2012

Dwell in possibility : an exploration of the use of metaphor in psychotherapy : a project based on interviews with fourteen psychotherapists

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An Exploration Of the Use of
Metaphor in Psychotherapy

ABSTRACT

This qualitative study explored the use of metaphor in psychotherapy. Fourteen interviews were conducted with psychotherapists with a variety of training and expertise. Each clinician was asked the same six interview questions which attempted to shed light on which metaphors in particular emerged during treatment with patients, whether or not these metaphors reflected the patient's history or diagnosis, the metaphor's relationship to patient affect, the metaphor's influence on the therapeutic alliance, as well as other topics.

Primary themes that emerged in multiple interviews included the fact that metaphor may arise from various sources, including dreams as well as spontaneous co-creations in the therapeutic encounter. Furthermore, metaphor was found to be a useful tool in the process of externalization and subsequent integration of parts of the self that have not yet been adequately acknowledged. Metaphor also was found to be conducive to playfulness via language that is capable of bypassing an exclusively cognitive space to connote affect and sensation via stark imagery, and necessitates a stance of openness and receptivity on the part of the clinician who is handling these salient symbols. Finally, therapy itself was conceptualized as metaphorical as it involves the interplay between two individuals via transference and counter-transference so that the patient's experience is filtered through the psychotherapist's.

DWELL IN POSSIBILITY: AN EXPLORATION OF THE USE OF METAPHOR IN PSYCHOTHERAPY

A project based on interviews with fourteen psychotherapists, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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2012

ACKNOWLEDGEMENTS

I would like to thank the psychotherapists who took time out of their daily lives to contribute to this thesis via interviews. I was both moved and inspired by their dedication to this important work and their critical thinking regarding how language has the potential to be curative, even given it's incredible limitations.

I would also like to thank my thesis advisor, Roger Miller, for assisting me throughout this process.

And lastly, this thesis is dedicated to a specific Jungian psychotherapist who reminded me, during our interview, that therapy is an art where the therapist is a poet, reworking the possibilities and associations which arise in the patient. This interview reminded me once more why I had entered this field in the first place, and even more why it is imperative to view life through the lens of metaphor: that it is an ethical choice, in the end, and that, though literalism tempts us at every moment, to recognize that *nothing is what it seems* is a great source of energy and inspiration.

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CHAPTER I
INTRODUCTION

Emily Dickinson once wrote, “I dwell in Possibility / - a Fairer House than Prose” (Dickinson, 1960, p. 55). One could argue that because Emily was a poet, the “possibility” she spoke of was poetry, “a Fairer House than Prose / - More Numerous of Windows – Superior – for Doors” (Dickinson, 1950, p. 55).

Indeed poetry is rarely a “Fairer House than Prose” without metaphor, that abstract and tenuous literary device defined most commonly and simply as “one thing in terms of another” or “a figure of speech in which a word or phrase is applied to something to which it is not literally applicable” (Mays, 1990, p. 425). However even its mere definition seems vague and abstract. One is left immediately with questions: couldn’t metaphor then be so various as to almost elude definition, as abstract connections could potentially be made between all sorts of disparate things—as so often happens in the unconscious? The “dwelling in Possibility” that Dickinson depicts is a dive into the multifaceted world of metaphor, where words connote images and connections that depict the self in its true fluidity.

Poetry is not the only space where metaphor exists and has the capacity to shift and spark the psyche. The currency in the clinical encounter between patient and therapist is language; language is the tool we depend on to enliven, to deepen, to connect and associate. Mere words do what they can to communicate a deep conflict or an unidentified feeling that lurks and threatens, but often, as in the case of prose, the windows are not as various or as expansive in literal explanations and phrases as they are in the possibility of the figurative, in the immediacy of the apt metaphor.

Metaphors abound in the therapeutic encounter, arising both from the therapist as well as the patient. This thesis seeks to demonstrate, via the perspectives of clinicians extracted from fourteen interviews, how metaphor has been used and perceived by clinicians in their work. It sheds light on not only metaphors which emerged during the therapeutic encounter but also the metaphor's influence on the patient's affect, the therapist's stance in the face of metaphor, the playfulness inherent in figurative language and the way in which metaphor has the power to bypasses the limits of cognition and implicate the senses given its vivid imagery.

Because each participant came from a different background as far as training and expertise were concerned, theories regarding metaphor were extensive and eclectic. However shared perspectives did emerge, and a general consensus regarding the power of metaphor to articulate in a different manner was evident. Many clinicians spoke about the capacity metaphor had to concretize parts of the self and externalize these parts so as to address them directly. In "anthropomorphizing" (as one clinician put it) fragments of the self by making metaphors out of these parts, one can then seek to fit the pieces back together through interrogating each part to perceive its place in the whole. Depending on the therapist, this was accomplished via role-playing, the use of props and psychodrama, and/or a nuanced exploration of the metaphor via verbal engagement with it on the part of the therapist as well as the patient. Occasionally, the metaphor was followed through time and so its mutability was witnessed, reflecting the state of the self in its process of development.

Metaphors spring from various sources but tend to be uniquely personal, crystallizing a conflict or providing a road map for where to proceed next. Many clinicians identified clients' dreams and dream imagery as providing apt metaphors for exploration, freeing up what had come to be a monotone treatment: enlivening it, providing it with a new and pertinent direction.

Clinicians trained in forms of therapy where specific tools were utilized to manage troubling emotional states speak of the tools themselves as metaphors, as transitional objects that can be used to monitor affect outside of the therapist's office. Many of the metaphors then served as a gauge, lending abstract feeling states a spatial and temporal quality. Associating an image with what was yet-to-be-articulated but yet felt to such an extreme allowed patients to gain a sense of control over what seemed to be overpowering due to its incoherence.

Perhaps some of the strength of the metaphor is its capacity to bypass cognition and tune into the energy of the body, reintroducing long-repressed affect. Many clinicians conceptualized of metaphor as a window into the prohibitions of the self, a way to view—without judgment—what has been denied—be it behaviors, emotions or reactions—for the sake of continued survival or in order to maintain a crucial relationship with a caregiver for example. Metaphors hint at what has been shut away but not abolished, as clinicians reported that such denials often rise up again in symbols. These metaphors house energies that have not yet been integrated into the self, and so may spark fear and caution on the part of the patient. They may also be associated with a memory that resists integration, such as a moment of trauma. Conversely, many metaphors mentioned by clients to clinicians were sustaining and buoying, encapsulating a buried resilience or an untapped hope. In each case, the metaphor desired confrontation and integration, and we learn that the job of the clinician is to allow the patient to engage in this process, unhindered by internal judgment or fear.

Many clinicians spoke about the appropriate stance to take in the face of the metaphor, about the way in which the clinician's relationship to the symbolic defines, in some sense, how the integration will occur within the client. The fine balance between reaching after a pure meaning for the metaphor and letting the metaphor dwell in possibility was described by many as

being a necessary yet complicated process. How can a metaphor be curative if it is not concretely defined, if its meaning is not extracted? Yet if the self is fluid and not static, if the self in its nature is always subject to change, then won't a metaphor navigate towards new meanings over time? It is then the job of the clinician to maintain an openness of mind that invites and coaxes the metaphors to emerge but also to transform.

Finally, the bond between patient and therapist was conceptualized not only in the preexisting literature but also throughout the interviews as possibly metaphorical in itself as "nothing is what it seems" and the very nature of transference is one person *in the terms of another*. In addition, empathy is metaphorical, as we understand our patient's pain via our own experience of pain. Some clinicians spoke only of the way in which clinical practice asks of one to consistently dwell in possibility, as taking what a client says or how he or she behaves or reacts *literally* is eradicating the complexity of motivation. Furthermore, if a client was denied the joy of exploration and play as a child, responding to a client's metaphors is akin to communicating an acceptance of spontaneity, humor and, of course, playfulness. This can be curative, a corrective emotional experience for the patient who then may begin to look upon his or her inclinations to imagine, create and explore with curiosity and compassion.

In conclusion, it was generally agreed upon that metaphors are very hard to escape and that, when heeded and attended to, represent a very subjective relationship in regards to shared and recurring struggles in human existence. Though a similar metaphor may arise for different patients, it is the patient's subjective construction of and response to the metaphor that becomes fodder for examination. The subjective memories and struggles of the patient are imbedded in the metaphor like the lines of a fossil on a rock: at once long past and eternal.

CHAPTER II
LITERATURE REVIEW

In much of the preexisting literature regarding metaphor and psychotherapy, a common definition of metaphor emerges. This definition, though quite simple on the surface, suggests that metaphor's surreptitious nature is explained by its capacity to express "one thing in terms of another, shedding new light on the character of what is being described" (Mays, 1990, p. 423). Metaphor is *possibility*, expansive by nature, introducing "additional associations and connections" that have hitherto been left untapped (Waldron, 2010, p. 74). As Ellen Siegelman (1990) writes in her book *Metaphor and Meaning in Psychotherapy*, metaphor is able to "hint without attacking" (p. 103). A patient is in turn able to "entertain a possibility he or she is defending against" due to the fact that metaphor is not plain speech but figurative language, a way of "playing" with reality so as to liberate it from the threat of literalism, from the blacks and whites of splitting (Siegelman, 1990, p. 104). Literalism gives way to the complex layers of thought and language, where the psychotherapist reflects back to the patient the "symbolic attitude" via metaphor: a stance that subtly casts off the safety of the concrete for the expansiveness of the allegorical (Siegelman, 1990, p. 175).

This is all assuming, however, that the individual patient will engage in metaphor and will recognize the significance of doing so. Though much of the literature supports the notion that patients take to metaphors, it is also argued that the way in which a patient responds to metaphor and even the metaphors that a patient introduces reflect the struggles specific to the patient and so may embody diagnosis. Figurative language is potentially threatening as it asks

the individual to unearth the complexity in regards to fragile psychic material…and to allow the therapist to do so as well. This may require a bit of trust on the part of the defended patient.

Thus a patient's trust in others and in reality may be mirrored in his or her capacity to hold the depressive position of the figurative and actively respond to metaphor. For example, though Siegelman (1990) argues, "Some…feel that interpreting within the metaphor is especially useful with borderline patients" so as to "show them that they are heard and to enter into their frightening or shadowy world in a way that preserves distance while maintaining connection," one study suggests that this process may not be so simple (p. 84). Using qualitative analysis to explore metaphor use in a single therapy session with two patient-therapist dyads where the patients were diagnosed with Borderline Personality Disorder, and two patient-therapist dyads where the patients were not diagnosed with BPD, the results of the study suggest that those patients diagnosed with borderline may not take to metaphor so easily (Rasmussen & Angus, 1996). The dyads were asked to listen to audio-recorded psychotherapy sessions and to reflect on what they (both patient and therapist) were thinking and feeling during moments when metaphor was being used, in an effort to determine and depict the "phenomenological experience of the participants associated with the metaphoric sequences from the clinical interview" (Rasmussen & Angus, 1996, p. 524).

In borderline and non-borderline patients alike, "metaphors functioned as links to associative phenomena, often steeped in childhood experience" (Rasmussen & Angus, 1996, p. 528). However, those diagnosed with borderline had a harder time using the metaphor to develop "conceptual bridges" or "stable themes" which could be returned to in subsequent sessions (Rasmussen & Angus, 1996, p. 528). Conversely, a "shared therapeutic vocabulary" was developed through metaphor use amongst the participants not diagnosed with borderline and

their therapists, suggesting that the capacity to which a patient can sustain metaphor reflects also a capacity to sustain the reciprocity of therapeutic inquiry and language, a capacity that may be encouraged or discouraged by patient diagnosis (Rasmussen & Angus, 1996, p. 528). It is important to note that this thesis will not concern itself with the diagnosis of patients specifically, but more the content of the patient's metaphors and the way in which this content reflects a history of memory and experience.

Just as the degree to which a patient is able to *maintain* metaphor may be a reflection of diagnosis, so may the *content* of the patient's metaphors. Two studies explored the reoccurring metaphor amongst patients diagnosed with Major Depressive Disorder of "carrying a burden" where the predominant fear is one of "weighing down" loved ones with a perceived "heaviness of need" (Levitt, Korman & Angus, 2000; McMullen, 1999). The internal self-reproach we associate with the experience of depression is given an image and a physical sensation; it is made heavy, threatening its ominous and lonely weight via metaphor.

In productive therapy, one of the aforementioned studies suggests, metaphor transforms over time to reflect increased insight and a reconstruction of the patient's individual narrative (Leavitt et al., 2000). This correlation study used two dyads (one male patient and his therapist, one female patient and her therapist) where the patient experienced his or herself as a "burden" to others. The degree of patient emotional involvement in therapy was measured as it related to occurrence of metaphoric phrases during the treatment; emotional involvement was measured using a scale that gauged the patient's "ability to explore his or her inner state and his or her ability to be guided by an inner referent" (Leavitt et al., 2000, p. 27). Burden metaphors were then coded and measured for their frequency and transformation over time. Productive therapy was found to be transpiring in the "good outcome dyad" as measured by the degree to which the

"burden" metaphor was reframed over time to define hope as an unburdened state. Conversely, the "burden" metaphor did not evolve in the "bad outcome dyad" but instead remained in a perpetual stasis (Leavitt et al., 2000). As Ellen Siegelman (1990) suggests, key metaphors should "shift as therapy enables the patient to change his or her basic sense of self" (p. 64). "Images of constriction and limitation should gradually give way to images of expansion and possibility," while "metaphors of isolation" transform into "metaphors of connection" (Siegelman, 1990, p. 72).

In turn, it may be that the degree to which a patient can engage and follow the threads of metaphor—perhaps even attach his or herself to metaphor so as to lend it power to unravel and transform—depends on the patient's ability to trust what is multifaceted and not immediately reducible. Siegelman (1990) suggests that the psychotic patient takes metaphors as literal; the schizophrenic experiences a "true loss of deliberateness" in that "my father *is* an armored tank" (p. 165). The creative comparison is lost; the distance between the imagined object and its likeness closes completely. This phenomenon is often evident in the psychotic patient's response to proverbs.

We may begin to understand, then, how a patient perceives the world and others through the tool of metaphor. Not only will we begin to gauge how the patient responds to indefiniteness (as it is an essential quality of metaphor), but we will also gauge something about the history of the patient and his relationship to his internal world via the metaphors he uses. As metaphor has the potential to lend coherence to vaguely sensed memories that may not be integrated into one's overarching narrative, research suggests that these "vaguely sensed" experiences will be revealed, like it or not, via the reoccurring and emotionally-charged metaphor (Berlin et al.,

1991; Holmes, 2004; Houssier et al, 2011; Kopp & Eckstein, 2004; Martins, 2005; Siegelman, 1990).

II.

