figurative language identified were beyond the scope of this thesis (such as metonymy (substitution of an attribute for the name of the person or thing); the whole stands for the part, *suit* for
A further approach to identifying figurative language is described by Kreuz, Roberts, Johnson, and Bertus (1996, pp. 86-88). They describe eight categories and define metaphor as ‘segments in which two objects are implicitly compared, typically by identifying one for the other’. Like Pollio and Barlow’s approach, Kreuz et al. (1996) include a broader range of figurative language than the scope of this thesis. Several problems with this approach have been identified (Gibbs & Colston, 2012, pp. 49-50): the claim that metaphor involves the implicit comparison of two unlike objects does not suggest in what way two objects must be dissimilar; metaphor often does not involve the simple comparison of two dissimilar objects (e.g. ‘lawyers are sharks’), but in many cases alludes to implicit mappings of event structures onto more abstract concepts (e.g. ‘our marriage has hit a roadblock’). Developing the metaphor vehicle (in this case roads/roadblocks) is an important issue which Kreuz’s definition of metaphor does not help with.

A detailed linguistic method for metaphor identification procedure (MIP), was developed by Steen et al. (2010a). MIP is one way of identifying density of metaphoric words in discourse and the circumstances in which novel metaphors are likely to arise. The MIP approach has been shown to be reliable and replicable, although considerable variability exists within and across individual analysts. This approach is careful not to instruct analysts to search for word’s literal meanings because that instruction would be too vague, with too many varied associations (Gibbs & Colston, 2012). While this approach has been helpful in establishing a reliable process by which experts can agree whether a word is metaphorical, it is not clear whether ordinary speakers and listeners engage in similar processes during conversations.

A number of methodological problems with the MIP approach were encountered by Semino et al. (2004) in identifying and analysing metaphors in a corpus of conversations about cancer. The main problems were: (i) the boundary between the literal and the metaphorical in the identification of linguistic metaphors; (ii) the precise identification of topic and vehicle in
relation to each linguistic metaphor; (iii) the extrapolation of conceptual metaphors from
linguistic metaphors; and (iv) the extrapolation of conventional metaphors from patterns in
the data. They presented examples demonstrating how different decisions in the process of
analysis lead to dramatically different conclusions as to the way in which cancer appears to be
metaphorically constructed. A further drawback of the approach is that it is used only to
identify metaphoric words, not phrases, such as ‘letting off steam’. This made MIP unsuitable
for the current study, in that both metaphorical words and phrases need to be identified as
clinical observation makes it clear that both words and phrases occur in therapy interactions.

4.3 Discourse Dynamics metaphor identification and rationale for its use in
this study

As discussed in Chapter 1, Discourse Dynamics (Cameron & Maslen, 2010) is based on
Dynamic Systems theory from the physical sciences literature (Aihara & Suzuki, 2010). It
sees language (including metaphorical language) as a complex, self-organising system that
unfolds fluidly over time, influenced by individual, cultural, contextual factors, present bodily
states, previous conversations, goals and motivations (Cameron, 2008b). Metaphor is seen as
a tool to uncover people’s ideas, attitudes and values, which is a view compatible with the
CBT model. The relatively recently developed Discourse Dynamics metaphor identification
approach was developed through a series of empirical studies (Cameron & Maslen, 2010;
Cameron et al., 2009). It is a variant of the MIP approach described above.

It was selected for this study for a number of reasons:

a) It is based on the clearly articulated Discourse Dynamics model which is outlined fully
in Chapter 1 and emphasises the importance of context in understanding metaphor.

b) It includes metaphoric phrases as well as individual words (e.g. ‘I am in a torrent and
struggling to get a grip on the side’), which clinical experience suggests regularly
occur in psychotherapy.

c) It was developed for face to face discourse as opposed to written texts or speeches,
making it suitable for investigating therapeutic interactions.

d) It is inductive, moving from identified metaphors to a set of ‘systematic metaphors’
that are not necessarily identical to conceptual metaphors and may have idiosyncratic
meaning for the speaker. This contrasts with the dominant metaphor identification
approach, CMT, in which coders assume a set of conceptual metaphors and search for
related linguistic expressions, which may result in missing many metaphors actually
occurring in discourse (Steen, Dorst, Herrmann, Kaal, & Krennmayr, 2010b).
e) The approach does not assume that identified metaphors are conceptual metaphors, instead arguing that emergent and evolving sets of connected metaphors gathered from actual discourse events are not necessarily the same constructs as the fixed and stable ‘conceptual metaphors’ of CMT and may be more appropriately labelled ‘systematic metaphors’. The benefit of this approach is that it allows for individual idiosyncratic meaning of client metaphors rather than assuming the client’s meaning is the same as that generally used by a speech community.

f) Discourse Dynamics does not include the broader types of figurative language such as metonymy in identifying metaphors.

g) In addition, unlike CMT, Discourse Dynamics provides methods for calculating metaphor frequency, as number of metaphor vehicles per thousand words and for calculating reliability (Cameron, 2008a). Metaphor researchers have been urged to include frequency counts where feasible, as they are a valuable aid to interpreting overall patterns of metaphor use (Todd & Low, 2010).

h) It has been described as currently the most clear operationalised, comprehensive method of metaphor identification in spoken language (Cameron, 2007; Cameron & Deignan, 2006) and was developed to deal with face to face conversations (investigating how metaphors are negotiated between speakers) rather than analysis of written texts or speeches, making it suitable for the therapy context (Cameron, 2007; Cameron & Deignan, 2006).

One problem with Cameron’s approach is that many words have many related meanings. It is unclear what constitutes the basic, core, concrete or literal sense of such words. For example, the word ‘cell’ can refer to cells of the body, battery cells, prison cells, communist cells and so on. Each of these uses may possibly be a member of a structure of some sort. It is not clear which of these meanings can be defined as primary (Gibbs & Colston, 2012). However, this is also an issue with all the other identification methods above.

This study aimed to use the Discourse Dynamics metaphor identification procedure (Cameron & Maslen, 2010) to determine the frequency of metaphor use in CBT sessions by therapists and clients. In addition, the reliability and utility of this approach to identifying metaphor in CBT was explored.

### 4.4 Research questions

1) How frequent are metaphoric words and phrases in regular CBT therapy sessions?
2) How reliable is the Discourse Dynamics metaphor identification procedure?

4.5 Method

The verbatim CBT transcripts analysed in this study were a subset of those used in a process study (Carter et al., 2012; Crowe et al., 2011), using data from a trial of psychotherapy for depression (Luty et al., 2007) in a New Zealand urban centre; The transcripts used involved four therapists and twenty clients in a series of fifty-minute CBT sessions. The therapists were psychiatrists, senior registrars or clinical psychologists, with at least two years’ experience of working with people with depression as out-patients and had to treat at least two patients with CBT under supervision, to a satisfactory level of competence before they were deemed eligible to treat study patients.

There were a number of aspects of the Luty et al. (2007) study that suggested that the transcripts would likely be good quality CBT sessions: The CBT provided was based on the treatment manuals of Aaron and Judith Beck (A. Beck, Rush, Shaw, & Emery, 1979; A. Beck, Steer, & Brown, 1987; J. Beck, 1995), with the therapy tailored to meet each patient’s specific needs in terms of pace and content; Adherence to treatment protocols was assessed using the Collaborative Study Psychotherapy Rating Scale (CSPRS) (Hill, O'Grady, & Elkin, 1992). Therapist competence was assessed using the Cognitive Therapy Scale (Dobson, Shaw, & Vallis, 1985), and therapists received regular CBT supervision, with an emphasis on treatment integrity.

The advantage of investigating metaphor use using these transcripts was that the sessions were collected in a naturalistic way, rather than as part of a ‘study of metaphor’ (which may have altered therapist or client behaviour). Coding all 245 therapy transcripts available was impractical due to the time required for the intensive metaphor identification process (Initial coding attempts found this took one to two hours plus breaks, per transcript).

A total of forty-eight transcripts were selected from the Luty et al. study (a total of twelve clients with three different therapists from sessions one to four only). One therapist was male and two were female. Clients were assessed prior to the treatment sessions, so sessions one to four were treatment sessions. One therapist was excluded because they had only seen one client and transcripts were not available for all of sessions one to four. Another therapist had only seen three clients, so all were included. The other transcripts were randomly selected from those clients of the other two therapists where full data sets for sessions one to four were available. The average age of the clients was 38.3 years (range 26-56) and 75% of clients
were female. Sessions one to four were selected for several reasons: The dose-response literature suggests that the greatest amount of change occurs in early sessions, with approximately 50% of clients showing a reliable improvement in the first eight sessions of therapy (Harnett, O'Donovan, & Lambert, 2010) therefore if metaphor is an important process variable, then it may be operating at this stage of therapy; and for the next part of our study (see chapter 5), the intention was to investigate how shared metaphors are co-constructed in early sessions.

The sessions were previously assessed as adhering to the CBT model and therapists were assessed as having at least adequate competence.

4.5.1 Ethical Approval

We sought permission to examine de-identified therapy transcripts that had been collected in a different study: ‘Patient psychotherapy process in CBT and IPT for depression’ (Principal Investigator, Janet Carter) (Carter et al., 2010), which had full HDEC ethical approval prior to commencing from Upper South Canterbury Ethics Committee (97/12/148). The study by Dr Carter was part of a secondary analysis of data from a randomised controlled trial by Luty et al. (2007).

Approval for access to the data was granted by the principal investigator in the randomised controlled trial and under the oversight of Dr Janet Carter. An MOU between Fiona Mathieson, Dr Maria Stubbe, Dr Jennifer Jordan and all the researchers in the CBT/IPT study was also signed (see Appendix B. MOU CBT IPT study). While the current study was not envisaged when the CBT/IPT study was conducted, it was argued that the current study fits with the general research question within the original trial of exploring patient response to therapy and therapy quality. In order to protect client confidentiality, approval was sought for access to de-identified transcripts of sessions. No audio recordings had been retained. Ethical approval was received from the University of Otago Category A ethics committee (reference 13/140) (See Appendix A. Ethics approvals). Formal consultation also occurred with the Ngai Tahu Research Consultation Committee as required by the University of Otago research policy. The Ngai Tahu approval letter is included in Appendix A. Ethics approvals.

4.6 Discourse Dynamics metaphor identification procedure

In Discourse Dynamics, words and phrases are identified that are potentially metaphorical. It is not claimed that listeners will interpret the words or phrases metaphorically, or that they are intended metaphorically. This broad definition captures obvious metaphors, novel metaphors
and conventionalised metaphors that are unlikely to be interpreted metaphorically but have potential to be understood as metaphor. Conventional metaphors are technically metaphorical, but their metaphorical character has faded over time, such as ‘the neck of a bottle’ or the legs of a chair’ (McMullen, 1985). Words or phrases are identified as metaphorical where they can be justified as somehow anomalous, incongruent or ‘alien’ in the ongoing discourse, but can be made sense of through a transfer of meaning in context. ‘Incongruity’ is defined having one meaning in the context and another different meaning which is more basic in some way, usually more physical and more concrete than the contextual meaning (Pragglejaz Group, 2007).

The Discourse Dynamics metaphor identification approach is operationalised using a four-step procedure (adapted from the MIP developed by the Pragglejaz Group (2007) and Steen et al. (2010a)):  

1. The researcher familiarises her/himself with the discourse data (i.e. reads through the whole transcript).
2. The researcher works through the data looking for possible metaphors (i.e. looks carefully at every word or phrase).
3. Each possible metaphorical word or phrase is checked for:  
   a) Its meaning in the discourse context.
   b) The existence of another, more basic meaning.
   c) An incongruity or contrast between these meanings, and a transfer from the basic to the contextual meaning.
4. The possible metaphor is coded as metaphorical, if it satisfies both these criteria:  
   a) There is a contrast or incongruity between the meaning of the word or phrase in its discourse context and another meaning; AND
   b) There is a transfer of meaning that enables the contextual meaning to be understood in terms of basic meaning.

The method of deciding where a metaphor vehicle begins and ends is to start from the most clearly incongruous word and work outwards, including words that also have a more basic meaning or tend to be used together (collocate). Thus, the phrase ‘flaw in the system’ is identified as one metaphor vehicle on the basis that this is a single phrase, rather than two metaphors as in: ‘flaw in the system’ (Cameron & Maslen, 2010, pp. 108-110).

Personification is identified as metaphorical and occurs when something inanimate is described as if possessing life, such as ‘The river is moving sluggishly’. Similes are only
identified as metaphorical if there is an alien metaphorical term (such as ‘he is like a volcano’); a direct comparison (e.g. ‘She is like her sister’) is not metaphorical. Very common verbs and nouns such as: make, do, give, have, get, put, thing, part and way arguably have basic meanings e.g. thing is a concrete object. Have, do and get are omitted but the others are included in the identification stage. Prepositions such as into, over, from, on, in, up, down, within, between, out of, through and behind have a basic spatial meaning thus are included.

4.6.1 Coding Process

Coding involved making multiple decisions, which were carefully recorded in project notes allowing future researchers to use the same approach. These notes are included as Appendix C. A corpus-based dictionary; Collins Cobuild Advanced Dictionary of English (National Geographic Learning, 2013) was used to check basic meanings and phrasal verbs (such as get from), as recommended by Cameron (1999).

Therapy sessions one to four were coded because research suggests that considerable therapeutic gains can occur in early therapy sessions, with diminishing returns at higher doses (Foster, 2011; Harnett et al., 2010; Illardi & Craighead, 1994). An iterative approach was taken to coding: First, using the Discourse Dynamics approach, FM (a clinical psychologist) independently coded twelve transcripts and discussed issues arising with MS (a linguist). FM and MS then jointly coded samples of six randomly selected transcripts, to establish a shared understanding. This comprised 8 hours of coding and discussion over three months. Inclusion and exclusion decisions were carefully documented. FM then coded forty-eight transcripts making at least three passes over each transcript. Further words and phrases for which coding was uncertain were noted and discussed with MS, and inclusion/exclusion decisions were documented (see Appendix C). Coding was done in half hour chunks to reduce errors from fatigue. Automatic word searches were conducted for the prepositions into, over, from, on, in, up, down, within, between, out of, through and behind and other common words deemed metaphorical (homework, goal, sounds and see). A final consistency check was performed by FM.

4.6.2 Frequency calculation

The frequency of metaphoric words or phrases per 1000 words was calculated (Cameron, 2008a)\textsuperscript{10}. Identified metaphoric words or phrases were exported to Excel using a specially developed computer programme. The programme was called \textit{Discombobulator} and was

\textsuperscript{10} Speaker identification and other non-speech characters were deducted from the word counts.
written for this study by Jayden MacRae. It extracted identified metaphors within ‘elementary discourse units’ (van der Vliet, Bouma, & Redeker, 2013), which were used as an alternative to Cameron (2010)’s ‘intonation units’. Intonation units are described as ‘idea units’. Elementary Discourse Units were used because the transcripts were not transcribed into intonation units and access was not available to the audio recordings in order to arrange this. Headings were: ‘turn number’, ‘speaker’ (client or therapist) and ‘metaphor’, to enable frequency calculations. Discombobulator is available on request from Fiona Mathieson.

4.6.3 Reliability

Metaphor research has been hampered by a lack of reported reliability, so assessing the reliability of the Discourse Dynamics method was important in order to show that the data and findings from this study are valid and replicable. A rate of inter-rater agreement in identifying metaphor of around 75% is usually considered acceptable (Cameron, 2003). In this study, the aim was to achieve at least 75%, allowing some flexibility in where the metaphor vehicle began and ended. Density calculations are based on the number of vehicles per thousand words, so the indeterminacy of beginnings and endings is not usually an issue (Cameron et al., 2009). Another experienced linguist (JH) independently coded 10% of transcripts (five randomly selected transcripts) so as to ensure the coding was free from bias or manipulation. In line with Cameron and Maslen’s recommendation of a strong foundation of initial rater training, the independent coder was trained in the Metaphor Identification Criteria over an hour-long session. Samples of coded transcripts were provided along with explanation of common CBT techniques and articles by Cameron & Maslen (2010).

Inter-rater agreement was calculated for: the extent to which JH agreed with FM’s coding; the extent to which FM agreed with JH’s coding; and the overall frequency of metaphors identified by both raters as a simple proxy for agreement.

4.7 Results

4.7.1 Frequency

Figure 4.1 shows the frequency of metaphors used by therapists and clients over four sessions. Therapists produced metaphors at approximately twice the rate of clients. The therapist frequency was 21.2 (range: 7-36) versus client frequency of 10.3 (range: 3-24) per thousand words. Therapists produced more metaphors than clients in forty-six out of the forty-eight individual sessions. The total number of words in the sessions analysed was 352,256.
Figure 4.1. Metaphor frequency by therapist/client dyad

Figure 4.2 shows the overall (total) metaphor frequency per thousand words in each dyad (i.e. therapist-client pair) over four sessions. Total metaphor frequency was 31.5 metaphors per thousand words. A paired t-test was conducted on the 12 therapist-client dyads, to compare the rate of metaphor usage between clients and therapists. There was a significant difference in the frequencies for therapists (M = 21.2, SD = 4.7) and clients (M = 10.3, SD = 4.4); t(11) = 6.2, p <0.001, which suggests that therapists used metaphors at a significantly higher frequency than clients. There was considerable variation between therapy dyads (range: 17-49).

Table 4.1 provides a sample of what was produced after metaphors were identified and exported to Excel. The letters ‘T’ or ‘C’ indicate whether the therapist or client was speaking; ‘turn’ means the complete utterance by the speaker; elementary discourse unit is the idea unit containing the metaphor vehicle; and the identified metaphor vehicle is in the right-hand
column. Common, conventional metaphors, such as ‘homework’ and ‘see’ are evident, along with novel metaphors such as ‘tackling’ and ‘having blinkers on’.
Table 4.1. A sample of identified metaphors

<table>
<thead>
<tr>
<th>Session</th>
<th>speaker</th>
<th>turn #</th>
<th>Elementary Discourse Unit</th>
<th>Metaphor</th>
</tr>
</thead>
<tbody>
<tr>
<td>319X-4</td>
<td>T</td>
<td>1</td>
<td>what do you put that down to?</td>
<td>put (that) down</td>
</tr>
<tr>
<td>319X-4</td>
<td>C</td>
<td>2</td>
<td>spent the day at the beach</td>
<td>spent</td>
</tr>
<tr>
<td>319X-4</td>
<td>T</td>
<td>9</td>
<td>I want to talk about the homework</td>
<td>homework</td>
</tr>
<tr>
<td>319X-4</td>
<td>T</td>
<td>9</td>
<td>what is up there to the front for you</td>
<td>up there to the front</td>
</tr>
<tr>
<td>319X-4</td>
<td>C</td>
<td>10</td>
<td>I still can’t seem to block things out of my mind</td>
<td>block things out</td>
</tr>
<tr>
<td>319X-4</td>
<td>T</td>
<td>11</td>
<td>A lot of thoughts going on.</td>
<td>going on</td>
</tr>
<tr>
<td>319X-4</td>
<td>T</td>
<td>15</td>
<td>looking forward to things</td>
<td>looking forward</td>
</tr>
<tr>
<td>319X-4</td>
<td>T</td>
<td>17</td>
<td>how about we spend some of the session of how to deal with those worrying thoughts</td>
<td>spend</td>
</tr>
<tr>
<td>319X-4</td>
<td>T</td>
<td>17</td>
<td>a way of tackling them.</td>
<td>tackling</td>
</tr>
<tr>
<td>319X-4</td>
<td>C</td>
<td>18</td>
<td>I know I can’t block (them) out</td>
<td>block (them) out</td>
</tr>
<tr>
<td>319X-4</td>
<td>C</td>
<td>18</td>
<td>I would just love to sit them in the back of my mind</td>
<td>sit (them) in the back</td>
</tr>
<tr>
<td>319X-4</td>
<td>T</td>
<td>19</td>
<td>that fits in the CT cognitive therapy skills about how to deal with worrying thoughts</td>
<td>fits in</td>
</tr>
<tr>
<td>319X-4</td>
<td>C</td>
<td>20</td>
<td>when the day comes to sort (them) out</td>
<td>sort (them) out</td>
</tr>
<tr>
<td>319X-4</td>
<td>T</td>
<td>21</td>
<td>I think it would be really useful to focus on that actually</td>
<td>focus on</td>
</tr>
<tr>
<td>319X-4</td>
<td>T</td>
<td>21</td>
<td>whether it would be useful to spend some time on</td>
<td>spend</td>
</tr>
<tr>
<td>319X-4</td>
<td>T</td>
<td>21</td>
<td>I noticed that you tended to discount the things</td>
<td>discount</td>
</tr>
<tr>
<td>319X-4</td>
<td>T</td>
<td>21</td>
<td>you kind of had those blinkers on</td>
<td>had those blinkers on</td>
</tr>
<tr>
<td>319X-4</td>
<td>T</td>
<td>21</td>
<td>don’t see the good stuff</td>
<td>see</td>
</tr>
<tr>
<td>319X-4</td>
<td>T</td>
<td>23</td>
<td>that kind of fits into there a wee bit</td>
<td>fits into</td>
</tr>
</tbody>
</table>

4.7.2 Reliability

Across the five independently coded sessions, the two raters identified the same metaphors 70.2% of the time. FM identified 17.4% of metaphors that JH did not identify; while JH identified 12.4% that FM did not identify.

FM found a frequency of 36.8 metaphors per thousand words in the five sessions coded, while JH found a frequency of 34.7 metaphors per thousand words, suggesting the raters were identifying metaphors at a similar frequency.

4.8 Discussion

This study aimed to determine the frequency of metaphor use by therapists and clients. The study also evaluated the utility and reliability of the Discourse Dynamics method of identifying metaphors in CBT sessions. Ongoing conversations have been described as an
unruly ‘jungle’ by Steen et al. (2010a). This study found that identifying and ‘nailing down’ metaphors reliably in this jungle was challenging but possible.

The frequency of 31.5 per thousand words (range: 17-49) in our sample of the first four therapy sessions of adults with depression was similar to that found in other studies. Cameron (2003) found twenty-seven metaphors per thousand words in conversations in an educational setting, using the Discourse Dynamics approach, and Ferrara (1994) found thirty words per thousand in a single hour of psychotherapy, although her identification process was not clearly specified.

Therapists used metaphors at a much higher frequency than clients; however, the reason for this is unclear. Therapists may have a number of ‘stock’ metaphors they use. Highly conventionalised CBT terms such as ‘goals’ and ‘homework’ may have contributed to higher therapist frequency counts and seem unlikely to have been deliberately used as metaphors. CBT is an active therapy with an emphasis on psycho-education and skill development, which results in therapists using teaching analogies. On the other hand, previous researchers have argued that use of a similar frequency of metaphors by clients and therapists is an indicator of collaboration (Hill & Regan, 1991). It is possible that the marked difference in frequency found in this sample may be related to this study’s focus on the first four therapy sessions, in which therapists may be relatively more active.

An adequate level of reliability was found between coders (70.2% agreement). The extent of agreement may have been decreased by the independent coder’s limited knowledge of CBT processes, and limited duration of metaphor-specific training. Reliability may be increased by having all transcripts initially coded by more than one coder (Cameron & Maslen, 2010).

The Discourse Dynamics identification approach proved to be broad, capturing many commonly used, conventionalised expressions, which may not be intended to have metaphorical meaning (for example ‘It sounds like’ and ‘I see what you mean’). However, it is not possible to know before carrying out the analysis which metaphors may contribute to emergent themes across the conversation, therefore a broad approach is needed (Cameron & Maslen, 2010).

Challenges in coding using the Discourse Dynamics approach included instances where therapy dyads occasionally embarked on extended ‘literalisations’. For example, one therapy session included a long conversation about learning to drive in the city versus the country, to illustrate the difficulty in establishing new patterns of behaviour. These literalisations might start off as an analogy (e.g. ‘changing behaviour is like learning to drive a car: it becomes
more automatic with practice’), which was coded as metaphorical, but extension of the
metaphor into a literal discussion (e.g. of driving itself) without clear transfer of meaning to a
topic domain was not coded as metaphorical. This approach may have reduced frequency
counts. These and other coding challenges were discussed, and decisions recorded.

Conversely, highly conventionalised metaphor vehicles such as ‘a short time’ do not stand out
initially as incongruous or alien and are easy to miss. Moreover, incongruity is subjective,
depending on the coders’ approach and perspective. Decisions were therefore not always clear
cut. These coding issues highlight the complexity of metaphor use in real life interactions, and
the inherent limitations of attempts to quantify such a complex interactional and linguistic
phenomenon. Coding and counting can only ever be one part of an ongoing investigation of
how metaphors are used in naturally occurring conversations, including CBT therapy
sessions.

The identification approach has been described as ‘reliable and relatively easy to acquire’
(Steen et al., 2010a, p. 165). Although this may be a reasonable assumption for a linguist, the
approach proved challenging for a non-linguist to acquire and only adequate inter-rater
reliability was achieved. Metaphor identification using this approach is an acquired skill,
even with clearly specified criteria. Supervision by a linguist is essential for a non-linguist
using the Discourse Dynamics approach as is a thorough reading of Steen et al. (2010a) and
Cameron and Maslen (2010).

In terms of the identification approach used, beyond the most obvious metaphors, there were
many borderline instances where metaphor slid into non-figurative comparison or extension
of meaning and use. Decisions needed to be made about each of these borderline cases. It
seemed that the more closely transcripts were examined, the greater the number of possible
metaphors.

Some caution is needed when interpreting the results of this study. Only three therapists’
transcripts (with twelve clients) were used and it is possible the rate of therapist metaphors
was influenced by idiosyncratic therapist communication styles (meaning the findings may
not be representative). Further, information as to the professional background and ethnicity of
the therapists was not available and it is possible that different professional backgrounds (e.g.
psychologist or psychiatrist) or ethnicity may influence therapist metaphor use. The raw data
was from a 2007 study and so may not fully reflect current metaphor use or awareness by
CBT therapists following the publication of recent books and texts (e.g. Blenkiron (2010);
Stott et al. (2010)). However, any such change is unlikely to be large.
Reliance on written transcripts rather than video recordings meant prosodic features and gestures and other embodied aspects of interaction were unavailable for analysis. The importance of gesture, speech sounds and other body movements, is increasingly being recognised as an important aspect of people’s communicative actions (Cienki, 2010) and figurative language production has been shown to include gestures (Corts & Pollio, 1999). For example, a speaker may be talking about someone who is depressed, while making a downwards hand motion, reflecting a conceptual understanding of SAD IS DOWN.

A further limitation was that there were some unclear passages and omissions in the transcripts (due to transcriber error and/or poor sound quality in the original recordings). Consequently, a cautious approach to identification was taken, which may have reduced the frequency of metaphors identified.

Our aim was to describe the frequency of metaphor use. A review of previous studies (not specifically CBT studies and not using the Discourse Dynamics approach) found that patterns of overall use of figurative language by clients and therapists are variable (both within and across sessions, and across individuals); that figurative language accounts for a relatively small amount of total talk; that rates of production are dependent, in part on the definition used; and that there is no relation between overall use and degree of success in therapy. The review concluded that any study which proposes a simple relation between frequency of metaphoric language and psychotherapy outcome is doomed to failure (McMullen, 1996). Accordingly, given the findings of this review, we cannot assume that the metaphors identified in the present study were necessarily productive, consciously or intentionally used, helpful, or processed metaphorically by the speaker. Nor does this study tell us anything about the functions or helpfulness of the metaphors used. A more detailed qualitative discourse analysis is required to answer these questions.

There may not be a clear line between metaphorical and non-metaphorical language due to words and phrases gradually becoming conventionalised expressions with little or no metaphoric meaning such as the ‘leg’ of a chair. “The reality of language in use seems to rule out the possibility of producing a precise and finite set of sufficient conditions that will delineate a classical category of ‘linguistic metaphor’” (Cameron, 2003, p. 61). Nevertheless, it is possible that even conventional expressions captured by this approach could have mileage clinically, even when not deliberately used metaphorically e.g. ‘slipping back into depression’.
Moreover, whether a given word or phrase is metaphorical may be unstable, as with literal language. The term ‘literal’ implies many different things to different people and judgements of literality are deeply inconsistent both within and across individuals (Gibbs, Buchalter, Moise, & Farrar, 1993). Similarly, whether something is judged as metaphorical may be influenced by a variety of personal and contextual factors (e.g. past attempts to identify metaphors, written versus oral language, knowledge of the speaker/writer, the genre). This is in line with research in cognitive psychology showing that individual concepts are not consistently-defined, pre-established mental entities, but are created in the moment, depending on the history and context of the person (Gibbs & Colston, 2012).

