

The role of patient-generated metaphors on in-session therapeutic processes

Ronda Rowat, Jack De Stefano, Martin Drapeau

Summary

Aim. This study examined the relationship of patient-generated metaphors to in-session experiencing.

Material and method. It was assessed by the Experiencing Scale (EXP). Patient-generated metaphor events were randomly selected from psychotherapy transcripts of forty-seven patients (N = 47) in therapy with therapists in training. Patient utterances before, during, and after the metaphor were identified and rated using the EXP Scale.

Results. From a repeated-measures ANOVA indicate that patient-generated metaphors are not significantly different from pre-metaphor or post-metaphor patient utterances. Furthermore, the patients' experiencing did not increase following a metaphor.

Conclusion. These results are discussed in relation to the role of metaphors in psychotherapy and their implications for future research.

metaphor / psychotherapy / Experiencing Scale / process research

INTRODUCTION

Language plays a central and complex role in psychotherapy [1, 2, 3, 4]. Psychotherapists and patients make use of "talk" that is both metaphoric and interpretative as they interact with each other. In fact, the use of metaphors by patients is a common occurrence [5, 6] and can be viewed as a patient's shorthand communication of an aspect of his or her psychological or emotional experience.

While research into metaphors is not a new area of study, it is gaining in interest across a broad spectrum of overlapping domains, including linguistics, poetics, cognition, pragmatics, philosophy, and psychotherapy. What is clear from this renewed attention is its relationship

to the cognitive and emotional processes that are used when we make sense of the world [7]. That metaphors play a central role in the process of psychotherapy is therefore not surprising.

Metaphor, Neuropsychology and Psychotherapy

Until recently, a large part of psychotherapy research into metaphor use stemmed from an interest in how therapists use this linguistic form when working with patients [8, 9]. This research cuts across many theoretical orientations to include psychodynamic, psychoanalytic, humanistic, constructivist, narrative, and process-experiential approaches. Possible outcomes of a therapist's intentional use of metaphors include: heightening the patient's emotional awareness; enhancing recall of significant therapeutic events; increasing memorability for important in-session events, enhancing the therapeutic relationship; and, elaborating and re-making of

Ronda Rowat¹, Jack De Stefano¹ and Martin Drapeau^{1,2}: ¹McGill University, ²Institute of Community and Family Psychiatry, J.G.H. Correspondence address: Jack De Stefano ECP – Clinic Director, 3700 McTavish Street, Montreal, Quebec, H3A 1Y2, Canada, E-mail: jack.destefano@mcgill.ca

meaning [10, 11, 12, 13]. These positive outcomes may be associated with the brain's processing of metaphor. Using event-related functional magnetic resonance imaging (fMRI), Rapp, Leube, Erb, Grodd, and Kircher [14] examined the neural correlates of metaphor processing and found that activation in the left inferior frontal gyrus was related to the semantic inferencing processes used to understand metaphors. Since the left inferior frontal gyrus is associated with semantic language comprehension [e.g. 15], this finding suggests that there are direct and immediate neurological underpinnings to the cognitive demands of metaphor comprehension. By implication, a patient engaging in productive cognitive work has greater potential for building new semantic associations through the use of metaphor generation. Enhanced activation at the neural substrate level offers opportunities for cognitive broadening. Clearly, such neurological realities have important implications for outcomes in psychotherapy.

Metaphor and In-session Experiencing

Metaphors reveal both meaning and affect. In psychotherapy research, the patient's speech content and its level of personally meaningful material has been used as a measure of in-session experiencing [16]. This concept of "experiencing" concerns the idea that the patient's inner referents become the focus of attention during therapy, and that the patient is a willing participant in exploring them. The most widely used measure to assess level of experiencing is the Experiencing Scale (EXP Scale) [17]. Research concerning the depth of experiencing has shown it to be associated with a positive outcome in therapy [17]. At present, the EXP Scale appears to offer the best measure of a patient's exploration of inner feelings, affect, and meaning. Given that metaphors manifest such meaning and affect, use of the EXP Scale may allow us to identify where metaphor and experiencing intersect.