An intense, unprocessed feeling, born in response to a fragmenting experience, may convert itself into a symptom—but the symptom presents a restricted view, a "wordless presentation of an unnamable dilemma—an abortive metaphor that stops below the level of speech" (Wright, 1976, as cited in Siegelman, 1990, p. 32). Like the symptom, the metaphor is "born out of intense feeling" but unlike the symptom, it does not stop before speech occurs; instead, it does quite the opposite by approximating via the figurative what may be "too vague, too complex or too intense for ordinary speech" (Siegelman, 1990. p. 36). The psychotherapist acts as an interpreter, translating the silencing and silenced symptom into a verbalized metaphor so as to "undo the symptom" (Lakoff, 1980, as cited in Siegelman, 1990, p. 36).

All this is accomplished, research shows, because of the surreptitious nature of metaphor. Traumatic, repressed memories are temporarily and indirectly conceptualized as having a visceral quality via metaphor; thus sensation is linked to experience without directly confronting either initially. However, it should be noted that the "need to disguise" is not paramount to metaphor (Siegelman, 1990, p. 81). Instead, it may be that the experience which the metaphor encapsulates eludes direct expression due to the fact that the affects related to the experience are "overwhelmingly strong" and so were never articulated and so never integrated into the comprehensible, familiar narrative of everyday life (Siegelman, 1990, p. 81).

A study of trauma explored a patient's repeated use of the metaphor of "heat," manifested in his experience of his skin as constantly "on fire" and "burning" (Houssier et al,

2011). The patient, having experienced incestuous relations with his mother and sexual and physical abuse at a very young age, began (alongside his therapist) to conceptualize of his metaphor as indicative of early experiences of sexual arousal towards his mother. This arousal had hitherto been repressed but was unearthed and explored given the patient's interaction with his metaphor. In following the metaphor's leads together, the therapist and the patient were also able to retrieve a forgotten memory of the patient's where he was forced by a babysitter to put his hand on top of a scalding hot stove (Houssier et al, 2011). Thus the physical sensation of sexual arousal, equated with heat in the patient's psyche, and the actual memory of touching a hot surface, are embodied in the metaphors of "fire" and "burning" on the patient's skin. A trauma history is embodied in the metaphor and in its associations: what should have been warm and safe (a mother's love, a babysitter's watch) was scalding hot and dangerous—sexually in the case of the mother and her desire, physically in the case of the babysitter and her command. And both experiences, having their "origin in (the) psychophysical," represent pain and confusion and so create a "live metaphor" of heat where the underlying affect must be processed and controlled (Siegelman, 1990, p. 32).

If "true insight occurs in and through the body," (Siegelman, 1990, p. 24) then psychosomatic patients, such as David, a patient diagnosed with Irritable Bowel Syndrome and struggling with a history of repression, (or, in his words, a "constipated mentality"), are invested in the language of the physical symptom (Kohutis, 2010, p. 421). "Instead of talking it out," David explains to his therapist during the course of this theoretical study, "I'm shitting it out" (Kohutis, 2010, p. 423).

We learn that David's childhood was one in which his innocent fantasies, such as "what it would be like to fly," were often "firmly squelched" by a father who demanded that he remain

sensible (which is itself a form of literalism) when his imagination was inviting him to play (Kohutis, 2010, p. 426). David, in response to his father's demands, became "preoccupied with control," a preoccupation that was "challenged by his uncooperative gut"—the voice of opposition (Kohutis, 2010, p. 420). Though we learn that treatment with David involved confronting his defensiveness, which manifested itself often in his tendency to remain concrete, "what eventually taught him," the author explains, "were his symptoms" (Kohutis, 2010, p. 426). She continues, "The language of his gut was David's entrée into the language of feeling" (Kohutis, 2010, p. 426).

The patient's "fiery bowels," (akin to the "fire" depicted in the aforementioned case of trauma), revealed underlying, repressed negative affect regarding the early impingements on David's fantasy world and innocent, imaginative inquiries. His bowels were attempting to "say something about his inner world" and David learned, through therapy, to conceptualize of his symptoms as not purely physical but metaphorical as well (Kohutis, 2010, p. 417). He therefore learned to think "metaphorically about his gut," inspecting the symptom for its symbolism and listening for its message (Kohutis, 2010, p. 428). The psychotherapist worked to give back to David what had initially been denied him: the capacity to free associate which is akin to the play of children…the free, unfettered expression of the self where symbolic thought expands because it is welcomed.

III.

In both the case of David and the trauma patient, we see how metaphor can unearth what has hitherto been repressed. Once unearthed, the affect associated with the repressed experience may begin to flow once more, freed from its clogged position via metaphor. "Metaphor flows

from affect," Siegelman (1990) writes, "because it usually represents the need to articulate a pressing inner experience of oneself and one's internalized objects" (p. 16). The aforementioned examples represent the way in which what has historically been clogged in the psyche becomes integrated or "mentalized" once more using figurative language. Mentalization, then, can be defined as the welcoming back of a part of the self, or a memory, into the natural flow of thought.

This phenomenon transpires quite clearly in a study of metaphor use amongst four patients using a qualitative research design. All patients carried different diagnoses, but it was found, via the analysis of transcriptions for metaphors (which were subsequently grouped by theme), that "mentalizing exchanges"—or exchanges that consisted of the therapist assisting the patient with exercises such as "focusing on mental states" or "sensitizing the patient to affective states"—occurred to a greater extent and with more intensity when metaphor was used (Long & Lepper, 2008, p. 361).

Metaphor is, then, a new kind of cognition, encouraging the integration of affect related to historically repressed sensations that live not only in and through the body, but also in the recesses of the psyche. As we have gauged from the aforementioned studies, patient may begin to integrate what has been left unspoken and unexamined via metaphor, which provides an artful and multifaceted mode of articulation and avoids the bleak safety of the concrete.

But a patient must first wish to engage metaphor and must desire to experiment with the symbolic attitude that the psychotherapist embodies and attempts to introduce into the patient's psychological repertoire. This requires, of course, a strong therapeutic alliance—which is, by nature, metaphorical itself. As metaphor is defined as understanding one thing in the terms of another, therapy embodies correlation as the psychotherapist may only understand the patient's

pain in terms of his or her own experience of pain. Therapy is indeed one person in the terms of another where the "deliberate yoking of the counter transference" is "metaphorical" in that past relational patterns are examined in the terms of the present alliance between therapist and patient (Siegelman, 1990, p. 104).

If we recall the case of the psychosomatic patient, David, we can only assume that the therapist and David had a strong alliance that enabled David to trust the process enough to shift his literal understanding of his symptoms as purely physical to a more metaphorical, more expansive understanding of his somatic complaints. He grew to see his physical symptoms as embodying his psychic struggles, even giving them a voice. The curative aspect of David's shift in understanding is a result of his eventual willingness to play with his language—the "fiery bowels"—so as to explore the significance behind the metaphor of "fire" and its symbolism in his unique narrative. Because his therapist was presumably empathic and attuned, he or she was able to hold David in a new relational experience. David's tendency to approach his symptoms in terms of black and white where "a thing either is or is not" and the "literal meaning of something is the only meaning" can in his case and in others be attributed to "the excessive early impingement of controlling or disturbed parents" (Siegelman, 1990, p. 169). We see evidence of this in David's father's response to David's childhood fantasy regarding flying; David's father responded judgmentally, discouraging David's imaginative capacity. David, then, is "forced to construct boundaries rigidly and prematurely," which leads him to adopt a "flattened realism" (Siegelman, 1990, p. 169). He is no longer curious about his physical symptoms; they are interpreted in literal terms. However, the therapist is curious about David's symptoms, inviting him to speculate about them even if the speculation feels arbitrary. The therapeutic alliance becomes not only a trust in the other, but a trust in the symbolic, a trust that reality will stay

intact—and perhaps even become a bit richer—even in the context of free association. To a patient like David whose navigation towards imagination was always denied, the symbolic attitude can be anxiety provoking, a threat to one's sense of the clarity and orderliness of reality. But beyond the blacks and whites of literalism is the poetic iridescence of complexity: the therapist invites the patient to play once again via metaphor and the patient, albeit apprehensive, accepts.

CHAPTER III
CONCEPUTALIZATION: WHY STUDY METAPHOR?

As much of the prior literature explores and analyzes the *patient's* experience of metaphor during therapy, this project captured instead the narratives of *therapists* who have witnessed and experienced the salience of figurative language, metaphor particularly, during sessions with patients. I sought to capture these narratives through interviews with fourteen clinicians, all of whom were both seasoned in the field and expressed interested in discussing their observations regarding metaphor and its role in therapy.

Given metaphor's unique position in language as a "figure of speech in which a term is transferred from the object it ordinarily designates to an object it may designate only by implicit comparison or analogy," it may appeal more readily to the dichotomies of unconscious versus conscious thought (Long & Lepper, 2008, p. 343). In turn, it serves as a door to memories and sensory experiences that may have been buried in the psyche, perhaps too difficult to process or confront directly via literal statements. The way in which metaphor approximates, naming and disguising simultaneously, lends it the power of safely hinting at what may be too charged to express in plain terms. My research question asked: what is the role of metaphor in psychotherapy from the perspective of clinicians?

As budding clinicians, my colleagues and I are often struggling to situate ourselves comfortably as far as the language we use during sessions is concerned. This project captures the narratives of seasoned clinicians who have come to experience some comfort and familiarity with the way in which they respond to and encourage nuance via both their own language and the language used by patients. Therapy is another form of poetry, another space where words are

used to shift and construct, and where each expression or even individual word *matters*. Words spoken by the therapist to the patient are curative because they may be the beginning of a reconstruction of the patient's biography. This biography may entail a history of experiences that render the patient speechless or confused, without a coherent narrative and so without meaning to ascribe to existence. The fragmentation of terrifying or painful moments can be witnessed in the fact that words often fall short in adequately representing the weight of these memories. In trying to describe what has been fragmenting, words themselves fragment and sometimes ultimately fail. In the face of this frustration, beginning therapists may feel at a loss as far as what to say and may navigate towards bland, clichéd statements to quickly remedy what is, by its nature, complex and vague. This project serves to reflect how language, figurative specifically, may work in reframing a patient's experience *creatively*.

Furthermore, metaphors constructed by the clinician regarding the patient's experiences may be a form of "holding" the patient, as, at their best, they communicate a honed and intimate knowledge of the patient's unique narrative. The level of specificity of the metaphor indicates that the clinician is paying attention and engaged in the patient's concerns: the clinician is *right there with* the patient, acutely attuned to his or internal world. If we, as clinicians, are aware of how significant metaphor can be in communicating that we have seen the patient as an individual, we are more apt to understand how metaphor, and language in general, impacts the therapeutic alliance and helps provoke insight given its capacity to resonate. This resonation exists in the successful metaphor and so in the attuned therapist, who recognizes that "something about our patients has become unstrung and discordant and they need a resonant responder to restore something that got jammed along the way," (Siegelman, 1990, p. 179).

In focusing on the actual metaphorical statements that transpire between patient and therapist during the psychotherapy session, I hope to draw our attention back to the fact of language in therapy. As a beginning clinician and a student of social work, I am acutely aware of the rise in popularity of certain forms of therapy where the intervention targets the dissipation of dysfunctional behaviors, as in the case of CBT. Though I have seen CBT work wonders, I am also aware that it has arisen in an age of consumerism where the "quick fix" is the modus operandi; a sense of urgency regarding our perceived needs is commonplace and accepted. In turn, psychological struggles come to represent the anti-product: a stopped-up system of self does not function with an efficiency that mirrors the expectations of the fast-paced, productive system in which this self locates itself. A psychological issue is then approached in the same manner as anything that threatens the system is approached: it is a crisis of the economy (the self constituting the economy) and so the crisis is identified, isolated and gently attacked. Exploration as far as the root of the issue is a digression. One must simply locate the tools to tackle the issue and use these tools to do the job.

There is nothing wrong with this inclination. It makes sense if one is suffering greatly from the weight of anxiety or obsessive thoughts and wishes to find relief from painful symptoms. But the values and language of consumerism are implicit in therapies that *target* behavior and measure success via *evidence*. Creativity and introspection are not missing from the process but they are not stressed, as, to a certain extent, they represent the antithesis of the "quick fix." The self is an economy of sorts and the problematic behavior or emotion is the stagnation that threatens to send the system into disarray, rendering it useless and inefficient.

To draw our attention back to the metaphors used by therapist and patient alike during therapy is to shift the emphasis back on the language that passes between these two individuals.

Language itself becomes conceptualized as a behavior, transpiring in real time, intimately, during the session. How does the patient feel about speaking; what words or phrases does he or she use; how does he or she speak; is there space in the speech of a patient or is it tight and clasped, or endless and wandering? All of this is significant to take note of and was originally at the root of psychoanalytic observations. Slips of the tongue and free association were perceived as articulations like doors during the session, providing access to that which was left unsaid and unprocessed by the patient. Free association, like figurative language, like metaphor, was a way in which the therapist and patient alike could commit themselves to the expansiveness of the symbolic and honor its place in the psyche.

I choose to undertake this research because I feel we have moved away from scrutinizing the language we as well as our patients use during sessions. We are focused instead on outcomes and eliminating the problematic behavior. Culture itself has abandoned the symbolic attitude and there are little spaces left where the symbolic stance and language itself is truly honored. Language is free from production in therapy; it is not an end in itself. Every word counts. In therapy, language is still sacred.

The need for this study also related to the previous literature published on the subject. Each study I reviewed placed the concentration on the patient's experience of metaphor in the session and the patient's narrative regarding this experience. This makes sense, as the patient is the site of change. My study continued to focus on the patient as clinicians were asked to relate metaphors, either patient-generated or clinician-generated, which clinicians recognized were salient for the patient. However, we hear about this experience via the clinician's perspective and so may begin to understand what it is like to use language as a sort of currency each day, sifting through what works and what does not while remaining focused on the process. What is it like to

work everyday with words? If we conceptualize of the therapist as a sort of editor, parsing through the patient's autobiography that is spoken by the patient but co-authored by therapist and patient alike, how is it that the editor begins to recognize the latent themes in the metaphors?

In addition and perhaps more generally, even given the fragility of language, it was assumed that most of the clinicians interviewed had reached a place of comfort and confidence regarding the way in which they respond to and use language in sessions. If nothing else, this study may begin to provide solace to the beginning therapist who feels perplexed by the notion that one of the therapist's responsibilities is dealing creatively and sensitively with the patient's words. This is a daunting task, but we will hear from those clinicians who have become versed in this capacity and so may begin to understand how to hone it ourselves.

METHODOLOGY

My research is a qualitative methods study, as I conducted interviews with fourteen therapists from a variety of therapeutic backgrounds. Each interview lasted approximately 30 to 40 minutes and each clinician was asked the same six questions regarding the role of metaphor in psychotherapy. Clinicians were asked, prior to each interview, to recall one or two patients with whom metaphor was used. The metaphor could have been either patient-generated or clinician-generated, but the important factor is that metaphor was present in the course of treatment.