Many areas of metaphor use in CBT are ripe for future investigation, now that an adequate method for identifying metaphors is available. Possible questions include: How do therapists and clients co-construct shared metaphors? To what extent do therapists take up client metaphors and vice versa? Does working metaphorically ‘suit’ some clients more than others? Does using the client’s metaphors assist with sharing the conceptualisation? If so, what impact does it have? Some of these questions are addressed in Chapters 6 and 7. Future research could identify Elementary Discourse Units (or Cameron’s Intonation Units) in larger samples of therapy transcripts in order to investigate the development of systematic metaphors in therapist-client dyads over time.

Because the Discourse Dynamics procedure is quite broad in its identification of metaphors, further studies will be needed to test its clinical application, particularly ways to reliably identify clients’ central metaphoric conceptualisations (described as ‘metaphoric kernel statements’ by Witztum, van der Hart, and Friedman (1988)). While using the Discourse Dynamics approach at times feels rather like ‘nailing down jelly’, it does provide a coherent underlying model and adequate reliability and as such is the most reliable and well-operationalised method available for identifying metaphor in future CBT research.

4.9 Chapter Summary

The Discourse Dynamics approach was used to identify metaphors in forty-eight CBT session transcripts (from twelve clients and three therapists) and the reliability of this approach was evaluated, using an independent rater. The total frequency of metaphors was 31.5 per 1000 words of therapy conversation (range 17-49) and therapists produced metaphors twice as often (21.2, range 7-36) as clients (10.3, range 3-24). Reliability of the Discourse Dynamics approach was adequate. Conclusions were that metaphors clearly occur in CBT sessions, with therapists using them at a higher rate than clients. While Discourse Dynamics is currently the
most detailed identification approach available for investigating metaphor in CBT sessions, it is challenging to acquire skill in it and this study found only adequate reliability. Future research possibilities were discussed.

The next chapter describes the second study in this thesis, which builds on the study in the current chapter in an attempt to describe how metaphors are co-constructed between therapists and clients.
Chapter 5
The metaphoric dance: Co-construction of metaphor in cognitive behaviour therapy

5.1 Introduction

The use of metaphor in psychotherapy has been a topic of research for a number of years. Recently, cognitive behaviour therapy (CBT) experts have advocated a collaborative approach to developing client metaphors on the basis that if a metaphor comes from the client, rather than the therapist, it is thought to have personal meaning and resonance (Kuyken, Padesky, & Dudley, 2009). Socratic questioning has been suggested as a way to explore client metaphors (Blenkiron, 2005) and third wave CBT approaches such as ACT also encourage an interactive approach to developing metaphors (Stoddard & Afari, 2014). This stance is aligned to the work of Kopp (1995) who has also suggested that metaphors should ideally be a collaborative venture, with therapist and client actively incorporating, extending and altering each other’s metaphors to establish a shared therapeutic vocabulary that serves to organise and link large amounts of knowledge and experience. As noted in Chapter 2, previous research has also shown that metaphors in therapy tend to occur in bursts: elaboration via bursts of metaphoric language or development of a metaphor over time has been found to be more consistently present in successful cases of therapy (McMullen, 1989). Also, novel metaphors, as opposed to conventional metaphors, tend to occur in extended bursts (Barlow, Kerlin, & Pollio, 1971).

Clients often reveal a great deal about their major concerns, their perceptions of self and others, and their affective experiences in their use of metaphoric language. For example, Angus and Rennie (1989) found that metaphors (excluding common, everyday figures of speech) emerged from the associated meaning context when participants attempted to verbally depict felt experiences during therapy sessions. The metaphors symbolized inner experience by (1) providing an associative link to experience, (2) representing aspects of self-identity, and (3) depicting role relationship patterns. The view of co-construction of metaphors as beneficial in creating a shared language is shared by Angus and Korman (2002) who concluded, based on their study of themes in therapy transcripts, that:

’it appears that the re-use and co-creation of metaphoric themes creates a mutually understandable terminology and context of meaning between the therapist and client’ (p. 160).

Little is known about how use of metaphoric language by therapists and clients actually evolves in the therapeutic dialogue. Whilst an early paper by Barlow, Pollio, and Fine (1977)
described how a therapist and client repeatedly used, responded to and built upon each other’s metaphors, evidence of co-construction, or joint sharing of metaphor, is not very common in the existing literature. For example, Hill and Regan (1991) reported in their single case study of a therapist and client, that the client repeated only 3% of therapist introduced metaphors within the same session, while the therapist repeated 13% of client-introduced metaphors. The extent to which clients in successful cases ‘took up’ therapist-introduced metaphor was found to be minimal. Another study of twelve transcripts based on four patients undergoing psychoanalytic psychotherapy by (Long & Lepper, 2008) found higher rates of co-construction: 17% of total metaphors were co-elaborated, with 50% of these being therapist-generated and 50% being client-generated.

Some attempts have been made to describe the responses made by therapists and clients to each other’s metaphors during therapy. Ferrara (1994, p. 134) describes the following response types: comprehension without comment; misunderstanding; failure to comprehend or get the point; ratification (by comment, repetition, or use of associated word in later discourse); and extending the metaphor jointly (weaving an elaborate web of correspondences, teasing out additional ramifications, adding new dimensions). In another study (Sims & Whynot, 1997), therapists working with families were found to: assume meaning; ignore or miss the occurrence of metaphor; express curiosity about the metaphor; praise the metaphor’s expressive power; and explore imagery or feelings associated with the metaphor.

A range of therapist responses to client metaphors was described by Strong (1989): explicating what is implicit in the metaphor (i.e. reflective listening, focussing attention on the metaphor and exploring the personal meaning, creating a shared understanding of the metaphor); therapeutically extending or modifying the metaphor (modifying metaphoric conceptions of problems, situations or experiences) and responding to a client metaphor with a metaphor of their own which is isomorphic (i.e. corresponds in form and in the relations between the elements) to the client’s metaphor in order to reframe the problem. A further therapist response was recognising and remembering a client’s metaphor for possible future use (Bayne & Thompson, 2000).

The studies described above, of how therapists respond to client metaphors, are limited in that the methods for identifying metaphors clearly specified, and neither is the process of categorising responses made explicit. In the previous chapter, I described how a method developed by linguists Cameron and Maslen (2010) was used to identify metaphors in 48 CBT sessions analysed for the first study of this thesis, finding that metaphors occurred at a
rate of 31.5 per thousand words in CBT sessions and that therapists used metaphors more frequently than clients in 46 out of 48 CBT sessions.

Spontaneous talk is dynamic, with metaphors being introduced, adjusted and developed as an interaction proceeds. As speakers pursue their discourse aims and topics, connections are ‘sparked in their minds, which may divert them sideways’ (Cameron, 2008b, p. 60), linking to other concepts. Types of ‘metaphor shifting’ that can occur in conversation are grouped into four categories by Cameron (2008): 1) Vehicle redeployment: where the same or semantically connected metaphor is re-used with a different topic; 2) Vehicle development, where the metaphoric vehicle term is repeated or relexicalised (i.e. a near synonym or equivalent is used); 3) Vehicle explication (i.e. the metaphor is exemplified, elaborated, expanded or contrasted); and 4) Vehicle ‘literalisation’ i.e. where the metaphor is connected to life experience (Cameron, 2008a). For example, in a classroom discussion the atmosphere might be described as a blanket of gases, and later in the discussion someone says ‘when you are in bed, you’ve got a blanket protecting you from the cold’ (a literalisation).

Collaboration in metaphor development between therapist and client was operationalised in three ways by Hill and Regan (1991): a) a correlation between the number of metaphors used by the therapist and client within sessions; b) a repetition, using the exact wording introduced by the other person during the same session; c) an elaboration of the content of the metaphor, i.e. the contiguous use of different but conceptually related metaphor. The related metaphor had to occur within three speaking turns after the initial metaphor and only one elaboration was counted no matter how many metaphors were in the sequence. These authors also looked at the ‘direction’ of the collaboration (in one therapy session, one therapy dyad) and found that the main direction involved the therapist picking up on the client’s metaphors, often repeating it.

This second study of the thesis drew on the work of Cameron (2007) and Hill and Regan (1991) to describe the responses used by therapists and clients to each other’s metaphors in early CBT sessions, and explored whether the client or therapist metaphors were developed. The aim was to shed light on the process of co-construction at the time a shared language may be developing.

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11 A metaphor ‘vehicle’ is the word or phrase from which there is a transfer of meaning relating to a topic. For example, in ‘a mountain of debt’, mountain is the vehicle and debt is the topic.
5.2 Research questions

1) What responses do therapists and clients make to each other’s metaphors during bursts of metaporphic exchange in CBT sessions?

2) Are such bursts more likely to be initiated by therapists or clients?

5.3 Method

The twelve transcripts of CBT sessions used in this second study of the thesis were sessions one to four for three therapist-patient dyads which were randomly selected from forty-eight transcripts coded in the previous study (Chapter 1). Sessions one to four were selected to allow exploration of co-construction of metaphors in early therapy sessions. The twelve transcripts were from three clients with depression. Two clients were female (aged 32 and 48 years); one client was a male aged twenty-eight years. The three therapists were all female, experienced in treating depression and with at least two years’ experience using CBT.

Metaphors had already been identified in the transcripts, using the Discourse Dynamics approach (Cameron & Maslen, 2010) (as described in Chapter 4).

The focus for this study was on the initial responses clients and therapists make to each other’s metaphors. Therefore, the decision was made to focus on the first three speaking turns after an identified metaphor, as in the approach taken by Hill and Regan (1991). Limiting the coding to three speaking turns also increased coders’ confidence in the connections between vehicles and responses. Both therapist and client responses to each other’s metaphors were coded, in order to explore the developing interaction.

5.3.1 Ethical approval

Ethical approval for this study was granted as part of the application described in the previous chapter (section 4.5.1.).

5.3.2 Iterative development of categories

1. Initial coding of several transcripts was conducted (by FM), looking at client and therapist responses within three speaking turns\(^{12}\) of each identified metaphor. The following trial categories were used: Repetition; Re-Phrasing; Exploration;

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\(^{12}\) ‘Three speaking turns’ means the back and forth exchange immediately following the utterance of a metaphor vehicle, namely the speaker utters a metaphor vehicle, then there is a response by the second speaker a response by the first speaker and a further response by the second speaker.
Development; Disagreement; No response; Other response. These trial categories drew on the existing literature and clinical experience, while allowing for other possible categories.

2. The categories were discussed and refined with thesis supervisors MS (a linguist) and JJ (a clinical psychologist). For this study, it was decided that rather than coding at the level of the initial metaphor and coding every metaphor whether or not there was a response, coding would be trialled only where there was a clearly identified orienting response to a previous metaphor (or metaphors). The rationale was that the focus of the analysis was on the interaction, not the occurrence of metaphor per se. In addition, it was decided that metaphorical rephrases (where a different metaphor vehicle is used in a rephrase), would be included as a form of rephrasing.

3. JJ then coded samples of transcripts using the categories identified and the categories were discussed and refined further. A category was initially created a category for literalisations (i.e. taking the metaphor into the real world, such as an extended conversation about learning a new therapy skill being like learning to drive a car), but subsequently decided that literalisations should be included as a form of elaboration/extension of the metaphor vehicle, because it was not possible to clearly delineate these from other extensions. A category observed in the data was added: ‘explicit praise of the metaphor’, for example, the client saying, ‘that’s a really good metaphor’.

4. FM coded all twelve transcripts and refined the categories further after discussion with MS and JJ. The trial category of ‘disagreeing’ was removed because it did not occur. Only one code was given per response, even if the response was linked to more than one metaphor vehicle by the other speaker. Where two codes seemed to apply the more elaborated code was used (e.g. coding ‘elaboration/extension’ rather than ‘exploration’). If there were several responses to one metaphor vehicle, these were all coded.

5. JJ cross-coded all twelve transcripts and met with FM several times to compare notes and make final decisions, using a consensus approach. JJ and FM then checked six sessions each to ensure the correct revised coding was used.

6. MS did a final check of all twelve transcripts, in order to check coding consistency and review the robustness of the categories. In response to her feedback, the name of the category ‘Exploration’ to Clarification’ was changed as this specified the category more clearly.
5.3.3 Final Response Categories

Responses were only coded if they were clearly orienting responses to a metaphor vehicle, rather than simply responding to the general topic by the other speaker (therapist/client).

For each identified metaphor vehicle the coder looked at the next three speaking turns, systematically looking for a response by the other speaker in the following categories:

C means spoken by client. T means spoken by therapist. Underlined words and phrases are identified metaphors. Table 5.1 shows the final response categories, with examples.

Table 5.1. Final response categories with examples

<table>
<thead>
<tr>
<th>C1/T1: Repetition</th>
<th>of metaphor vehicle, using same or similar words</th>
</tr>
</thead>
<tbody>
<tr>
<td>Similar words example:</td>
<td></td>
</tr>
<tr>
<td>C: Even the remotest suggestion I feel like I freeze up.</td>
<td></td>
</tr>
<tr>
<td>T: So you mention freezing up...</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C2/T2: Rephrasing</th>
<th>of metaphor vehicle, using simple rephrasing, synonym, different metaphor or simple metaphorical expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple expansion example:</td>
<td></td>
</tr>
<tr>
<td>C: make my circle (of friends) wider</td>
<td></td>
</tr>
<tr>
<td>T: increase your circle.</td>
<td></td>
</tr>
<tr>
<td>Rephrase with different metaphor vehicle example:</td>
<td></td>
</tr>
<tr>
<td>C: it is kind of a steady improvement, but it has got lumps in it.</td>
<td></td>
</tr>
<tr>
<td>T: Yeah a few dips here and there, I can imagine</td>
<td></td>
</tr>
</tbody>
</table>

| C3/T3: Clarification | of meaning of metaphor vehicle, so as to create a shared understanding. (Response does not have to include metaphoric language). May include asking questions re associated imagery, thoughts or feelings, where referring to the metaphor (possibly implicitly- i.e. can include anaphoric references). Can include answers to questions if the answer has an exploring quality. |

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13 In linguistics, an anaphoric reference is the use of an expression the interpretation of which depends upon another expression in context: In the sentence ‘Sally arrived, but nobody saw her, the pronoun her is anaphoric, referring back to Sally. Similarly, ‘What’s good about that?’ could be an exploring response when a metaphoric expression occurs.
Clarification example:
C: I guess the nightmare is my house, having to pack it all up and leave.
T: Oh, so that is the downside, the whole hassle of shifting.

C4/T4: Elaboration/extension of metaphor: teasing out additional ramifications and dimensions, extending or modifying it; includes literalisation (i.e. taking it into the real world) or extended analogy.

Can include extended related metaphor that is associated with the same topic. In cases of literalisation, the whole speaking turn was coded as one literalisation.

Elaboration/extension example:
C: It’s like bases. You know first base, second base, third base… So obviously he played this all the way.
T: How are you going to make sure that he plays this game with you?

C5/T5: Explicit praise of / agreement with the metaphor. Must be explicitly in relation to the metaphor itself, not just general content.

Explicit praise /agreement example:
C: You know, it is like before I even get out the doors I sabotage myself …you want to win the race but you take the engine out of the car.
T: Yeah that is a really good analogy.

Metaphor vehicles with identified responses were underlined in the word document and linking lines were drawn to assist visual identification in the text. The response code was noted in a comments box. A conservative approach to coding was taken: because only access to written transcripts was available, responses were not coded in some cases, for instance where the intonation could affect how the response might be categorised.

Figure 5.1 is an example of how the final coding was conducted. The underlined words are identified metaphors, the italicised sections are identified responses and the linking lines show the links between metaphor vehicles and responses. Comment boxes show how italicised responses were coded. (T means spoken by therapist and C means spoken by client.)
Okay, so the fact that your room remains untidy in general, by the sound of it, what
does that say about you as a person?

C: Sort of a reflection of my life really, that room is like a physical reflection of what is
going on inside me.

T: Which is?

C: It is a mess inside, it needs to be tidied up, if I don’t change it. I am going to be like
this for the rest of my life. I will be worse, because it will keep reinforcing itself
and eventually I will just you know, five to ten years from now - Yeah I have got to
change.

T: So the messy room keeps reinforcing the worthlessness.

C: It reinforces the messy room plus it reinforces the worthlessness

Figure 5.1. Coding example

5.3.4 ‘Who started It?’ analysis

The coded transcripts were examined next for whether metaphoric exchanges were initiated
by the client or therapist. As noted earlier, it was decided that only metaphor vehicles that
occurred at the start of metaphoric exchanges would be coded (where there was a response
within three speaking turns). Coding of the initial metaphor in an exchange occurred at the
first speaking turn in a burst of metaphoric language. Where the first vehicle in a burst had
been observed to occur earlier in the session as well (which happened reasonably often), this
was noted separately, at the point where it occurred, along with whether it was first used by
the therapist or the client.
5.4 Results

Figure 5.2 shows the range and proportions of response types to each other’s metaphors (within the next three speaking turns) used in the three therapy dyads (therapist-client pairs), per thousand words. The third dyad had a lower rate of metaphors across most categories. *Explicit praise of/ agreement with* the metaphor was the least frequent response overall. The use of metaphor was highly variable across dyads, with *Extension/Elaboration* used relatively frequently.

The ‘Who started it’ analysis results indicated that bursts of metaphoric language were initiated by therapists and clients at a similar rate (therapists 170 versus clients 168 in total across all sessions); which also means that clients and therapists took up each other’s metaphors at a similar rate. The first metaphor in a burst was often a recurrence of a previous metaphor (44%). Bursts initiated by therapists were more likely to be a recurrence of a metaphor previously used by the therapist, than of a metaphor previously used by the client (forty-nine vehicles were previously used by therapists versus twenty-three vehicles previously used by clients). Bursts initiated by clients were almost equally distributed between recurrences of therapist or client metaphors (thirty-five were re-use of client metaphors while thirty-three were re-use of therapist metaphors).
5.5 Discussion

The metaphor of communication as a *dance* is a widely used figure of speech in everyday conversation and in psychotherapy research (Bucholz & Reich, 2014; Von der Lippe, Monsen, Ronnestad, & Eilertsein, 2008). This study found a range of common initial responses (or ‘dance moves’), within three speaking turns made by therapists and clients to each other’s metaphors occurring in early sessions of treatment for depression. These were categorised as: repetition, rephrasing, clarification, elaboration/extension and praise of/agreement with the metaphor. The frequency of different response types varied across the three dyads (therapist-client pairs). *Elaboration/extension* was used relatively frequently. This category is the one that is likely to be more clinically productive because it may facilitate an interesting, vivid creative process with potential for new understandings.

Extended literalisations (taking a metaphor into the real world), were classified as a form of *elaboration/extension*. Speakers’ metaphoric responses to each other also often involved a synonymic metaphor vehicle. For example, a client is talking about not giving a clear commitment to going for a visit home and the therapist says: ‘*So you can have an out*’. The client responds: ‘*Yeah a back door*’.

Therapists and clients ‘took up’ each other’s metaphors at a similar rate, suggesting a collaborative interaction was occurring, consistent with suggestions from Kopp (1995), Stott et al. (2010) and Blenkiron (2005). This may be due in part to the emphasis on collaboration in the CBT approach, though it is also possible that this result may have been influenced by the coding methodology used and coding of some highly conventionalised metaphors such as ‘homework’ and ‘goals’.

In this study there was clear evidence of metaphors being appropriated (i.e. adopted), by the other speaker. The term ‘appropriation’ comes from socio-cultural theory (Wertsch, 1998). Cameron (2008) notes that the appropriating and sharing of metaphors across speakers is a significant indicator of achievement of discourse goals, particularly where the vehicle expressions are emotive: “...an important signal and measure of increasing alignment between participants” (p. 50), and thus has potential relevance for the use of metaphor in therapy. This interpretation is supported in our study by the fact that Dyad three showed a lower frequency of co-construction of metaphor. Dyad three’s sessions also had a disproportionate amount of therapist talk versus client talk, suggesting opportunities to engage the client in collaborative discussion, including metaphoric exchanges, may have been missed. This pattern could have
been due to therapist style or perhaps the client was unresponsive due to depression, or other factors.

A limitation of this study was that it was based on written transcripts, meaning other aspects of metaphoric communication, such as tone of voice and gesture were not captured. The coding was complex, requiring close attention to cohesive links between text. The main coding challenge was deciding whether a response was simply a general response to the topic being discussed or whether it was a response to a metaphor vehicle. This was dealt with by coding conservatively, i.e. only coding those instances where there was a clear link between metaphor and response. The coding was limited to three speaking turns after a vehicle occurred, so did not capture instances where the metaphor vehicle was ‘saved up for later’, which is a further potential therapist or client response. Another response option which was not seen in the transcripts studied or described in the literature is to create a metaphor from a real life experience that the client refers to for example ‘climbing a hill to hang out the washing, with a broken arm and a broken leg’ (Example noted clinically by FM, which was then referred to as a metaphor for the client’s resilience).

The co-construction identified does not necessarily indicate a productive process in all cases. Although extended bursts of novel metaphoric language by clients have been found to relate to the development of major themes and problem solving (Pollio & Barlow, 1975), other studies have found a more complex picture (Rasmussen, 2000; Rasmussen & Angus, 1996). This complexity may occur because metaphoric language may serve a range of functions, including, enabling intellectualising or a focus on cognitive content to avoid emotional distress, both of which can be counter-productive for the therapy process.

The frequent use of synonyms, often metaphoric synonyms that was observed (e.g. client describes anger as ‘boiling over’; therapist responds ‘you explode’) is not consistent with recommendations made by advocates of therapies with a strong emphasis on metaphor, who advocate exploring, developing and transforming a particular metaphor vehicle (Kopp, 1995; Ronen, 2011; Sims & Whynot, 1997). However, the use of synonyms fits with the results of another study that concluded that successful therapy cases include a) the elaboration of major therapy themes in terms of bursts of figurative language or the development of a single metaphor over time and b) the existence of a central metaphor, evidenced by several conceptually related figures that fit the metaphor (McMullen, 1989). Our results suggest that synonyms can be productive in the development of shared language, supporting McMullen’s finding.
An observation during coding was that in almost half the cases (44%), the first utterance in a burst of metaphoric language between client and therapist was actually a recurrence of a metaphor vehicle used previously in the session, or even echoing a metaphor from a previous session. Further, some bursts of metaphoric language were much richer and more extended than others. These observations fit with clinical understandings about therapists and clients picking up on and developing shared understanding of the problem that becomes a reference point within and across therapy sessions. Although these phenomena were not the immediate focus of the analysis and require separate investigation, it was observed that shared metaphors, like other kinds of shared language, become fine-tuned or whittled into their final form through such repeated iterations and elaborations.

If therapists attend to the occurrence of metaphor and are aware of the range of potential responses, they can be selective in their choice of response, depending on the desired communication or therapeutic outcomes. While it is unlikely to be helpful for therapists to respond metaphorically to (or ‘pounce on’) every metaphor clients utter, responding by applying the same metaphor vehicle to key metaphoric descriptions in order to develop a stable metaphoric theme may be beneficial. If embarking on extended literalisations, there is potential to lose the thread, so it is likely to be beneficial if therapists continue to ensure there is mapping back to the original topic. Responding to clients’ metaphor vehicles with a different metaphor vehicle has potential to negatively affect rapport, potentially implying ‘my metaphor is better than yours.’ Conversely, intentionally responding with repetition, clarification, elaboration or extension to the client’s metaphor has the potential to assist rapport and align the therapist more effectively with the associated feelings, physiological responses and beliefs associated with the client’s metaphor.

5.6 Chapter summary

Attention to client metaphors has been asserted as a way of enhancing cognitive behaviour therapy. Metaphors can be part of the shared language that is co-constructed between clients and therapists. Recent advances in cognitive linguistics have provided the most clearly operationalised method yet to identify metaphors in conversations, allowing analysis of how shared language develops. This second study aims to explore how metaphoric shared language develops in early cognitive behaviour therapy sessions. Based on twelve transcripts of early cognitive behaviour therapy sessions, an iterative process led to the identification of a range of therapist and client responses to each other’s metaphors, and identification of whether therapists or clients initiated metaphoric exchanges. Types of responses to therapist
or client metaphors within three speaking turns were found to be: repetition, rephrasing, clarification, elaboration/extension, or agreement. Bursts of metaphoric exchange were initiated and taken up by therapists and clients at a similar rate. Conclusions are that therapists need to attend to the occurrence of metaphors and be aware of the range of potential responses that can engage the client in the ‘metaphoric dance’ (co-construction of shared metaphors). This has the potential to enhance engagement and outcomes though more salient reformulating of the problem for the client.

The next chapter describes a study that applied what has been learned in the first and second study to the therapy situation, through training therapists to intentionally co-construct metaphors and bring them into shared conceptualisations with clients.
Chapter 6
Juicy conceptualisations: increasing alliance through attending to client metaphoric language

6.1 Introduction

Appropriate and well-designed metaphors have been suggested as a particularly effective way of changing clients’ distorted views (Elliott, Adams, & Hodge, 1992), and as potentially offering a route to access structures of meaning that remain resistant to our traditional therapeutic efforts in CBT (Goncalves & Craine, 1990).

The importance of conceptualisation in CBT was emphasised in section 2.4.1. Metaphors can be a way of understanding a client’s overall perspective, with CBT experts encouraging therapists to bring them into CBT conceptualisations (Butler et al., 2008; Kuyken, Padesky, & Dudley, 2009). Client metaphors have been described as offering rich sources of meaning about how people conceptualise themselves, the world, and other people. They make valuable contributions to case conceptualisations because they are personalised, easy to remember and often offer sources of creative information to facilitate change and as an effective way to distil complex conceptualisations into much simpler ones (Kuyken et al., 2009, p. 90 & 317).

Additionally, use of metaphor has been described as one way of going ‘beyond’ competence in CBT by (Newman, 2015)\(^\text{14}\). He described ‘virtuoso’ CBT, likening evidence-based treatment protocols to musical scores in which we must learn to play the notes faithfully, but also use techniques such as metaphor to make the ‘performance’ more emotionally meaningful and memorable (thus assisting retention of learning). He added that the ‘performer’ (the therapist) has to connect and communicate with the ‘audience’ (the client) via a good sense of timing, and an individualized case conceptualisation, crafted in words that best suit the client.

Where metaphors are explored and developed in CBT, they may become an important shared reference point, allowing client and therapist to ‘speak the same language’. This may enhance the feeling of being understood for the client, thus strengthening the therapeutic alliance (Stott et al, 2010), which is an important predictor of outcome (as noted in section 2.4.2). ACT proponents (Hayes, Strosahl, & Wilson, 1999) also

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\(^{14}\) This is a paraphrase, confirmed by personal communication on 5th October 2016
emphasise the benefits of metaphor use for developing rapport and empathy, suggesting the development of ‘juicy’ metaphors that are rich in associations.

Clearly, assertions have been made about the benefits of metaphor in CBT, including in case conceptualisation. However, while there is some empirical literature on metaphor use in psychotherapy (McMullen, 2008; Tay, 2013), there is a paucity of empirical research on this topic specific to CBT, probably because metaphor research is challenging methodologically and because CBT research has tended with focus on therapy outcomes, with the interest in process research only occurring more recently (S. Hayes & Hofmann, 2017).

The previous two studies in this thesis found preliminary evidence that metaphors are frequent in CBT sessions and that metaphors can be con-structed between therapist and client, with potential therapist responses of: repetition; rephrasing; agreeing/praising; clarifying and elaborating client metaphors that occur during bursts of metaphor exchange. This third study builds on these findings and extends them to explore the impact of intentional use of metaphor during CBT case conceptualisation.