The impetus for this study stems from a belief that something unique happens when a patient voices a metaphor. Indeed, there is much that happens at a metaphorical level in therapy that is neither fully understood nor utilized [9, 18, 19]. Recently, empirical research has tried

to learn more about the ways in which patients use metaphors. For example, in a study by Levitt and colleagues [16], patients' use of burden metaphors in depression was the subject of interest. The study compared features of a good and a poor therapy outcome during process-experiential short-term therapy. In the good therapy outcome case, the burden metaphor was transformed into a metaphor of unloading the burden over the course of therapy. In the poor therapy outcome case no such transformation was evident. Moreover, the good therapy outcome showed higher levels of experiencing compared to the poor therapy outcome. The researchers observed that patients were able to incorporate constructive change by altering negative metaphors (i.e., weighed down by burden) to more positive metaphors (i.e., lifting the burden). It appears that metaphors offer a very direct way for patients to pinpoint and transform experiences of difficulty.

Some research is beginning to explore the types of metaphors that patients generate as well as the purpose that metaphors serve for patients [20, 21, 22]. For example, in an examination of Carl Rogers' filmed session with "Gloria," recurrent metaphors of the patient feeling "all in one piece" are representative of a personal ideal state [9]. There is also evidence [16] that some types of metaphors are consistent with the patient's expression of specific forms of psychopathology. Metaphors of depression are one instance of this [22]. Novelist William Styron [23] wrote eloquently about his depression in *Darkness Visible* and used the metaphor of a journey from darkness to light as emblematic of his recovery. Extrapolating from Styron's experience, patients themselves acknowledge the power of their own metaphors [24].

The goal of this study is to extend the current line of metaphor research by exploring the idea that the patient's use of metaphors during the process of psychotherapy occurs as the manifest expression of a subjective awareness of a significant experience [17]. Thus, while much psychotherapy is reflective, metaphor use may be a particularly salient manifestation of this process [12].

The present study examines the role of patient-generated metaphors in 47 psychotherapy sessions. More specifically, the relationship of pa-

tient-generated metaphors to in-session emotional experiencing was examined. Additionally, change in subsequent experiencing following metaphor use was studied.

SUBJECT AND METHODS

Subjects

The events of interest to this study, i.e., metaphor usage, were drawn from a pool of interviews that is part of an archival set of data collected by the McGill Psychotherapy Process Research Team. The material for the present study consisted of therapy sessions conducted by therapists in training. The patients were students from another large North American university. They were enrolled in an undergraduate class in a health-related discipline and participated in personal therapy as part of their course requirement. Participation was voluntary and based on the understanding that the patients would use their counselling experiences to address personal issues, questions or concerns. The patient population was diverse with regard to age, gender, and cultural/racial identity. Information based on Symptom Checklist-Revised [SCL-90-R; 25] and Target Complaints Inventory [26] indicates that these patients are similar to those who typically request services from university counselling centers in that they experienced moderate levels of distress. Patients met with their therapists for 15 sessions. All sessions were videotaped. The first three sessions had been transcribed for various research projects and the data for the present study came from this pool of interviews. Early sessions were used for study to maintain a consistent training level among the therapists.

Definition of a Metaphor Event

A metaphor is defined as a comparison between two disparate things. Merriam-Webster's Collegiate Dictionary [27] provides a linguistic definition of a metaphor as: "A figure of speech in which a word or phrase literally denoting one kind of object or idea is used in place of another to suggest a likeness or analogy between them."

Thus, for the purpose of this study, a metaphor or metaphorical phrase was operationalized as any linguistic referent made by the patient of the self and his or her experience. These criteria were adapted from Kopp and Eckstein [8] and Kopp [28], with their categories used as a reference guide to train the coders in identifying the metaphor events. These categories were: a) metaphors representing one's image of self or one's relationship to self, b) metaphors representing one's image of others, c) metaphors representing one's image of personal situations, d) metaphors representing a relationship of self to others, and e) metaphors representing a relationship of self to situations. While these categories have been used to identify metaphors, their reliability or validity has not been examined.