Each interview served to explore the ways in which the particular therapist conceptualized of the role of metaphor in psychotherapy using one or two case studies as guidelines. The interview questions were designed so as to begin to shed light on what specifically leant the metaphor its strength and capacity to resonate. The following questions were posed to each participant:

- Please think about two to three clients with whom you have worked and with whom metaphor has been used. Tell me a bit about these clients (diagnosis, psychosocial history, setting in which you encountered them).
- What were the primary metaphor or metaphors that arose during the course of treatment for these two to three clients?
- Did the metaphor or metaphors that emerged change or in some way reflect the course of therapy?
- Do you feel there was any relationship between the metaphor(s) and the context of the alliance in which it (or they) emerged?
- Was there a connection, in your mind, between the metaphor and the patient's relationship to affect or the expression of affect?
- What do you feel is the function of metaphor in psychotherapy?

I asked the aforementioned interview questions during one interview with each clinician. Each interview occurred face-to-face but the telephone was utilized if the clinician was not local. I was drawn toward the format of the open-ended and casual interview because it allowed for the spontaneous growth of pertinent themes. Though I had uniform questions I asked each clinician, I allowed the interviews to take their own twists and turns so as to honor our mutual curiosity regarding this somewhat enigmatic topic.

Sampling

In regards to sampling, I recruited fourteen therapists from a variety of backgrounds and with a variety of training. However, all of the clinicians I interviewed had been in the field for many years. They were each asked identical interview questions but, as stated previously, I

allowed and encouraged each interview to unfold naturally as far as pertinent themes were concerned.

My sample was a non-probability sample of convenience, as I recruited clinicians who I was familiar with through current colleagues or I had worked with in some capacity in the past. Some of the participants were known to me through the School for Social Work in the role of professor but had private practices in addition to teaching.

The primary prerequisite for each participant was a willingness and interest in discussing metaphor use during therapy. Each clinician had a patient with whom they had worked in the past or currently where metaphor was perceived as an effective tool in provoking insight or had shifted the therapy in some manner.

The recruited clinicians were from a variety of therapeutic backgrounds and had worked with a variety of client populations. Therefore, the data I collected could not be generalized to a single client population.

Furthermore, it is important to mention that I did not examine metaphor use through the lens of a specific genre of therapy. More accurately, metaphor's place in a variety of psychotherapies (psychodrama, traditional psychotherapy, Jungian psychoanalysis) is reflected in my study. This is not intentional but springs more from the fact that the clinicians I had access to via my own network were not oriented towards a single form of therapy.

Recruitment transpired via email. Copied and pasted into the space below is the initial email I sent to potential participants:

Hello,

Some of you I haven't spoken to in quite awhile; I hope this email finds you very well.

I'm writing to you with good news: I've begun my final year in the MSW program at Smith College School for Social Work. With the pending completion of the program comes the exciting opportunity to explore a thesis topic of interest.

So, after much thought and research, I've decided to focus on the use of metaphor in psychotherapy, exploring specifically the experience of psychotherapists and psychoanalysts in regards to a single patient where metaphor was used (perhaps the same metaphor, perhaps multiple metaphors). This metaphor could have been either patient-generated or therapist-generated; I'm interested in exploring more the way in which the therapeutic alliance was aided by the use of this metaphor in that it reflected to the patient that the therapist had understood his or her subjectivity. Furthermore, the metaphor may have shed light on what had been consistently difficult to verbalize, and subsequently integrate into the patient's experience and sense of self.

This is, of course, a very rough summary of my interest. However I am contacting you to ask whether you would be interested in engaging in a 50-minute interview regarding one patient with whom metaphor was utilized and was effective. This interview could transpire via Skype, face-to-face, or over the telephone. All interviews will be kept strictly confidential.

Please let me know if this piques your interest. And if you are aware of other therapists who are familiar with the use of metaphor and encounter it often in their work, I would greatly appreciate it if you forwarded this email to them.

Thanks again and I look forward to hearing from you!

Heather Clarke
Smith College School for Social Work, '12

I then received responses from ten clinicians who agreed to participate in the study. These clinicians sent my email to other clinicians in an effort to assist me in my recruitment efforts (snowball sampling). I followed up, a few weeks later, with those who had agreed to participate with an email that served to thank those who had offered their time, and sought to elaborate on the kind of reflection each clinician should have been taking some time to do prior to the interviews. Specifically, I reminded participants to recall specific patients with whom

metaphor was used effectively, and to begin to take some notes regarding the perimeters of the therapeutic alliance, the content of the metaphor and the perceived psychological insight triggered by the metaphor. The targeted content of my inquiries was fleshed-out so as to allow participants time to formulate their thoughts:

Dear all,

Thank you for agreeing to participate in my research study of the use of metaphor in psychotherapy. I will be in touch shortly to set up a date and time for a 30-minute interview with each of you.

Before we talk, I'd like to ask you to take a little time to consider the following.

Mark Mays, in his article "The Use of Metaphor in Hypnotherapy and Psychotherapy" explains, "The use of metaphors in psychotherapy refers to a way of speaking in which one thing is expressed in terms of another, shedding new light on the character of what is being described."

Metaphor can therefore manifest itself differently in psychotherapy. It can be as clear as a direct correlation as in: "He is a monster," or it can be ambiguous; for example, a depressed patient explains that he feels he is a "burden" to others. In the second example, because we hear this sort of expression often, (another example would be something like "I'm drowning in sorrow"), it may not be as readily identified as metaphor—even though it is. So keep this in mind when you are considering the metaphor you will describe.

In preparation for the interview, please take a little time to think back to a patient with whom you've worked where you feel metaphor was used effectively. The metaphor could have been used on multiple occasions or only once. It could be a single metaphor or multiple metaphors. Please consider the following questions:

- Please think about two to three clients with whom you have worked and with whom metaphor has been used. Tell me a bit about these clients (diagnosis, psychosocial history, setting in which you encountered them).
- What were the primary metaphor or metaphors that arose during the course of treatment for these two to three clients?
- Did the metaphor or metaphors that emerged change or in some way reflect the course of therapy?
- Do you feel there was any relationship between the metaphor(s) and the context of the alliance in which it (or they) emerged?
- Was there a connection, in your mind, between the metaphor and the patient's relationship to affect or the expression of affect?
- What do you feel is the function of metaphor in psychotherapy?

Please review the patient's history and the course of treatment. All information will be confidential and of course, you will not use any identifying information when speaking of the patient.

If you are finding that remembering a specific patient (or metaphor) is difficult, please let me know.

Thank you!

Data Collection Method/Data Analysis

The qualitative data I analyzed was generated through open-ended questions conducted during one sit-down interview with each of the fourteen clinicians. This data reflected memories of salient metaphor use as well as each therapist's thoughts regarding why a particular metaphor was effective.

I did not adhere strictly to a specific interview method or style but attempted to go with the interviewee where he or she wished to go so as to gain a more spontaneous, genuine understanding of the individual clinician's relationship to metaphor. Answers to the interview questions reflected this, as some follow-up questions differed depending on the clinician's particular response to one of the uniform questions.

Once I gathered the qualitative data, I measured the interviews for recurring themes. A theme was considered a similar insight or experience regarding metaphor that was offered by more than one clinician. I coded these themes and measured their recurrence and subsequent significance. I did this by color-coded the themes in the transcripts and then extracting the quotations which reflected a specific theme from each transcript. I then pasted the color-coded quotations on note-cards, deconstructing each transcript so as to group passages which reflected similar themes together. If one clinician had spoken about the necessity of integration regarding metaphor and another clinician had spoken about this as well, I pasted both of these passages to

one note-card. I then depicted the shared perspectives in the body of my thesis, grouped under a similar heading.

The majority of the interviews took place in the office of the individual therapist; all other interviews transpired over the phone in my home. I audio recorded each interview and then transcribed the interviews after they have been completed.

The methodological weakness of this study lies in the fact that the efficacy of metaphor for the patient was measured according to the therapist. Thus, all data was filtered through the perception and experience of the therapist. In turn, it is not "from the horses' mouth" but is instead from the therapist's mouth regarding the patient.

Discussion

Because amateur clinicians are often overwhelmed by the question of *what to say* in session with clients, this study provides a beginning understanding of what curative language may look like. Thus the findings directly pertain to clinical social work practice in that the study provided clues into the ambiguous relationship between words and their potential influence, between metaphor and insight. Because therapy is a profession where the primary tool is language, this study sought to draw attention to the power language has to effect change and to instigate memory and reflection.

An important ethical concern I considered in this study was the fact that sensitive information was shared and so confidentiality was imperative. I made it clear to all interviewees that the information they shared with me would be kept in a secure location after its collection. I was also sure to specify that all identifying information would be removed from my thesis or any presentation or publication.

The generalizability of the results was quite limited, as I interviewed a very small segment of individuals who practice psychotherapy. And because I recruited those individuals who recognized the place of metaphor in psychotherapy and had used it previously, I was limiting my exploration of figurative language to metaphor specifically.

My study was further limited by the fact that I placed a great deal of emphasis on language in psychotherapy and a specific sort of language. I link this language with insight, but it could be that clients locate insight in other elements of therapy such as mindfulness exercises or CBT techniques. In addition, my study excluded those clients who may attend therapy but may experience a disability that makes expression via language difficult. Their experience of meaning making differs from those clients who primarily use language to make sense of the world.

In conclusion, because I was an English major in college, I have always navigated towards the idea of characters as defined by the narratives they tell themselves and which are told about them by others. I enjoy words and I enjoy the exchange of personal stories. I see this process as integral to an understanding of who one is in the world and how one sees one's self. The idea of exploring how metaphor is used and transformed in the therapy setting was stimulating to me as a researcher because it is an exploration of language in its curative form, in its ability to spark psychological growth and change.

CHAPTER IV
FINDINGS

Metaphors with Couples

Depending on the specific plight of the patient or patients, the form and content of the metaphor differs. Perhaps it seems quite obvious to say so, but this becomes relevant when clinicians described the way in which metaphor emerges in work with couples—the way in which it invites negotiation and active communication between two people—as opposed to the very personal, almost secretive quality of metaphors in work with individuals. The sense of the other is paramount and inescapable in metaphors directed towards the dynamic between two people and the "stuckness" that can sometimes result when neither individual is nudging, both stubbornly glued to their own preference. Metaphors with couples illuminate the way in which two selves are attempting to negotiate needs that are perceived as incongruent by the individuals asserting these needs. We see the battle of wills extracted from the selves of the individuals in the couple and displaced in a metaphor that can then be tinkered with so as to soften and expand the potential responses of the couple to each other.

Elaine, a clinician who works often with families as well as couples, described an older couple that was caught in "the same old circular argument that they'd been hashing out for the last four decades and neither of them had been feeling understood or validated." Communication skills were posited as the therapeutic goal, as each member of the couple was "trying to offer the other something…offering what they feel is being asked of them." Yet a basic disconnect was resulting, as what was being offered was continually "rejected or unnoticed or downright

unwanted—or criticized. So the withholding happens. And then the withholding turns into misunderstanding and then the misunderstanding turns into isolation."

One could perhaps argue that in the case of couples work, the objective of the metaphor is to counteract this isolation, reconnecting both individuals to each other via the externalized power of the apt image which zeros-in on the conflict sans pointing a finger to place blame. Ideally, "images of constriction and limitation should gradually give way to images of expansion and possibility, metaphors of isolation to metaphors of connection" (Siegelman, 1990, p. 68).

We shall see that the metaphors depicted below initially offer some breathing room and some space in the destructive patterns of communication, so that each individual can obtain some distance from responses that have hitherto felt like the only options: immediate, kneejerk reactions that have rarely been challenged and so perpetuate discontent. As Elaine explained:

> And this metaphor popped up for the first time with this couple. And I said, 'this is how I see you. One of you likes tomatoes and the other despises them. And one of you says, 'Here I brought you some tomatoes' and the other person goes, 'um, um thanks but I really don't like tomatoes—but thank you,' and puts them over there. And then the other person appears again and says, 'Here, I brought you some tomatoes—they're organic! So you should like these.' And the other person is going 'Thank you—I—I—thank you…I don't like tomatoes but thank you' and then puts them over there. And then the person shows up again and says, 'I GREW THEM MYSELF!' and the more offering that comes, the more anger that comes until it's like, ' I DON'T LIKE TOMATOES! WHAT DO YOU WANT ME TO DO WITH THESE TOMATOES?' And then the response is, 'WHY DON'T YOU LIKE WHAT I GIVE YOU? YOU NEVER LIKE WHAT I GIVE YOU!' and it turns into this thing.

By using this metaphor, Elaine is attempting to highlight the arbitrariness of preferences; how, in a couple, both individuals can become stuck in the need to assert themselves but it is this need that creates a claustrophobia of literalism. Neither budges and so nothing shifts, and the

cycle continues unhindered. We see that there is no space to consider other responses or even to begin to conceive that there may not be intention or aggression behind an individual's preference. It may simply exist, as one person prefers tomatoes and the other does not and there is no logical explanation for this difference. The metaphor externalizes the push and pull of the dynamic, encapsulating the absurdity and corrosive power of the ego in its struggle to gain dominance at the expense of the solace and peace of intimacy.

The metaphor thus is able to capture the truth that though two people may love each other dearly, they are not the same person. They exist in two different bodies with two different sets of opinions, preferences and responses. They must find a way to negotiate the fact that they will always exist separately, that they are autonomous beings, with the fact that they desire closeness through deep love.

In turn, some peace and understanding, some calm, must occur if two people are to successfully share intimacy. All couples struggle with the essential contradictory need to both experience autonomy *and* to depend on the other. Derek, a clinician working with a couple struggling with negotiating these needs used the following metaphorical fable to capture the dance of, as he put it, "the natural constriction and expansion, or rhythm, of intimate relationships."

> So a family of porcupines in the middle of the woods, coldest night of the year, coldest night of the winter, terribly cold winter, and they're freezing to death. And so in order not to freeze, they have to huddle up and get closer to each other to stay warm and share their warmth with each other. And as they do, they started to warm up but as they get closer and closer, because they're porcupines, they start to prickle and impale each other—so then they have to move apart. And they do and they get further apart but because it's a terribly cold night, they start to get cold again and they start to freeze…

As in the case of Elaine's metaphor of tomatoes, the intention behind the use of Derek's metaphoric fable was to encourage both individuals in the couple to "be more curious and open to really understanding and knowing the other's needs, while differentiating enough so that they didn't feel responsible for not meeting or for meeting that person's needs."

The metaphor, then, "can minimize defensiveness and reveal to us the patient's inner experience of his or her defensive situation"—yet it does not shy away from simultaneously revealing the contradictions (such as autonomy versus dependence) inherent in these needs (Siegelman, 1990, p. 79). One member of the couple moves away while the other moves towards; one demands that what is being offered be accepted while the other rejects it. Both distance and closeness are necessities for intimacy, but distance cannot be accomplished without first temporarily loosening the knots of the self so as to gain a little perspective. Part of this is accomplished via the novelty of the metaphor, its power to shift dynamics while remaining essentially nonthreatening.