This third study of the thesis aims to evaluate the effect of training therapists to enhance CBT with intentional responses to client metaphor use. It tests assertions in the literature that intentionally working to develop shared metaphoric language during case conceptualisation is beneficial, looking specifically at the impact on therapeutic alliance. It explores whether working metaphorically suits some client-therapist pairs better than others. More broadly, it aims to add to the literature on process variables in cognitive behaviour therapy.

6.2 Research questions:

1) Does intentional use of metaphoric language by CBT therapists in case conceptualisation sessions increase client ratings of alliance and external ratings of the quality of therapy?

2) Does working metaphorically suit some therapists and clients better than others? That is, are therapy sessions which include intentional use of metaphor rated differently by clients on alliance measures depending on:

(a) therapist or client preference for metaphoric language; or

(b) the degree of congruence in preference for metaphoric language between the clients and therapists?
6.3 Method

Therapist participants were clinical psychologists, recruited via professional networks. They were included if they had experience of working with adults with depression and a minimum of three years’ experience of using CBT in secondary mental health, primary care, or private practice settings. Twelve therapists attended two half-day workshops, a fortnight apart, on metaphor-enhanced CBT. The training was delivered by an experienced clinical psychologist and postgraduate CBT trainer (FM). The workshops were delivered in April 2015 to eight therapists and repeated in November 2015 with a further cohort of four therapists.

Simulated ‘client’ participants were eleven graduate psychology students recruited from local training programmes. Nine ‘clients’ participated in role plays at the April workshops and five participated in the November workshops. Three of the April workshop ‘clients’ also participated in the November workshop role plays.

During the first workshop, the therapists practiced identifying metaphorical language and were asked to attend to their actual clients’ use of metaphorical language and the impact of different responses to this during the fortnight between workshops. At the second workshop they learnt to elicit client metaphors and practiced a range of responses to client metaphors, based on the existing psychotherapy literature (Butler et al., 2008; Kopp & Craw, 1998; Ronen, 2011; Sims & Whynot, 1997; Tay, 2013), and on the responses identified in the study described in Chapter 5. Further details of the training are provided in chapter 7.

The therapists role-played a full therapy session with a ‘client’ at the start of the first workshop (before training commenced) and at the end of the second workshop. The role play was of a second therapy session based on a depressed client scenario, which was sent to the therapists and role play ‘clients’ before the workshop. The therapists were instructed to develop a shared conceptualisation during the session. At the second workshop, a depressed client scenario based on a different client (second therapy session) was provided and the therapists were asked to elicit and develop client metaphors in the shared conceptualisation. The therapists also provided demographic data and completed a measure of preference for metaphorical language.

The ‘clients’ participated in the role plays, completed alliance ratings based on this experience, and completed a measure of their preference for metaphorical language. The therapists were paired with different ‘clients’ for each role play.
The role plays were videoed and subsequently rated by an external rater, who was blind as to when the recordings were made (pre- or post-training). Video recordings were used in the hope of better sound quality and visual cues to assist comprehension. The external rater was a clinical psychologist with a PhD and twenty years of CBT experience, and was familiar with the measures. The external rater assessed the therapists’ competence in CBT, along with rating the quality of the case conceptualisation.

6.4 Measures

A number of measures were used to evaluate the metaphor training. The Working Alliance Inventory Short-Revised and Session Rating Scale and Language Preference Report were administered to the ‘clients’ at both workshops after the role play. Both therapists and clients completed the Language Preference Report at the second workshop. The external rater used the Cognitive Therapy Scale-Revised and Cognitive Case Conceptualization Rating Scale based on video recordings of role play therapy sessions from both workshops. The timing of administration of the measures is summarised in Table 6.1.

Table 6.1. Measures used in Metaphor enhanced CBT workshops

<table>
<thead>
<tr>
<th>Measure</th>
<th>Workshop 1</th>
<th>Workshop 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist rated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language preference report (LPR)</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>‘Client’ rated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working Alliance Inventory Short-Revised WAI-SR</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Session Rating Scale</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Language Preference Report (LPR)</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>External rater session ratings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive therapy Scale-Revised (CTS-R)</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Cognitive Case Conceptualization Rating Scale (CCC-RS)</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

6.4.1 Working Alliance Inventory Short-Revised (WAI–SR)

The WAI–SR (Hatcher & Gillaspy, 2006) is a twelve item self-report measure of therapeutic alliance based on the Working Alliance Inventory (Horvath & Greenberg, 1986, 1989). It assesses the extent to which the client feels emotionally connected to the therapist in terms of mutual trust, liking and appreciation; and the extent to which the client believes there is a
mutual and purposeful agreement on what the tasks and goals are in the therapy (Munder, Wilmers, Leonhart, Linster, & Barth, 2010). Clients rate the alliance in response to twelve statements, from one to five (seldom - always). The WAI-SR has three factor scores: Tasks (agreement on the tasks of therapy); Goals (agreement on the goals of therapy) and Bond (development of an affective bond). The WAI-SR has demonstrated good psychometric properties in psychotherapy patients in the USA (Hatcher & Gillaspy, 2006) and good reliability ($\alpha > .80$) and convergent validity with another alliance measure ($r > 0.64$) in German outpatients and inpatients (Munder et al., 2010). The WAI-SR was completed by the ‘clients’ immediately after each role play.

While there is an abundance of scales for measuring the working alliance (e.g. Alexander and Luborsky (1986); Gaston and Marmar (1994); O'Malley, Suh, and Strupp (1983)), the Working Alliance Inventory is one of the most widely used (Falkenstrom, Hatcher, & Holmqvist, 2015). The short form has the advantage of brevity, while having good psychometric properties, hence its selection for this study.

6.4.2 The Session Rating Scale (SRS)

The Session Rating Scale (SRS) (Duncan et al., 2003) is a brief alliance measure comprising four 10cm visual analogue scales. It is part of a movement toward feedback-informed treatment (Maeschalck & Barfknecht, 2017), which is consistent with the collaborative approach taken in CBT, and widely used to measure therapy alliance (Shaw & Murray, 2014). It has been used by other researchers in conjunction with versions of the WAI (Godkin, 2011; Maitland & Gaynor, 2016). The SRS has been evaluated against existing longer alliance measures such as the WAI and Revised helping alliance questionnaire II (HAQ-II; (Luborsky et al., 1996)), and demonstrated good reliability and concurrent validity with the longer alternatives (Campbell & Hemsley, 2009).

The Relationship scale rates the session from “I did not feel heard, understood, and respected” to “I felt heard, understood, and respected.” The Goals and Topics scale rates the session from “We did not work on or talk about what I wanted to work on or talk about” to “We worked on or talked about what I wanted to work on or talk about.” The Approach or Method scale (an indication of a match with the client’s theory of change) asks the client to rate the session from “The approach is not a good fit for me” to “The approach is a good fit for me.” The fourth scale asks the client to rate the session ‘Overall’: from “There was something missing in the session today” to “Overall, today's session was right for me.”
The SRS is scored by measuring the distance in centimetres from the left-hand end of the line to the client’s score. The Total score is the sum of the client's marks on the four 10-cm lines (i.e. with a maximum score of 40). A score between zero to thirty-four reflects a poor alliance; thirty-five to thirty-eight reflects a fair alliance and thirty-nine to forty reflects a good alliance. The SRS is usually completed in session and discussed with the therapist, but in this study, it was completed by the ‘clients’ immediately after each role play due to time constraints and possible lack of therapist familiarity with the use of the SRS tool.

The rationale for the choice of the SRS was also that it is widely used and client-rated. Research shows that client ratings of alliance are far more predictive of improvement than the type of intervention or the therapist’s ratings of the alliance (Horvath & Luborsky, 1993; Schuckard, Miller, & Hubble, 2017).

**6.4.3 The Language Preference Report (LPR)**

The LPR is a fifty-item measure in which statements are rated on a Likert scale from one (strongly disagree) to seven (strongly agree). It has three factors: Liking to Produce figurative language, Dislike of figurative language and Liking to Study texts with figurative language. The LPR has been found to have internal consistency estimates of .92 to .84 and test-retest reliability estimates ranging from .86 to .69 (Yarbrough, 1991). It was administered at the end of the second workshop to both therapists and ‘clients’. This scale was used because it is the only scale available to measure preference for metaphoric language and it has good psychometric properties.

**6.4.4 The Revised Cognitive Therapy Scale (CTS-R)**

The CTS-R (Blackburn et al., 2001) is a widely used tool and the current gold standard measure of therapist competence in CBT across a range of skill areas. Items are rated by an external expert rater on a seven-point Likert scale ranging from incompetent (zero) to expert (six). The CTS-R has thirteen items and a total score. It has high internal consistency and adequate average inter-rater reliability. Validity has been demonstrated by improved ratings of competence for trainees who saw patients early and later on during the course of training (Blackburn et al., 2001).

**6.4.5 The Collaborative Case Conceptualization Rating Scale (CCC-RS)**

As noted in section 2.4.1, the collaboratively developed case conceptualisation is considered to be the foundation for achieving an understanding of client difficulties in CBT (Beck, 1995;
Kazantzis, 2003), with an emphasis on the importance of collaborative development of conceptualisations (Dudley & Kuyken, 2006). The CCC-RS (Padesky, Kuyken, & Dudley, 2011) measures therapist competence in CBT case conceptualisation. The authors of this tool argue that there is a need to systematically train CBT therapists in case conceptualisation and they developed this tool as a way of assessing such training. The CCC-RS has fourteen items, rated zero (incompetent) to three (proficient/expert), with a maximum overall score of forty-two. Item scores contribute to five main scores: (1) Levels of conceptualization; (2) Collaboration; (3) Empiricism; (4) Strengths/Resilience focus and (5) Overall.

The CCC-RS has excellent internal consistency ($\alpha = 0.94$), split-half (0.82) and inter-rater reliabilities (ICC = .84). Total scores on the CCC-RS were significantly correlated with scores on the CTS-R ($r = .54$) and the collaboration subscale of the CCCRS significantly correlated ($r = .44$) with the collaboration subscale of the CTS-R (Kuyken et al., 2016). This suggests that the CCC-RS is a reliable measure with adequate face, content and convergent validity.

### 6.5 Ethical Approval

A second ethics application was made in relation to this thesis in relation to this current study and the study described in chapter seven of the thesis. This application was made to the University of Otago Ethics Committee for approval for the metaphor training workshops. Therapists and ‘clients’ provided written informed consent (see Appendix D). Ethics was approved by the University of Otago Ethics Committee, Category A, # 15/017 (See Appendix A), with a subsequent minor amendment due to small changes to the metaphor training workshop evaluation questionnaires. An application was made to Ngai Tahu in relation to this ethics application and was approved (see appendix A).

### 6.6 Data analysis

A within-subjects analysis was conducted. Parametric assumptions were checked using Kolmogorov-Smirnov (Kolmogorov, 1933; Smirnov, 1948) and Shapiro-Wilk (Shapiro & Wilk, 1965, p. 593) tests. As normality assumptions were not met, a Wilcoxon signed ranks test was conducted to assess whether there were any significant differences between pre and post-training scores on the CCC-RS, CTS-R, WAI-SR, and SRS. Total scores were examined, along with hypothesis-relevant subscales.

Effect sizes were calculated using the approach taken by Cohen (1988) where $d = (M_2 - M_1)/SD_p$, and SD is the standard deviation. Effect sizes were based on Cohen’s (1988) effect sizes
small = 0.1; medium = .3 and large = 0.5 for non-parametric data when Wilcoxon signed ranks tests have been used.

Brinley plots were used to visually display only the significant changes as a result of training. Such plots have the benefit over group mean data of displaying both systematic effects and the full range and variability of individual responses (Blampied, 2007; Brinley, 1965); Brinley plots are a form of scatter plot where each participant’s pre and post training scores are plotted together as co-ordinate pairs. Where the pre and post scores are identical or very similar, the resulting data lies on or close to the diagonal line of no change. When pre and post scores differ, positive changes show above the line, while negative changes show below the line.

The following LPR Spearman’s correlations were calculated: 1) Therapist scores on LPR factors Produce and Dislike and their correlations with the other post-training measures (for hypothesis-relevant scales and sub-scales); 2) ‘Client’ scores on LPR factors Produce and Dislike and their correlations with the other post-training measures (for hypothesis-relevant scales and sub-scales); and 3) The size of the difference between Therapist and ‘Client’ LPR Produce and Dislike scores and the correlations of these variables with other post-training measures (for hypothesis-relevant sub-scales).

Internal consistency estimates of the reliability of test scores (Cronbach coefficient alphas) were calculated for two of the three LPR factors previously identified by Yarbrough (1991), using the scores from all therapists and ‘clients’. These are: Produce (Like to produce figurative language); Dislike (Dislike using figurative language). A third factor, Study (Like to study texts using figurative language), was omitted from the analysis as it was not relevant to the study hypothesis. For three participants with one or more missing item scores, the mean score was used, rather than trying to interpolate the value for the missing item.

### 6.7 Results

#### 6.7.1 Participants

Of the twelve participating therapists, eleven were female and one was male. All therapists had at least Masters level qualifications in clinical psychology. The mean therapist age was forty-five (range 36-60 years). The mean number of years of clinical experience was 13.1 years (range 6-24 years).
Role play ‘clients’ included nine postgraduate clinical psychology students who were paid to participate, and two academic colleagues who volunteered, one with a graduate diploma in psychology and one with a PhD in sociolinguistics. Of the total of eleven participating ‘clients’, ten were female and one was male. The mean age of the ‘clients’ was thirty-four (range 22-59 years). The mean rating by the ‘clients’ of their knowledge of CBT was 3.3 (range 2-4), rated on a six-point Likert scale (zero: None at all to five: A great deal).

6.7.2 Changes on measures

Although the pre-post change following the training programme was in the expected direction for all hypothesis-relevant variables, only three results reached statistical significance (SRS Goals and Topics subscale, SRS Total, CCCRS Collaboration subscale and CTS-R Application of Cognitive Techniques subscale).

Table 6.2 shows the means and significance tests for all hypothesis-relevant total scores and sub-scales, along with the effect sizes. The effect size was large for SRS Goals and Topics and CCC-RS Collaboration and medium for CCC-RS Total, CTS-R Guided Discovery, and CTS-R Application of Cognitive Techniques.
Table 6.2. Pre and post training changes on hypothesis-relevant measures of therapeutic alliance

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean Time 1</th>
<th>Mean Time 2</th>
<th>Wilcoxon p-value (exact, 2 tail)</th>
<th>z scores (based on negative ranks)</th>
<th>SD Time 1</th>
<th>SD Time 2</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working Alliance Inventory (WAI-SR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bond</td>
<td>17.08</td>
<td>18.00</td>
<td>.54</td>
<td>-.67</td>
<td>2.3</td>
<td>1.7</td>
<td>0.14</td>
</tr>
<tr>
<td>Total</td>
<td>48.08</td>
<td>52.25</td>
<td>.27</td>
<td>-1.1</td>
<td>7.5</td>
<td>4.6</td>
<td>0.23</td>
</tr>
<tr>
<td>Session Rating Scale (SRS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship</td>
<td>8.99</td>
<td>9.27</td>
<td>.46</td>
<td>-.79</td>
<td>.81</td>
<td>.56</td>
<td>0.16</td>
</tr>
<tr>
<td>Approach or Method</td>
<td>8.46</td>
<td>8.92</td>
<td>.62</td>
<td>-.53</td>
<td>1.8</td>
<td>.88</td>
<td>0.11</td>
</tr>
<tr>
<td>Goals and Topics</td>
<td>8.23</td>
<td>9.51</td>
<td>.01**</td>
<td>-2.7</td>
<td>1.2</td>
<td>.29</td>
<td>0.56</td>
</tr>
<tr>
<td>Overall</td>
<td>8.57</td>
<td>9.14</td>
<td>.25</td>
<td>-1.2</td>
<td>.17</td>
<td>.92</td>
<td>0.25</td>
</tr>
<tr>
<td>Total</td>
<td>34.24</td>
<td>36.83</td>
<td>0.05*</td>
<td>-2.0</td>
<td>4.7</td>
<td>2.4</td>
<td>0.41</td>
</tr>
<tr>
<td>Collaborative Case Conceptualization Rating Scale (CCC-RS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collaboration</td>
<td>6.92</td>
<td>8.83</td>
<td>0.00**</td>
<td>-2.8</td>
<td>1.6</td>
<td>.39</td>
<td>0.58</td>
</tr>
<tr>
<td>Strengths &amp; Resilience</td>
<td>7.83</td>
<td>9.83</td>
<td>.20</td>
<td>-1.3</td>
<td>3.5</td>
<td>2.5</td>
<td>0.27</td>
</tr>
<tr>
<td>Total</td>
<td>33.92</td>
<td>39.00</td>
<td>.08</td>
<td>-1.8</td>
<td>6.8</td>
<td>3.0</td>
<td>0.36</td>
</tr>
<tr>
<td>Cognitive Therapy Scale-Revised (CTS-R)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collaboration</td>
<td>4.75</td>
<td>4.92</td>
<td>.59</td>
<td>-.64</td>
<td>.75</td>
<td>.36</td>
<td>0.13</td>
</tr>
<tr>
<td>Interpersonal Effectiveness</td>
<td>4.62</td>
<td>4.83</td>
<td>.38</td>
<td>-.95</td>
<td>.71</td>
<td>.58</td>
<td>0.19</td>
</tr>
<tr>
<td>Facilitation of Emotional Expression</td>
<td>4.37</td>
<td>4.67</td>
<td>.38</td>
<td>-1.1</td>
<td>.64</td>
<td>.49</td>
<td>0.21</td>
</tr>
<tr>
<td>Charisma &amp; Flair</td>
<td>4.29</td>
<td>4.62</td>
<td>.30</td>
<td>-1.1</td>
<td>.11</td>
<td>.57</td>
<td>0.23</td>
</tr>
<tr>
<td>Variable</td>
<td>Mean Time 1</td>
<td>Mean Time 2</td>
<td>Wilcoxon p-value (exact, 2 tail)</td>
<td>z scores (based on negative ranks)</td>
<td>SD Time 1</td>
<td>SD Time 2</td>
<td>Effect size</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------------</td>
<td>-------------</td>
<td>----------------------------------</td>
<td>-----------------------------------</td>
<td>-----------</td>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td>Guided Discovery</td>
<td>4.58</td>
<td>4.96</td>
<td>.20</td>
<td>-1.5</td>
<td>.79</td>
<td>.40</td>
<td>0.30</td>
</tr>
<tr>
<td>Conceptualisation</td>
<td>4.79</td>
<td>4.96</td>
<td>.47</td>
<td>-.86</td>
<td>.54</td>
<td>.45</td>
<td>0.18</td>
</tr>
<tr>
<td>Focus on Key Cognitions &amp; Emotions</td>
<td>4.54</td>
<td>4.71</td>
<td>.52</td>
<td>-.88</td>
<td>.69</td>
<td>.54</td>
<td>0.18</td>
</tr>
<tr>
<td>Application of Cognitive Techniques</td>
<td>3.33</td>
<td>4.33</td>
<td>.02*</td>
<td>-2.3</td>
<td>1.15</td>
<td>1.01</td>
<td>0.47</td>
</tr>
<tr>
<td>Total</td>
<td>52.86</td>
<td>56.37</td>
<td>.147</td>
<td>-1.5</td>
<td>10.92</td>
<td>8.12</td>
<td>0.31</td>
</tr>
</tbody>
</table>

* p < .05; **p < .01  SD Standard deviation
Brinley plots for the SRS Total; SRS Goals and Topics subscale; CCC-RS Collaboration subscale and the CTS-R Application of Cognitive Techniques subscale are shown in Figure 6.1. In all four Brinley plots the majority of pre-post data points are above the line, indicating a positive change has occurred by the post assessment point. The CCC-RS Collaboration subscale plot is notable as all therapists received the maximum score for collaboration following the intervention, as rated by the independent rater.

![Brinley plots showing pre- versus post-training scores for the Session Rating Scale Total; Session Rating Scale Goals and Topics subscale; Collaborative Case Conceptualisation Rating Scale Collaboration subscale and Cognitive Therapy Scale-Revised Application of Cognitive Techniques subscale.](image)

**Figure 6.1.** Brinley plots showing pre- versus post-training scores for the Session Rating Scale Total; Session Rating Scale Goals and Topics subscale; Collaborative Case Conceptualisation Rating Scale Collaboration subscale and Cognitive Therapy Scale-Revised Application of Cognitive Techniques subscale.

### 6.7.3 Language Preference Report (LPR) results

The internal consistency estimates (Cronbach coefficient alphas) for the LPR were: *Produce* 0.93; *Dislike* 0.79 indicating excellent and acceptable levels respectively. These were at a level as those found by Yarbrough (1991).
In the Spearman’s correlational analysis only one statistically significant association was found: The ‘Bond’ factor score (‘development of an affective bond’) of the WAI-SR was significantly negatively correlated with size of difference between therapists and ‘clients’ on the factor LPR ‘Produce’ (liking to produce metaphors) (Spearman’s rho -.62; *p* = .03). This means as the discrepancy between therapists and client increased, the WAI-SR rating by the ‘clients’ on the ‘Bond’ factor score decreased. A number of the other correlations, while not statistically significant, reached medium - large effect sizes. For example, the correlation between ‘Client’ LPR Produce and WAI-SR Bond was 0.53, *p* = .08; the correlation between therapist Produce and SRS Overall was -.55, *p* = .07 and the correlation between the size of the difference between therapists and ‘clients’ and SRS Approach or Method was -.51, *p* = .09. The full correlation matrix is shown in Table 6.3.
Table 6.3. Correlations\(^1\) between Therapist, ‘Client’ and Difference between therapist and client Language Preference Report ‘Produce’ and “Dislike” scores and hypothesis-relevant measures, post-training (N = 12 therapist-client pairs)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Language Preference Report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Therapist Produce</td>
</tr>
<tr>
<td>Cognitive Therapy Scale-Revised (CTS-R post-training)</td>
<td></td>
</tr>
<tr>
<td>Collaboration</td>
<td>.29</td>
</tr>
<tr>
<td>Interpersonal effectiveness</td>
<td>.25</td>
</tr>
<tr>
<td>Facilitation of emotional expression</td>
<td>.21</td>
</tr>
<tr>
<td>Charisma &amp; flair</td>
<td>0.44</td>
</tr>
<tr>
<td>Conceptualisation</td>
<td>0.29</td>
</tr>
<tr>
<td>Focus on key cognitions and emotions</td>
<td>0.42</td>
</tr>
<tr>
<td>Application of behavioural techniques</td>
<td>-0.09</td>
</tr>
<tr>
<td>Collaborative case conceptualization rating scale (CCCRS post-training)</td>
<td></td>
</tr>
<tr>
<td>Levels of conceptualization(^2)</td>
<td></td>
</tr>
<tr>
<td>Collaboration</td>
<td>0.20</td>
</tr>
<tr>
<td>Working alliance inventory (WAI-SR post-training)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>-0.18</td>
</tr>
<tr>
<td>Bond</td>
<td>-0.41</td>
</tr>
</tbody>
</table>

Session rating scale (SRS post-training)
<table>
<thead>
<tr>
<th>Variable</th>
<th>Therapist Produce</th>
<th>Therapist Dislike</th>
<th>Client Produce</th>
<th>Client Dislike</th>
<th>Produce Difference Therapist-Client</th>
<th>Dislike Difference Therapist-Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship</td>
<td>-0.33</td>
<td>-0.17</td>
<td>0.27</td>
<td>-0.10</td>
<td>-0.21</td>
<td>-0.26</td>
</tr>
<tr>
<td>Goals &amp; topics</td>
<td>-0.42</td>
<td>-0.12</td>
<td>0.19</td>
<td>-0.30</td>
<td>-0.27</td>
<td>-0.05</td>
</tr>
<tr>
<td>Approach or method</td>
<td>-0.45</td>
<td>-0.20</td>
<td>0.47</td>
<td>-0.03</td>
<td>-0.51</td>
<td>-0.31</td>
</tr>
<tr>
<td>Overall</td>
<td>-0.55</td>
<td>-0.03</td>
<td>0.23</td>
<td>-0.21</td>
<td>-0.38</td>
<td>0.09</td>
</tr>
<tr>
<td>Total</td>
<td>-0.52</td>
<td>-0.14</td>
<td>0.42</td>
<td>-0.13</td>
<td>-0.49</td>
<td>-0.15</td>
</tr>
</tbody>
</table>

Notes:  
1 Correlations are Spearman’s correlations. *p<.05  
2 SPSS could not compute the correlations with the CCC-RS post-training Levels of Conceptualization scores because all the scores were the same.
A Brinley plot of the one significant LPR correlation (between the ‘Bond’ factor score of the WAI-SR and the size of difference between therapists and ‘clients’ on the factor ‘Produce’ metaphors on the LPR) is shown in Figure 6.2. The negative slant shows the negative correlation that was found, which indicates that the bigger the discrepancy between therapists and clients in terms of liking to produce metaphor, the lower the bond rating was.

Figure 6.2. Brinley plot illustrating the relationship between the size of the discrepancy in therapist-client liking to produce metaphor and post-training scores on the therapy bond.

6.8 Discussion

6.8.1 Results in relation to research questions

The first research question was: Does intentional use of metaphoric language by CBT therapists in case conceptualisation sessions increase client ratings of alliance and external ratings of the quality of therapy? Two measures of alliance were used (including subscales) and there were mixed findings. Training experienced therapists to attend to and develop client metaphors in role played CBT conceptualisations had a positive impact on the client’s experience of the shared goals and topics discussed as being relevant to them. This is a key aspect of alliance that is thought to be influential on treatment outcome (e.g. Hoffart, Borge, Sexton, Clark, & Wampold, 2012; Snippe et al., 2015), but did not significantly alter the ‘clients’ sense of ‘Bond’ on the Working Alliance Inventory. Following training in using metaphors, the sessions were also rated independently as being more collaborative in arriving
at a case conceptualisation, though not more collaborative in a more general sense. While the improvements on the Working Alliance Inventory (Short-revised) were non-significant, there were statistically significant changes from pre- to post-training on the Session Rating Scale Total score and Goals and Topics subscale and the Collaborative Case Conceptualization Rating Scale Collaboration sub-scale, indicating improvements in this measure of alliance post-training.

The second research question was: Does working metaphorically suit some therapists and clients better than others? That is, are therapy sessions which include intentional use of metaphor rated differently by clients on alliance measures depending on (a) therapist or client preference for metaphoric language; or (b) the degree of congruence in preference for metaphoric language between the clients and therapists?. The LPR Factor 1(Produce) difference was significantly negatively correlated with session rating on post-training WAI-SR Bond: the greater the difference between the therapist and ‘client’ in terms of liking to produce metaphorical language, the lower the rating of the session by the ‘clients’ in terms of Bond. This finding provides some tentative guidance as to client (and therapist) suitability for metaphorical work, suggesting that working metaphorically may be most effective when both therapist and client like to speak metaphorically.

6.8.2 Other findings

The Revised Cognitive Therapy Scale Application of Cognitive Techniques sub-scale also reached significance (p< 0.05), with a medium effect size. It is possible that the external rater may have scored metaphor as a cognitive technique: as a bridge to unpacking different perspectives or as a technique to enhance therapeutic alliance.

The SRS Total scores improved from ‘poor’ to ‘fair’. The generally low scores may have been due to self-consciousness by the therapist and ‘clients’ about being filmed (and having their performance rated) and because it was the first full session in which the therapists deliberately brought in metaphor, post training. Further, as it was a role play of a second therapy session, participants had not had a chance to establish the relationship in the first session before sharing the conceptualisation.

6.8.3 Limitations

The SRS is designed to be completed in session as a feedback tool, but in this study it was completed independently by the ‘client’ immediately after the session. This could have impacted on the ratings. Another study has also used the SRS in a non-standard way for
research purposes (Cocklin et al., 2017). Further research would be required to clarify whether variations in administration have an effect.

The study size (N = 12 therapists) limits the power and generalisability of this study, although some medium to large effect sizes were found. The non-significant findings could be simply due to the small sample size, especially given that all the hypothesis-relevant measures improved post-training. However, this would need to be investigated in a larger study. This study also had the limitation of being an analogue study, which used role play ‘clients’ rather than actual therapy sessions. This was due to the practicalities of arranging informed consent, setting up video recordings and efficiently collecting data from therapists and clients, given that this researcher was not based in a large centralised service and this was a preliminary study. This was nevertheless still a useful and ethical approach to use at this early investigative stage. The gender imbalance (both therapists and clients being mostly female) may also limit the generalisability of this study. It is possible that despite being instructed to ‘give their honest opinion from their perspective as a client’, the ‘clients’ gave higher ratings on the post training sessions due to the knowledge that the study was evaluating a training session. While there were advantages to having psychology students as role play ‘clients’ in terms of their knowledge of depression, their knowledge of what is involved in a CBT session may also have influenced their ratings, leading to higher scores than might be the case with a real client new to psychotherapy. In addition, attention to the idiosyncratic metaphors of actual clients, which are actually meaningful to the client, may have a different (or stronger) impact than the metaphor provided to the ‘clients’ in the role play (‘the cloak of depression’).

6.8.4 Conclusions

Despite these limitations, this study found promising trends regarding the impact of metaphor on alliance in an analogue situation. Future research may attempt to replicate the current findings using larger samples (in both analogue situations with non-clinical student ‘clients’, and in real life therapy sessions), and investigate whether attending to client metaphors benefits other parts of sessions such as homework, and goal setting. Future research might also consider whether these findings generalise to client presentations other than depression, whether training in metaphor enhanced CBT has continued impact on alliance over time, and whether the same training effect would be found with inexperienced CBT therapists. Other aspects of metaphor in therapy that warrant further investigation include the degree of phenomenological match between the metaphor topic and vehicle, the degree to which the metaphor is generated by the client or therapist, and the vividness of mental imagery. All of
these may mediate the impact of metaphoric language. Future studies could also usefully explore the directionality of the mismatch in preference for producing metaphor to lower ratings of bond: is it that the lower rating of bond comes when the therapist uses too much metaphoric language, or when they use too little and the client is talking in metaphor? In other words, does this finding reflect therapists who are being too literal and concrete or too flowery in their language? Or is it that the metaphors used are just not a good fit to the situation?

This preliminary investigation provides empirical support for claims by metaphor experts that attending and responding to metaphoric language and bringing it into case conceptualisations is beneficial for alliance. Links have consistently been found between measures of alliance and therapy outcome ((Horvath & Symonds, 1991; Martin, Graske, & Davis, 2000), including CBT (Raue & Goldfried, 1994). Client metaphors are rich with personal meaning and working to develop them may prove to be beneficial for outcome, possibly through helping people feel fully understood.

6.9 Chapter summary

There is increasing interest in the use of metaphor in cognitive behaviour therapy. Experts advocate bringing client metaphors into case conceptualisations; however, there is little empirical research to support this. This study evaluated the effect of training 12 therapists to attend to client metaphors and bring them into case conceptualisations. Pre and post-training role played therapy sessions were conducted and video-recorded. Alliance was rated by role play ‘clients’ and an external CBT expert therapist rated the quality of the sessions and of the shared conceptualisations. Results were that there were significant increases in some ratings of alliance, based on role play ‘client’ ratings and external ratings of role plays of therapy sessions before and after training. The greater the difference between therapist and ‘client’ on a measure of preference for producing metaphor, the lower the rating of the session by the ‘client’ on the Bond factor score of a therapeutic alliance measure, the Working Alliance Inventory. This result suggests that working metaphorically may be most effective when the therapist and client have a similar degree of preference for speaking metaphorically. This study provides preliminary support for the idea that attending to client metaphors during conceptualisation can be beneficial for alliance.

The next chapter describes the metaphor training provided and explores its impact based on therapist self-report ratings and reflections on their ongoing application of learning over a three-month period.
Chapter 7
Keeping metaphors in mind

7.1 Introduction

As discussed in Chapter 2, metaphor has long been of interest to many schools of psychotherapy (see Kopp, 1995; O’Hanlon & Hexum, 1990; Törneke, 2017; Winnicott, 1989) with numerous potential benefits asserted including: enhancing conceptualisation (Berlin, Olson, Cano, & Engel, 1991), expression of emotion (Siegelman, 1990), building alliance (Brooks, 1985), transforming meaning (Lyddon, Clay, & Sparks, 2001), being memorable (Bonanno, 1990) and providing compact communication (Pearce, 1996).

Within cognitive behaviour therapy (CBT), there has been growing interest in the value of metaphor, with CBT experts advocating for increased use in therapy (Kuyken, Padesky, & Dudley, 2009). Intentional use of metaphors is described as an important therapist skill, which may be particularly effective in helping to change clients’ distorted views (Elliott, Adams, & Hodge, 1992). One focus has been on therapist’s use of metaphor (Blenkiron, 2010; Stott et al, 2010). A second focus has been on the need for attention to client metaphors, bringing them into case conceptualisations as a shared reference point (Butler et al, 2008; Kuyken et al., 2009) and as a way of increasing alliance, given that alliance has been found in numerous studies to be an important predictor of outcome (Horvath & Bedi, 2002).

To date, however, there have been no studies either within the CBT literature or the broader psychotherapy literature which have examined how to train therapists in this skill. This fourth study of the thesis reported in this chapter extends empirical research on the use of metaphor in CBT into the domain of therapist training. It was conducted as part of the metaphor-enhanced CBT training referred to in Chapter 6. It is a separate but related study and explores how experienced therapists might be trained in metaphor-enhanced CBT during two half-day training workshops in metaphor-enhanced CBT and what the impact of this might be on therapists.

This chapter further describes the metaphor training workshops (mentioned previously in Chapter 6) and reports therapists’ evaluations of the training and their use of metaphor post-training. The metaphor training was based on a growing literature on therapist training, suggesting that best practice involves:

1. Use of a variety of methods to enhance declarative and procedural skills such as didactic teaching, live and video demonstration, interactive exercises, and role-play
and self-practice of skills (Bennett-Levy, McManus, Westling, & Fennell, 2009; Padesky, 1996; Sudak et al., 2016)

2. Ongoing consultation or supervision to enhance learning post-workshop (Beidas, Edmunds, Marcus, & Kendall, 2012; Lyon, Stirman, Kerns, & Bruns, 2011; Mannix et al., 2006) and


The purpose of the training programme was to train therapists to intentionally bring metaphors into shared CBT conceptualisations. Immediately after, and for three months following the training, the therapists were asked to rate their experience of the training and how this influenced their ongoing use of metaphor in practice. Self-report questionnaires were completed by the therapists to determine whether there was any change in: awareness of metaphor, intentional use of metaphor and confidence in metaphor use, and increased intentional use of metaphoric language. These ratings were also intended to serve as a structured method of promoting ongoing reflection.

7.2 Research questions

The research questions were:

1) Does the training increase ratings of awareness, confidence and frequency of application of metaphor use?
2) Is there a change in perceived importance of metaphor in therapy as a result of training?
3) Does the training in applying metaphor in case conceptualisation generalise to other areas of therapy over time?
4) What is the pattern (if any) of uptake of training?
5) What barriers did therapists identify to metaphor use and how were they addressed?
6) How did the therapists rate the content and delivery of the workshop itself?

7.3 Method

7.3.1 Sample

As outlined in the previous chapter (section 6.3), twelve clinical psychologists with a minimum of three years’ experience in using CBT were recruited using professional networks. They completed two half-day training workshops, held a fortnight apart, on
metaphor-enhanced CBT. Of the twelve participating therapists, eleven were female and one was male. All therapists had at least Masters level qualifications in clinical psychology. The therapists were all mature and experienced therapists, with a mean therapist age of forty-five (range 36-60 years) and mean number of years of clinical experience of 13.1 years (range 6-24 years).

### 7.3.2 Training Process

The psychologists completed two half-day training workshops, held a fortnight apart, on metaphor-enhanced CBT. These were delivered by an experienced clinical psychologist and postgraduate CBT trainer (FM). In line with best practice CBT training (Sudak et al., 2016), the training comprised formal teaching; discussion; small group skill practice; role play practice; video demonstrations; homework practice and structured self-reflection.

The workshop content is summarised in Table 7.1 below. Further details of the training are available from (FM) on request.

<table>
<thead>
<tr>
<th>Table 7.1. Workshop content and rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Workshop 1</strong></td>
</tr>
<tr>
<td><strong>Content</strong></td>
</tr>
<tr>
<td>Theoretical Foundation including conceptual metaphor theory, which describes metaphors such as ARGUMENT IS WAR, which are shared across speech communities (Lakoff, 1993)</td>
</tr>
<tr>
<td>Metaphor definition and identification (including the Discourse Dynamics approach to metaphor identification (Cameron &amp; Maslen, 2010). Practice identifying metaphors in CBT session transcripts.</td>
</tr>
<tr>
<td>Outline of possible metaphor functions in therapy, including in case conceptualisation</td>
</tr>
<tr>
<td>Existing literature on metaphor in CBT</td>
</tr>
<tr>
<td>A CBT model of metaphor as a conceptual bridge (Stott et al., 2010, p. 21)</td>
</tr>
<tr>
<td>Therapist, client and co-constructed metaphors</td>
</tr>
<tr>
<td>Use of Stem Sentences Test as a prompt ((Kaviani &amp; Hamedi, 2011)</td>
</tr>
<tr>
<td>Homework-setting: metaphor log (own and client’s metaphor use and verbal and written instructions to reflect on how they and the client responded and what the impact of this was on the interaction); experimenting with Stem Sentences Test; Relevant readings</td>
</tr>
<tr>
<td>Workshop 2 (two weeks later)</td>
</tr>
<tr>
<td>Review homework logs</td>
</tr>
<tr>
<td>Comparing protocols for exploring and transforming client metaphor (Butler et al., 2008; Kopp &amp; Craw, 1998; Ronen, 2011; Sims &amp; Whynot, 1997; Tay, 2013)</td>
</tr>
<tr>
<td>Metaphor signalling devices (Tay, 2013)</td>
</tr>
<tr>
<td>Practicing co-construction of metaphors based on responses identified by (Mathieson, Jordan, &amp; Stubbe, 2014) (repeat, rephrase, clarify; extend/elaborate and praise) and metaphor protocols above.</td>
</tr>
<tr>
<td>Practice bringing client metaphor into case conceptualisation, using the five-part model, a widely used method of conceptualising (Kuyken et al., 2009; Williams &amp; Garland, 2002)</td>
</tr>
<tr>
<td>Discussion of different parts of therapy where metaphors can be used in order to form a stable theme (e.g. goals setting, homework rationales)</td>
</tr>
<tr>
<td>Discussion of potential pitfalls in metaphor use and client suitability</td>
</tr>
</tbody>
</table>
7.3.3 Measurement

**Core Ratings**: The therapists completed Likert scale ratings (zero: not at all to four: extremely) of their:

- extent of intentional metaphor use;
- awareness of metaphors occurring;
- view on the importance of metaphor in therapy, and
- confidence regarding intentional use of metaphor in CBT
- confidence in developing shared metaphors in CBT conceptualisation.

These core ratings were made pre-training (T1), immediately after training (T2) and at 1 month (T3) and 3 months post-training (T4). The Likert scale measures were bespoke measures, developed specifically for this study after consultation with Dr James Bennett-Levy who had developed similar scales (Bennett-Levy & Padesky, 2014).

Immediately post training (T2), in addition to the core ratings, the therapists were asked to rate the training workshop itself (again using zero: not at all to four: extremely Likert scale ratings) in terms of the degree to which the training:

- stimulated interest;
- used appropriate teaching methods;
- provided relevant content;
- provided useful readings and handouts;
- balanced theoretical and applied learning;
- provided content at and appropriate level of difficulty;
- covered a manageable amount;
- was paced appropriately;
- provided enough practice

Therapists were also asked to rate the likelihood that they would recommend the workshop to a friend and to identify any barriers to implementing metaphor-enhanced CBT and how they would address these.

At one month (T3) and three months (T4) post-training, in addition to the core ratings the therapists were asked to rate their application of training (using the same Likert scales) to indicate to what extent:

- their frequency of metaphor use had increased;
- clients had responded well to metaphor-enhanced conceptualisations;
• they had used the Stem Sentence Test as a prompt;
• they had used the metaphor protocols provided;
• they had spent more time elaborating on client-generated metaphors;
• they had intentionally used metaphors during: engagement; goal setting; five- part model (conceptualisation); in rationales for thought records; during problem solving; in rationales for behavioural experiments and in relapse prevention.

They were again asked to describe barriers to using metaphors and how future workshops could address these. The T2-T4 questionnaires also had a section for other comments regarding metaphor experiences.

The questionnaires are provided in Appendix E.

The T3 and T4 questionnaires were administered via email.

7.3.4 Ethical approval

As noted in Chapter 6, ethical approval for this fourth study was received from the University of Otago Ethics committee. Details are provided in Appendix A.

7.3.5 Data analysis

Estimated marginal means were calculated on the five core ratings (extent, awareness confidence in metaphor use in CBT and confidence in metaphor use in conceptualisations), and a repeated measures ANOVA was used comparing total scores on the five core ratings, across T1, T2, T3 and T4, to test the effect of time. Mauchly’s assumption of sphericity was confirmed (F (3,33) =.56 p =.59). Pairwise comparisons were also used to test the effect of time for each of the specific core questions. Mauchly’s test of sphericity was conducted for each of these and it was assumed for all items except the question: Do you intentionally use metaphors in therapy?

The application ratings were analysed using paired samples two tailed t-tests.

7.4 Results

Likert scale ratings (0 not at all to 4 extremely) by the therapists of the quality of the workshops suggested these were well received with means ranging from 2.8-3.5 (N = 12). Mean scores are shown in Table 7.2.
Table 7.2. Therapist ratings of workshop quality

<table>
<thead>
<tr>
<th>Extent to which workshops:</th>
<th>Mean score (0 not at all to 4 extremely)</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stimulated my interest in using metaphors</td>
<td>3.4</td>
<td>.51</td>
</tr>
<tr>
<td>Used appropriate teaching methods</td>
<td>3.1</td>
<td>.79</td>
</tr>
<tr>
<td>Provided content relevant to my clinical work</td>
<td>3.2</td>
<td>.58</td>
</tr>
<tr>
<td>Provided useful additional readings and handouts</td>
<td>3.5</td>
<td>.67</td>
</tr>
<tr>
<td>Balanced theoretical and applied learning</td>
<td>2.8</td>
<td>1.06</td>
</tr>
<tr>
<td>Provided content at an appropriate level of difficulty</td>
<td>3.1</td>
<td>.79</td>
</tr>
<tr>
<td>Covered a manageable amount of material</td>
<td>2.8</td>
<td>.72</td>
</tr>
<tr>
<td>Paced the content appropriately</td>
<td>3.2</td>
<td>.72</td>
</tr>
<tr>
<td>Provided enough opportunity to practice clinical skills</td>
<td>2.7</td>
<td>1.23</td>
</tr>
<tr>
<td>Likelihood of recommending the workshops to a colleague</td>
<td>3.1</td>
<td>.90</td>
</tr>
</tbody>
</table>

Several additional written comments by therapists suggested they would have liked less theory and more role play practice, more workshop time, more written or video examples to observe and more discussion of each other’s use of metaphors in practice. Some therapists commented that role plays of a second therapy session were challenging, as they had not been able to do the usual engagement and information-gathering that would typically occur in a first session.

7.4.1 Core Question Results

Table 7.3 presents the core question total score and individual core question results (extent of intentional use; awareness of metaphors; importance of metaphor; confidence regarding intentional use of metaphor in CBT and in developing shared metaphors in CBT) at all four time points (T1, T2, T3 and T4).

The overall ANOVA for the Total scores on the five core question ratings was statistically significant ($p < .005$) with a small-medium effect size (based on Cohen’s guidelines (Cohen, 1988, pp. 284-287)). Mauchly’s assumption of sphericity was confirmed. Pairwise comparisons of the Total scores on the core ratings indicated that ratings increased, with statistically significant differences between T1-T2, T1-T3 and T1-T4.
Table 7.3. Data table showing core question totals and individual core question results across T1-T4.

<table>
<thead>
<tr>
<th>Question: to what extent…</th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
<th>T4</th>
<th>F</th>
<th>df</th>
<th>p</th>
<th>Effect size (partial eta squared)</th>
<th>Significant pairwise comparisons (p &lt; .05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Totals (Total of the 5 specific questions)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>5.6</td>
<td>3.33</td>
<td>.003</td>
<td>.34</td>
<td>T1 &lt; T2, T3, T4</td>
</tr>
<tr>
<td>Specific core questions: To what extent…</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you intentionally use metaphors in therapy?</td>
<td>2.4 (1.3)</td>
<td>2.5 (.91)</td>
<td>2.6 (1.0)</td>
<td>2.8 (.84)</td>
<td>.46</td>
<td>3.33</td>
<td>.72</td>
<td>.04</td>
<td></td>
</tr>
<tr>
<td>Do you think metaphors are important in therapy?</td>
<td>2.8 (.75)</td>
<td>3.1 (.67)</td>
<td>2.8 (.58)</td>
<td>2.9 (.67)</td>
<td>.94</td>
<td>3.33</td>
<td>.43</td>
<td>.08</td>
<td></td>
</tr>
<tr>
<td>Do you feel confident to respond intentionally to metaphors in your clinical work?</td>
<td>2.3 (.62)</td>
<td>2.8 (.62)</td>
<td>3.1 (.67)</td>
<td>2.9 (.52)</td>
<td>5.2</td>
<td>3.33</td>
<td>.005</td>
<td>.32</td>
<td>T1 &lt; T3, T4</td>
</tr>
<tr>
<td>Are you aware of metaphoric language occurring in treatment sessions?</td>
<td>2.2 (.72)</td>
<td>2.8 (.84)</td>
<td>3.2 (.58)</td>
<td>2.7 (.65)</td>
<td>4.5</td>
<td>3.33</td>
<td>.009</td>
<td>.29</td>
<td>T1 &lt; T3</td>
</tr>
<tr>
<td>Do you feel confident to develop shared metaphors with clients?</td>
<td>2.8 (.45)</td>
<td>3.2 (.84)</td>
<td>3.3 (.78)</td>
<td>3.1 (.67)</td>
<td>1.9</td>
<td>3.33</td>
<td>.16</td>
<td>.14</td>
<td></td>
</tr>
</tbody>
</table>

Notes: Effect size is partial eta squared
*Mauchly’s test of sphericity was not accepted, therefore pairwise comparisons not appropriate
There was no significant difference between T2-T3, T2-T4 or T3-T4. This means a significant difference was found between pre-training and post training mean of the overall total scores on the core questions, and pre-training and three months post training means of overall total scores on the core questions. The assumption was made that this is multivariate normal, but this was not able to be tested due to the small sample size. The results are shown in Figure 7.1. The biggest increase was between T1 (pre-training) and T3 (1 month post-training), with a slight drop off at T4 (3 months post-training).

![Figure 7.1. Mean total scores of core questions across T1-T4](chart)

### 7.4.2 Individual specific question results for the five core questions

For the specific question: *Do you feel confident to respond intentionally to metaphors in your clinical work?* pairwise comparisons indicated statistically significant differences between T1 and T3 ($F (3,33) = 5.2, p = .005$) and T1 and T4 ($F (3,33) = 5.2, p = .005$), with a small-medium effect size for the overall ANOVA. This means confidence improved between baseline and one month and held up as significantly different at 3 months.

For the specific question: *Are you aware of metaphoric language occurring in treatment sessions?* pairwise comparisons indicated significant differences between T1 and T3 ($F (3,33)$
= 4.51, \( p = .03 \)), with a small to medium effect size for the overall ANOVA. This means awareness increased significantly between pre-training and 1 month post training. T1-T2 was trending \(( p = .05 \)). The T4 mean was lower than the T2 mean suggesting a drop off in awareness, though this was not significant.

The overall ANOVAs for the other specific questions were not significant.

For the question: *Do you feel confident to develop shared metaphors with clients?* Sphericity could not be assumed \(( p = .156 \)), therefore pairwise comparisons were not appropriate.

### 7.4.3 Ongoing application of learning results (administered at T3 and T4)

Overall, 11/14 means for the *application* questions increased between T3 and T4. None decreased significantly. There was a statistically significant increase \(( p = .005, t(11)= -3.4 \) between T3 and T4 in terms of the amount of reported time spent elaborating on client-generated metaphors. There was also a significant increase between T3 and T4 of reported use of metaphors during use of the five-part model in conceptualisation \(( p = .03, t(11)= -2.6 \)).

There increase in use of the Stem Sentences Test (a method of prompting clients to generate metaphors) was trending \(( p = .05 \)). There were no statistically significant reported changes in the extent to which metaphors were intentionally used during: problem solving; goal-setting; in rationales for automatic thought records; rationales for behavioural experiments or in relapse prevention. Nor were there significant changes in ratings of frequency of intentional metaphor use or use of metaphor protocols provided during training.

### 7.4.4 Identified Barriers and solutions

Barriers to implementing metaphor enhanced CBT identified by therapists immediately post-training were: the cognitive capacity of the client; identifying metaphors in the first place; and the appropriateness for the client (taking therapy goals into consideration). Several therapists did not respond to this question. At one and three months post-training, identified barriers were: limited opportunity due to the nature of work being done (assessment only role); lacking time to go through the workshop materials; not remembering to consciously attend to subtle metaphors; lack of client uptake of metaphorical work; the challenge of integrating new behaviour and therapist work overload/fatigue. One therapist noted that not having a handy set of questions to ask to assist elaboration of metaphor was a barrier to use.

Solutions identified by therapists included: keeping metaphors in mind and actively reflecting; knowing it is all right to pull back when clients do not respond positively to
metaphor exploration and elaboration; and sharing with other therapists about their metaphor use.

7.4.5 Feedback from Therapists

The written self-report feedback comments in Table 7.4 from therapist participants’ post-workshop feedback (collected in the ‘Other comments’ section of the feedback forms) provide some qualitative support for the increases in confidence reported and suggest a degree of post-workshop reflection was occurring. Nine of the twelve therapists opted to provide additional written feedback. These have been grouped into themes of: benefits of metaphor, awareness of metaphor and suitability of metaphor.
### Benefits of metaphor

**T3**: I think clients like it when I pick up on their own metaphors, they feel heard.

**T3**: The metaphors developed were helpful for both me and the clients because the visual imagery associated with the metaphor easily summarised the client’s needs and goals. So when it came to reviewing how the previous week had gone and where the client sees themselves now, revisiting the metaphor helped keep us on track and focused on the client’s goals.

**T3**: I have been using the metaphor steps and combined this with drawing images, This I believe has led to a richer growth in client understanding of their process and a deeper recognition of issues facing them and ways of resolving these.

**T3**: [Metaphor use] provides depth and flavour to a client’s experience while also fostering that all important ‘shared understanding’ which is vital to a therapeutic relationship.

**T3**: I am aware [metaphor] can provide a platform for more elaborated exploration and a ‘short-cut’ for touching base with and consolidating the new processing and responses clients are wishing to establish.

**T4**: I found there is a deeper richness in capturing clients’ experiences, I have combined this with drawing images of the metaphors and it has appeared to generate greater problem solving/recognition of issues for some clients. For some clients it has enabled more focussed reflections and pathway choices.

### Awareness of metaphor

**T3**: I’ve been more aware of my own use of metaphors and I think more likely to notice and use client-generated metaphors since the workshop.

**T3**: I am more aware and run with the metaphors more, utilising the metaphor more fully.

### Suitability of metaphor

**T3**: Some clients seem to like it and others don’t. I tend to take their lead on that.

**T4**: I think some people pick them up and relate to them better than others. It is really rewarding when you introduce one and they start elaborating on it. It feels like there is a deeper understanding on both sides.

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*T3 feedback was provided at one month post-training; T4 was three months post-training*
7.5 Discussion

As far as can be ascertained, the study reported in this chapter is the first in the literature to describe the contents of a metaphor training programme for therapists and evaluate its effectiveness. Participants rated the quality of the workshops positively. They reported increased awareness of metaphors occurring in treatment sessions and increased confidence in responding intentionally to metaphors and bringing them into shared conceptualisations, as a result of training. The pattern of uptake of training alongside regular reflection (although not compared to a control group in this study) is consistent with the results reported by Bennett-Levy and Padesky (2014).

The improvement in the scores on awareness and confidence provide an indication that the training program was useful, though it is possible that increases in confidence may have been due to the therapist workshop attendees being self-effacing in relation to their existing use of metaphors prior to the workshop. The lack of significant change in ratings of importance of metaphor may have been because the therapists were a self-selecting group, who are unlikely to have attended the training unless they already believed metaphor to be important in therapy. Therapists who do not consider metaphors to be important might be less likely to benefit from training in metaphor-enhanced CBT.

In terms of the follow-up reports regarding application of workshop learning at one and three months, there were significant changes in terms of relatively structured application of training (use of the Stem Sentences Test, use of metaphors during conceptualising with the five-part model, and increase in time spent elaborating on client-generated metaphors). These were all specifically taught and practiced at the workshop, whereas there was only brief mention of application at other stages of therapy such as relapse prevention. It is possible that generalisation of learning to other stages in therapy will occur at a later stage, or it may need to be explicitly taught in a subsequent workshop.

This small-scale study found promising results regarding the impact of training experienced therapists in metaphor-enhanced CBT. However more research is needed, using control groups and larger samples, potentially also comparing experienced CBT therapists to less experienced therapists and looking at the impact of training over a longer period. Ideally, if evaluating training using video-recorded role plays, or simply practicing skills, the therapists would role play both sessions one and two, rather than session two alone, as therapists fed back that they found this difficult, due to not having developed engagement and drawn out client metaphor in the first session. Less certainty and confidence regarding their
understanding of the ‘client’ compared to how they would be feeling at session two in a usual clinical therapy interaction could affect their ability to demonstrate skill development. If possible, real therapy sessions could be used pre and post-training as a method of evaluating the training and providing feedback to therapists.

In future studies, an expanded qualitative study in which therapists are interviewed by an independent person regarding their training experience is recommended to provide a richer and more rigorous examination of participants’ responses.

Limitations of this study were the small sample size (due to the limited number of experienced local psychologists with an interest in and availability to attend the training) and the fact that there was no control group to assess to what extent the ongoing learning was as a result of the reflection process itself. The Likert scale ratings were a bespoke, un-validated measure developed for this study (due to the unavailability of existing validated measures), and self-report measures are prone to bias. However, small feasibility studies such as this study provide necessary preliminary information to identify problems, fine tune processes and provide data to inform subsequent phases of the research, which might include control group studies with larger samples (Tickle-Degnan, 2013).

Retention and uptake of future skills-based training could be improved by offering supervised practice post workshops (which could focus on generalisation of skills to other parts of CBT than conceptualisation) or offering feedback on an ongoing self-monitoring/reflective record of metaphor use. Future workshops would also be improved by allowing more time and increasing the number of audio or video therapy excerpts (possible via a self-access online resource) so therapists can further practice identifying metaphors and ways of responding to them. Having a handy metaphor protocol to guide exploration of identified client metaphors, may also prove useful for some therapists, particularly in the early stages of applying metaphor enhanced CBT.

CBT continues to evolve, with the development of so-called ‘third wave’ CBT related therapies over the past twenty years. Most recently, ‘process-based therapy’ has been proposed as a way forward, i.e. an evidence-based search for powerful and coherent change processes (Hayes & Hofmann, 2017). Further exploration of the effects of metaphor use in therapy fits well with this direction, as it aims to enhance outcomes by identifying and enhancing a potentially potent element of therapy.
Based on therapist self-report, training in metaphor-enhanced CBT, supported by ongoing structured reflection on learning, appeared to have an ongoing impact for three months post-training, particularly in terms of increased awareness and confidence. Post-workshop reflection by means of a structured questionnaire is one way to assist ongoing uptake of learning. It would seem that therapists can learn to keep metaphors in mind and that training workshops of this sort are one way that therapists can learn to achieve this.

7.6 Chapter summary

While there has been increasing interest in the use of metaphor in cognitive behaviour therapy, there has been no previous research into how to training therapists use metaphors in CBT. Details are provided of a metaphor-enhanced CBT training workshop which was provided to twelve therapists. The therapists rated the workshop quality and provided structured self-report ratings and reflections on their ongoing application of learning over a three-month period which were compared to pre-training ratings. Therapists reported significantly increased awareness of metaphors, with increased confidence in responding intentionally to client metaphors and bringing them into shared conceptualisations. In addition, there were significant increases in reported time spent elaborating on client metaphors and use of metaphors when conceptualising with clients.