We see in both the porcupine metaphor as well as the tomato metaphor the way in which metaphor reintroduces a child-like quality back into the dynamic. The couple, along with the therapist, can play with the image, examining the humor in the absurdity of a never-ending, almost nonsensical argument.

Sometimes, however, therapists do not ask permission to use metaphor in the case of couples who are absolutely resistant to examining painful dynamics. Melanie, a clinician trained in psychodrama, uses props as metaphors, coaxing patients to externalize parts of the self in the physicality of a chain or in rocks. The tangible quality of these materials makes the conflict all too real, removing it from the realm of the cerebral and giving it a form that may house the content. Melanie described a couple with whom she worked:

> …who was having horrendous issues because they were unprepared—they had joined the whole swinging lifestyle world. And they just didn't have a solid enough marriage to maintain that and to stay strong in that world. And the woman got totally obsessed with a man who sounded like a real jerk. And she—it was destroying their marriage. And her drinking was destroying their marriage. But it was never spoke about in here. It was alluded to.

The incapacity of the couple to speak sincerely about the obstacles they were experiencing and the subsequent monotony of the treatment prompted Melanie to use the prop of the beer bottle to address the issue while not naming it directly. Melanie explained that in her work, props and metaphors are used interchangeably—even though a beer bottle may very clearly connote substance abuse in the case of this couple, it still eludes direct interpretation so as to "simultaneously keep and reveal a secret" (Siegelman, 1990, p. 79).

This particular couple exhibited a fascinating response to Melanie placing a beer bottle, without explanation and spontaneously, between them during a session. Though the prop, which was serving to metaphorically embody the way in which something (the woman's drinking) had lodged itself between them, the couple ignored the bottle, did not move it, address it or ask why Melanie had used it. Melanie explained that the woman simply stared at her for a matter of seconds and then began to speak about something else. The subject of her drinking was therefore not approached but was living in the middle of the room, very much alive in the body of the prop. It was entirely visible, even tangible, and the very fact that no one spoke about it illuminated its strength as an unarticulated struggle, always present yet never sincerely examined. The metaphor not only embodied the issue itself but also the way in which such an issue was ignored: again, the "patient's inner experience of his or her defensive situation."

We see quite the opposite response to the tomato and porcupine metaphors depicted previously. Both Derek and Elaine described the couples with whom they had worked as not

only exhibiting the capacity to identify their struggles in the metaphors, but also as interpreting the metaphors as transitional objects which they utilized outside of therapy to identify moments when they engaged in destructive behavioral patterns.

Sometimes, as in the case of Anne, a clinician trained in Sensory-Motor Psychotherapy, the clinician may feel it necessary to integrate herself into the metaphor so as to deepen its strength and staying power. As Anne describes:

> A couple came in because they were fighting a lot
> and the way they would end up fighting is they would
> end up either screaming at each other—well, the pattern
> is that one would leave. But before the leaving, there
> would be a lot of screaming at each other… Each of them
> had difficulties regulating their own affect. And that,
> in spite of all the love they had for each other, when
> they fight it is as if they aren't able to see that they've
> lost sight of the bond that they have.

Here again we see the negotiation of closeness and distance that is implicit in any intimate relationship. The couple fights and they "lose sight" of the connection they have. The foundation of the relationship teeters and may verge on toppling over completely. They become strangers to each other, detached from the history they share together. In response, Anne introduced a metaphor that externalizes the structure and the process of a relationship as a house and the therapist as a consultant in the building of this domestic, intimate space that still exists and is still being built, even if it is in danger of collapse.

> The metaphor I used was that their relationship is
> a house that they are building together, and there's a
> foundation and there are the walls, there are the windows,
> the structure and all that. And it appears that the tools they
> use the most are hammers and nails. And if that's all you use,
> then you're going to break some walls and foundations. And
> I expanded on the metaphor and told them, you know,
> they are architects and I am their consultant. And they have
> got to figure out what kind of house they want to build, and
> I'm there to help them—and that really resonated; they liked that.

As we shall read later on when we begin to examine the metaphors of individuals, the apt image may display not only the "state of things in process," as one clinician put it, but it may also reveal the state of the dynamic in process—the dynamic as a construction that is being built via responses. Anne illuminates this in her depiction of the relationship as a structure that, for this particular couple, is being constructed purely with the harshness of the hammer and the nail: we can almost hear the cacophony of the arguments and feel the reverberations of the walls shaking with the repetitive motion of the hammer.

This metaphor is rich with other metaphors: the hammer, in its singular power to fall steadily, repeatedly, is akin to the ego wedded to a straight, literal path to a familiar response. Here, however, Anne becomes the intermediary between the age-old ways of building by acting as a "consultant" and posing the idea that there may be other possibilities or attitudes towards construction, that indeed the couple has the capacity to choose what sort of house they would like to live in.

Anne externalizes the struggle of moving through a relationship without damaging the structure permanently—given the inevitable and natural conflicts that may occur—by enlisting a neutral task, such as construction, to contain the conflict. The fact that building is akin to negotiating needs together makes it able to represent the process, but extracts it from negative associations that may activate the defenses. Instead Anne enlists the individual agency of each member of the couple to assist in the mutual construction of the relationship; the metaphor implies that both individuals have an influence on the frame of the dynamic and may proceed in the building however they please. Anne implicates herself in this building by introducing herself as a consultant who is on-hand to suggest alternatives to simply hammering away without

consideration for the possible nuanced building implicit in the endurance of the structure over time.

As we may note in the aforementioned examples, metaphors are used with couples to externalize a specific troublesome dynamic in an effort to decrease the cycle of blame and defensiveness that so often occurs when two people become close. Minimizing defensiveness also transpires via metaphor in the case of work with individual patients. However, metaphor use is less about aptly depicting a specific dynamic—which always inevitably implicates two histories—but more about the internal and very private world of the specific patient and the many dynamics *within* the self, which transpire between and through parts of the self that have yet to be examined and integrated.

Metaphors with Individuals

A variety of clinicians spoke during the interviews about specific patients who brought to the session a dream image that served as a metaphor, containing an unaddressed battle within the self and giving it a form. Just as "metaphor is deeply rooted in primary process in that one thing stands in for another," so alike is the dream image where displacement is primary (Siegelman, 1990, p. 10). "Displacement," writes Siegelman, "is the process that underlies symbol formation…both in dreams and in waking life," and so the dream image becomes the metaphor, as the "dream imagination unites and condenses a number of images with remarkable brevity" (Siegelman, 1990, p. 13). The patient is then provided with a singular, stark image that is fodder for therapeutic inquiry. As Mary, a clinician who works primarily with individuals, explained:

> Many of the metaphors came out of dreams that people would come in and say, "I had this incredible dream" and then describe the dream and then some image in the dream became a metaphor for what we're

> talking about in the treatment, for what they need to do or how they need to think about themselves. It becomes a way of zeroing-in on what the issue is and what's going on.

Roger, a clinician trained in Jungian psychotherapy, works often with dream interpretation during his sessions. He sees dream images and metaphors as one in the same, just as Melanie sees props and metaphors as interchangeable in the space of psychodrama. Regarding a patient who struggled with bipolar disorder and would often put his business in danger due to his tendency to undercharge instead of overcharge, Roger describes a dream the patient had which crystallized the issue at hand.

> So he had a dream. And it was a very crucial dream in terms of the therapy at that stage. And what he dreamt was that he was being pursued, he was being chased, he was being hounded, and the leader of the pack that was hounding him was this old man who was very shrewd. And the metaphoric name he gave him was "The Old Jew." And he could not escape—every time he would find a perfect hiding place, somehow this man would sniff him out and off he would be, running away again.

As we shall see when we begin to examine metaphor through the lens of theory—in particular the idea that the need for integration of disparate parts of the self is communicated via the metaphor—this patient's dream instructs Roger's next move.

"Metaphorically," Roger explains, "this (image) would be interpreted in Jungian terms as a shadow figure…what happens with one's shadow is it's all the unacceptable parts of one's self that one pushes down and they go into the dark." The dream, which gives form to all of the "unacceptable parts" because it arises from the dark of the unconscious, instructs both Roger and the patient to address the "Old Jew" and ask him what he desires. Roger, like the majority of the clinicians interviewed, describes the process of doing so as akin to role-playing where one

interprets the image as a living entity that will not budge until it is interrogated to reveal its meaning. In the case of the patient depicted above, what needed to be integrated was a sense of thrift that had eluded him during moments of mania when he would run his business without a sense of balance and scrutiny for the finances. The person of the "Old Jew" was interpreted by both Roger and the patient as embodying characteristics that needed to be heeded to if the patient was to succeed in his business. In the process of externalizing the person of the "Old Jew" and addressing him, it was unearthed that the patient's father had struggled as well with how to balance a certain laxness regarding finances with a need to maintain a successful and profitable business. Thus the dream image embodied a conflict whose tentacles stretched back to before the patient's time.

Roger describes the image as prompting a turning point in the therapy, as often happens when both patient and therapist become attuned to the content of dreams. As Ellen Siegelman (1990) writes in her seminal work,

> I am awed when such pregnant symbols either from dreams or "real life" present themselves in the therapeutic hour. A hush of mutual contemplation occurs and something peculiar happens to time. It seems to cease to exist or become infinitely expanded. This quality of uncanniness, of being out of time and the everyday world, of entering the realm of the numinous—these are the cues that my patient and I have jointly entered the domain of the symbolic. (163).

Entering the "domain of the symbolic" may mean that the probability of encountering what Siegelman refers to as a "key metaphor," or those metaphors that "take center stage and demand attention," increases (Siegelman, 1990, p. 46). They are so rich with the need for integration that they seem to halt time, to request a position of awe on the part of the observers. There is something "uncanny" about these metaphors as they speak from the very bottom of the unconscious: haunting, perhaps long buried and deeply intimate.

Often, as Roger clarified during his interview, these "key metaphors" take the form of animal bodies in dreams, as animals exude raw instincts that are often repressed in the service of constructing a cohesive identity. In working with another patient who was struggling in his relationship with his fiancé, Roger requested that the two begin to look more closely at the dream images which were emerging for this patient in an effort to make sense of the root of his relational struggles. As per Roger's report, the patient experienced the following dream:

> And the man had a dream of being at a familiar cottage at a lake that his father had built. And he went out into the night and what he saw was a silver snake that had been killed. Its head had been partially severed at the neck, and he was aware that his father had done this.

What subsequently emerged as well was the fact that this would have been, in Roger's words, "a very heroic act" for his father, as his father was "very afraid of snakes." But the patient "felt it was a tragedy because the silver snake was so beautiful to him." However if we are to take the Jungian notion of the shadow figure (or image) as "all the unacceptable parts of one's self that one pushes down and they go into the dark" as true, then this image is far richer than simply a snake the patient preferred but which his father wished to annihilate.

In the process of interrogating the figure of the silver snake, it was revealed that this metaphor embodied the patient's repressed female aspect, which had always encouraged creativity in the patient but he had denied such creative impulses, as they were not welcomed by his fiancé. The patient's father, who had resigned himself to a life as an accountant, had also denied himself his artistic inclinations so as to construct a life which was more congruent to what was imagined for him by his wife, the patient's mother.

Sam, a clinician trained in psychoanalysis, spoke also of a patient whose "dream and fantasy images involve animals, and usually they are sort of half-tame, half-wild animals with

human qualities." Even before the onset of treatment, this particular patient had "connected in all kinds of ways" with the body of animals, as she felt an "affinity to the natural world and I think the animals captured a number of qualities…I think she experienced herself as sort of having a wildness in her as positive thing: that she has a raw, wild quality to her which she values." However, one of this patient's major struggles was her inability to be "fully assertive with people, particularly if she was upset with them." Thus the animal body, full with pure instinct and unbridled energy, epitomizes the antithesis of tentativeness. This patient brought to Sam the following dream:

> So she had a dream about two tigers, sort of human like tigers. So one is an older tiger—I don't know if it had a defined gender or not. I think of the older tiger as male. The older tiger is sick in some way and is in the hospital, or some kind of medical setting. So there's the older tiger, and then a young child, like a baby tiger. And the main image in the dream is that the baby tiger is sort of sparring with the older tiger. And the older tiger isn't so sick that he or she can't playfully spar with the younger tiger. So it's an image that has some aggression in it and playfulness and love in a certain way. So it's a complex image.

What gradually emerged in the conversations Sam and the patient had about the dream was the idea that these two tigers were Sam and the patient, negotiating the "aggression, playfulness and love" that are inevitable in any human relationship. The tiger epitomized affective experiences, such as aggression, which were traditionally difficult for this patient to experience but she could do so via the metaphor of the tiger. Perhaps it could be deduced that because Sam's patient struggled with asserting herself, the metaphor of the two tigers "sparring" speaks to the patient's feeling of safety in Sam's presence and her beginning ability to experiment with affect that had traditionally been unacceptable.

Animals are not the only entities that may serve as vibrational metaphors, containing primitive urges and affects that have been cast aside to ensure a certain cohesiveness of self. The human body, where all of our physiological and psychosomatic symptoms dwell, houses energies that may often be expressed through the succinct metaphor. Both Sam and Mary spoke of patients who described the human leg as a metaphor of substantial depth and meaning, relating a dream, in the case of Mary's patient, and an image in the case of Sam's. As Sam related,

> At one point she brought in a picture of a ferocious looking sort of wild dog, like a wild, ferocious dog that is eyeing a woman's leg as if wanting to eat it. And the leg was depicted in the picture as a drumstick. So a very powerful and disturbing image. So that image sort of represented her experience I think primarily of her mother but also, in a way, a part of herself. So it's very primitive, disturbing.

And in the case of Mary's patient, Mary summarized:

> And her dream is that she's pregnant and she's going to have this baby and her husband is there, and they are in some situation in the dream—I don't remember all the details—but what was striking about it is her overall feeling in the dream was one of embarrassment, of being embarrassed. And what she thought she was embarrassed about is that when she pulled up the leg of her husband's pants, he did not have a real leg. He had a prosthetic leg. And so his leg was gone, halfway down. And he had this fake thing that was helping him get around.

The metaphor of the leg, in both scenarios, is representative of vulnerability; in the first scenario, the leg is in danger of being consumed violently. In the second, the leg is inefficient, in danger of not performing its duty. It exists but it is not real, whereas the second leg's realness threatens its existence as the leg's flesh, its definition of life, may fast become devoured by the dog.

We can see the leg in both of these scenarios as a metaphor of extension. And indeed the leg is a literal extension—a limb in the case of the human form. The first patient's mother was said to have been highly destructive to her and so is preying on the leg, a flesh and blood protrusion. There is a sense in which the patient must hide her leg from the dog—her mother—so as to remain intact. We almost wish that she had the capacity to pull it into herself, removing the vulnerability inherent in what juts out and so is open to the elements, to the whims of the appetites of others, such as the dog. But just as the dog may be the patient's mother, Sam explains that it may also represent a part of the patient's self that is aggressive or ready to pounce. We see deep affect and impulse in this image, filtered through both the dynamic between the dog and the leg—as well as in the pure vulnerability of the leg itself, subject to attack at any moment.