The next chapter will discuss the overall conclusions and implications of the four studies that comprise this thesis and consider future research directions.
Chapter 8  
Discussion and Conclusions

8.1 Introduction

The overall aim of this thesis research was to begin the process of building an empirical literature around the use of metaphor in CBT. This chapter will summarise the main findings, discuss these findings and consider the theoretical implications. Future research directions will be discussed in terms of both building directly on the four studies that comprise this thesis and also wider possibilities identified during the literature review process.

8.2 Summary of main findings

The first three chapters of this thesis described how metaphors are pervasive in language, rich with meaning and difficult to define and identify. While CMT is the dominant theory in the area, Dynamic Systems theory has benefits for researching therapeutic conversational interactions, takes context into account, and sits within constructivism. CBT is also a constructivist approach and the model proposed by Stott et al, (2010) is consistent with a Dynamic Systems approach. Previous literature on metaphor in CBT was based on clinical observations rather than empirical research and tended to focus on therapist-delivered metaphors rather than client or co-constructed metaphors, which are likely to be more meaningful to the client. There are many assertions as to the functions of metaphors in psychotherapy, but the empirical literature is limited and has methodological problems. There is a range of potential methodological options for investigating metaphors empirically and these were outlined for the benefit of future researchers.

The four empirical studies within this thesis explore metaphor use in CBT. The first study explored how metaphors can be identified reliably in therapy conversations. The Discourse Dynamics approach was used to identify naturally occurring metaphors in CBT sessions and determine their frequency (Cameron & Maslen, 2010) and the reliability and utility of this method was assessed. A frequency of 31.5 metaphoric words or phrases per 1000 words of conversation was found in forty-eight transcribed regular CBT sessions, which was similar to other literature on metaphor frequency in therapy. The reliability of this approach was found to be adequate and it yielded potentially useful information. However, learning this approach was time-consuming and challenging, although it was possible for a non-linguist to acquire the necessary skills.
The second study explored how therapists and clients co-construct metaphors. An iterative process was used to explore how clients and therapists co-construct metaphors, contributing to development of a shared language in early therapy sessions. This analysis examined the extent to which therapists or clients initiated metaphoric exchanges, and how these were responded to. Bursts of metaphoric exchange were initiated and taken up by therapists and clients at a similar rate. This study also identified several types of response to metaphors initiations (repetition, rephrasing, clarification, elaboration/extension, or agreement).

The third study trained therapists in metaphor-enhanced CBT and explored what happens when metaphor is intentionally used in CBT conceptualisation and whether metaphors suit some clients and therapists better than others. The data comprised video-recorded pre- and post-training role played therapy sessions which were independently rated by an experienced CBT practitioner, and participant self-report measures. Significant increases were found in some aspects of therapy alliance, based on role play ‘client’ ratings and on the independent external ratings of the role-played therapy sessions before and after training. Correlations between ratings of preference for metaphoric language and alliance ratings suggested that working metaphorically may be most effective when the therapist and client have a similar degree of preference for speaking metaphorically.

The fourth study described the metaphor training provided and explored its impact based on therapist self-report ratings and reflections on their ongoing application of learning over a three-month period. These were compared to pre-training therapist ratings. Therapists reported the following effects: significantly increased awareness of metaphors; increased confidence in responding intentionally to client metaphors and bringing them into shared conceptualisations; significant increases in reported time spent elaborating on client metaphors; and significantly increased use of metaphors when conceptualising with clients. Barriers and solutions to application of learning were also identified.

While there are no existing empirical studies within the CBT literature with which to compare these findings, the results have been consistent with some studies in the broader metaphor-in-psychotherapy literature, particularly in terms of frequency of metaphor use in therapy and therapist and client responses to each other’s metaphors as part of the ‘metaphoric dance’. Details of these consistencies have been provided in the relevant chapters.
8.3 Strengths of this thesis

This thesis has made a contribution to the development of research methodology in this challenging interdisciplinary field through finding a suitable definition and identification method for analysing metaphors in the dynamic conversational context that is therapy, and by demonstrating that metaphor in CBT can be usefully explored through a constructivist/Dynamic Systems lens. The co-construction described in Chapter 5 supports the constructivist position of individuals as active meaning-makers. Such analysis allows the researcher to study the unfolding therapy conversation over time. This is consistent with the Dynamic Systems model, like Barnard and Teasdale’s ICS model of how we process meaning and emotions (Barnard & Teasdale, 2008) (section 1.7.2) and Stott et al.’s conceptual framework for metaphor in CBT (Stott et al., 2010) (section 2.11).

The series of four studies reported here represents the first empirical research into the impact of metaphor in CBT, producing findings that affirm the significance of metaphor in psychotherapy. The new knowledge that has been generated provides important groundwork for further exploring a range of theoretical and applied questions (see section 8.5 below).

Perhaps the greatest strength of this thesis is that it has taken the empirical study of metaphors in CBT out of the ‘too hard basket’. It shows that CBT can go beyond clinical observation and exhortation regarding metaphor use in therapy. While this is preliminary work comprising a set of small studies, these were carefully designed so that each part built on the questions answered in the previous one. Together they form a whole that is greater than the simple sum of the parts. Taken in combination, the four studies in this thesis show that a systematic approach to building understanding of metaphor use is possible.

This groundwork provides a basis for the future research directions laid out below in section 8.5. The thesis has provided an essential starting point to inform future research into metaphor use in CBT by clearly delineating the existing literature, and the theoretical and methodological context. It demonstrates that metaphors can be identified with adequate reliability and patterns of usage can be explored based on this.

The focus on client metaphors and joint co-construction of metaphors is a shift from the majority of the clinical literature which has focussed on therapist-delivered metaphors, and this is a particular strength of this thesis. CBT is intended to be a collaborative, Socratic process rather than something that is ‘delivered’ by the therapist. Therefore, if we can attend
to, explore and work with the client’s metaphors, this is likely to be more meaningful to the client.

In addition, the Dynamic Systems lens and Discourse Dynamics method takes into account the interactional therapeutic context emphasised by Dynamic Systems theory, rather than evaluating de-contextualised phrases. Therapy sessions are fast moving, somewhat unpredictable but focused conversations with considerable spontaneity. The approach used in this thesis has allowed naturally occurring metaphors within such therapist-client interactions to be explored.

The thesis also shows that therapists can be trained to use metaphors intentionally in therapy and that this can assist therapy alliance. Metaphors are a rich source of meaning for therapists to explore. As discussed in section 2.4.2, alliance is a vital therapy process variable\textsuperscript{15} that contributes strongly to therapy outcome. Therefore, this thesis has potential to contribute towards new developments in therapy practice, in terms of future training of CBT therapists to use metaphor protocols routinely in practice so as to enhance therapy alliance.

The four studies comprising this thesis also make a distinctive methodological contribution to research on metaphor and CBT through the use of innovative mixed methods approaches within an inter-disciplinary framework. Researchers from different academic fields tend to work within fairly distinct communities of knowledge, with specific frameworks and preferred methodologies. Our understanding may be enriched by fostering connections between communities of knowledge (Castonguay, 2011). The timing of this thesis was fortunate in that the Discourse Dynamics approach to metaphor identification had recently been developed by linguists. The interdisciplinary supervision panel for this thesis of a linguist and clinical psychologist has provided a rich collaboration, bringing different perspectives and approaches. While metaphors may serve as therapeutic bridges, these studies also serve as an important bridge between different research communities.

Finally, this thesis also makes a contribution to psychotherapy process research, in that intentional metaphoric language is part of how CBT is conducted. For many years the process aspects of CBT, although clearly present and necessary, were relatively neglected at the expense of the technical competence in delivery of CBT-specific strategies. The efficacy and effectiveness of CBT is now well established, but the question of exactly how it works is not fully resolved (Newman, 2015). There is considerable debate as to whether non-specific

\textsuperscript{15} Therapy process refers to factors relating to how therapy is conducted rather than specific intervention techniques.
common factors or specific techniques are to be considered as the essential ingredients of therapeutic change (Miller, Hubble, Chow, & Seidel, 2013). Rather than investigating therapy-specific aspects of outcome, research endeavours are now exploring powerful change processes in therapy and there is a shift by therapists towards process-based therapy practice (Hayes & Hofmann, 2017). The findings of this thesis suggest that intentional use of metaphorical language may prove to be an important process variable. In particular, it may be relevant to exploring patterns in the development of alliance (Weiss, Kivity, & Huppert, 2014).

8.4 Limitations of this thesis

Specific limitations of the four studies comprising this thesis have been discussed in detail in the relevant chapters. A broader limitation of this research is the fact that all the component studies are small and preliminary, and therefore only cautious conclusions can be drawn.

The method of identifying metaphors used was found to be only adequate in terms of reliability. This means some caution is needed in interpreting results. While the identification method used was the most operationalised approach available and was suitable for conversational data, the first study found that a degree of subjectivity remained as to whether words and phrases were metaphorical or not. This is consistent with recent developments in empirical metaphor research that suggest there may not be a fundamental distinction between literal and figurative language (Gibbs & Colston, 2012). This does not mean that Cameron and Maslen’s approach is not valuable, but simply that identifying metaphors in this way is only one part of the complex challenge of investigating metaphors in therapy. Supervision by a linguist is recommended for future research using the Discourse Dynamics method.

The analysis in the first and second studies (Chapters 4 and 5) was based on written transcripts of audiotaped sessions; these had some unclear passages and omissions due to poor sound quality, and the transcripts omitted gestural information, other prosodic features and embodied aspects of interaction. This may have reduced the frequency of metaphors identified. Future studies would benefit from having recordings available for analysis in addition to transcripts, and the ideal would be to use video-recordings rather than audio-recordings.

There was also a gender imbalance in participants with 75% female clients in the therapy transcripts analysed in the first and second studies, and both therapists and clients were mostly female in studies three and four (Chapters 6 and 7). This gender imbalance means that
findings were not necessarily representative. As well as using larger samples, future studies will need to ensure a gender balance and consider other demographic factors such as the age and cultural background of the clients.

Further, there were some limitations in terms of applicability to practice. While this thesis found that attention to metaphors is an opportunity to enhance conceptualisation by contributing to the strength of the therapy alliance, significantly improved scores were not found on all alliance sub-scales and measures in Chapter 7, possibly due to the small size of the sample. Secondly, this thesis did not directly examine whether intentional metaphor use had a positive effect on treatment outcomes for clients such as reduced distress or improved functioning. Nor is this thesis claiming that any and all metaphor use is necessarily productive, beneficial for alliance, or beneficial in other ways. In fact, the third study (Chapter 6) identified that a mismatch between therapist and client in preference for metaphor is important and needs to be taken into account.

8.5 Future research directions

There are many other areas that are ripe for future investigation, potentially using the methods outlined in Chapter 3. This section has been divided into four parts. First, research directions that follow directly from this thesis will be described, then research suggestions from the CBT literature will be outlined, followed by discussion of possibilities for broader research on metaphor in psychotherapy, of relevance to CBT. Finally, general recommendations for future research in this area will be provided.

8.5.1 Research following directly from this thesis

Specific suggestions for future research based on the four studies in this thesis are made at the end of chapters 4-7. Key points from these chapters are summarised here along with some additional suggestions.

As noted in Chapter 4, because the Discourse Dynamics metaphor identification procedure is quite broad, further studies will be needed to test its clinical application, particularly ways to reliably identify clients’ central metaphoric conceptualisations, described as ‘metaphoric kernel statements’ by Witztum, van der Hart, and Friedman (1988). Future studies could usefully explore whether attending to client metaphors benefits other parts of sessions such as engagement with homework, and relapse prevention. Future research could also consider whether these findings generalise to client presentations other than depression, whether
training in metaphor enhanced CBT has continued impact on alliance over time, and whether the same training effect would be found with inexperienced CBT therapists.

The most obvious next step to extend the findings of this thesis would be to assess the impact of training therapists in metaphor enhanced CBT in sessions with real therapy clients. If conducting such a study using video-recordings it may be useful to record the first session and at least the next two sessions. Such a study could potentially use a single case experimental design (Kazdin, 2011) to investigate the clinical impact of bringing client metaphors (or collaboratively developed metaphors) into therapy. An example of this method is provided by (Hague, Scott, & Kellett, 2015). Such an approach fits well with process research.

There is also scope for a more detailed analysis of metaphor co-construction, capturing the richness and meaning of metaphor use, as it emerges across as series of therapy sessions. The method recently developed by (Cocklin et al., 2017), involving clients looking at recordings of sessions and making a rating on the Session Rating Scale every two minutes, could be used to assess client responses during sessions. Future studies can further investigate when and how a metaphor is introduced; what work it does; how it is further shaped by the client and therapist; what it means and how meanings change; how it works in conjunction with other rhetorical devices and how metaphors are part of wider cultural discourses (McMullen, 2008). Use of video recordings would have the benefit of allowing analysis of metaphoric gestures.

In Chapter 4, a method of identifying Elementary Discourse units (idea units containing metaphoric words or phrases) in written transcripts of CBT sessions is described. This approach (similar to ‘intonation units’ which were used by Cameron and Maslen) could be used to investigate a series of recorded sessions with a client, using the approach to identifying systematic metaphors described by Cameron and Maslen (2010), to explore how metaphoric themes develop in therapy.

Qualitative work, assessing clients’ responses to metaphors in therapy, would add richness and depth to such a study. Thematic Analysis could be used to explore client’s experiences of bringing metaphor into CBT conceptualisation, along the lines of a study by Kahlon, Neal, and Patterson (2014), who explored the experiences of CBT formulation in depression. Some form of interactional analysis would also potentially be very fruitful. This might include, for example, looking at longer sequences or ‘bursts’ of metaphorical talk and how these are structured and unfold, or building on previous work in applied conversation analysis of psychotherapy sessions looking at formulations and alliance (Voutilainen & Perakyla, 2016; Weiste, Voutilainen, & Perakyla, 2016) by adding a focus on co-construction of metaphor.
Future research into individual differences in metaphor use could further investigate preference for metaphor and the extent to which metaphors may suit some people more than others. Use of a larger sample would increase confidence in the results. Possible research questions include: What factors affect the uptake of therapist metaphors by clients? Does it make a difference if you like the therapist? Does it make a difference if you perceive the therapist as competent? Does the therapist’s professional background make a difference? Does cultural attunement affect preference? To what extent do individual differences impact on the therapeutic value of metaphor (e.g. age differences; people high/low on cognitive flexibility such as people on the autistic spectrum) (Stott et al., 2010)?

8.5.2 Other future research areas with particular relevance to metaphor in CBT

Various research possibilities were identified within the CBT metaphor literature as warranting further exploration. Where these were suggested by other researchers, the references have been provided. Possible topics and questions include:

a) Further investigation of the function of metaphors:
   - In what ways do metaphors impact the cognitive system and how might they be useful in assisting people to change (Stott et al., 2010)?
   - Under what conditions could metaphors ‘work’ differently than literal language’?
     According to McCurry and Hayes (1992, p. 768), this could be done through:
     - establishing factors that influence the memorability of metaphorical expressions.
     - determining what factors enhance metaphor comprehension.
     - determining what factors improve the aesthetic quality or aptness of metaphors.
     - identifying client and therapist factors that enhance or decrease metaphor efficacy.
     - investigating the interpersonal or environmental variables that make a metaphor function differently.

b) Further exploration of the extent and manner of metaphor use in CBT?

This could include:
   - Is there a rationale for the given (therapist-delivered) metaphor?
   - Are (therapist-delivered) metaphors used consistent with the conceptualisation or underpinning theory?
   - What is the mode of delivery of therapist metaphor (Socratic or Didactic)?
o To what extent are the implications of the metaphor carried through e.g. for future client behaviour (Stott et al., 2010)?

c) How well does the ‘Conceptual framework for metaphor in CBT’ proposed by Stott et al. (2010) (described in section 2.11) stand up to empirical testing? Does it need developing or refining?

d) Do metaphors assist memory?

  o Experimental studies could examine the extent to which metaphor impacts differentially on encoding versus retrieval of memories (Stott et al., 2010). The function of metaphors as a memory aid could be investigated both in clinical and analogue populations (Stott, 2010, personal communication 10/11/2010).

  o Does metaphor really does become a form of shorthand? Therapists may think they are giving clients something to ‘hang onto’ by using metaphors or developing shared metaphors; but does it really become a short-hand from the client’s point of view? Does it actually reduce the cognitive load for clients and/or therapists?

e) Given that sudden gains in therapeutic alliance can occur (Foster, 2011), could metaphor be a factor in such gains?

f) How important is the vividness of a metaphor in therapy? Is it important whether there is a match between therapist and client in terms of how vivid the metaphor is?

  This could potentially be explored using the Vividness of Visual Imagery Questionnaire (Eton, Gilner, & Munz, 1998; McKelvie, 1995). Such an exploration could also consider how this interacts with the appropriateness of metaphor. The metaphor may not be vivid but may still be appropriate (or the converse).

g) To what extent can clients flexibly apply a newly acquired therapist-delivered metaphor? For example, rumination may be metaphorically compared to ‘tangles of spaghetti’, but it is not clear whether this can be helpfully drawn on outside the therapy room in order to reduce the frequency of rumination (Stott et al., 2010)?

h) Given that many metaphors are applicable trans-diagnostically, what might be the impact of different therapist-delivered metaphors across different diagnostic groupings (Stott et al., 2010)?

i) What is the effect of the degree of emotional content of a metaphor and what impact might this have in different contexts (such as in PSTD, where metaphor may help clients to process difficult material, through being less direct) (Stott et al., 2010)?
j) Are there differences between metaphor use and its effects in CBT versus other kinds of therapy?

**8.5.3 Broader research ideas on metaphor in psychotherapy**

A number of future research ideas emerged during the literature review. Again, where these were suggested by other researchers, the references have been provided. Future researchers into metaphor in therapy (either within or outside the CBT field) may wish to consider exploring the following questions:

a) When does a metaphor work and when does it not work? (McMullen, 2010). Are there specific applications of metaphor that may do harm, or different ways of using metaphors that are more helpful?

There is some literature to suggest that metaphors may be used in different ways in therapy and have different impacts (Angus & Rennie, 1988; Rasmussen & Angus, 1996), but this area would benefit from further exploration. For example, an analogue study could be conducted where people come to talk about a problem that they are stuck with and the intervention either involves metaphorical imagery and questioning around this or some kind of control condition (such as reflective listening (a motivational interviewing technique) and levels of distress about the problem and client-rated effectiveness of the intervention could be assessed.

b) What might be the cross-cultural applications of metaphor (Dwairy, 2009) and how might this apply in the therapy context? In particular, what is the role of culture in conceptualisation, application and utility of metaphors?

As noted in Chapter 1, there will be commonalities across speakers with similar cultural experiences and from our shared physical interactions with the world, but there will also be many individual differences’ (Cameron, 2008b, p. 46). Sensitivity to culturally specific and salient metaphors may assist (Ahammed, 2010; Dwairy, 2009).

c) What is the effect of deliberate use of metaphor?

As noted in Chapter 1, deliberate use of metaphor is an emerging research area (Reijnierse, Burgers, Krennmayr, & Steen, 2018). One possibility would be to study therapists who endorse deliberate use of metaphor and do a case series exploring the effects of metaphor use over time on key appraisals and symptoms.

d) In what ways might clients resist metaphor (and how can therapists respond when this occurs?). Does resistance to metaphor correlate with more general resistance in therapy? As noted in Chapter 1, ‘resistance’ to metaphor is currently being
investigated by Steen and colleagues. A fuller understanding of such resistance may have applications in the therapy context.

e) Given that metaphors draw on our physical, embodied experience, is this a further way in which metaphors may contribute to the therapy process?

Embodied cognition (see 1.7.1) is a developing research area and may be a common factor in therapy (Tschacher & Pfammatter, 2017). Bringing metaphor into shared conceptualisations as the therapists were trained to do in Chapter 6 may be a powerful way of accessing and working with such embodied cognition. This is consistent with working with the interacting cognitive subsystems holistic implicational system (Barnard & Teasdale, 2008) (section 1.7.2).

8.5.4 General recommendations for future research

Research in this area will face the challenges of assessing the effectiveness of metaphor and explaining the therapeutic mechanisms of metaphor beyond what has been tentatively established in this thesis. Researchers will also need to embrace the inherent cross-disciplinarity of psychotherapeutic metaphor research. Psychologists need to keep abreast of the relevant theoretical nuances emerging from (psycho) linguistic research, while linguists need to move beyond simply seeing therapy talk as a conversational context and move towards discussing how theoretical knowledge might help address specific mental health concerns. As Tay (2017) observes, we need to work together collaboratively to achieve this.

Future research needs to take into account context and not necessarily focus solely on metaphors: McMullen (2008, p. 408) writes that “one way to begin thinking about what a contextual approach would entail is to start not with a focus on metaphors, per se, but rather on events of clinical interest”. To use a metaphor is an act and to understand its point, we need to take an interest in the consequences of this act in the context of which it is used.

Successful application of a therapist-delivered metaphor in therapy may, for example, depend on a therapist weaving it skilfully into the therapy dialogue, picking up sensitively on factors such as whether it has captured the client's attention, whether it 'resonates' for the client, and adjusting the amount of Socratic dialogue needed to check that the client has understood the intended message and is able to relate it to their own concerns. One way to explore the clinical impact of metaphor in therapy would be to use recordings from existing randomised controlled trials of CBT and compare good and poor outcome clients, looking at therapy tapes for skilful metaphor use to see if there is any correlation. However, a clinical research paradigm which ignores all the contextual factors and simply looks at the metaphor in
isolation, may prove problematic and to be of limited clinical benefit. (See also other methodological considerations in Chapter 3).

Clearly there are many interesting questions yet to be answered regarding metaphor in therapy which arise from considering both the broader psychotherapy literature and the CBT literature\textsuperscript{16}.

\subsection*{8.6 Conclusion}

Psychological therapies depend on language; therefore, given that metaphor is pervasive in language, they depend at least to an extent on metaphor. Collaborative metaphor-making offers possibilities in terms of enhancing or altering how experiences are viewed. Trying to fully pin down the process is unlikely to be possible. Language is slippery and inexact, culturally nuanced and subjective; therefore uncertainty is to be expected. However, through collaborative metaphor making we may be able to organise experience without needing or expecting to pin it down in any final sense (Seiden, 2004).

Speaking a client’s language has long been seen as a means to join with clients, build trust and bring about the necessary and sufficient conditions for change (Rogers, 1957). Therapists who are able to evoke and attend to metaphor and communicate in a way that is congruent with their clients’ conceptual metaphor systems may be able to communicate more deeply and empathically, by helping clients explore the logical conclusions and consequences of their metaphors more effectively. Each client brings a set of existing metaphors and experiences which structure their idiosyncratic language and understanding. Therapists can increase common understanding with clients by consciously exploring metaphor mappings as part of the therapeutic conversation. Meaningful communication is a key component of conceptualisation. Metaphors affect how we influence others and how others attempt to make sense of their experience and the answers may be found in their words, not ours.

Metaphor research is methodologically challenging, and metaphor research in CBT is an emergent area. Having said that, as demonstrated in this thesis, empirical research into metaphor in CBT is not beyond the bounds of possibility and practicability. Exciting future research possibilities abound. While the CBT approach tends to focus on changing thoughts and beliefs in order to reduce distress, future CBT can likely benefit from changing both

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\textsuperscript{16} Future researchers into metaphor in therapy are strongly encouraged to join the Researching and Applying Metaphor organisation (RaAM.org.uk) as their conferences are an extremely useful way to update as to interdisciplinary advances in the field.
thoughts and metaphors in order to reduce distress. Metaphoric language is a rich source of meaning that therapists can draw on in CBT. Where necessary, collaboratively developed metaphors can be generated which more helpfully represent the client’s situation, along with possible new actions or ways forward. Metaphor may indeed (as suggested by Goncalves and Craine (1990)) offer a privileged route to access structures of meaning that remain resistant to our traditional therapeutic efforts in cognitive therapy.

I would like to finish with a couple of quotes:

He moana pupepuke e ekengia e te waka *A rough sea can still be navigated*
(Traditional Maori proverb) (Ryan, 1996)

Metaphor is a medium of fuller, riper knowing (Wheelwright, 1954)
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Appendices

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Appendix A. Ethics Approval

Dr M Stubbe
Department of Primary Health Care and General Practice (Wgnt)
Faculty of Medicine
University of Otago, Wellington

22 April 2013

Dear Dr Stubbe,

I am writing to let you know that, at its recent meeting, the Ethics Committee considered your proposal entitled “Metaphor in Cognitive Behaviour Therapy”.

As a result of that consideration, the current status of your proposal is: Approved

For your future reference, the Ethics Committee’s reference code for this project is: 13/140.

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

Yours sincerely,

[Signature]

Mr Gary Witte
Manager, Academic Committees
Tel: 479 8256
Email: gary.witte@otago.ac.nz

c.c. Assoc. Prof. S R H Pullon Department of Primary Health Care and General Practice (Wgnt)
Ngāi Tahu Research Consultation Committee  
Te Komiti Rakahau ki Kai Tahu

Tuesday, 19 March 2013.

Dr Maria Stubbe,  
Wellington School of Medicine,  
WSM&HS.

Tēnā Koe Dr Maria Stubbe,

Metaphor in Cognitive Behaviour Therapy

The Ngāi Tahu Research Consultation Committee (The Committee) met on Tuesday, 19 March 2013 to discuss your research proposition.

By way of introduction, this response from The Committee is provided as part of the Memorandum of Understanding between Te Rūnanga o Ngāi Tahu and the University. In the statement of principles of the memorandum it states “Ngāi Tahu acknowledges that the consultation process outlined in this policy provides no power of veto by Ngāi Tahu to research undertaken at the University of Otago". As such, this response is not “approval” or “mandate” for the research, rather it is a mandated response from a Ngāi Tahu appointed committee. This process is part of a number of requirements for researchers to undertake and does not cover other issues relating to ethics, including methodology they are separate requirements with other committees, for example the Human Ethics Committee, etc.

Within the context of the Policy for Research Consultation with Māori, the Committee base consultation on that defined by Justice McGechan:

“Consultation does not mean negotiation or agreement. It means: setting out a proposal not fully decided upon; adequately informing a party about relevant information upon which the proposal is based; listening to what the others have to say with an open mind (in that there is room to be persuaded against the proposal); undertaking that task in a genuine and not cosmetic manner. Reaching a decision that may or may not alter the original proposal.”

The Committee considers the research to be of interest and importance.

As this study involves human participants, the Committee strongly encourage that ethnicity data be collected as part of the research project. That is the questions on self-identified ethnicity and descent, these questions are contained in the 2006 census.

We wish you every success in your research and The Committee also requests a copy of the research findings.

This letter of suggestion, recommendation and advice is current for an 18 month period from Tuesday, 19 March 2013 to 8 September 2014.

Nīho kō, rd

Mark Brown  
Karetuhua Rangahau Māori  
Research Manager Māori  
Research Division  
Te Whare Rūnanga o Otago  
Ph: +64 3 479 9738  
Email: mark.brown@otago.ac.nz  
Web: www.otago.ac.nz

The Ngāi Tahu Research Consultation Committee has membership from:
Te Rūnanga o Ōtāhuhu Incorporated  
Kāti Huirapa Rūnanga o Pakekākāriki  
Te Rūnanga o Moutaki

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Wednesday, 18 February 2015.

Dr Maria Stubbe,  
Wellington School of Medicine,  
WSM&HS.

Tēnā Ko e Dr Maria Stubbe,

Metaphor enhanced cognitive behaviour therapy

The Ngāi Tahu Research Consultation Committee (the committee) met on Wednesday, 18 February 2015 to discuss your research proposition.

By way of introduction, this response from The Committee is provided as part of the Memorandum of Understanding between Te Rūnanga o Ngāi Tahu and the University. In the statement of principles of the memorandum it states "Ngāi Tahu acknowledges that the consultation process outlined in this policy provides no power of veto by Ngāi Tahu to research undertaken at the University of Otago". As such, this response is not "approval" or "mandate" for the research, rather it is a mandated response from a Ngāi Tahu appointed committee. This process is part of a number of requirements for researchers to undertake and does not cover other issues relating to ethics, including methodology they are separate requirements with other committees, for example the Human Ethics Committee, etc.