In the second metaphor of the leg, we see the revelation of a contradiction: the leg is not real yet it sustains. As far as background history for this patient, she had reported to Mary that she was struggling with the idea that her husband made less money than she did and was wondering how he must feel about this or whether or not he considered it at all. She was from a family where her mother was the sole provider because her father had squandered much of the family money on business ventures that ultimately failed. Therefore she was already carrying a sense of financial imbalance and failure in the internalized introjects of her parents.

Again the metaphor of the limb arises in a patient of Sam's who he had worked with for a significant amount of time: over 30 years. She was "massively abused" as a child and so was struggling with symptoms of Borderline Personality and Narcissistic Personality Disorder with some paranoid ideations.

Upon leaving Chicago (where he had originally seen this patient) and coming to Maine, he began to meet less frequently with her. As he summarizes, "I saw her every week for two years and then it became once a month but even when I was seeing her every week, just the fact that I had left and what that meant..." In response, she brought to Sam the metaphor of amputation, explaining that seeing him less frequently was "like an amputation. Like a limb had been amputated."

In this particular instance, the metaphor speaks to the loss the patient feels without her therapist. It is also a metaphor of functionality, as the leg no longer functions and once did.

Sam spoke often during his interview about the need for the aforementioned patient to use metaphor almost aggressively to make sure Sam understood her inner experiences. He explained that her metaphors were often stark and sometimes violently detailed, as she sought to approximate her pain in images. Sam conceptualized of her use of metaphor as a desperate attempt to use language, our only tool, to paint a vivid picture of her suffering. Literal descriptions may fall short, but the power of the metaphor to ignite not only the mind but also the senses put Sam exactly where she wished him to be: in the truth of her pain. In this case, "necessity is the mother of metaphor," as Sam summarized.

His departure was clearly traumatizing for her and she was searching for the words to depict this loss. On another occasion during the treatment, she explained that the loss of their treatment relationship was akin to feeling as if "she was now trying to sleep in a cold room and all she had was a think blanket, a thin sheet, whereas she used to have a warm blanket."

Siegelman (1990) writes of the image-laden metaphor:

> (It) is usually born out of intense feeling: the need to communicate something never communicated in that way before, to make others see what you have seen, and very often to express psychological states that can only be

> approximated in words. These ineffable feeling states are either too vague, too complex or too intense for ordinary speech (p. 10).

In the example of Sam's patient, the metaphors she used were indeed "born out of intense feeling," to make Sam see what she had seen and experience what she had experienced. They were not used to necessarily sustain her but instead as a vehicle through which her anger, deep sadness and fear could begin to materialize. The metaphors evoke sensation, such as cold in the case of the thin blanket or violence, true physical pain, in the case of the loss of a limb or an amputation. These images contain also the memory of trauma: neglect, loneliness and isolation. The fragmentation of her self, the lack of cohesion and the absence of hope, are embodied in the harshness of the images, which indeed speak to "ineffable feeling states" which elude ordinary language.

Conversely, we see patients who may have a trauma history using metaphors to communicate what has sustained them through the pain, as in the case of Jane's patient, a woman who experienced severe neglect and abuse at a young age. According to Jane, a clinician who works primarily with individuals, this patient

> ...had a schizophrenic mother and a younger sister who was bipolar, and one other sibling who was younger than she…The mother was really, really disturbed. The father divorced the mother but the mother had custody of the kids on the weekends, and she would drive them around at 90 miles per hour and feed them ice cream for breakfast, lunch and dinner. She was pretty unreliable.

Again, we see a history of abuse and neglect. And though Jane is not in the process of terminating with this client, and so loss is not on the agenda so to speak, a metaphor of sustenance emerged which also encapsulated an affinity to the senses. Through all of this patient's tribulations, what she described to Jane:

> …was this little teeny flame that was in her, and she said it was like the flame at the Kennedy Memorial in Arlington and it had always been there, she had always know there was something alive in her. And there was something burning that was real and that was sort of hopeful.

In both the case of Sam's patient with a trauma history and Jane's patient, we hear—and so feel—the sensation of temperature. Sam's patient is shivering, alone with one sheet, freezing in the night. Jane's patient is warmed by the flame inside of her, as it burns to signify hope, and, in Jane's words, "energy and this drive, resilience and passion." Both of these metaphors are physiological, as they instigate the response of not only the mind but also the body. Again, "the need to articulate a pressing inner experience of oneself is paramount" and so the metaphor's imagery becomes vivid, sparking a sudden, head-to-toe response. It could perhaps be argued that the more difficult the experience is to integrate into the self, the more pressing the metaphor, the more it demands attention and perhaps the more creative it is, as it seeks to contain what consistently escapes understanding and verbalization alike. As Siegelman (1990) argues,

> A metaphor can be used not out of a need to disguise but because there is no way to express that thing directly. This happens when any or all of the following apply: the affects are overwhelmingly strong, our ordinary language is impoverished, and/or the experience being processed was nonverbal to begin with (p. 81).

We see in the case of trauma that the intention of the metaphor is to articulate the experience that may have been processed on a "nonverbal" level initially, too terrifying or shocking to live in the memory in simple language or coherent imagery. The goal of these metaphors is to assist others in conceptualizing, whereas in the case of metaphors that emerge from anxiety, the intention is to contain and manage the symptoms via, most often, images from the natural world.

The capacity the natural world has to embody consistent rhythms and cyclical patterns makes it orienting to those patients who suffer from anxiety and so feel capsized in disorienting and unpredictable symptoms. In working with a patient who had recently graduated from college and been accepted to a "highly competitive graduate school…and was both excited but very anxious and insecure about going…wondering whether she could make it…and whether it was something she would love," Anne introduced the metaphor of a tree. The tree's unerring capacity to stand tall despite fluctuations in weather is significant to patients who easily topple over via anxiety in the face of uncertainty. As Anne described,

> So the metaphor I used was a tree, and that each of us
> are trees with trunks and branches and leaves, and that
> with her anxiety, I described the weather, the storm, the rain
> as things that happen, as what we deal with everyday,
> as our situation, environment or other people. And if you
> live in the branches, then if there's a wind blowing, you
> could easily get tipped off and feel like you're going to
> fall and break. Whereas if you're in the trunk, then,
> you know, things can happen, you can break a limb,
> you can lose all your leaves, but you know you're ok.

The metaphor gives a spatial quality to the abstract feeling of anxiety, suggesting that to counteract the weight of the weather of symptoms, one must live sturdily in the roots of one's self. It calls for the patient to locate a core of peace and contentment that can then provide strength when change occurs. Anne describes the patient utilizing the metaphor outside of the therapy sessions and subsequently altering the way in which she held herself physically. In the patient's internalization of the metaphor, her symptoms decreased and, Anne reports, her posture changed as she began to hold her back straighter and walk with greater ease and confidence. The metaphor dwelled in her body.

Iris, a clinician who works primarily with individuals, described using the metaphor of quick sand to help a patient conceptualize of her anxiety and its destructive effects. "You know,

with quick sand," Iris explained, "if you struggle, you get more sucked in—but if you open up to the quick sand, you can pull yourself to safety. The same with anxiety: the more you struggle, the more you get stuck in it." But if one begins to "open up to it, the more you're accepting" and so the strength of the anxiety to pull one under is counteracted.

Both of these metaphors are containing, as they draw a connection between the whims of the natural world and the internal experiences of humans. They normalize the experience of fluctuating anxiety as well, as they suggest that fluctuation is a prerequisite for life and so cannot be avoided. States of mind change; it is an inevitable fact of human life as well as natural life, where states of mind are akin to the fierce strength of quick sand or a powerful storm. The question becomes how to locate a place of acceptance amidst the uncertainty, a place of silence amidst the mutability.

Katie, a clinician who also worked with a graduate student distressed by anxiety "centered around her career and what she was going to do with her career," who was having a lot of "second thoughts" and dwelling in a place of ambiguity, worked with the student in containing anxiety via metaphor. However Katie and the patient explored times when the patient experienced an absence of anxiety and utilized this experience as metaphorical in itself.

> She was on the crew team. This was something she had always really liked doing and so somewhere in the course of therapy, we ended up talking about it. And she ended up reflecting, "you know, when I'm in the boat, I'm not anxious and I'm not thinking." And she ended up using this idea of different times in her life or during her day, is she in the boat? Or is she out of the boat? And this became a really good way for her to talk about it. And so we were able to talk about like, "Ok, so what allowed you to be 'in the boat'?

In a sense, Anne's "living in the roots of the trees" and Katie's "being in the boat" are similar metaphors in that they both work to regulate distressing affect. The difference lies in the

next step Katie took the metaphor: she located an experience which grounded her patient, and invited exploration of moments during the day when the feelings associated with this experience (calm, concentration, presence) emerged. The repetitive nature of the rowing of crew calms the body and the mind, just as the rhythms of the natural world may represent an antidote to the speeded-upness, the adrenaline rush, of panic. If the patient can identify in what instances the body and mind may calm itself almost automatically given the task at hand, such as rowing in crew, then this experience can be metaphorized and made into an image of containment that may be re-imagined when symptoms arise.

Integration

A pertinent thread throughout many of the interviews was the idea of metaphor as representing a part of the self that has yet to be integrated. This was touched upon in many of the aforementioned examples, but was made particularly clear in certain interviews. As Rob, a clinician and educator explained, there are multiple metaphors that arise with clients that suggest an investment of energy in a belief regarding one's self, such as the often-heard phrase "I feel like a burden." Rob suggests,

> That part of you that thinks you're a burden, could it be worth getting to know that part of yourself? You're going to lose whatever you're getting from believing that and that's not necessarily a small loss. But it might be the cost of admission that is inherent in having a different kind of experience.

To address this idea, which has been made into a part via metaphor, is thus the "cost of admission that is inherent in having a different kind of experience." Again and again, we hear examples from clinicians regarding a patient addressing a metaphor in hopes of beginning a dialogue with it.

In the previous example of the "Old Jew," Roger's patient and he staged role-playing encounters with the dream image because his patient "had to turn to it and meet it and face it in order to integrate the essential goodness that was in this person, (the Old Jew)." In doing so over the course of many sessions, Roger and his patient unearthed the fact that the "Old Jew…knew the margin of profit that the patient would need to make but which he had shoved down and so was not thinking about." His father had also been a restaurateur but had failed at his business because similarly, he was incredibly generous with all of his customers, not monitoring the financial aspects of the business. Thus the metaphor represented qualities that were necessary for integration if the patient was to have a different sort of experience than his father's. Roger explains that at the conclusion of the treatment with this patient, he had improved significantly. The metaphor, and the process of addressing it and attempting to integrate it,

> …provided a grounding for him that he hadn't had. Because if he's subject to ego inflation with the mania and then bottoming out in terms of the depression, he needed a ground, literally, to come to that had to do with a ground for the business, but a ground for himself in the sense of being able to see what he had always considered unpleasant qualities. They are actually underlying strengths.

Because Roger is a traditional Jungian psychoanalyst, he understood the patient's integration of the "Old Jew" as an integration of a shadow figure who had an inherent message that sought to ground and assist the patient as opposed to threaten him. The patient needed to resist continued suppression or repression of the figure.

Furthermore, in addressing the metaphor, the patient could "make a decision regarding how much power (he) wanted to give the metaphor." As Barbara, a clinician who often uses metaphors to represent parts of the self explains, "and that's very liberating for people." She

explains that she will often use a metaphor which depicts the parts of the self in increments, such as suggesting that a patient imagine:

> …sitting on a hillside and watching a train go by and the boxcars of the train, and imaging that the cars are---what's inside some of these boxcars has to do with various stressors or worries or anxieties or nervousness, uncertainty, that kind of thing. And the concept is of sitting and watching them go by.

Distance in the Process of Integration

This may allow for what Rob refers to a "breaths worth of space" to reflect on which metaphors take center-stage in one's identity. "Even if it is just a half-second worth of space," Rob explains, "within that space there is some sort of possibility" and the mind may begin to realize, "'oh, that's not me' and metaphor is a vehicle to allow that to occur…You are externalizing or displacing it into this image. And then you take it a step further and try to interact with it."

A crucial step, which was reflected in multiple interviews, was the necessity of creating some distance between the patient and the metaphor via the process of externalizing and concretizing it. As Robert suggests, this can create a different relationship to the metaphor—and so to that part of yourself—as the patient is no longer "overtaken by affect" related to the metaphor but is also not numbed from it either. Iris explains:

> I think for people who really buy into the metaphor…it can be very containing because it allows some space between themselves and the affect. They are no longer drowning in it; they are labeling it and putting it outside of themselves and themselves outside of it.

Anne elaborates on this idea, suggesting that the "very processing of noticing" which occurs when a part of the self is made into a metaphor and the image is returned to in times of

distress, “slows down their reaction and allows them to make a decision about whether they want to go on and react the way they usually do or whether they want to…take time out.” Iris agrees:

> It gives patients a way of thinking about what is going on so it’s no longer just this big, overwhelming cloud of scary stuff. But it’s something that they can understand and label and bring outside of themselves. It gives you pause to consider what is going on, and then make your choice of action.

This can have a profound influence on a patient’s capacity to watch moods pass as they occur without necessarily acting on them. In Anne’s work with a man who struggled with his temper, he was able to use the metaphor of the Window of Tolerance to notice when he was “going outside” his window towards aggression. “He would turn and walk away” if he felt he was edging towards anger, “and then come back later on.” As Anne explains, “He’s been able to make changes and it’s been shown in how his children relate to him.” As Barbara concurs, a metaphor “pays attention to the fact that you’re watching something, and it’s real that a particular kind of distressing emotion is happening.” To return to her metaphor of the train, she explains, “the emotion is inside the boxcar, and it’s real that it’s there, but it’s also real that it passes along on the track. I think the message is that it doesn’t always have to be with you,” particularly if you can visualize it as a possible color of the self but not its full iridescence.

The “observing ego,” after it has managed to exert some separation between itself and the ideas, or metaphors, it holds regarding itself, may observe the parts and conclude, “Oh wait, that’s not me.” “And the question arises within,” Rob suggests, “every time you do that, you’re asking, ‘well then, what is? If *that* isn’t me and *that* isn’t me and *that’s* not me, then what is me?’”

The process of sifting through the metaphors of the self is all with the ultimate goal of integration in mind. Yet this can only occur if the purpose or intention behind each metaphor is

unearthed. Rob used the example of a "guard standing there with armor and a big stick." Perhaps this image occurs in a dream or perhaps it is a vision of waking-life. The guard has become convinced that he is "serving a purpose" of protecting the patient from "real, perceived threats." And historically, the parts of the self embodied in the figure of the guard may have indeed felt the guarantee of safety via the presence of the guard. However, there may still be other parts of the self that "have feelings about that," may not like or feel the necessity for a guard any longer. The guard, as a metaphor for a particular defense, which worked in the past, may now need to be addressed in order to "create a relationship with that element of my experience," as Rob suggests. The therapist's role is to allow the mind of the patient to "spontaneously" begin to address the guard and see what is generated from the process of addressing it. The question then becomes, "if that part, that mentalized, metaphorical part of my experience no longer sees the need to play that role, will it still do so? And therefore, will it still inhabit the same metaphorical body?" Robert explains, "No it will not. It will change; it will morph. It will see that it is free to do something else."