Within the context of the Policy for Research Consultation with Māori, the Committee base consultation on that defined by Justice McGechan:

"Consultation does not mean negotiation or agreement. It means: setting out a proposal not fully decided upon; adequately informing a party about relevant information upon which the proposal is based; listening to what the others have to say with an open mind (in that there is room to be persuaded against the proposal); undertaking that task in a genuine and not cosmetic manner. Reaching a decision that may or may not alter the original proposal."

The Committee considers the research to be of interest and importance.

As this study involves human participants, the Committee strongly encourage that ethnicity data be collected as part of the research project. That is the questions on self-identified ethnicity and descent, these questions are contained in the latest census.

The Committee suggests dissemination of the research findings to Māori health organisations regarding this study. We wish you every success in your research and the committee also requests a copy of the research findings.

This letter of suggestion, recommendation and advice is current for an 18 month period from Wednesday, 18 February 2015 to 18 August 2016.

Mark Brunton  
Karetuhau Rangahau Mōtori  
Research Manager Mōtori  
Research Division  
Te Whare Wānanga o Ōtago  
P: +64 3 479 8735  
Email: mark.brunton@otago.ac.nz  
Web: www.otago.ac.nz

The Ngāi Tahu Research Consultation Committee has membership from:

Te Rūnanga o Ōtautara Incorporated  
Kāti Huirapa Rūnaka ki Puketawhiru  
Te Rūnanga o Moeraki
Dr M Stubbe  
Department of Primary Health Care and General Practice (Wgnt)  
Faculty of Medicine  
University of Otago, Wellington

20 February 2015

Dear Dr Stubbe,

I am writing to let you know that, at its recent meeting, the Ethics Committee considered your proposal entitled "Metaphor enhanced cognitive behaviour therapy".

As a result of that consideration, the current status of your proposal is:- Approved

For your future reference, the Ethics Committee’s reference code for this project is:- 15/017.

The comments and views expressed by the Ethics Committee concerning your proposal are as follows:-

While approving the application, the Committee would be grateful if you would respond to the following:

The Committee asks that item 4 on the Consent Form is separated out in to two points; 1) the potential discomfort and 2) the nature of financial reimbursement.

Please provide the Committee with copies of the updated documents, where changes have been necessary.

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

Yours sincerely,

[Signature]

Mr Gary Witte  
Manager, Academic Committees  
Tel: 479 8256  
Email: gary.witte@otago.ac.nz

c.c. Assoc. Prof. S R H Pullon  
Department of Primary Health Care and General Practice (Wgnt)
Appendix B. MOU CBT IPT study

Memorandum of Understanding

1. Parties to the Memorandum:

Professor Peter Joyce, Dean, University of Otago, Christchurch (UOC)  
Principal investigator for “The predictors of response to cognitive behavior therapy and interpersonal psychotherapy for depression” (IPT CBT) study

Dr Janet Carter, Psychology Department, University of Canterbury  
Principal investigator, Psychotherapy process study

Dr Jennifer Jordan, Department of Psychological Medicine, UOC

Fiona Mathieson, Department of Psychological Medicine, University of Otago, Wellington (UOW)

Dr Maria Stubbe, Department of Primary Health Care and General Practice, UOW

2. Short Title of Project: Metaphor in Cognitive Behaviour Therapy

3. Term of Research Project: April 2013 until the completion of this PhD

4. Brief Description of Roles of parties to this agreement:

Ms Fiona Mathieson is conducting PhD research into the use of metaphors in cognitive behaviour therapy. She proposes to analyse de-identified transcripts of CBT therapy sessions (using linguistic analysis), from the ‘Predictors of response to interpersonal psychotherapy and cognitive behaviour therapy for depression’ (IPT CBT) study which have already been transcribed for the ‘Psychotherapy Process study’. This research will form an initial part of her PhD thesis. The study of the use of metaphors in cognitive therapy fits within the broad goals of the IPT CBT study, which were about client response to therapy and therapy quality.

Jennifer Jordan and Maria Stubbe (primary supervisor) are supervisors for her thesis and will also have access to the transcripts. Jennifer Jordan is also an investigator on the Psychotherapy Process study, and will act in a liaison role between Fiona and the other investigators. Fiona Mathieson, Jennifer Jordan and Maria Stubbe will not have access to the original audio recordings of sessions.

Janet Carter is the PI on the Psychotherapy Process study and an investigator on the IPT CBT study. Professor Joyce is the PI on the IPT CBT study and an investigator on the Psychotherapy Process study. It is not planned that the principal investigators of the original studies will be involved in this particular research project unless this is specifically negotiated. Associate Professor Carter will act as a consultant in relation to publication of these data.

5. Use of data

- Approval to use the data is limited to this proposal and use of data beyond this approval must come back to the original PIs (Joyce and Carter).
• The original data belong to the original team and are not to be distributed to third parties.
• The metaphor analyses and the intellectual property resulting from this belong to Fiona Mathieson.
• Publication is likely after this research. There may be the opportunity for PIs to be co-authors, or for original investigators to be involved in the paper if they can make a meaningful contribution to the project, in line with standard expectations of authorship.
• The description of the original trial/study is to be approved by the PIs of the original studies to ensure consistency with other publications. Acknowledgement of the original study should be made in all publications.
• Ethical approval is the responsibility of Fiona Mathieson, in conjunction with her supervisors and the PIs of the original studies.
• In verbal presentations or written material, no identifying information can be used in line with ethics approval and best practice.
• Storage and disposal of data. Original transcripts are required to be stored securely by Fiona Mathieson and will be destroyed 10 years after the completion of the research.

6. Funding:
No funding is associated with this MOU. Any direct costs in printing materials or transcribing for the purpose of this study will be met by Fiona Mathieson.

7. Agreement:

This Memorandum formalises the intention of the parties to collaborate in the research project outlined above and to enter into a sub-contract.

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Professor Peter Joyce</td>
<td>[Signature]</td>
<td>5-6-13</td>
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<tr>
<td>Dr Janet Carter</td>
<td></td>
<td>5-6-13</td>
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<tr>
<td>Dr Jennifer Jordan</td>
<td>[Signature]</td>
<td></td>
</tr>
<tr>
<td>Ms Fiona Mathieson</td>
<td>[Signature]</td>
<td>6-4-13</td>
</tr>
<tr>
<td>Dr Maria Stubbie</td>
<td>[Signature]</td>
<td>6-4-15</td>
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</tbody>
</table>
Appendix C. Identification decisions and intonation units

These relate to the study described in Chapter 4.

Identification decisions

Decisions made during the iterative coding process (in consultation with supervisor, MS)

Underline actual metaphor. If object occurs during metaphor, put round brackets ( ) around it and underline the whole thing. Eg. get (a certain amount of satisfaction) out

Coders will not code for more than half an hour at a time due to fatigue having the potential to reduce accuracy.

Phrasal verbs

1) Check whether it is a phrasal verb using Collins CoBuild dictionary
2) If it is a phrasal verb, consider whether it is metaphorical using above criteria. Phrasal verbs are when words are used together and may have a separate, non-metaphorical meaning when used together e.g. ‘bring up’ children, ‘deal with’ people, pick up on (Many of these are specified below as phrasal verbs to include; some are specified as exclusions).
3) If the decision is that it is metaphorical, underline all of the phrasal verb

Extended analogies: Underline first, primary instance of the metaphor. Put a comment in the margin saying extended metaphor. Then only underline other metaphors that occur in that segment. If the metaphor recurs in a subsequent turn, underline it.

E.g. It is like driving a car. At first it can feel a bit awkward. You have trouble with the clutch. You don’t know which side the indicator is. You take the corners a bit slowly. But over time you start to get the hang of it.

Exclude

Have, do, get

By, of, for

Big deal (as in ‘Not a big deal”; only include deal if transfer of meaning from business deal)
Boring (as in ‘found it boring’)
Brassed off
Bring up (if re bringing up children)
Carry on (as in ‘carry on, what happened”; meaning continue) (phrasal verb)
Check out
Coming on (as in summer ‘coming on’)
Congenial time
Dare (as in ‘how dare him’)
Dead right
Deal with
Dependent on
Develop (as in Symptoms develop)
Down (where it refers to a physical location, such as going down to Dunedin)
Ends up/ end up (only include if clearly related to a metaphorical statement re movement/ journey; not just if something ending)
Evidence (generally exclude, because hard evidence is actually written down)
Experiment
Fine (as in ‘assume you were fine’)
Find (as in ‘how did you find being a mother?’)
Forthcoming
Get away with (phrasal verb)
Get up (Out of bed)
Give an example
Global
Going on (as in ‘a lot going on’) Only include if part of broader metaphor re movement/ journey or if about thought ‘going on’
Heart pumping (because heart is a pump)
Half (as in half the time)
Hangover (if alcoholic hangover; include if hangover of issue from the past)
Hard (when it means ‘difficult’)
Homesick
Issue (too conventionalised to have any transfer of meaning);
Jotting it down
Missed/ missing (unless it draws on the idea of a target)
Missing out
Modify
Negate (as in undermine) (only include if clearly drawing on debate idea)
Point (when used re an argument e.g. ‘that is a good point, versus sense of journey)
Pop it on (meaning turn it on)
Progress (only include if part of a broader metaphor of movement or journey)
Put (it) off
Put down/on this side (if likely something is being written down, based on context)
Put up with
Raising (a child)
Roughly (meaning generally, as in to give a rough idea)
Scenario (check context) Means unfolding pattern of events or story of a film or drama
Stop
Start
Sticking up (for self) (include if referring to sticking up mental note or sticking to a plan)
Stage (unless clear reference to theatrical stage)
Straight away (unless referring to journey/ movement)
Straightforward (unless clearly referring to journey in context)
Trial and error/ give a trial (only include trial if not just meaning a test or experiment e.g. ‘On trial’ has transfer of meaning from court trial)
Turn out (as in ‘work did not turn out well’) (Phrasal verb)
Way (as in way that you feel/ think); only include if clearly referring to direction)
Work on an issue
Work out

Include
make, give, put, thing, part and way
into, over, behind, in, on, up, down, within, between, out of, from, through
Agitated (as in feeling agitated)
Around (as in ‘Thoughts around something happening’)
Automatic thought
Bang-on
Bearing on (as in ‘have a bearing on x’)
Bias (as in thinking bias in depression)
Big wig
Block out (phrasal verb)
Break (meaning holiday)
Break down (as in breaking problems down)
Bringing on
Bring up (as in bring issues up) (Phrasal verb)
Bug-bear
Build up (e.g. build up to bed time)
Burst (as in burst into tears)
Calm
Clear
Challenge; challenge thoughts (only include challenge if clear transfer of meaning from fight/competition)
Changed your mind
Cheer up
Chill out

**Cognitive-emotional verbs:** e.g. notice, monitor, focus, see, look, evaluate, **IF** in relation to thoughts, feelings, relationships (non-concrete things) being treated as objects
Condense
Constructively (as in working constructively)
Comes up/ Come up with
Crack (as in ‘having a crack at it’)
Credit (as in ‘give yourself credit for’ your actions)
Crop up (as in problems that crop up) (Phrasal verb)
Cross fingers
Day dreaming
Degree (worried about yourself to a degree)
Depressed
Depression
Diabolical
Distortion (as in cognitive distortion)
Down (as in feeling down)
Downcast
Downhearted
Downside
Draw (as in draw attention to)
Driving at
Dwelling (as in dwelling on issues)
Earmarked
Fed up
Feels (if it refers to a tactile sensation, not emotions e.g. ‘Feels right’)
Feedback
Fifty-fifty (as in weighing up)
First place (as in ‘shouldn’t be doing this in the first place’)
Fix up (as in fixing emotional problems)
Fluffing around
Follow up (as in follow up on that) (Phrasal verb)
Foresee
Frame of mind
Function (as in ‘can’t function mentally’; not if talking about general functioning
Generate (as in generate animosity)
Get back under control (if referring to abstract things like thoughts, feelings)
Give (yourself) a break
Giving [to self] (as in ‘giving myself’ a hard time)
Give up/ give up on
Goals
Go against (as in ‘that will go against my record’) (Phrasal verb)
Got at (as in ‘feeling got at’)
Groggy (as in feeling groggy)
Hang with (I want to hang with her) (as in hang out)
Hard on (as in ‘being hard on’ someone)
Hell (as in ‘what the hell was going on’; used to indicate surprise)
Hide (as in hiding information or feelings, not actual objects)
Highlight (meaning emphasise)
Hindsight
Homework’ (on the basis that it refers to the school context and not necessarily paper and pen
tasks as in traditional homework)
Idioms: only include if metaphorical
Inclined (as in more inclined to do other things)
Jumble (thoughts all a big jumble)
Keep in mind
Kill him (as in otherwise I would kill him) (if used hyperbolically)
Left wing
Link
Lost it (as in she might lose it (mentally))
Maintenance (of therapeutic change)
**Make of it**
Mindset
Mouthy (she gets so mouthy)
Negative
Neutral (as in ‘be neutral about it’ (if describing emotional state))
Nineteen to the dozen
Nut out
Occupied (as in mentally occupied)
Out of control (when describing emotion or behaviour)
Packed a sad
Pattern (of behaviour)
Peaceful (as in peaceful feeling)
Picking on (meaning picking up on) (phrasal verb)
Piss off/ Pissed off
Point (as in ‘getting to the point; sense of journey; not argument)
Position (but only if it refers to location (where you stand), not a job).
Positive
Pottering around
Poured (as in poured with rain)
Precious (as in precious day off) Time as having monetary value.
Press on
Put it down to
Putting it on (Put on is a Phrasal Verb; M if used in a way that draws on ‘acting’)  
Racking (your brain)
Reach an ideal
Related/ relate/relating
Right (as in ‘get myself right’; sense of balance)
Run out (if used metaphorically as in run out of time) (phrasal verb)
Secure/ security
Set the agenda
Set up (as in setting yourself up emotionally; exclude if literally setting up an office)
Shit (as in ‘Oh Shit’ (expletive) as opposed to ‘don’t give a shit’)
Shock (as in ‘it must have been a shock’)

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Sick (as in sick and tired of life; getting sick of)
Size/ Big (as in ‘decent sized subjects’ or ‘big problem’)
Skin (if used as ‘can’t be in your skin’)
Snap out (as in snap myself out of it) (Phrasal verb)
Stand for (as in represent someone)
Stay with (as in staying with an idea, rather than literally staying in a location)
Stop (if in relation to thoughts/ feelings as objects)
Stew on it
Stick with
Stick at/ Stick on
Stress (when describing emotional state)
Stressed out
Stressful
Suffer (as in she does not suffer fools)
Sum up (if not used literally re money)
Supportive (when referring to emotional support)
Tabled (as in ‘things that could be tabled’ (meaning put on the agenda)
Take it easy on yourself (easy on is a phrasal verb)
Target (as in Achieve a target (if not used literally to describe a shooting target)
Tease out (if referring to teasing out thoughts/ non objects) (phrasal verb)
Threw a wobbly
Timeframe
Track (if in ‘Keep track of’) (Phrasal verb) (or ‘keep track’)
Tricky (origin in performing trick)
Under the sun (as in he called me all the names under the sun) (hyperbole)
Uptight (if describing emotional state; exclude only if specifically referring to tight muscles)
Upset
Ways (as in ‘No two ways about it’)
Went off (As in went off alcohol)
Whip out (phrasal verb)
Work on
Write off (if not used literally re money)
**Intonation Units**

The Discourse Dynamics approach uses Excel spreadsheets to condense the data into a more manageable form than the transcript, allowing researchers to sort and re-sort data and perform both quantitative and qualitative description of the data. The Cameron et al. (2009) study included the following headings: vehicle, speaker, line number, metaphor vehicle and vehicle grouping. In the current study, Excel spreadsheets were also used and included these headings. The (Cameron et al., 2009) approach also included a heading for ‘intonation units’. An intonation unit is the speech produced under a single intonational contour: often, but not always with a single breath. It tends to be marked by cues such as a pause and a shift upwards in overall pitch level at its beginning, and a lengthening of its final syllable. (Chafe, 1993, 1994; Du Bois, Schuetze-Coburn, Cumming, & Paolino, 1993). Intonation units often coincide with syntactical clause units, but are sometimes truncated syntactically (Cameron et al., 2009). Chafe (1994) claimed cognitive reality for intonation units by suggesting each was an *idea unit*. Each intonation unit occupies a new, numbered line in a transcript. Transcription using intonation units requires specialised training and must be done from audio tapes. The transcripts available from the CBT/IPT study did not use the intonation unit transcription approach (which requires specialised training), so it was not possible to use formal intonation units.

**EDUs**

As an alternative syntactic way of segmenting the text into idea units in a standardised way, elementary discourse units (EDUs) were used. EDUs like intonation units, have the advantage of being quite short, which makes them easily transferred to columns in the Excel spreadsheet. This approximation of intonation units is taken from Rhetorical Structure Theory, which is a linguistic approach that works with large corpora and has criteria for EDU’s (van der Vliet, Bouma, & Redeker, 2013). One minor adaptation to the criteria was made. It is specified in the list of adapted criteria below:

**Adapted Criteria for EDUs:**

**Inclusion criteria:**

- Independent clauses (Simple sentences)
- Adverbial clauses (e.g. ‘when you were stewing’; stewing is a verb; ‘when you were’ is adverbial)
- Fragments e.g. ‘Yeah’
Non-restrictive relative clauses (non-restrictive means non-defining, not essential, just extra information that could be left out without affecting the meaning or structure of the sentence e.g. ‘Professor Marvin, who was always early, was there already’; non-restrictive clauses often start with wh- words or ‘that’; are usually separated by commas; must begin with a relative pronoun).

Restrictive relative clauses. This is when the relative clause is defining (e.g. Depression is an illness, which tends to have ups and downs). The clause ‘which tends to have ups and downs’ gives essential information about the noun that comes before it. Restrictive relative clauses were excluded by (van der Vliet et al., 2013), however other authors include them in EDUs (Carlson & Marcu, 2001). It was decided to include them on the basis that at times such clauses will contain metaphorical words or phrases and including them will be simpler and will allow shorter units of speech to be coded, which is more practical.

Both parts of an elliptical clause are counted as separate EDUs. Ellipsis is when 2 clauses are joined by a conjunction such as ‘and’, where the second clause has an implicit reference to the first. These are counted as separate EDUs (e.g. ‘[You would like to see yourself become less moody] and [be more stable in your mood]’. The brackets indicate the 2 EDUs).

Exclusion criteria

Apposition (e.g. a neighbour, Fred, is on the telephone). This would be counted as one EDU because Fred and the neighbour are the same person.

Parentheticals: If the speaker is quoting what another person has said, it is not counted as a separate unit e.g. He says “get over it, go to sleep”, would be counted as one EDU. (Note: quoting is not the same as simply repeating e.g. ‘You feel like you have lost sight of your wife’ is not parenthetical).

Complement clauses: A complement clause is a clause introduced by a complementizer like whether or that. A complement clause is attached to a preceding noun, adjective or verb. In the sentence ‘My mother suggested that I should see a doctor’, ‘that I should see a doctor’ is a verb-complement clause attached to the verb suggested. ‘The news that she was dead shocked us all’, ‘that she was dead’ is a noun complement clause attached to the noun news. In ‘I am sure that she is coming’, ‘that she is coming’ is an adjective-complement clause.
attached to the adjective *sure*. In some cases the complementizer may be optionally omitted e.g. I am sure she is coming. OR I am sure that she is coming.

Clarification and further examples of these linguistic terms can be found in (Willis & Wright, 1991).

The EDUs which contained identified metaphoric language were inputted to Excel spreadsheets for subsequent analysis. The spreadsheets also included the transcript line number; the metaphoric word or phrase; whether it was spoken by the therapist or client and the vehicle grouping. The vehicle grouping was an initial attempt to categorise the metaphors, for example there were large numbers of metaphors that related to the idea of a journey (e.g. *rocky path*; *got to a point*; *long way to go*). Vehicle groupings are determined by the semantic content of vehicle words or phrases. This step is informed by conceptual metaphor theory, but with a difference. A linguistic metaphor is not assumed to be an instantiation of a pre-existing conceptual metaphor. Vehicle groupings are developed from the data, bearing in mind the kinds of source domain found in the cognitive literature, but always guided by the actual spoken interaction. Each metaphor vehicle is assigned to a grouping that captures its essential semantic meaning (e.g. *way* is assigned to *MOVEMENT (PATH)* and *bullying* to *VIOLENT/ACTION*). The groupings are kept tentative and temporary. They are only firmed up at the last moment (Cameron et al., 2009). Each grouping decision carefully follows a central principal of interpretive analysis: rigorous assessment of the quality and limits of the discourse evidence underpinning a decision. Reliability is maximised by discussion, cross checks by colleagues and project notes that aid consistency. It is acknowledged that the vehicle groupings will inevitable have blurred boundaries and a degree of overlap (Cameron et al., 2009).

The spreadsheets created as part of this thesis can be subjected to further analysis in the future, for example they can be examined for recurring metaphoric themes.
INFORMATION SHEET – Clinical Psychology Students, Metaphor in CBT Study, Wellington, 2015

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

What is the Aim of the Project?
You are invited to participate in a study evaluating the impact of a training course in cognitive behaviour therapy (CBT). Your role would be to act as a ‘client’ in role plays. One role play will be on 8th April and one will be on 22\textsuperscript{nd} April, 2015.

The principal investigators of the research team involved in this study are Dr Maria Stubbe (Senior Lecturer, Department of Primary Health Care and General Practice) and Fiona Mathieson, (Senior Lecturer in Psychology, Department of Psychological Medicine, University of Otago, Wellington (UOW)). Dr Jennifer Jordan (Senior Lecturer, Department of Psychological Medicine, University of Otago, Christchurch) and Associate Professor Paul Merrick, School of Psychology, Massey University, Albany are also part of the research team.

CBT is an ever evolving form of psychotherapy therapy, with increasing focus on process issues that may enhance therapy. It has been asserted in the practice-based literature that working with metaphors is beneficial for clients.

This study aims to evaluate a training course (run over two half-days), designed to assist clinicians to work more effectively with metaphoric language as a way of enhancing CBT. The course will be evaluated through video-recorded role plays at the start and end of the training, which will be assessed by an external rater (a registered clinical psychologist), who
will be unaware when the recordings are made, in order to assess whether there is a difference as a result of the training course.

**What Type of Participants are being sought?**
We are seeking post graduate clinical psychology students, recruited by email through Massey and Victoria University PG Dip Clin Psych programmes to participate. We are seeking 8-10 students who are willing to participate in video recorded role plays, as the ‘client’ in mental health treatment scenarios. Acting experience and ability is not required, nor is knowledge of cognitive behaviour therapy.

You will be paid $70 (inc GST) for each 1 1/4 hour role play session. $140 (inc GST) in total for two and ½ hours work. There is no specific payment for travel time and costs. We are inviting you to participate because you will be contributing to the mental health field through potentially enhancing the effectiveness of cognitive behaviour therapy.

**What will participants be asked to do?**
Should you agree to take part in this project, you will be asked to come to the University of Otago Wellington on two occasions to take the role of a client in a video recorded role play, lasting an hour. You will need to familiarise yourself with a role play scenario of a client with depression or anxiety, which will be emailed to you before each role play session. You will also be asked to complete some measures after the role plays, which will take approximately 15 minute on each occasion.

Participating in role plays may cause some self-consciousness or anxiety. Role plays will be conducted in a supportive, appreciative environment. There is a chance that recordings used in future workshops would be seen by people you know. A clear statement would be made that this recording was a role play using graduate students as role play ‘clients’ if this material is shown.

**When:** The workshop will be held on both 2nd and 16th November. You are expected to attend both days if you decide to participate. You will need to attend from 8.30am-10am on 2nd November and 11.00am-12.30pm on 16th November.

**Where:** It will be held in the Totara room, Level F, Department of Primary Health Care and General Practice, University of Otago, Wellington School of Medicine and Health Sciences, Mein Street, Newtown, Wellington.
You are not able to attend the teaching component of the workshop. It is an advanced workshop and may affect role play behaviour if you attended the teaching component.

Car parking is not provided. Metered car parks are available near the Medical School and parking is available in surrounding streets. This can often be some distance away so please allow an extra 15 minutes if taking this option.

Please be aware that you may decide not to take part in the project without any disadvantage to yourself of any kind.

**What data or information will be collected and what use will be made of it?**

As well as the recorded role plays, you will be asked to complete questionnaire measures based on the role play experience. You will also be asked to provide demographic information and to complete two metaphor questionnaires.

Recordings will be viewed by the external rater and by the transcriber. Fiona Mathieson, Maria Stubbe, or Jennifer Jordan may watch selected segments. All written data will be de-identified by Fiona Mathieson before being seen by any other members of the research team.

The clinicians attending the training course will be provided with copies of the recordings, if they wish, for their own professional development purposes. They will not receive copies of ratings you make of your experience of the role play sessions.

No material which could personally identify you will be used in any reports on this study.

The paper data from the study will be de-identified and kept for a minimum 5 years in a locked store room at the University of Otago, Wellington and sent for secure disposal when no longer required. Electronic data and recordings will be stored in a password-protected system for a minimum of 5 years and deleted when no longer needed.

The video recordings will be transcribed for further analysis. By agreeing to participate in the study you would also be consenting to recorded role plays potentially being used for future training purposes.

The results from this study will be reported as part of Fiona Mathieson’s PhD thesis and in an article(s) submitted to a peer-reviewed academic journal(s). We will send you a copy of the article, if you wish.
This research is supported by a University of Otago Fanny Evans PhD scholarship, and grant applications are being made to the Wellington Medical Research Foundation and Oakley Mental Health Research Foundation. The results will not be used for commercial purposes.

**Can Participants change their mind and withdraw from the project?**

You may withdraw from participation in the project at any time and without any disadvantage to yourself of any kind. You have the option of withdrawing from the study after the first role play (before the second role play) and would still be paid for work done. You are requested to give at least one week’s notice if you decide not to attend the second role play session, so that a replacement for you can be arranged.

**What if participants have any questions?**
If you have any questions about our project, either now or in the future, please feel free to contact either:- Fiona Mathieson, Department of Psychological Medicine, University of Otago, Wellington, Phone: 04 9186034, email: fiona.mathieson@otago.ac.nz or Dr Maria Stubbe, Department of Primary Health Care & General Practice, University of Otago, Wellington, phone 04 806 1838, maria.stubbe@otago.ac.nz ext. 4838.

If you have any questions or concerns about your rights as a participant in this research study, you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.

Telephone, NZ wide: 0800 555 050; Free Fax, NZ wide: 0800 2787 7678 (0800 2 SUPPORT); Email: advocacy@hdc.org.nz

This study has been approved by the University of Otago Human Ethics Committee (#15/017). If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph +643 479 8256 or email gary.witte@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

*Te tiro atu to kanohi ki tairawhiti ana tera whiti te ra kite ataata ka hinga ki muri kia koe.*

*Turn your face to the sun and the shadows will fall behind you.*
Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

What is the Aim of the Project?

You are invited to participate in a study evaluating the impact of training course in cognitive behaviour therapy (CBT). The principal investigators of the research team involved in this study are Fiona Mathieson, (Clinical Psychologist and Senior Lecturer in Psychology, Department of Psychological Medicine, University of Otago, Wellington (UOW)), Dr Maria Stubbe (Senior Lecturer, Department of Primary Health Care and General Practice), Dr Jennifer Jordan (Clinical Psychologist and Senior Lecturer, Department of Psychological Medicine, University of Otago, Christchurch) and Associate Professor Paul Merrick, School of Psychology, Massey University, Albany.

Metaphors can be part of the shared language that develops in therapy. It has been asserted in the practice-based literature that metaphorical language may be an important process variable.

This study is part of Fiona Mathieson’s PhD research. It aims to evaluate a training course (comprising two half-day workshops), designed to assist clinicians to identify metaphoric language and respond intentionally as a way of enhancing CBT. The workshop is based on Fiona Mathieson’s PhD research as well as the latest experimental and practice based literature. It will be conducted by Fiona Mathieson, who is an experienced clinician and CBT trainer: She has taught the University of Otago post graduate CBT course for the past 13 years; regularly attends local and international CBT conferences and works in private practice.
The video recordings will be transcribed for further linguistic analysis and will be evaluated by an external rater, using standard CBT session rating tools. Readings and resources will be provided at the first workshop which you will be asked to look at before the second workshop (1-2 hours). You will also be encouraged to reflect on and apply the first part of the workshop with your clients before the second workshop occurs.

**What type of participants are being sought?**

We are recruiting by email flyer through NZCCP and DHB networks. Clinical psychologists who work with adults and are experienced clinicians (minimum 3 years), working in DHB, PHO or private practice settings are invited to participate. You need to be confident with using cognitive behaviour therapy and in particular with using Christine Padesky’s 5 part model and sharing conceptualisations with clients. You also need experience in treating depression using cognitive behaviour therapy. Many clinicians will be using Acceptance and Commitment Therapy techniques as part of their practice. You are welcome to participate as long as you are confident to work in a primarily Beck/Padesky CBT approach.

If you are not sure whether you meet the inclusion criteria, please discuss this with Fiona Mathieson.

Numbers are limited to 8-10 participants in the training group.

The workshop is offered for free in exchange for participating in the study. There will be no cost to you apart from possibly some travel costs getting to and from the workshop. Parking is available in the nearby streets and some free carparks have been reserved on a first-come-first-served basis (by emailing Fiona Mathieson). **Lunch is provided.**

We are inviting you to participate because as an experienced clinician, you may find some benefit to your practice through participating in a course on intentional metaphor use to enhance cognitive behaviour therapy. You will receive useful resources during the training to support your learning and the application of the skills developed in the workshops. You can also receive a copy of the video recordings taken during the workshop and the ratings done on these recordings by an external rater, for your own learning purposes.
You are welcome to discuss this with Fiona Mathieson and/or your clinical supervisor to help you decide whether you want to take part in the study.

**What will participants be asked to do?**

Should you agree to take part in this project, you will be asked to attend two half-day training workshops, held on 2nd and 16th November from **8.30am-1pm**, in the Totara room, Level F, Department of Primary Health Care and General Practice, University of Otago, Wellington School of Medicine and Health Sciences, Mein Street, Newtown, Wellington. You are expected to attend both parts of the workshop.

During the training will be expected to participate in two video-recorded role plays of working with a client using CBT, based on a scenario of a client with an anxious depression, which will be sent to you prior to the workshop. There will be a role play at the start of the first workshop and one at the end of the second workshop. The ‘client’ will be played by a clinical psychology graduate student.

There will be some written resources provided at the first workshop and you will be asked to read these between workshops to support your learning. This will be 1-2 hours of reading. You will also be asked to reflect on the learning from the first workshop when seeing clients.

Participating in role plays may cause some self-consciousness or anxiety. Role plays will be conducted in a supportive environment. Clinicians can be assured that confidentiality will be respected and recordings will be viewed appreciatively.

Please be aware that you may decide not to take part in the project without any disadvantage to yourself of any kind.

No material which could personally identify you will be used in any reports on this study.

**What data or information will be collected and what use will be made of it?**

The training course will be evaluated primarily through the video-recorded role plays, which will be assessed by an external rater (a registered clinical psychologist), who is blind to when the recordings are made. Questionnaire measures based on the role play experience will be completed by the clinical psychology graduate student who participates in the role plays with you. You will also be asked to provide demographic information; to complete two metaphor
questionnaires and to complete likert rating scales evaluating the workshops. These will be given at the start and end of the workshops and at one and three months after the workshops.

Recordings will be viewed by the external rater and by the transcriber. Fiona Mathieson, Maria Stubbe, or Jennifer Jordan may watch selected segments. All written data will be de-identified by Fiona Mathieson before being seen by any other members of the research team.

Recordings will not be played in a public arena. Fiona Mathieson may approach you in future to seek consent for a recording to be used in a public arena, such as a future training workshop. This would involve a separate consent form and would be entirely your choice.

The paper based data from the study will be kept for a minimum of 5 years, in a locked store room at the University of Otago, Wellington, and will be sent for secure disposal when no longer required. Recordings will be kept on password-protected digital files for a minimum of 5 years and will be sent for secure disposal when no longer required. Recordings may be used for subsequent training purposes if, subsequent to the training, but only if you agree to this. A separate consent form would be used for this purpose. Where separate consent is granted for use of recordings for future research and training purposes, we intend to archive these indefinitely using the new Otago secure data storage facility (and/or as a satellite collection within the secure ARCH data collection, which Dr Stubbe’s research group has developed.

The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve your anonymity.

The ratings made of the session by the role play ‘clients’ will not be available to you, as this could affect the ratings made.

The results of this study will be reported as part of Fiona Mathieson’s PhD thesis and in paper(s) submitted to a peer-reviewed academic journals. We will send you a copy of the main results article.

This research is supported by a University of Otago Fanny Evans PhD scholarship. Extra funding will be sought from the Wellington Medical Research Foundation and possibly the Oakley Mental Health Research Foundation. The results will not be used for commercial purposes.
Can Participants Change their Mind and Withdraw from the Project?

You may withdraw from participation in the project at any time, even after the first workshop has been conducted, without any disadvantage to yourself of any kind.

What if Participants have any Questions?

If you have any questions about our project, either now or in the future, please feel free to contact either:-

Fiona Mathieson, Department of Psychological Medicine, University of Otago, Wellington, Phone: 04 9186034, email: fiona.mathieson@otago.ac.nz

Or Dr Maria Stubbe, Department of Primary Health Care & General Practice, University of Otago, Wellington, phone 04 806 1838, maria.stubbe@otago.ac.nz ext. 4838.

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Email: advocacy@hdc.org.nz

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Te tiro atu to kanohi ki tairawhiti ana tera whiti te ra kite ataaata ka hinga ki muri kia koe.

Turn your face to the sun and the shadows will fall behind you.

Tēnā rā koe, mōu I aro mai ki tēnei rangahau.
Thank you for considering participating in the study.
CONSENT FORM – Clinical Psychology Students, Metaphor in CBT study

Name:_____________________________ Clinical Programme__________________________

Email:_____________________________ Mobile number __________________________

I have read and understood the information sheet dated 1/2/15 concerning this project. I understand that I am free to request further information at any stage.

I know that:

1. My participation in the project is entirely voluntary;
2. I am free to withdraw from the project at any time without any disadvantage;
3. Personal identifying information in questionnaire data and transcriptions of recordings will be removed, but any raw data on which the results of the project depend will be retained in secure storage for at least five years.
4. There is potential discomfort of being video recorded;
5. A transcriber and an external rater will have access to the video-recorded data;
6. I am aware of the nature of the financial reimbursement for participating.
7. Recordings of the sessions may be used for future training purposes and that they will be transcribed for further analysis.
8. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand), but every attempt will be made to preserve my anonymity.

I agree to take part in this project.

.................................................................................................  .........................
(Signature of participant)  (Date)

.................................................................................................
(Printed Name)

This study has been approved by the University of Otago Human Ethics Committee (reference number 15/017). If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph +643 479 8256 or email gary.witte@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
CONSENT FORM – Clinicians, Metaphor in CBT Study

Name:________________________________________

Email:________________________________________ Mobile number ____________________________

Current workplace:________________________ Current Client Group________________________

Number of years of experience with CBT:________________

I have read the information sheet dated 1/2/15 concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:

1. My participation in the project is entirely voluntary;
2. I am free to withdraw from the project at any time without any disadvantage;
3. Personal identifying information in questionnaire data and transcriptions of recordings will be removed, but any raw data on which the results of the project depend will be retained in secure storage for at least five years;
4. There is potential discomfort of being video recorded;
5. That a transcriber and an external rater will have access to the video-recorded data;
6. The training workshops are free, in exchange for participating in the study;
7. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand), and every attempt will be made to preserve my anonymity.

I agree to take part in this project.

.......................................................... ..........................................................
(Signature of participant) (Date)

..........................................................
(Printed Name)

This study has been approved by the University of Otago Human Ethics Committee (reference number 15/017). If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph +643 479 8256 or email gary.witte@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
Appendix E. Copies of key measures

Name: __________________________  Date: __________________________

Scorer: __________________________  Session No.: __________________________

RATING OF THE SCALE

The present scale has incorporated the NCVQ system in order to assess the level of competence shown by the therapist. There are six levels; one more level than the original NCVQ-system.

Level 0: Incompetent - The therapist commits errors and displays poor and unacceptable behaviour, leading to negative therapeutic consequences.

Level 1: Novice - At this level the therapist displays a rigid adherence to taught rules and is unable to take account of situational factors. He/she is not yet showing any discretionary judgement.

Level 2: Advanced beginner - The therapist treats all aspects of the task separately and gives equal importance to them. There is evidence of situational perspective and discretionary judgement.

Level 3: Competent - The therapist is able to see the tasks linked within a conceptual framework. He/she makes plans within this framework and uses standardised and routinised procedures.

Level 4: Proficient - The therapist sees the patient's problems holistically, prioritises tasks and is able to make quick decisions. The therapist is clearly skilled and able.

Level 5: Expert - The therapist no longer uses rules, guidelines or maxims. He/she has deep tacit understanding of the issues and is able to use novel problem-solving techniques. The skills are demonstrated even in the face of difficulties (e.g. excessive avoidance).

Parallel to the level of competence categories there is a rating scale consisting of seven points along a 0-6 likert scale. This includes a negative impact score (0) which should be selected if the therapist's work is considered to have had a negative impact on the patient with respect to that item.

To aid with the rating of items on the scale, an outline of the core function of each item is provided at the top of each section. A description of the various rating criteria is given in the right hand margin.

The scale assesses both the skill of the therapist and the impact of the therapy on the patient. Hence, the core functions and the criteria highlight both these features in their descriptions. At times the patient's difficulties (e.g. excessive avoidance) may prevent the therapist from demonstrating his/her competence. This aspect should be taken into consideration when rating the therapy. However, one must be careful not to award high marks when skills have not been adequately demonstrated or impacts not achieved, even when patient difficulties are evident.
Example of the scoring layout:

Core function: this is an operationalised description of the item (see examples within the CTS-R).

Mark with an 'X' on the vertical line, using whole and half numbers, the level to which you think the therapist has fulfilled the core function. The descriptive features on the right are designed to guide your decision.

N.B: When rating, take into consideration the appropriateness of therapeutic interventions for stage of therapy and perceived patient difficulty.

<table>
<thead>
<tr>
<th>Impact on patient</th>
<th>Competence level</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Impact</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Incompetent</td>
<td>(see CTS items for details)</td>
</tr>
<tr>
<td>No Impact (Neutral)</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Minimal Impact</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Advanced beginner</td>
<td>x</td>
</tr>
<tr>
<td>Some Positive Impact</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Competent</td>
<td>or</td>
</tr>
<tr>
<td>Moderately Successful Impact</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Proficient</td>
<td></td>
</tr>
<tr>
<td>Successful Impact</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Expert</td>
<td>E.g. a score of 5.0</td>
</tr>
<tr>
<td>Highly Successful Impact</td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>

Please note that the top marks (i.e. near the 'expert' end of the continuum) are reserved for those therapists demonstrating highly effective skills, particularly in the face of difficulties (i.e. highly aggressive or avoidant patients; high levels of emotional discharge from the patients; and various situational factors).

It is important to remember that the scoring profile for this scale should approximate to a normal distribution, with relatively few therapists scoring at the extremes. However, the distribution is likely to be biased slightly towards the positive end, as evidence of negative impact will probably be more uncommon in a sample of professionals.

Expected distribution; with scores of 3 at the mid-point.
Part 1 General Interview Procedure

ITEM 1 - AGENDA SETTING

Core function: To set an appropriate agenda collaboratively, which involves the setting of discrete and realistic targets. These targets should be followed within the session although appropriate flexibility must be shown (N.B the format for setting the agenda may vary according to the stage of therapy).

Three features need to be considered when scoring this item:

(i) Presence/absence of an agenda
(ii) Appropriateness of the contents of the agenda, including prioritisation of items
(iii) Whether or not the agenda is adhered to appropriately.

Mark with an 'X' on the vertical line, the level to which you think the therapist has fulfilled the core function. The descriptive features on the right are designed to guide your decision.

<table>
<thead>
<tr>
<th>Nature of impact</th>
<th>Competence level</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>0</td>
<td>No agenda set, inappropriate agenda set, or appropriate agenda not adhered to, resulting in a negative impact.</td>
</tr>
<tr>
<td>No impact</td>
<td>1</td>
<td>Ineffective agenda set (e.g. lack of focus, unrealistic) or poorly adhered to (e.g. no attempt at collaboration, no account of patient's presentation), or agenda not adhered to resulting in no impact.</td>
</tr>
<tr>
<td>Minimal impact</td>
<td>2</td>
<td>Effective agenda, though unilaterally set. Agenda not adhered to adequately.</td>
</tr>
<tr>
<td>Some impact</td>
<td>3</td>
<td>Effective agenda, attempt at collaboration evident, but not adhered to adequately.</td>
</tr>
<tr>
<td>Moderately successful</td>
<td>4</td>
<td>Effective agenda set collaboratively, but no prioritisation and no review at the end. Agenda adhered to.</td>
</tr>
<tr>
<td>Successful</td>
<td>5</td>
<td>Effective agenda set collaboratively with discrete and prioritised targets plan adhered to.</td>
</tr>
<tr>
<td>Highly successful</td>
<td>6</td>
<td>Highly effective agenda set which was adhered to in the face of difficulties or was adapted flexibly/skilfully.</td>
</tr>
</tbody>
</table>
ITEM 2 - ELICITING FEEDBACK

Core function: The patient's and therapist's understanding of key issues should be helped through the use of two-way feedback. The use of appropriate feedback helps both the therapist to understand the patient's situation, and the patient to synthesise material enabling him/her to gain major insight and make therapeutic shifts.

Three features need to be considered when scoring this item:

(i) frequency, or absence, of feedback [feedback material should be given/elicited at three points in therapy - beginning (review of week(s)); during; end (session summary etc.)]

(ii) appropriateness of the contents of the feedback

(iii) manner of its delivery.

<table>
<thead>
<tr>
<th>Nature of impact</th>
<th>Competence level</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>0</td>
<td>Presence or absence has a negative impact on the patient (e.g. ignored, fed back incorrectly or destructively).</td>
</tr>
<tr>
<td>No impact</td>
<td>1</td>
<td>Presence or absence of feedback has no impact.</td>
</tr>
<tr>
<td>Minimal impact</td>
<td>2</td>
<td>Appropriate verbal feedback, but not given frequently enough by therapist, with no attempt to elicit feedback from patient.</td>
</tr>
<tr>
<td>Some impact</td>
<td>3</td>
<td>Appropriate verbal feedback given and elicited frequently, although some difficulties evident in terms of content or method of delivery, e.g. questioning style.</td>
</tr>
<tr>
<td>Moderately successful</td>
<td>4</td>
<td>Appropriate verbal and written feedback given and elicited frequently, facilitating some therapeutic gains.</td>
</tr>
<tr>
<td>Successful</td>
<td>5</td>
<td>Appropriate verbal and written feedback given and elicited regularly, enabling significant therapeutic gains.</td>
</tr>
<tr>
<td>Highly successful</td>
<td>6</td>
<td>Highly effective verbal and written feedback given and elicited regularly in the face of difficulties, which promotes a shared understanding of the patient’s problems and make major therapeutic gains.</td>
</tr>
</tbody>
</table>
ITEM 3 - COLLABORATION

Core function: The patient should be encouraged to be active in the session. There must be clear evidence of productive teamwork, with the therapist skilfully encouraging the patient to participate fully (e.g. through questioning techniques, shared problem solving and decision making).

Three features need to be considered: the therapist style should encourage effective teamwork through his/her use of:

(i) verbal skills (e.g. questioning techniques)
(ii) non-verbal skills (including listening skills)
(iii) sharing of written summaries.

<table>
<thead>
<tr>
<th>Nature of impact</th>
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<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>0</td>
<td>Patient is actively prevented or discouraged from being collaborative. Therapist is excessively either controlling and dominating, or passive.</td>
</tr>
<tr>
<td>No impact</td>
<td>1</td>
<td>Either no, or ineffective, attempts at encouraging participation.</td>
</tr>
<tr>
<td>Minimal impact</td>
<td>2</td>
<td>Some occasional attempt at collaboration, but didactic style encourages passivity and leads to misunderstanding.</td>
</tr>
<tr>
<td>Some impact</td>
<td>3</td>
<td>Teamwork evident, but difficulties with collaborative set, e.g. not enough time allowed for the patient to reflect and participate actively.</td>
</tr>
<tr>
<td>Moderately successful</td>
<td>4</td>
<td>Effective teamwork is evident, but not consistent.</td>
</tr>
<tr>
<td>Successful</td>
<td>5</td>
<td>Effective teamwork evident throughout most of the session, both in terms of verbal content and of generating written summaries.</td>
</tr>
<tr>
<td>Highly successful</td>
<td>6</td>
<td>Excellent teamwork evident in the face of difficulties.</td>
</tr>
</tbody>
</table>
ITEM 4 - PACING AND EFFICIENT USE OF TIME

Core function: The session should be well 'time managed', with the session flowing smoothly through discrete start, middle, and concluding phases. The work must be paced well in relation to the patient's needs, and while important issues need to be followed, unproductive digressions should be dealt with smoothly.

Two features need to be considered:

(i) the degree to which the session flows smoothly through the discrete phases

(ii) the appropriateness of the pacing throughout the session.

<table>
<thead>
<tr>
<th>Nature of impact</th>
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<th>Features</th>
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<tbody>
<tr>
<td>Negative</td>
<td>0</td>
<td>Poor time management leads either to an aimless or overly rigid session, resulting in a negative experience.</td>
</tr>
<tr>
<td>No impact</td>
<td>1</td>
<td>Too slow or too fast for the current needs and capacity of the patient. Reasonable pacing, but digression or repetitions from the therapist and/or patient leads to ineffective use of time. Therapist allocates time poorly so that not all agenda items are covered.</td>
</tr>
<tr>
<td>Minimal impact</td>
<td>2</td>
<td>Good pacing evident some of the time, but diffuse at times.</td>
</tr>
<tr>
<td>Some impact</td>
<td>3</td>
<td>Discrete start, middles and concluding phases evident.</td>
</tr>
<tr>
<td>Successful</td>
<td>5</td>
<td>Good time management skills evident, session running smoothly. Therapist working effectively in controlling the flow within the session.</td>
</tr>
<tr>
<td>Highly successful</td>
<td>6</td>
<td>Highly effective time management skills evident in the face of difficulties.</td>
</tr>
</tbody>
</table>
ITEM 5 - INTERPERSONAL EFFECTIVENESS

Core function: The patient is put at ease by the therapist. The patient should feel that the core conditions. (i.e. warmth, genuineness, and empathy) are present.

Three features need to be considered:

(i) empathy - the therapist is able to understand the patient's perspective, and use this understanding to promote change

(ii) genuineness - the therapist has established a trusting working relationship

(iii) warmth - the patient feels liked and accepted by the therapist.

<table>
<thead>
<tr>
<th>Nature of impact</th>
<th>Competence level</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>0</td>
<td>Therapist’s manner and interventions make the patient disengage and become distrust and/or hostile.</td>
</tr>
<tr>
<td>No impact</td>
<td>1</td>
<td>Inability to show empathy, genuineness and warmth.</td>
</tr>
<tr>
<td>Minimal impact</td>
<td>2</td>
<td>Therapist’s style (e.g. intellectualisation) impedes his/her understanding of the patient’s communications.</td>
</tr>
<tr>
<td>Some impact</td>
<td>3</td>
<td>Moderate interpersonal effectiveness (e.g. able to understand explicit meanings of patient’s communications), resulting in some trust developing.</td>
</tr>
<tr>
<td>Moderately successful</td>
<td>4</td>
<td>The therapist is able to understand the implicit, as well as the explicit meanings of the patient’s communications and demonstrates it.</td>
</tr>
<tr>
<td>Successful</td>
<td>5</td>
<td>Demonstrates good interpersonal effectiveness (empathy, genuineness and warmth). Patient appears confident that he/she is being understood, which facilitates self-disclosure.</td>
</tr>
<tr>
<td>Highly successful</td>
<td>6</td>
<td>High interpersonal effectiveness in the face of difficulties.</td>
</tr>
</tbody>
</table>
ITEM 6 - FACILITATION OF EMOTIONAL EXPRESSION

Core function: The therapist facilitates the expression and processing of appropriate emotions and deals effectively with issues which might interfere (e.g. hostility, over intellectualisation, excessive anger).

Two features have to be considered:

(i) the facilitation of appropriate emotional expression (i.e. neither too little nor too much)

(ii) the creation of optimal dissonance and arousal for learning.

<table>
<thead>
<tr>
<th>Nature of impact</th>
<th>Competence level</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>0</td>
<td>Patient’s feelings are ignored or dismissed in a manner which has a negative impact, and/or the therapist’s own mood adversely influences the session (e.g. provokes inappropriate emotions in the patient).</td>
</tr>
<tr>
<td>No impact</td>
<td>1</td>
<td>Ineffective facilitation of emotional expression and/or lack of emotional dissonance or arousal impedes learning.</td>
</tr>
<tr>
<td>Minimal impact</td>
<td>2</td>
<td>Some facilitation of emotional focus or reflection, but many relevant opportunities missed. Failure to create any significant dissonance or arousal in order to promote learning.</td>
</tr>
<tr>
<td>Some impact</td>
<td>3</td>
<td>Some effective facilitation of appropriate emotional expression, and appropriate affective energy created (i.e. neither too much nor too little) and or maintained. Patient enabled to become slightly more aware, understanding and/or expressive.</td>
</tr>
<tr>
<td>Moderately successful</td>
<td>4</td>
<td>Effective facilitation of appropriate emotional expression leading to the patient becoming more aware, understanding or expressive of relevant emotions.</td>
</tr>
<tr>
<td>Successful</td>
<td>5</td>
<td>Very effective facilitation of emotional expression, optimally arousing patient’s awareness, understanding and expression of relevant emotions; done in an effective manner; leading to new perspectives.</td>
</tr>
<tr>
<td>Highly successful</td>
<td>6</td>
<td>Excellent facilitation of emotional awareness and expression in the face of difficulties.</td>
</tr>
</tbody>
</table>
ITEM 7 - CHARISMA AND FLAIR FACTOR (CFF)

Core function: The therapist's verbal and non-verbal style of communication inspires trust and motivates the patients to engage in therapy.

Three features need to be considered.

(i) therapist's appropriate level of energy and drive
(ii) therapist's qualities (e.g. confidence, sensitivity and creativity)
(iii) communication style (e.g. fluid, adapted to the needs of the situation, incorporates verbal and non-verbal behaviours).

<table>
<thead>
<tr>
<th>Nature of impact</th>
<th>Competence level</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>0</td>
<td>Therapist’s lacklustre and interpersonal ineffectual manner (e.g. too pre-occupied, self-centred, philosophical or excessively energetic) reduces the likelihood of energising or inspiring the patient and/or confuses, angers, demotivates him/her.</td>
</tr>
<tr>
<td>No impact</td>
<td>1</td>
<td>Therapist’s style fails to motivate and energise the patient leading to an aimless, wooden and mundane atmosphere which does not promote engagement on the part of the patient.</td>
</tr>
<tr>
<td>Minimal impact</td>
<td>2</td>
<td>Therapist’s style motivates and energised the patient minimally, lack of confidence and poor communication evident (e.g. overactivity, weariness, poor eye contact, avoidant posture, hesitant or disengaging).</td>
</tr>
<tr>
<td>Some impact</td>
<td>3</td>
<td>Therapist’s style facilitates some communication and change (e.g. by verbal and non-verbal communication, confidence and energy), although not consistently.</td>
</tr>
<tr>
<td>Moderately successful</td>
<td>4</td>
<td>Therapist shows appropriate energy and drive levels, clear purpose and effective interpersonal skills: engages the patient, shows spontaneity, alertness, good sense of humour, calming influence and incisiveness. Patient responds positively.</td>
</tr>
<tr>
<td>Successful</td>
<td>5</td>
<td>Therapist’s style is very effective (e.g. maintains patient’s attention, enables the patient to take risks and open up). The therapist is creative, confident, intuitive, insightful and inspires the patient.</td>
</tr>
<tr>
<td>Highly successful</td>
<td>6</td>
<td>As in 5, but in the face of difficulties.</td>
</tr>
</tbody>
</table>
ITEM 8 - GUIDED DISCOVERY

Core function: The patient should be helped to reflect accurately on their perceptions of their current situation, and to generate new insight and discover potential solutions for themselves. The patient is helped to re-interpret his/her experience.

Two elements need to be considered:

(i) the style of the therapist

(ii) the effective use of questioning techniques, which help the patient to recognise and link important themes (i.e. synthesis).

Both (i) and (ii) should encourage reflective problem solving by the patient leading on to the development of action plans.

<table>
<thead>
<tr>
<th>Nature of impact</th>
<th>Competence level</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>0</td>
<td>No attempt at guided discovery (e.g. hectoring and lecturing) leading to a negative impact.</td>
</tr>
<tr>
<td>No impact</td>
<td>1</td>
<td>Minimal use of questioning style – persuasion and debate used excessively. No opportunity for reflection given.</td>
</tr>
<tr>
<td>Minimal impact</td>
<td>2</td>
<td>Some use of questioning, but unhelpful in assisting the patient to gain access to their thoughts and emotions or to make connections between themes.</td>
</tr>
<tr>
<td>Some impact</td>
<td>3</td>
<td>Uses primarily a questioning style which is following a productive line of discovery, but fails to help the patient to reflect and make important connections.</td>
</tr>
<tr>
<td>Moderately successful</td>
<td>4</td>
<td>Uses a questioning style throughout with skill, and this leads to some synthesis and some development of action plans.</td>
</tr>
<tr>
<td>Successful</td>
<td>5</td>
<td>Skilful questioning style leads to reflection, discovery, synthesis and action plans.</td>
</tr>
<tr>
<td>Highly successful</td>
<td>6</td>
<td>Highly effective techniques used in the face of difficulties, with evidence of a deeper understanding having been developed.</td>
</tr>
</tbody>
</table>
ITEM 9 - CONCEPTUALISATION

Core function: The patient should be helped to gain an appreciation of the history, and maintaining features, of their problem. This theory-based understanding is used to guide the therapy forward.

Three features need to be considered:

(i) the presence absence of an appropriate conceptualisation
(ii) the way in which it is arrived at (i.e. achieved collaboratively with patients gaining insight re. their problems)
(iii) the manner in which the conceptualisation is used (e.g. used as platform for interventions, no homework etc.).

<table>
<thead>
<tr>
<th>Nature of impact</th>
<th>Competence level</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>0</td>
<td>The lack, or inappropriateness or misapplication of a conceptualisation leads to a negative impact (e.g. interferes with progress or leads to aimless application of procedures).</td>
</tr>
<tr>
<td>No impact</td>
<td>1</td>
<td>Problems with conceptualisation (e.g. absence, manner in which used, manner in which arrived at), leading to neutral impact within the session.</td>
</tr>
<tr>
<td>Minimal impact</td>
<td>2</td>
<td>Some rudimentary conceptualisation arrived at. But absence of collaboration or underlying cognitive framework.</td>
</tr>
<tr>
<td>Some impact</td>
<td>3</td>
<td>Cognitive conceptualisation partially developed with some collaboration, but difficulties evident (e.g. in synthesising and in sharing it with the patient).</td>
</tr>
<tr>
<td>Moderately successful</td>
<td>4</td>
<td>Cognitive conceptualisation well developed collaboratively and shared with the patient, facilitating some change.</td>
</tr>
<tr>
<td>Successful</td>
<td>5</td>
<td>Patient and therapist are able to gain good cognitive understanding of the relationship between presenting problems and possible underlying mechanisms. This is then used in verbal and written form to move the therapy forward and promote change.</td>
</tr>
<tr>
<td>Highly successful</td>
<td>6</td>
<td>Therapist and patient arrive at a consistent and credible cognitive understanding which is used to produce major shifts - even in the face of difficulties.</td>
</tr>
</tbody>
</table>
ITEM 10 - FOCUS ON KEY COGNITIONS AND EMOTIONS

Core function: To help patient to gain understanding of the relationship between their distressing emotions and cognitions (thoughts and beliefs) and to work with them appropriately.