Once the metaphors of the self begin to access the understanding that they are not wedded to a particular role, and that a function perceived as useful for some time may not prove necessary anymore, the building up of new ideas regarding the self may begin. Integration of the lasting metaphors, directed towards the purpose of having each part of the patient's self "playing on the same team," as Rob states, becomes the new focus. Rob uses the example of the "negative affect that comes from anxiety or shame" and the subsequent "protective parts of the self that are there to kind of deal with it, be it my temper or some dissociation." Even though they may all be working to "keep things from flopping over," the parts may still be disparate. The question then

becomes if the metaphors themselves are "static" or "fluid"—and, furthermore, if they are addressed, will they "change as they are interacted with."

Many clinicians suggested that, in their experience, the metaphor as well as the patient alter as they interact with each other; in fact, it may be corrosive to believe the metaphor has a single meaning. Sometimes the process of addressing the metaphor may be quite tedious, however, and the initial response on the part of the patient will be apprehension and resistance, as it may mean the erosion of the previous structure of the self. As noted previously, Melanie's use of props in working with a couple demonstrates this phenomenon. The wife struggled with alcoholism but was opposed to discussing her substance abuse during therapy. Melanie decided to externalize this conflict in the prop of a beer bottle and place the beer bottle in the middle of the room as the couple walked in for their session. She explained that she felt she was not getting anywhere with the couple and she had to do something a bit drastic, as nothing was progressing. The wife walked into the room and…

> could not get around the beer bottle because the chairs were so close. She had to kind of trip over it—and that was my hope. And he kind of looked at her and he kind of looked at it, and he didn't say anything. It stood there the whole time; nobody moved it.

Just as the metaphor can invite dialogue and eventual integration, it can also, when externalized, signal the patient's relationship to the conflict at hand. It is clear through Melanie's use of the prop as metaphor to externalize the patient's substance abuse struggles that the woman is not ready to speak to her alcoholism. She cannot imagine it exists; it is too large and overwhelming to name. It remains docile, quietly dictating her behavior without her acknowledgment. She cannot play with it; it exists in its literal, ominous form.

Conversely, we see other patients willingly conjuring up parts as metaphors and then repeatedly referring to them, as in the case of a particular patient of Katie's who ruminated often regarding his interactions with women. "He would analyze every single minute of every single date" which would then "fuel his depression because he would always come up with the same conclusion which was that there was something wrong with him." During one session with Katie, he began to talk about himself as having two disparate sides: "Sad Brian" and "Happy Brian."

> …and he would picture them in a room. So there was always one of them in the room and there was always one of them out of the room. And most of the time, because he was so down on himself and so hopeless, sad Brian would be out in the world. It reflected his black and white thinking because there was nothing in the middle.

Even though Brian did not learn to integrate these parts during the course of therapy, Katie explains:

> There was something about referring to these parts of him… which…allowed him to be a little more fluent than if he was saying, 'I feel this.' What we could do is we could refer to Sad Brian and Happy Brian and then by the end of a session, we could come back to it and I could say to him, 'So, what you're feeling is…'"

Though Katie observes that Brian's Sad and Happy metaphors reflect his splitting, his need to invest in the easiness of believing there is no middle ground only the simplicity of definitive opposites, still the literalism connotes a child-like quality which allows the patient to access his feelings. Brian uses simple language and simple metaphors, and so externalization is made possible. As Anne explains, metaphors "bypass the cognitive, intellectualizing tendencies that I think do not address affective issues or regulatory capacities of the person." Having an image, such as the image of Sad Brian or Happy Brian, helps a patient "gauge themselves in terms of where they are and where they want to be."

Playfulness

A prerequisite to making a part of the self into a metaphor, confronting it and then possibly working to integrate it is a patient's (and a therapist's) relationship to play. The capacity to externalize is naturally playful, as it requires an active imagination and a willingness to suspend belief for a moment. Children often create imaginary friends who accompany them into a co-created fantasy world. However what is the imaginary friend but a concretizing of the imagination, an entity that works to keep the self company by externalizing characteristics of the self which the self wishes to engage with. If the self exists singularly, these characteristics are not tangible. But if the self invents a body in which these characteristics can live, whether it is a metaphor or an imaginary friend, then play as a curative act may occur.

The capacity to speak figuratively requires a certain playing with language, a molding it as if it were clay. The hard lines of literalism soften to encompass the poetry of metaphor. Jane, the clinician who worked with a patient who envisioned a metaphorical flame burning inside of her, sustaining her and propelling her forward with hope, explained that metaphor is pertinent when one begins to consider "the role of creativity in therapy. And that includes joining with people's play and vision for themselves, being able to see beyond what they see for themselves in the most creative ways." If Jane were not to respond by asking her patient to try to describe what the flame looked like, how it felt within her, then the image would not develop between the two: a co-created, sustaining symbol.

The metaphor becomes the locus of play, as the therapist responds to it by coaxing it to emerge—yet the patient may only have an inkling of its strength. In the case of the burning flame, Jane imagined, alongside the patient, that it was true, thus making it true and investing it with a curative power. If the patient's experience of his or her own curiosity and imagination in

the past has been painful, as in the case of a patient whose caregivers have responded to all gestures towards curiosity and play in a literal manner, the improvisation of the self and its visions may have hitherto been associated with shame. A therapist's attention to the imaginative element inherent in a metaphor is a gesture of play that reintroduces creativity back into a patient's psyche via the therapist's acceptance of it.

In Sam's experience with a patient who used metaphor more readily, he explained, "play and joking was sort of part of our relationship. Metaphors exist in the a context of the relationship." Rob echoed this sentiment: "I think it was Winnicott who said: play is a curative act…and if people can develop the capacity to play with you as the therapist, then that is them getting better."

Language

But, as many clinicians suggested, the capacity to gauge the state of one's self is deterred by verbosity and intellectualism. At its best, metaphor is the scarcity of language because it is primarily visual; as one clinician put it, it is a "constellation of thoughts and feelings imbedded in the imagery a patient chooses." This presents an interesting conundrum for therapy, as all passes through language; language is the currency of the therapeutic exchange. But the "immediately accessible" nature of visuals, as Anne stated, "bypasses reason…and the cognitive noise." Elaine concurred, explaining that metaphor is language…

> …but it's also an expression of the soul. It's poetry.
> I think with poetry and metaphor, the question is sort
> of like: how do we use words to touch the gut or the heart?
> It bypasses the logic.

Part of what gives metaphor the power to "touch the gut or the heart" is that it express subtly, not overtly. It hovers, surrounds and hints but it does not articulate directly. As Roger

explained, if a therapist simply says, “Okay, you just have to express your anger and get it out because you’re stuffing it down and your wife is walking all over you,” this will not resonate immediately as the patient may not be ready for direct interpretation. Though it may “say what the problem is, it doesn’t say what the process is.” The space between the words and their content is tight and claustrophobic, not lending itself to the “breath’s worth of distance” spoken of before. The suggestion is literal, and so its capacity to expand the understanding of the patient is limited. In addition, it may be a suggestion the patient has heard before ad nausea—and so it’s effect is null. If the patient could simply express his anger, he may not be coming to therapy and so the creative capacity in metaphor is required to reflect the highly subjective and complex path down which the patient may begin to move in order to respond differently to his wife’s behavior and his own internal world.

Metaphors may introduce a flash of novelty to the stale entrapment of destructive thoughts and feelings because they are “news of difference,” as Derek explained. In his use of the porcupine metaphor with the couple, he reflected that the therapist and the patient or patients “could talk all day but we would forget a lot.” Metaphor presents the possibility of true resonation as something is expressed in “such a different way than (a patient or couple) would ordinarily think.” There is an immediacy to metaphor, confirmed by more than one clinician’s experience, and based on the fresh use of language that is inherent to the metaphor. As Katie explained, “I wouldn’t want to overuse them to the point where someone isn’t really working to express themselves but especially with people who struggle at times, it’s a way of instantly making someone understand.” Barbara explained that this has also been her experience, stating that she is aware with herself that if she is experiencing the tendency to start…

> going on and on in a more intellectualized kind of way,
> that the power of a clear metaphor makes the point in

> fewer words so that it can allow for more moments of quiet or to absorb something and be thoughtful and think about it, sort of muse over it.

Elaine states that some of the experiences patients come to therapy to address "are not about words" at all, and so when the therapist and the patient are "struggling wildly to find words for this feeling, but suddenly words become feeble or frustrating—or the words that we use are laden with meaning and judgment which interfere with the actual process."

This may be an inevitable casualty of living in a culture where "healing is understood in terms of verbal exchanges," as Mariah, a clinician trained in psychoanalysis as well as object-relations theory, stated. Something more is needed which the metaphor supplies, and this "more" can be understood in terms of, as Sam explained, "bringing things alive, capturing things." It is new language and thus encourages a novel way of thinking about a conflict. However, he continued, "Metaphor is not the only way that things come alive through language." The therapist is…

> …using language all the time, whether it's explicitly metaphorical or not, to capture the live, emotional process of the patient, or in the room, or whatever. And it's the ability of language to capture that in a usable way, and metaphor is part of that.

However in order to access the true functionality of metaphor, the therapist must be open to it: curious, ignorant yet wise, with evenly hovering attention but searching for nothing in particular.

Affect, the Body and Metaphor

As Ellen Siegelman (1990) writes, "true insight occurs in and through the body." The ego, she argues, "is first and foremost a body ego" and metaphor is able to trigger that "body

ego" because it serves as a "crucial vehicle for apprehending the many domains of experience that do not have a preconceptual structure of their own" (p. 28). One of these domains, she argues, is the domain of strong affect such as "terror, anger, depression and bliss" (Siegelman, 1990, p. 32). As "these affects originally had their base in body states," the way in which metaphor can trigger the senses may work to release affect that was originally left unprocessed (Siegelman, 1990, p. 32). Roger explains,

> …symbols come from body energy, they come from psychic energy, and they have energy to them. The symbols themselves are energized. The question is how to elicit that …but also to connect them to that energy in themselves. But the body itself is what's speaking. It's not just a head-trip, there's a body energy in the symbols…

As Roger uses symbol and metaphor interchangeably, we can understand that when he speaks of the energy of symbols, he is speaking as well about the affect which metaphor can spark, the way in which it can illustrate, literally, what is being held inside and so encourage a catharsis of sorts.

We see this in Jane's example of a patient who struggled immensely in his capacity to build and sustain a relationship with another man—something he strongly desired. Due to the ensuing isolation he experienced given this incapacity, his metaphor aptly described both the physical loneliness of this experience as well as the emotional barrier he had erected around himself to help counteract the pain. His metaphor, Jane describes, was of a "boy in a bubble" where he was the boy and the bubble was a constant, protective yet claustrophobic skin, encasing him wherever he was. As Jane explains,

> We followed the bubble metaphor the whole time. And then he met a guy and they had a relationship, and it was an intimate relationship. And it was the first person who ever permeated the bubble physically but also emotionally in an intimate way. And that was transformative and then it felt to him as if the

> bubble had burst, that he was no longer the boy in the bubble. And it had this sort of Pinocchio quality to it—he didn't say this but it was almost like, "I'm a real boy now. I'm not just a boy in a bubble. I'm real. I can feel; I can touch, I can touch someone, I can get pleasure." And it was so profound.

Not surprisingly, the bursting of the bubble corresponded as well to the patient's expression of affect, Jane reports. Just as he found someone with whom he could experience vulnerability, who permeated his bubble so to say, he was more capable of accessing difficult feelings in therapy as well. Jane explains that at this juncture in the therapy, she felt as if the "bubble melted. It was almost as if the tears…like with soap bubbles, the bubble got wet enough that there were holes and it became more permeable." In return, she explains that she was then more "truly able to feel his feelings; he was truly able to feel that I felt them. We were really connected."

In this particular instance, the metaphor serves as a womb for the "real boy" inside the patient who is born into affect through the process of the bubble's dissolving. It pops, as it can no longer bare the saturation of his "real tears" which have emerged from a new understanding of his needs. Crying is a very physical experience where a fragility of the body is implicated. The bubble, then, must break in order to make way for the hitherto unintegrated, unexpressed affect. The metaphor must be abandoned in the service of a new construction of the self.

As Barbara explains, metaphor "draws your attention to the body in a very different way." She continues: "And I'm always guided by this idea—that the body doesn't lie. It gives us so much information about what's going on emotionally." And Polly, a clinician working primarily with younger individuals, concurs, explaining, "Metaphors speak to our full physical, experiential self," drawing our attention to the way in which we feel in our own skin.

If we recall Elaine's metaphor of tomatoes, which she used to demonstrate the arbitrariness of preferences in the dynamic of a couple, we can see how the metaphor draws its power from the way in which it implicates the senses—and the sense then do their own work. She summarizes:

> I think food—because it's a direct, immediate sensory experience or sense, you know, is something that everyone can relate to immediately… And let's take that immediate sense of—you know in your gut, in your entire being—either it is attracted or repelled. It's a very, very fundamental human function.

This "direct, immediate sensory experience" can then catapult patients into an awareness of the moment and so can assist in reorienting them to their body as well as to their mind. Recalling Katie's patient with whom the metaphor of being "in the boat" was utilized, during the instances when Katie was "in the boat," she was simultaneously…

> …in the moment. So for most of the day, she was cycling through a lot of anxiety that was getting in the way of focusing. You know, like a lot of doctoral students, she was falling behind. Her advisor had wanted her to be progressed up to a certain point in her thesis, and she wasn't, and it was because she was bothered by all of this stuff. But as soon as she went down and was with the crew team and stepped into the boat and she had the oars—all that stuff was gone.

Thus not only can metaphor serve as a vehicle to ultimate catharsis, as we see in the case of Joan's patient's use of the metaphor of the bubble and it's subsequent popping, but metaphor may also serve to orient a patient to his her surroundings. Awareness of one's body is increased, and, as in the case above, the physiological experience of anxiety is dissipated via the recollection of a time when the mind and the body were in a unison state of concentration. Affect, then, can be both contained and released via metaphor, as it is a door to memories and associations about the self that have yet to be probed. In the case of Katie's patient, "being in the boat" is an exception to the rule of her anxiety; it is a powerful antidote given its calming

influence and Katie's patient need only will her imagination to recall its effect. The result is a decrease in symptoms, a containment that encourages the patient's functionality. However in the case of Jane's patient, the affect is released via the metaphor but produces the same effect: the patient's contentment increases due to a shift in relation to his or her perceived limitations. Both metaphors are used to instigate a new relationship to affect—whether, in the case of Katie's patient, it is a feeling of agency in relation to overwhelming symptoms of anxiety, or, in the case of Jane's patient, an increased capacity to exhibit signs of emotional vulnerability.