Three features need to be considered:

(i) identifying cognitions that are driving distressing emotions
(ii) evaluation
(iii) the skilfulness of the evaluation (i.e. appropriate monitoring, identifying, and evaluating of negative thoughts and beliefs leading to reduction in distressing emotions).

<table>
<thead>
<tr>
<th>Nature of impact</th>
<th>Competence level</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>0</td>
<td>Therapist colludes with patient's negative cognitions and emotions, and thereby increases distress.</td>
</tr>
<tr>
<td>No impact</td>
<td>1</td>
<td>Inappropriate cognitions and emotions selected, or key cognitions/emotions ignored, failed to notice or worked on in an ineffective manner.</td>
</tr>
<tr>
<td>Minimal impact</td>
<td>2</td>
<td>Some cognitions/emotions (or one key cognition, e.g. core belief) elicited, but links between cognitions and emotions not made clear to patient.</td>
</tr>
<tr>
<td>Some impact</td>
<td>3</td>
<td>Some cognitions/emotions (or one key cognition) elicited and evaluated.</td>
</tr>
<tr>
<td>Moderately successful</td>
<td>4</td>
<td>A number of cognitions and emotions (or one key cognition) elicited and evaluated in verbal and written form, leading to a new understanding of their relationship.</td>
</tr>
<tr>
<td>Successful</td>
<td>5</td>
<td>Effective eliciting and challenging of a number of cognitions/emotions (or one key cognition), which were generally dealt with appropriately.</td>
</tr>
<tr>
<td>Highly successful</td>
<td>6</td>
<td>Important key cognition(s)/emotion(s) worked on, and dealt with highly appropriately in the face of difficulties.</td>
</tr>
</tbody>
</table>
**ITEM 11-APPLICATION OF COGNITIVE TECHNIQUES**

**Core function:** Therapist skilfully uses, and helps the patient to use, appropriate cognitive techniques in line with the formulation. The therapist helps the patient devise appropriate cognitive methods to identify and evaluate the key cognitions associated with distressing emotions, leading to major new perspectives and shifts in emotions.

Two features need to be considered:

(i) the appropriateness and range of cognitive techniques (e.g. cognitive diaries, continua, distancing, downward arrowing, responsibility charts, evaluating alternatives, examining pros and cons, determining meanings, imagery restructuring, etc.)

(ii) the skill in the application of the techniques.

<table>
<thead>
<tr>
<th>Nature of impact</th>
<th>Competence level</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>0</td>
<td>Therapist fails to use or misuses appropriate cognitive techniques leading to negative consequences.</td>
</tr>
<tr>
<td>No impact</td>
<td>1</td>
<td>Therapist applies inappropriate methods which have no impact on the patient.</td>
</tr>
<tr>
<td>Minimal impact</td>
<td>2</td>
<td>Therapist applies at least one appropriate method, but without skill and flexibility.</td>
</tr>
<tr>
<td>Some impact</td>
<td>3</td>
<td>Therapist applies some appropriate methods, demonstrating a degree of skill, but the interventions are incomplete and limited in their impact.</td>
</tr>
<tr>
<td>Moderately successful</td>
<td>4</td>
<td>Therapist applies a range of methods with skill and flexibility, enabling the patient to develop new perspectives and leading to some decrease in emotional distress.</td>
</tr>
<tr>
<td>Successful</td>
<td>5</td>
<td>Therapist systematically applies an appropriate range of methods in a creative, resourceful and effective manner, leading to a meaningful decrease in emotional distress.</td>
</tr>
<tr>
<td>Highly successful</td>
<td>6</td>
<td>Therapist applies a highly appropriate range of techniques introduced and executed with great skill, in the face of difficulties, leading to major decrease in emotional distress.</td>
</tr>
</tbody>
</table>
**ITEM 12 - APPLICATION OF BEHAVIOURAL TECHNIQUES**

**Core function:** Therapist helps the patient to plan and apply effective behavioural techniques in line with the formulation. The therapist helps the patient to identify potential difficulties, think through the cognitive rationales for the tasks, and, if necessary, engage in rehearsal in the session.

Two features need to be considered:

(i) the appropriateness and range of behavioural techniques (e.g. behavioural diaries, behavioural tests, graded task assignments, response prevention, reinforcement, modelling, applied relaxation, controlled breathing, etc.)

(ii) the skill in the application of the technique.

<table>
<thead>
<tr>
<th>Nature of impact</th>
<th>Competence level</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>0</td>
<td>Therapist fails to use or misuses appropriate behavioural techniques leading to negative consequences.</td>
</tr>
<tr>
<td>No impact</td>
<td>1</td>
<td>Therapist uses inappropriate methods (e.g. impractical suggestion), which have no impact on patient.</td>
</tr>
<tr>
<td>Minimal impact</td>
<td>2</td>
<td>Therapist uses at least one appropriate method, but without skill or flexibility.</td>
</tr>
<tr>
<td>Some impact</td>
<td>3</td>
<td>Therapist applies one or some appropriate methods, demonstrating a degree of skill, but the plans or interventions are incomplete and limited in their impact.</td>
</tr>
<tr>
<td>Moderately successful</td>
<td>4</td>
<td>Therapist applies a range of methods (or one if appropriate) with skill and flexibility, enabling the patient to develop new perspectives, plans and coping strategies.</td>
</tr>
<tr>
<td>Successful</td>
<td>5</td>
<td>The therapist applies a range of methods (or only one if appropriate) in a creative, resourceful and effective manner, leading to major change.</td>
</tr>
<tr>
<td>Highly successful</td>
<td>6</td>
<td>Therapist applies a highly appropriate and successful range of techniques introduced and executed with great skill, in the face of difficulties.</td>
</tr>
</tbody>
</table>
ITEM 13 - USE OF HOMEWORK

Core function: There are two aspects to this item, (i) concerns the use of 'the previous' homework within the current session (ii) concerns the setting of homework.

(i) Use of previously set homework - The aim is to use the information gained from the previously set homework effectively (i.e. evaluating the lessons learned from and during the tasks etc).

(ii) Setting homework - The aim should be to negotiate an appropriate task for the stage of therapy with the patient, to explain the rationale, for example, to test out ideas, try new experiences, and experiment with new ways of responding. Ideally the task should be derived from material discussed in the session, and sufficient time should be allowed for it (i.e. explain, discuss relevance, predict obstacles, etc.).

<table>
<thead>
<tr>
<th>Nature of impact</th>
<th>Competence level</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>0</td>
<td>Therapist fails to set homework, sets inappropriate homework or fails to review homework, leading to negative consequences.</td>
</tr>
<tr>
<td>No impact</td>
<td>1</td>
<td>Therapist does not set homework and does not review previous homework, with no impact on the patient.</td>
</tr>
<tr>
<td>Minimal impact</td>
<td>2</td>
<td>Therapist reviews and sets homework unilaterally and in a routine fashion, without utilising previous homework or explaining the rationale for new homework.</td>
</tr>
<tr>
<td>Some impact</td>
<td>3</td>
<td>Therapist has set adequate previous homework, but which is reviewed in a cursory fashion. Appropriate new homework set, but not explained well and not collaboratively.</td>
</tr>
<tr>
<td>Moderately successful</td>
<td>4</td>
<td>Therapist reviews previous homework collaboratively. New homework collaboratively set with a clear rationale. Some problem with utilisation of previously set homework or relevance of new homework.</td>
</tr>
<tr>
<td>Successful</td>
<td>5</td>
<td>Therapist reviews previous homework collaboratively and uses material in session. Appropriate homework set collaboratively and adequately explained.</td>
</tr>
<tr>
<td>Highly successful</td>
<td>6</td>
<td>Previous homework reviewed extremely efficiently, appropriate even in the face of difficulties. Appropriate homework set, its rationale explained extremely well, even in the face of difficulties.</td>
</tr>
</tbody>
</table>
### Part IV - Therapist's non-verbal Behaviour

Rate on a scale of 0 to 6 as shown on page 2 (i.e. negative impact to highly successful impact).

<table>
<thead>
<tr>
<th>Video/Audio Features</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Makes appropriate eye contact with patient</td>
<td>V</td>
</tr>
<tr>
<td>Expressive facial communication</td>
<td>V</td>
</tr>
<tr>
<td>Expressive body movements</td>
<td>V</td>
</tr>
<tr>
<td>Appropriate posture</td>
<td>V</td>
</tr>
<tr>
<td>Uses humour appropriately</td>
<td>V + A</td>
</tr>
<tr>
<td>Appropriate tone of voice (pitch, variability, warmth)</td>
<td>V + A</td>
</tr>
<tr>
<td>Appropriate volume of speech (loudness)</td>
<td>V + A</td>
</tr>
<tr>
<td>Positioning of self and patient</td>
<td>V + A</td>
</tr>
<tr>
<td>Appropriate silence</td>
<td>V + A</td>
</tr>
<tr>
<td>Clarity of speech</td>
<td>V + A</td>
</tr>
<tr>
<td>Facilitatory grunts/noises</td>
<td>V + A</td>
</tr>
<tr>
<td>Professional demeanour (dress)</td>
<td>V</td>
</tr>
<tr>
<td>Professional demeanour (language)</td>
<td>V + A</td>
</tr>
</tbody>
</table>
Language preference report (Yarbrough 1991)

All items are rated on 7 point Likert scales indicating strength of agreement

1= strongly disagree
2=moderately disagree
3=slightly disagree
4= neither agree nor disagree
5= slightly agree
6= moderately agree
7=strongly agree

Instructions:
Listed below are a number of statements concerning your preference for literal or figurative language. Literal language conveys something that is in reality or ‘literally’ true, whereas figurative language, such as metaphor or simile, relates something that is not really true but that can nevertheless be interpreted and understood, as for example when we say a brave soldier is a ‘tiger’ or that an elderly person has ‘entered the autumn of life’. There are no right or wrong answers on this survey. Please indicate your personal level of agreement or disagreement with each statement by circling the number to the right which best approximates how you feel. Each statement should be read without regard to your previous responses. Please circle only one number for each statement.

Factor 1: Production
1. I like to entertain others by using figurative language when I write
2. I like to write creatively
3. I use figurative language when I tell stories
4. Writing is something I usually enjoy
5. I like to write stories
6. While I am writing, figurative language often pops into my head
7. I don’t hesitate to use good metaphors that come to me when I am writing
8. I often use figurative language to emphasise or illustrate
9. I like to produce images with words when I write
10. I use metaphors and similes to explain things to others
11. I often think in figurative language
12. I like to entertain others by using figurative language when I speak
13. When I write letters, I use figurative language
14. I like to tell good stories
15. Figurative language often makes me smile with pleasure
16. I use figurative language in my conversations
17. My dreams are often metaphoric
18. When I try to understand the events in my life, I prefer to think about them metaphorically
19. Making up metaphors helps me learn
20. Using metaphors helps me discover new insights about the world
21. I use (or would use) figurative language in my formal speeches or presentations

**Factor 2: Dislike Figurative language**

1. My imagination is more activated by literal than figurative language
2. Literal language is usually more stimulating than figurative language
3. Literal language is usually more exciting than figurative language
4. I find most figurative language irritating
5. Figurative language makes thoughts too vague
6. My imagination is more activated by figurative than by literal language*
7. Figurative language hides the real meaning
8. I prefer speeches that do not include figurative language
9. Figurative language is usually more interesting than literal language*
10. I could do without figurative language in most situations
11. I enjoy figurative language*
12. I think it is silly to compare two unrelated ideas metaphorically
13. Metaphor usually distorts reality
14. I enjoy concrete language
15. Figurative language is usually more vivid than literal language*
16. I prefer texts that include figurative language*
17. Figurative language should only be used in literary works
18. I prefer to study from a text written in literal language
19. Literal language is closer to the truth than figurative language
Factor 3: Affinity for studying with Figurative language

1. Scientific writing which includes figurative language is easier to understand
2. Scientific writing which includes figurative language is more interesting
3. I prefer to study scientific texts which include figurative language
4. I learn best technical material that is related metaphorically to things that I already know
5. Metaphors help me remember facts
6. I like for teachers to use figurative language when they speak
7. Figurative language is usually more informative than literal language
8. I learn best technical material that is described literally and concretely

* Denotes negatively loaded item
# Session Rating Scale (SRS V.3.0)

| Name ________________________ | Age (Yrs):____ |
| ID# _________________________ | Sex: M / F |
| Session # ____ | Date: ________________________ |

Please rate today’s session by placing a mark on the line nearest to the description that best fits your experience.

## Relationship

<table>
<thead>
<tr>
<th>I did not feel heard, understood, and respected.</th>
<th>I felt heard, understood, and respected.</th>
</tr>
</thead>
</table>

## Goals and Topics

<table>
<thead>
<tr>
<th>We did not work on or talk about what I wanted to work on and talk about.</th>
<th>We worked on and talked about what I wanted to work on and talk about.</th>
</tr>
</thead>
</table>

## Approach or Method

<table>
<thead>
<tr>
<th>The therapist’s approach is not a good fit for me.</th>
<th>The therapist’s approach is a good fit for me.</th>
</tr>
</thead>
</table>

## Overall

<table>
<thead>
<tr>
<th>There was something missing in the session today.</th>
<th>Overall, today’s session was right for me.</th>
</tr>
</thead>
</table>
Working Alliance Inventory – Short Form – Revised

Instructions: Below are a series of statements about experiences people might have with their therapy or therapist. For each statement, please take your time to consider your own experience and then put a circle around the number that fits your experience. Important: The rating scale is not the same for all the statements. PLEASE READ CAREFULLY!

1. As a result of these sessions I am clearer as to how I might be able to change.

   1  2  3  4  5

   Seldom  Sometimes  Fairly Often  Very Often  Always

2. What I am doing in therapy gives me new ways of looking at my problem.

   1  2  3  4  5

   Seldom  Sometimes  Fairly Often  Very Often  Always

3. I believe my therapist likes me.

   5  4  3  2  1

   Always  Very Often  Fairly Often  Sometimes  Seldom

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4. My therapist and I collaborate on setting goals for my therapy.

1  2  3  4  5

Seldom  Sometimes  Fairly Often  Very Often  Always

5. My therapist and I respect each other.

5  4  3  2  1

Always  Very Often  Fairly Often  Sometimes  Seldom

6. My therapist and I are working towards mutually agreed upon goals.

5  4  3  2  1

Always  Very Often  Fairly Often  Sometimes  Seldom

7. I feel that my therapist appreciates me.

5  4  3  2  1

Always  Very Often  Fairly Often  Sometimes  Seldom

8. My therapist and I agree on what is important for me to work on.

1  2  3  4  5

Seldom  Sometimes  Fairly Often  Very Often  Always
9. I feel that my therapist cares about me even when I do things that he/she does not approve of.

5  4  3  2  1

Always  Very Often  Fairly Often  Sometimes  Seldom

10. I feel that the things I do in therapy will help me to accomplish the changes that I want.

1  2  3  4  5

Seldom  Sometimes  Fairly Often  Very Often  Always

11. My therapist and I have established a good understanding of the kind of changes that would be good for me.

1  2  3  4  5

Seldom  Sometimes  Fairly Often  Very Often  Always

12. I believe the way we are working with my problem is correct.

5  4  3  2  1

Always  Very Often  Fairly Often  Sometimes  Seldom
Stem- Sentences Test (SST) (Kaviani and Hamedi (2011))

(This was used as a training tool only. Results were not formally evaluated)

Please complete each item below as a complete sentence.

1. My life is like …..
2. For me, the future is like …. 
3. Relationship with other people is like …. 
4. When I think about the past, I see it like …. 
5. I see myself as someone who …. 
6. To me, depression is like …. 
7. Failure is like …. 
8. Other people think I am like … 
9. Making an effort in this life is like …

Metaphor-enhanced CBT workshop evaluation

(This relates to Chapter 7 and was administered immediately before and after the metaphor workshops)

Name: __________________________

The rating scale is:
0 Not at all
1 Somewhat
2 Moderately
3 Very much
4 Extremely

To what extent:

1. do you intentionally use metaphors in therapy? 0 1 2 3 4
2. do you think metaphors are important in therapy? 0 1 2 3 4
3. do you feel confident to respond intentionally to metaphors in your clinical work 0 1 2 3 4
4. are you aware of metaphoric language occurring in treatment sessions 0 1 2 3 4
5. do you feel confident to develop shared metaphors with clients 0 1 2 3 4

To what extent did the workshops:

6. stimulate my interest in using metaphor in CBT sessions? 0 1 2 3 4
7. use appropriate teaching methods? 0 1 2 3 4
8. provide content was relevant to my clinical work 0 1 2 3 4
9. provide useful additional readings and handouts 0 1 2 3 4
10. balance theoretical and applied learning 0 1 2 3 4
11. provide workshop content that was at an appropriate level of difficulty 0 1 2 3 4
12. cover a manageable amount of material 0 1 2 3 4
13. pace the content appropriately 0 1 2 3 4
14. Provide enough opportunity to practice clinical skills

|   0 | 1 | 2 | 3 | 4 |

Please answer the following additional questions:

15. How likely are you to recommend this workshop to a colleague?

|   0 | 1 | 2 | 3 | 4 |

16. The change I would most like to see in the workshops is:

17. For me, the barriers to using metaphor enhanced CBT are:

18. I will attempt to address these by:

19. Any other comments:

Are you willing to be emailed short likert scale follow up evaluations (similar to this) in one and three months’ time? YES/NO

Would you be willing to be contacted regarding the possibility of participating in a study applying metaphors with clients in some way? (please not this would not commit you to anything) YES/NO

Thank you very much for completing this evaluation
Metaphor-enhanced CBT one and three month post-workshop evaluation

(This relates to Chapter 7)

Name_____________________

The rating scale is:
0  Not at all
1  Somewhat
2  Moderately
3  Very much
4  Extremely

To what extent:

1. do you intentionally use metaphors in therapy? 0 1 2 3 4
2. do you think metaphors are important in therapy? 0 1 2 3 4
3. do you feel confident to respond intentionally to metaphors in your clinical work? 0 1 2 3 4
4. are you aware of metaphoric language occurring in treatment sessions 0 1 2 3 4
5. do you feel confident to develop shared metaphors with clients 0 1 2 3 4

Application questions

Please answer the following additional questions:

6. Has the frequency of your intentional use of metaphoric language increased? 0 1 2 3 4
7. How well have your clients responded well to metaphor-enhanced conceptualisations? 0 1 2 3 4
8. I have used the stem sentences test as a prompt: 0 1 2 3 4
9. I have used the metaphor protocols (steps) provided during the training 0 1 2 3 4
10. I have spent more time elaborating on client generated metaphors than previously 0 1 2 3 4

I have intentionally used metaphors during:

11. • engagement & goal setting 0 1 2 3 4
12. • 5 part model/ conceptualisation 0 1 2 3 4
13. • Rationales for Automatic thought records

14. • During problem solving

15. • In rationale for Behavioural experiments

16. • Relapse prevention

17. • Other times (please specify)

18. For me the barriers to using metaphor enhanced CBT are:

19. Future workshops could address this by:

20. Please feel free to comment on how you and your clients experienced the metaphor-enhanced CBT:

Thank you very much for completing this evaluation
Appendix F. Therapy protocols and recommendations for using metaphor in therapy

Seven step protocol (Kopp 1995)

Kopp (1995) comes from an Adlerian background and has developed an entire metaphor-based approach to therapy. His approach is to assist the client to explore and transform their own metaphors through inviting the client to identify associated imagery and inviting them to change the image, then inviting them to consider the implications of this for them.

Kopp’s 7 steps are:
1. Notice the client metaphor: Write it down verbatim
2. Invite the client to explore the metaphoric image by asking ‘When you think of (the metaphor) what image/picture comes to mind? Or ‘What does (the metaphor) look like?’
3. Explore the metaphor as a sensory image. Therapists should avoid adding new content to the metaphor by asking only open-ended questions such as
   i) Setting: ‘what else do you see? Or ‘Describe the scene or an aspect of the scene [associated with the metaphoric image]
   ii) Action/Interaction: ‘What else is going on [in the metaphoric image]?’ or ‘What are the other people doing/saying/thinking?’
   iii) Time: What led up to this (the image)?’ or ‘What was happening just before [the metaphoric image] ‘What happens next?’ and ‘how does it turn out?’
4. Invite the client to describe feelings and experience associated with the image: ‘What is it like to be [the metaphoric image]?’ or ‘What is your experience of [the metaphoric image]?’ or ‘What are you feeling as you [the metaphoric image]?’ The therapist should guide exploration but carefully avoid introducing new content to the image themselves.
5. Invite transformation of the image: ‘If you could change the image in any way, how would you change it?’ or the therapist can suggest a change: ‘What if the [part of the metaphor to be changed] were a [suggested change].
6. Invite the client to ‘bridge back’ to the original situation: ‘What connections (parallels) do you see between your image of [the metaphoric image] and [the original situation]?’
   ‘How might the way you changed the image apply to your current situation?’
7. Apply the changed image to the current situation: ‘How might the changed image apply to your current situation?’ (Burns, 2007), p. 34
Sims 6-stage protocol

This approach was developed for working with families (Sims, 2003; Sims & Whynot, 1997).

1. Hear the metaphor (rather than simply assuming meaning, hear that metaphorical language has been used)
2. Validate (i.e. affirm) the metaphor (show interest and express value for the words used)
3. Expand the metaphor (ask about associated emotions, images, treating the metaphor as an embryonic story)
4. Play with the possibilities (for therapy with more than one patient, e.g. family therapy, this step also includes involving others) (explore meaning; through this new possibilities of meaning may emerge)
5. Marking and selection (select from aspects of the metaphor’s expanded significance those that promote the current treatment goals)
6. Connection with the future (the metaphor is now used to refer to themes and tasks for future therapy)

Ronen’s 5 stage protocol

Suggested steps from working with client generated metaphors within CBT from Ronen (2011):

1. Listen to clients and pinpoint casual use of metaphorical language
2. Invite clients to explore metaphorical images
3. Ask clients to experience and practice concentrating on the feelings and sensations elicited by the metaphors. Help clients shift attention to each sense to feel it more fully.
4. Invite clients to talk more about metaphors (a cognitive step) to better understand their meaning.
5. Invite clients to transform metaphors by changing the metaphorical images or meanings. Offer the idea of extending the metaphor at hand or of adding another metaphor to change its meaning.
Butler, Fennell and Hackmann’s approach (Butler et al., 2008)

1. Explore the felt sense (focus on a recurrent problem, a typical upsetting situation. Bring to mind a recent example, focussing on the emotions felt in that situation. Reflect on thoughts and feelings, and exactly what is experienced in the body)

2. Evoke a metaphor (having tuned in to the whole ‘felt sense’, let a metaphorical image arise that somehow stands for how all this feels. When an image arises, try to stay with it, even if it seems odd or banal. If several occur, choose the one that seems to be the most compelling)

3. Explore the metaphor (Consider all the sensory aspects of the image: sights, sounds, smells, size, texture, and so on. Also what it looks like from various angles, and distances, and associated feelings)

4. Reflect on the meaning (reflect on the meaning of this metaphorical image for the problem: what does it mean about the self, about others, and about the world? What is the history of this image? Does it resonate with any past experiences?)

5. Consider change (If this metaphor represents a predicament, what needs to happen to resolve the problem? What would need to change within the image? What would need to happen in real life?)

6. Visualise change (Staying with the metaphorical image, try to see these changes taking place and find ways of changing the picture to make this happen. May need to try a number of changes before a worthwhile shift occurs. Some changes that seem easy in prospect may prove impossible. There will be a change in affect, and the change will feel steady and complete, when the shift of perspective is made).

7. Reflect on the new metaphorical image and its meaning (If it feels better like this, what does the new metaphor mean about the self, others and the world? If it were possible to see the situation like this, how would this change the emotions and other reactions?)

8. Plan to test out the new perspective (In what situations could the new perspective be tested out? How could this be achieved (i.e. what would be appropriate behavioural experiments?)

Tay’s seven step protocol

A seven step protocol is described by linguist Dennis Tay (2016) (adapted from Tay (2012)), following his critique of several of the protocols above (Tay, 2013):
1) Notice metaphors
2) What does the metaphor look like?
3) Explore the metaphor as a sensory image
4) What is it like to be/ what are you feeling as you [the metaphoric image]?
5) If you could change the image in any way, how would you change it?
6) What connections do you see between [the metaphoric image] and the original situation?

Enhancement: If the focus is to discover previously unconsidered elements/relations in the client’s life circumstances:
- Expand the vehicle to elicit different entities, focusing on the relations between them;
- Transfer these attributes and relations to corresponding ones in the topic
- If the focus is to discover previously unconsidered attributes that characterise the client’s life circumstances, use class inclusion metaphor type:
  - Focus on attributes of source domain entities which could be applied to the topic;
  - Transfer these attributes and emphasise their applicability to both vehicle and topic.

7) How might the way you changed the image apply to the current situation?

**Recommendations**

Recommendations (as opposed to step by step protocols) for therapists have also been made:

**Bayne and Thompson (2000):**

1) Recognise that a client has moved out of the literal mode and is speaking figuratively. Conventional metaphors may be the most difficult to notice, requiring greater alertness by the therapist.

2) Decide whether or not to respond to the metaphor immediately. It would be a mistake to pounce on every metaphor in terms of making a verbal response. ‘Respond’ could include an internal response of resonating with the metaphor, according to Bayne & Thompson, Choose, either deliberately or intuitively, one of these four strategies: explicate (i.e. reflective listening, using the client’s language, to promote greater self-disclosure), extend, create and deliver, remember for possible future use. Which strategy is chosen depends on factors such as the personality and communication
styles of the therapist and client, the quality of the working alliance and the theoretical model(s) used by the therapist.

**Törneke’s approach (Törneke, 2017)**

This ACT-based approach to using metaphor in therapy is based on three principles based on relational frame theory (which is the theoretical model used in Acceptance and Commitment Therapy, described in section 2.9.2).

The ACT approach involves:

1. **Functional analysis:** The aim of this strategy is to help the client understand the link between the strategies s/he currently uses and the difficulties s/he experiences.
2. **Establishing an observational distance:** Learning to observe spontaneously triggered responses, so that we can change how we interact with these responses.
3. **Clarifying what is important in life and what concrete steps can be taken in that direction:** Identifying important values and learning to do things that have no short-term payoff, even when these things are painful.

Törneke explains three principles by which metaphors can be used in clinical work within the above ACT approach.

1) The metaphor’s topic must be a phenomenon that has an important function for the individual client.
2) The metaphor’s vehicle must correspond to essential features of its target.
3) The metaphor’s vehicle must contain a property or function that is more salient there than it is in the metaphor’s topic.

The approach taken by Törneke (2017) is consistent with a CBT approach in that there is a focus on functional analysis of the client’s problems (akin to CBT conceptualisation but with a different theoretical framework). The approach provides some clear guidance as to how a metaphor might be selected that corresponds to essential features of an important therapy topic and which contains a property or function that is more salient than the metaphor topic. However, salience is subjective and likely to vary between individuals. This quality may therefore not be a particularly reliable guide.
Appendix G: Other tools and measures

The EXP Scale (Levitt, Korman, & Angus, 2000; Rowat, Stefano, & Drapeau, 2008; Stuart, 1997)

The short version of the Bern Post Session report (Flückiger, Caspar, Holtforth, & Willutzki, 2009)

The Session Evaluation Questionnaire (Cummings, Hallberg, Slemon, & Martin, 1992; Stiles & Snow, 1984)

Therapeutic Information Processing Scales (Martin, Paivio, & Labadie, 1990)

The Session Progress Scale (Kolden, 1991; Kolden & Howard, 1992)

Episodic Memory Questionnaire Episodic Memory Questionnaire (Martin, Cummings, & Halberg, 1992)

Therapeutic Impacts Content Analysis System (Castonguay et al., 2010)
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Tuesday, 17 July 2018

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