The Therapist's Stance

Echoed again and again throughout the interviews is the opinion that the therapist must inhabit a stance of, as one clinician put it, "stupidity" if a rich metaphor is to emerge and develop over time. This "stupidity," one clinician argued, is defined as Columbo-esque, as the clinician is asking "inane questions" yet…

> eliciting information, in some sense the individual meaning and brining that out of the person from within themselves, then there is an alliance that's based on a partnership that hasn't to do with any authoritative imposition. But you're really bringing them into a deeper awareness of something that started out as unconscious in themselves.

In some sense, this stance extends beyond work with metaphor, yet it becomes particularly important given the playfulness and imaginative co-createdness of figurative language. The unconscious and its creations elude pure interpretation, and so one of the major pitfalls when working with metaphor, as many clinicians clarified, is the temptation to attach an absolute meaning to the image which has arisen in the therapist's psyche as opposed to the patient's. Mary, the clinician who worked with the dream image of the prosthetic leg, says she

felt distinctly that the leg had a particular meaning, given the patient's case history. The patient "had her interpretation…but I had mine. And then I thought, 'No this is really about figuring out what the metaphor means.'" As Kara, a clinician who works with adults explained, "metaphors have to be co-created. How about this image, I say. Does this fit? Then together we can change it to fit or throw it out."

This co-creative exploration was reflected also by Anne in her use of the metaphor of the consultant with the couple. She explained that the metaphor communicated that she could "facilitate exploration" and could help the couple ask, "Does this work for you? What other tools do you need? So let's figure this out together."

The intention behind resisting a single, consistent interpretation of a metaphor is put well by Rob who explained:

> One of the problems…with metaphor is we think
> we've got it when we've got it. Ah, I've got my metaphor!
> But the nature of the mind and the nature of experience
> doesn't stay the same. You can just look at the life cycle.
> I'm not the same person I was when I was 10. My mind
> works a little differently. It interacts with things differently;
> it has different assumptions. It has different beliefs.

The difficulty in avoiding interpretation lies in the fact that a pure, literal interpretation is often more comfortable and more soothing than an acceptance of the metaphor's ambiguity. However, as Mary explains, you also can't be "careless with metaphor." Quoting a documentary she had recently watched, she said, "metaphor is a powerful literary device but only if it is grounded to a literal meaning. Pure metaphor is corrosive and enfeebling." In a sense, then, the therapist must walk a fine line between dwelling in the possibility of meaning and steering the patient towards locating the function or "usability" the metaphor may have in his or her life. As Kara explains, "I only get in trouble with metaphor if I present it as truth and not as something

for the two of us to wonder about, and as a beginning of the other's musings about the truth of it for him." She elaborates:

> I was reminded of this the other day when a client I had seen years ago came back to see me and I used metaphor with her in the first session of our newly begun therapy. Later she told me she resented me shovel metaphor. But she didn't tell me this in the session, she told me this when she wrote to say she would not be continuing with me. I did not establish or reestablish the kind of give and take of the metaphor with her, and assumed we had this kind of contract because of the previous work we had done. Big mistake.

Thus not only must the meaning of the metaphor be expansive and co-created, but the timing of the introduction of the metaphor matters as well. Many clinicians spoke about the relationship between the patient and the clinician as serving as a backdrop for the metaphor and its exploration: some connection, some trust, must be established if the vulnerability inherent in sharing one's private images—and subsequently playing with these images—is to occur at all. Therapy in itself, then, becomes a "metaphor for relating," where the clinician's responsibility is to dwell in the possibility of the multiplicities of meaning and thus invite the patient to do the same. This can only transpire, however, if the clinician wills his or herself to be "concerned and worried about ideas of constructions or interpretations that may seem too definite or simplistic," as Mariah explains. She elaborates on this idea, extending it to the instances in the patient's life which beg for our patience and consistent exploration:

> We have become sometimes in this field very comfortable with saying, for example, somebody is depressed and they're angry and this must mean that they are turning the anger against the self. This is true but there's another aspect of that as well. And if you only stay with the person and think, maybe they're angry at another person and how can they express it and find closure and so on, you are then collapsing the level of complexity of the feeling in and of itself.

"Nothing is what it seems" in the therapeutic dialogue, as we are dealing with unconscious motivations and thus always living in metaphor. The client's experience, as it interacts with the therapist's psyche, is transformed—and thus therapy can be understood as one person in the terms of another, as evidenced in counter transference and transference. The collapsing of meaning comes when the therapist is triggered by the patient to invest his or herself in the counter transference, and so intervene from a place of unexamined fear or timidity. One begins to respond literally, as one is catapulted into the self, losing touch with the potential multi-layers of meaning in a patient's speech and behavior. If the clinician begins to dwell in the literal, in the concrete interpretation, if the clinician focuses, for example "just on the surface manifestation of competency and professional identity" that a patient is struggling with, he or she misses "the much deeper, unconscious dynamics," Mariah explains. And though the patient may not be conscious of these dynamics just yet, it is the clinician's responsibility to be thinking in metaphor, "holding the possibility" that there is a wealth of meaning and history behind a single emotional experience which has yet to be unearthed.

CHAPTER V
DISCUSSION

In conclusion, it is evident that metaphor is able to express what has been historically difficult to express because it lends new language to the "metabolization" of experience. In fact, biological processes within the body were utilized as metaphors for how metaphor functions in the therapeutic encounter by two distinct clinicians in the interview process. As Rob describes, therapy itself is "one kind of vehicle where people are trying to kind of metabolize, make sense of, maybe just improve the nature of their experience." He continues:

> It's impossible I think to—well, you can't. It is impossible. It's impossible to express directly the experience of the mind and of emotions and of God. And so we have to filter it through something—and by nature, that packaging limits it. It has to.

But even given the limitation of metaphor, of language in general, still it is able, as we've read throughout this paper, to represent existence in a novel way given its imagery and associative quality, its poetry of possibility. As all language is inherently limited, and most experiences, the poet Rainer Maria Rilke argues, "are unsayable, they happen in a space no word has entered," metaphor represents the possibility of coming as close as possible to that space—perhaps not entering it but at least opening the door (Rilke, 2010, p. 32).

Mirroring Rob's argument for the metabolization of experience metaphor encourages, Sam explains that metaphor poses the possibility of a similar process in the body: an "immunization." A metaphor he used with a patient served as a "immunization" in that it "lodged into her psyche—it entered her psychic immune system." He continues: "Metaphor is not

completely effective but this one did more than a lot of things I've said to many patients; this one somehow was forceful or had a long-term time release."

We see again reflected in this summarization of what metaphor is and how it works an indication that it must somehow dwell in the body as well as the mind. This is where its staying power is. It is not only a cognitive insight, but a physical insight, a word that becomes "lodged" in the physical self, in the memory which is by nature bodily. It is indeed interesting to note that when attempting to describe the use of metaphor in psychotherapy, clinicians utilize metaphor to do so—and metaphors that evoke affect, memory and the physical self.

If we conceptualize of metaphor as "possibility," as Emily Dickinson did of poetry in general, then we must consider the therapeutic encounter to be defined as a metaphor in itself as each moment invites a multiplicity of reactions and so possible directions down which clinicians can go. Though many clinicians spoke of how one is to hold one's self if a metaphor is to emerge, the position one must take in the face of the symbolic, it is more important, I have come to conclude, to understand the very difficult emotions of a patient as metaphorical in that they are not necessarily literal. Perhaps the most poignant moment in the interviews I conducted was the moment where this became clear. Joseph, a practicing Jungian, told a story of a very angry patient he was working with who had become quite aggressive towards him during a session. He explained that if he had taken this patient's behavior at face value and immediately denounced the patient for becoming angry, explaining "You can't talk to me that way!" then the patient and the clinician would have been caught in a cycle of literalism: anger begetting anger, condescension begetting condescension. The job of the clinician, then, is akin to the job of the poet: to foster possibilities that have not been considered through associations that have yet to be made. The "corrective emotional experience" lies in the holding environment, and the holding

environment is non-literal; it is, in its essence, metaphorical. To not take a patient as literal is to allow them to begin to heal, as all of the facets of metaphor—playfulness, its bypassing of the cognitive, its capacity to tap into unprocessed affect, the way in which it lives in the body, the fact that it welcomes externalization and then integration—require that the clinician "dwell in possibility," holding a multiplicity of intentions and meanings simultaneously.

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Appendix A: Human Subjects Review Application

Investigator Name: Heather Clarke

Project Title: *Metaphor Use in Psychotherapy*

Project Purpose and Design

I am interested in exploring the use of metaphor in psychotherapy from the perspective of fifteen clinicians from a variety of therapeutic backgrounds. For the purpose of my project, metaphor will be defined simply as understanding one thing in terms of another. Therefore I will not limit my understanding of metaphor to a direct correlation between two disparate entities (as in: "My brother is a monster") but will expand the definition to encompass such commonplace metaphorical statements as "I'm a *burden* to others" or "I'm *drowning* in sorrow." The purpose of expanding the definition will be to represent how deeply engrained metaphor is in our everyday speech, and how often we experience our internal worlds via the layered resonance of figurative language.

I will interview each clinician for approximately 30 to 40 minutes. These interviews will occur face-to-face or via Skype if a live interview is not possible. Each clinician will be asked the same six or so questions; these questions will constitute the basic structure of the interview. (These questions are attached as an appendix to this application.) However, even though I will use these questions to obtain pertinent information regarding metaphor use in psychotherapy, I will invite the interviewee to expand upon points or areas where he or she locates more extensive and richer meaning in regards to the topic. Though interview questions will be posed and explored, I will not limit our exploration to the paths down which these questions take us but will simultaneously invite participants to take me down paths they feel must be illuminated.

The purpose of the interview, and of the project itself, will be to understand how metaphor is used in therapy and to what purpose. I seek to explore if and when metaphor is used effectively, is it conducive to psychological insight? Furthermore, does it encompass the specific patient's history and dilemma; does it in any way reflect diagnosis? Because metaphors can be intimate in the sense that they reflect a correlation in the patient's mind that is private and multi-faceted, when a clinician is able to reflect this metaphor back to the patient and expand on it, a therapeutic alliance that is already strong may grow even stronger. I am interested in exploring the way in which a metaphor may shift the bond between clinician and patient, paying special attention to when the metaphor was introduced and whether it was patient-generated or clinician-generated.

I will ask each clinician to recall one patient prior to the interview. Clinicians will be ask to review the patient's history, diagnosis, and duration of treatment. I will ask each participant to try to remember the pertinent metaphor in detail and the subsequent path down which the metaphor took both the clinician and the patient. I will request each clinician to devote him or herself to a bit of a review of the case prior to the interview so as to ensure that the interview transpires more easily and efficiently.

Though there is much research and writing regarding the use of metaphor in psychotherapy, I did not encounter a study that sought to explore, specifically, the perspective of clinicians regarding metaphor use during psychotherapy sessions. The perspective of clinicians emerged mostly in cases where a single clinician wrote a book reflecting his or her individual

perspective and experience with metaphor. I did not encounter a study or an article that brought the narratives of various clinicians together to locate shared themes and collective responses to metaphor use. Therefore, though there is a wealth of information on the possible uses of metaphor and the depths to which it may reach, clinicians have not been asked so often to capture the way in which *they* experience metaphor in psychotherapy. In addition, capturing these narratives in a single project will help draw our attention to the commonalities that emerge; one narrative will be understood in the context of others—and though each voice will be different, I am hoping that common themes will emerge to further our understanding of curative language.

In reviewing the salient literature, some pertinent themes emerge regarding the potential power of metaphor in psychotherapy. Metaphor is often described as that which surreptitiously expresses what has historically been difficult to articulate and perhaps has become repressed. The utility of metaphor is identified in its capacity to lend coherence to what is vaguely sensed or perceived, but has not yet been integrated into the overarching story one consciously tells oneself about one's past or present experiences (Berlin et al., 1991; Holmes, 2004; Houssier et al, 2011; Kopp & Eckstein, 2004; Martins, 2005). The psychotherapist, in turn, acts as an interpreter, translating the silencing and silenced symptom into a verbalized metaphor so as to "undo the symptom" (Lakoff, 1980, as cited in Siegelman, 1990, p. 36).

Lending a visceral quality to repressed memories or shameful experiences (or linking sensation to lived experience) through metaphor helps patients relive these memories and ideally put them to rest. Some studies explore the way in which metaphors generated by clients work to expose traumatic memories by surreptitiously naming the sensation experienced during the trauma. A study of a patient who had experienced sexual and physical abuse at a young age explored the patient's repeated use of the metaphor of "heat," manifested in his experience of his skin as constantly "on fire" and "burning" (Houssier et al, 2011). Not only did the therapist and patient begin to conceptualize of this metaphor as indicative of early experiences of sexual arousal on the part of the patient towards his mother, but also unearthed a forgotten memory of the patient being forced by a babysitter to put his hands on top of a scalding hot stove (Houssier et al, 2011). Concrete connections between the metaphor and repressed memories are apparent in this case.

A similar process may occur in the case of the psychosomatic patient who has converted the unspoken into a symptom. One theoretical study depicts the case of David, a patient who suffered from Irritable Bowel Syndrome and conceptualized of his physical symptoms as *purely physical*. In the course of the therapy, "David learned to think 'metaphorically about his gut," addressing his "fiery bowels" as not only a physical symptom, but an articulation not yet verbalized which was attempting to "say something about (his) inner world" (Kohutis, 2010, p. 428). This was the beginning of a new found "foundation" in David "for an expanded capacity for symbolic and metaphoric thought" (Kohutis, 2010, p. 417). The capacity for figurative language to *imply* may relieve the patient of his defenses long enough so that he may begin to access the meaning of the memory and the process by which it first became repressed.

Often a patient's relationship to metaphor is reflective of patient diagnosis and the capacity to which the patient is able to hold ambiguity and abstraction. Patients who are diagnosed with Borderline Personality Disorder, one study demonstrated, may have a more difficult time responding to metaphor and examining its latent content alongside a therapist (Rasmussen & Angus, 1996). This is indicative of the difficulty those diagnosed with BPD may

have developing a therapeutic alliance and trusting in words spoken during therapy so as to believe in their capacity to be curative.

Just as the degree to which a patient *maintains* metaphor may be a reflection of diagnosis, so may the *content* of the patient's metaphors. One study examined the transformation of the "burden" metaphor in those diagnosed with depression, finding that in a "good outcome dyad" (therapist and patient), the "burden" was transformed into a lightened weight, whereas in less successful therapy the metaphor was not transformed at all (Leavitt, Korman & Angus, 2000). This study suggested that, if the therapy is productive, the metaphor transforms as insight increases, reflecting therapeutic progress.

In Ellen Siegelman's book Metaphor and Meaning in Psychotherapy, she argues that introducing the "symbolic attitude" back into a patient's life after it has been abandoned can be made possible through metaphor. "The trust in one's own reality," she writes, "comes from trusting another, from the experience that the other does not exist in disconnected pieces" (Siegelman, 1990, p. 166). If we work to honor the patient's symbolic language, we are honoring the patient's play: something that may have been historically forbidden or shamed. We begin to hold the patient through a mutual language, hinting at complexity and abstraction. "Ecstatic moments of fusion with the mother are essential," Siegelman writes, "if the world is going to be anything other than static, gray or literal" (1990, p. 169). She continues: "If the child becomes aware of his separateness too early, and too continually, the result may be … a premature cathexis of a meager reality" (Siegelman, 1990, p. 171). This "meager reality" on the part of the patient can be reflective of the fact that the patient has always been dealt with as a literal entity (sans complexity) by the caretaker, and so has interpreted the self as well as reality as reducible, black or white. The commitment to metaphor and to the patient's capacity to speak figuratively represents a new sort of nurturing; nothing is immediately reducible—not the self nor reality—but this is no longer threatening; it is accepted.

My research study is pertinent to clinical social work in that as budding clinicians, we are often struggling to situate ourselves comfortably as far as the language we use during sessions is concerned. Therapy is another form of poetry, another experience where words are used creatively; they shift, move, touch and construct. They are alive in the room. Words spoken by the therapist to the patient are curative because they may be the beginning of a reconstruction of the patient's autobiography. This autobiography may entail a history of experiences, trauma for example, that render one speechless or confused, without a coherent narrative and so without meaning to ascribe to one's existence. Metaphors represent a way in which experiences that rob one of words and meaning can be integrated into the self through the surreptitious nature of figurative speech. This project will capture the voices of therapists who are familiar with the power of metaphor and have experienced and witnessed its place in psychotherapy. It is hoped that the project will serve as a template to young clinicians entering the field who are curious and apprehensive about their own use of language, and the capacity language may have to heal.

The results of my research will be used to compose an MSW thesis. It will also be used in a presentation of this thesis and will possibly be published if it is found to be a significant advancement in the field of social work studies.

The Characteristics of the Participants

I am interested in recruiting fourteen clinicians from a variety of therapeutic backgrounds for a 30 to 40 minute interview each. As of this writing, I have recruited approximately ten

clinicians; the majority of the participants are women with only one male clinician responding to my inquiry. There is one clinician of color who has agreed to participate; the majority of the participants are Caucasian clinicians who range in age from approximately 30 to 65. Most of the recruited clinicians have maintained a private practice for some years, and all have experience in one-on-one individual psychotherapy with a variety of clients. The backgrounds vary: three of the participants are college counselors who are psychodynamic in their approach (with one trained and familiar with EMDR); one of the participants is a drama therapist who also works as a professor of drama therapy in Canada; one specializes in CBT; one uses psychodrama quite frequently in her work, and many of the clinicians are familiar with the theories of psychoanalysis. Many of the clinicians are affiliated with the Smith College School for Social Work in some way; two of the participants teach at the SSW, and three of the participants work at the Smith College Counseling Center.

As I was (and still am) interested in recruiting participants with a wide range of experience and backgrounds, there is little exclusion criteria. I am looking for those participants who are willing to engage in a conversation regarding metaphor use in therapy and so have presumably been attuned to their use of language in therapy and have recognized the emergence of metaphor in their work. All of the clinicians who have agreed to participate (thus far) have worked in the field for five years or more.

The Recruitment Process

My initial recruitment letter was sent via email. It is copied and pasted below.

Hello,

Some of you I haven't spoken to in quite awhile; I hope this email finds you very well.

I'm writing to you with good news: I've begun my final year in the MSW program at Smith College School for Social Work. With the pending completion of the program comes the exciting opportunity to explore a thesis topic of interest.

So, after much thought and research, I've decided to focus on the use of metaphor in psychotherapy, exploring specifically the experience of psychotherapists and psychoanalysts in regards to a single patient where metaphor was used repeatedly (perhaps the same metaphor, perhaps multiple metaphors). This metaphor could have been either patient-generated or therapist-generated; I'm interested in exploring more the way in which the therapeutic alliance was aided by the use of this metaphor in that it reflected to the patient that the therapist had understood his or her subjectivity. Furthermore, the metaphor may have shed light on what had been consistently difficult to verbalize, and subsequently integrate into the patient's experience and sense of self.

This is, of course, a very rough summary of my interest. However I am contacting you to ask whether you would be interested in engaging in a 30-minute interview regarding one patient with whom metaphor was utilized and was effective. This interview could transpire via Skype, face-to-face, or over the telephone. All interviews will be kept strictly confidential.

Please let me know if this piques your interest. And if you are aware of other therapists who are familiar with the use of metaphor and encounter it often in their work, I would greatly appreciate it if you forwarded this email to them.

Thanks again and I look forward to hearing from you!

I sent this email to thirteen clinicians, many of whom are local. The majority of the clinicians I knew through the School for Social Work; a few were former professors, and the rest I have worked with in the field of social work in some capacity in the past. My sample is a non-probability sample of convenience, given that the participants are those individuals who I have access to and am familiar with; I took into consideration, when I considered clinicians I could recruit, those who would be interested in engaging with me regarding metaphor and who I knew to be clinicians who are attentive to language. I attempted to recruit for diversity, but given there is little diversity amongst the clinicians I have known as far as gender, race and age is concerned, this was difficult. Most clinicians in the Northampton area seem to be Caucasian females, and many of the clinicians with whom I have worked fit this profile as well. Currently I have one clinician of color and one male participant.

Approximately ten of the clinicians I attempted to recruit replied to my email and explained that they would like to participate. A few said they would send my email to other clinicians so as to assist me in the recruitment process. Currently I am writing a follow-up email to touch-base with those clinicians who have agreed to participate. This email specifies what exactly the ten participants should be thinking about prior to our interview. I have asked each clinician to recall one patient with whom they have worked where metaphor has been used and where they have felt it was used effectively. I have listed some of the possible questions I may ask regarding the nature of the therapeutic alliance, the path down which the therapy took after the metaphor was introduced, and the specific metaphor that was introduced in the context of the patient's history. I have not sent the specific questions I will ask but instead a general template to inspire initial thought and inquiry on the part of the participants. I have also sent a definition of metaphor (and some examples) so participants will know what to look for and recall. The idea behind this follow-up, informative email is to ask participants to prepare a bit ahead of time so the interview can flow more freely and transpire more efficiently.

After I send this email, I will wait for the HSR board to approve my application. In the meantime, I will invite the recruited participants to send me questions or concerns prior to setting up the official interview with each clinician. Once the application is approved, I will begin to contact the participants to set up individual interview dates and times. If a clinician is local, we will meet locally. If a clinician is not local, I will arrange to interview this person via Skype or via the phone.

The Nature of Participation

Participants will engage in one interview with me for approximately 30 to 40 minutes. They will be asked six questions which pertain to the use of metaphor in psychotherapy; each participant will be asked the same six questions. However, depending on the content of the respective response, follow-up questions will be specifically geared towards the emerging and unique perspective illuminated via each interview.

Interviews will occur face-to-face if at all possible. I will ask each willing participant to review the case they will be speaking about prior to the interview, asking each clinician to familiarize his or herself with the patient's history and diagnosis, the course of treatment and the metaphor which emerged. If a patient's treatment has been terminated and he or she no longer sees the clinician, perhaps the preparation will be a bit more thorough. But only a brief review is suggested—enough to avoid spending the half hour with the clinician as he or she attempts to remember the patient and/or the metaphor and its transformation.

The interview questions will seek to explore the clinician's view on the use of metaphor in the psychotherapy of the individual patient. I will inquire, in general terms, into the patient's history, the nature of the therapeutic alliance, the life of the metaphor and the course of the psychotherapy.

I will be audio taping each interview. If an interview occurs via Skype, I will audiotape these interviews using Skype's recording component. I will transcribe the data myself, but, at my advisor's suggestion, I will review each of the interviews first for relevant data, which will be defined as those themes or perspectives on metaphor that emerge or occur in more than one interview. If there is a perspective on metaphor that runs through a variety of the interviews, I will transcribe the sections of the interviews where this perspective emerges before transcribing each individual interview, word for word. Thus I will search for common themes and responses to metaphor, and then I will review each interview for the prevalence of these themes or the emergence of a new perspective on the topic.

If an interview occurs via Skype, I will conduct it in my apartment in Northampton. It is a private space where noise does not carry. I will conduct the majority of the interviews in the private practice or work office of the specific clinician. These will be private rooms where white noise machines will be available to ensure information is not overheard.

Participation in the project involves the single interview as well as the half hour or so of preparation prior to the interview. In total, participants should expect to devote an hour of their time to the project.

Risks of Participation

There is little risk in participating in this study for clinicians. The primary objective prior to the interview is for participants to spend approximately one half hour reviewing the patient and the patient's treatment as well as the metaphor used. The interview will then seek to illuminate this information.

I imagine that reviewing such material could be experienced in a myriad of ways: some clinicians may find it laborious while others may enjoy the process of revisiting a case. Some review of prior or current treatment is required. Therefore, clinicians will be reflecting on the work they have done with a past or current patient. This could be experienced as a risk if the patient's history is particularly traumatic and reviewing it again is an emotionally trying experience. Another difficulty may be in examining the course of the treatment, as this may elicit some feelings of doubt or regret at how treatment terminated, for example. If the patient was a particularly difficult patient, reviewing the case may stir up memories that are not pleasant. Conversely, if the patient's treatment was considered a success by the clinician, it may bring joy to the participant to recall the experience.

Because I am interviewing individuals who have years of experience in the field and have presumably managed to reflect on their own countertransference regarding each patient, the risk to participating in this study is minimized.

All identifying information will be held in confidence. I will ask each clinician to change the name of the patient described; therefore, I will never know the identity of the patient. In addition, I will disguise the identity of each clinician by using a fictional name.

Benefits of Participation

Clinicians will benefit from participation in this study given the fact that they will be afforded the opportunity to reflect upon their past or current treatment of a specific patient. They

will then be able to articulate their experience and memory of this, while examining the language used during the therapeutic interactions as manifested in metaphors.

Due to the busy schedules of most of the participants, it is plausible that little time is devoted in their lives to the discussion and analysis of what, specifically, was useful about a specific metaphor, (or, in more general terms, what constitutes effective therapeutic language). To take a step back and engage in the analysis of this is beneficial in that it increases each clinician's awareness of what has been capable of producing or stirring insight in the past, and so what may continue to instigate insight in the future. We often speak without much reflection regarding what we are saying in our daily lives, and though it is assumed that therapists are more reflective when speaking to patients during the therapy hour, it is often my personal experience that even this site is not immune to unexamined speech. Participants will be asked to examine their use of metaphor and so distance themselves, momentarily, from what may often emerge quite naturally and without a second thought.

Participants will be involved in a project that will begin to define in what ways metaphor can be useful in therapy. Future clinicians will benefit from reading the narratives of those who have had a wealth of experience and have experienced first-hand the power of holding a patient's words and honoring the layers behind figurative language.

Informed Consent Procedures

The attached form will be distributed to willing participants. A careful reading and subsequent signature will be required of each participant before the interview transpires.

Precautions Taken to Safeguard Confidentiality and Identifiable Information

Clinicians will be asked to disguise all identifying information regarding the patients they describe during the interviews; there will be no material where the patient's identity is revealed. I will ask clinicians to use a fictionalized name when they speak of the patient.

In addition, all identifying information regarding clinicians will be disguised.

I will transcribe all of the interviews myself. No one else will be involved in this process. I will sign a confidentiality agreement regarding the identity of the participants. My thesis advisor will have access to the data after the identifying information has been removed.

Clinicians will be identified by fictional names. Therefore, when presenting regarding an illustrative vignettes, or when quoting a clinician, the clinician's personal identity will not be revealed. These fictional names will be used in my thesis as well as in any presentation or publication.

Because audiotapes will be used to record the interview, and each will capture the participant's voice (which could be used to identify the participant), I will store the tapes in a locked cabinet in my apartment. Tapes will be kept secure for three years as required by Federal regulations. After that time, they will be destroyed.

The Voluntary Nature of Participation

Participation in this study is voluntary and participants may refuse to answer any question during the interview process.

Participants should inform me if they wish to withdraw. They can do this via email or over the telephone. They cannot withdraw if they have participated in the interview and two weeks have passed since the interview transpired. In turn, they will have two weeks from the

date of the interview to withdraw from the project. Should a participant choose to withdraw, I will destroy all materials related to them and they information they provided.

Investigator's Signature: _____ Date: _____

Advisor's Signature (if applicable): _____Date: _____

Appendix B: Informed Consent Form

Dear Participant,

My name is Heather Clarke and I am a second year masters student at Smith College School for Social Work. I am interested in studying the role of metaphor during the psychotherapy hour. The focus of my research is the exploration of the role of metaphor in psychotherapy. I am interested in interviewing fourteen clinicians who have used metaphor during the psychotherapy hour and are interested in sharing their views. The data I collect will be used in my MSW thesis and will be disseminated both in presentations and possible publication.

If you would like to participate in my study, you will be asked to sit for one half-hour interview with me within the next few months. You will be asked open-ended questions to discern what your experience of metaphor in the psychotherapy hour has been. I am interested in recruiting experienced clinicians from a wide variety of therapeutic backgrounds who are interested in the role of language and metaphor in psychotherapy. All participants must be over 18. I am interested in recruiting individuals from different cultural as well as racial backgrounds, and males as well as females. I will audiotape each interview and then transcribe them to discern salient themes and information.

The risk involved in the interview process will be that clinicians may recall specific verbal exchanges in therapy with specific patients, and the memory of these exchanges may be emotionally charged—either positively or negatively. Participants will be encouraged to proceed only as they feel comfortable. The benefit of this process is that participants may begin to recall the curative moments of therapy and, in retelling these moments, will provide critical information for future clinicians. Compensation will not provided for participation in this study.

All information will be kept confidential and names of participants as well as patients will be coded and removed. Audiotapes will be kept in a locked cabinet. When brief quotes or vignettes are used, identifying information will be disguised both in presentations and publications. All data will be kept in a secure location for a period of three years as required by federal guidelines and data stored electronically will be protected. If I find that data is needed beyond three years, it will continue to be kept in a secure location and will be destroyed when it is no longer needed. My thesis advisor will be the only individual who will have access to this information during the thesis process.

Participation in the study is voluntary and participants may withdraw from the study at any time during the data collection process and may choose to refuse to answer any question. The final withdrawal date is March 31st, 2012. At this time, I will be quite involved in the writing of my thesis and removing data will be more complicated and time-consuming. If participants choose to withdraw, all data will subsequently be destroyed. If participants have any questions or concerns about their rights or about any aspects of the study, they are encouraged to call me or the chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR

PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Signature: _____