Coding of Metaphors

Two coders received approximately six hours of instruction, practice, and training in the task of identifying metaphors. Three transcripts from experienced therapists were used for training. Thereafter, five transcripts, randomly drawn from the data pool, were used for practice. None of these five transcripts were included in the final study. Coders independently identified metaphor segments and agreement as to what represented a metaphor was reached on 81% of the segments. Disagreements were discussed and used to refine the metaphor identification process. After a second round of independent rating, the coders reached an agreement level of 100%. Following training, the coders independently read through each transcript and identified all metaphors used by the patient. After ten transcripts were coded, the reliability of the coders' metaphor identification was re-tested. The interrater agreement level was 100%, and from then on the coders were randomly assigned separate transcripts to code for metaphors. Metaphor events that were described as part of dream sequences were not included. Dreams can be seen as complex, self-contained metaphorical narratives [29] that require their own particular coding system. This process produced a total of 160 metaphors.

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Methods

Data Preparation

Once all metaphors were identified in the transcripts, a single metaphor event was randomly selected from each session. This produced a final total of 47 metaphors. Following this, pre-metaphor and post-metaphor events were selected, by going backward and forward within the session, eight complete patient utterances from each selected metaphor. To create consistent units of material, all therapist remarks between patient utterances were removed. In keeping with similar criteria for utterance length used by other researchers [16], units consisted of no less than four complete sentences. For the metaphors, patient utterances that immediately preceded or followed the metaphor were included, if required, to make up the four sentences. In this way, all utterances, both metaphor and non-metaphor, were relatively equal in length. This was taken as a precaution against the possible cueing of the EXP raters to the metaphors.

The final inventory of pre-metaphor, metaphor, and post-metaphor utterances consisted of 140 randomly distributed segments. One metaphor event occurred at the beginning of the transcript, thus a pre-metaphor event for this dyad was not possible. EXP coders, who were blind to the nature of the study, were required to read through all the patient utterances and code the level of patient experiencing.

The Experiencing Scale

The EXP Scale [17] was used as a measure of the patient's participation and experiencing in the session. The scale is a frequently used and well validated measure of in-session experiencing [30], tapping into both cognitive and emotional components of a patient's in-session processing. The EXP Scale uses a seven-point scale (1 = lowest and 7 = highest) to rate psychotherapy sessions or segments of sessions. At the lowest level the patient's utterances are devoid of personal material while the highest level is reflective of new or more fully realized feelings and meanings. Raters assign a numerical

value to segments from the psychotherapy sessions under examination.

EXP Scale Rater Reliability

Two graduate students, independent of the metaphor coders, served as raters for the EXP Scale and had considerable experience with the EXP Scale and had conducted more than 25 hours rating of various transcripts and projects. Each rater independently read through each patient segment and assigned it a rating. The raters' pre-consensus agreement was 75%. Following independent ratings of sessions, raters met for a consensus meeting where any discrepancies were resolved.

RESULTS

A repeated-measures analysis of variance (ANOVA) indicated that there were no significant differences in the levels of in-session experiencing for pre-metaphor, metaphor, and post-metaphor events, $F(2, 44) = 1.59, p = .21$.

To further confirm this by examining extreme points in time (pre- vs. post-metaphor), a paired t test was used to compare pre-metaphor in-session experiencing with post-metaphor in-session experiencing. Results were nonsignificant, with $t(46) = .29, p = .78$ (see Tab. 1 for means and standard deviations).

Table 1. Mean EXP Scale Ratings Per Utterance Type

	M	SD
Pre-metaphor	2.17	.94
Metaphor	2.43	.95
Post-metaphor	2.21	.75

$p < .05$

DISCUSSION

The paradigm for this study is psychotherapy process research and, more particularly, the interface of language, i.e., metaphor, and the emo-

tional processing of experience. Contrary to expectation, this study found no evidence of a direct link between patients' metaphor use and in-session experiencing. These findings may be explained by several factors. First, the utterances used in the study were drawn from initial psychotherapy sessions. Therapists, and particularly novice therapists, struggle to establish rapport and manage their own anxieties in these early stages. These initial feelings of incompetence could interfere with patient engagement and block access to deeper content, thus impeding metaphor generation. In view of this, the use of later sessions, after therapists had developed greater confidence in their skills, may have led to different findings.

A second limitation concerns our linguistic habituation to metaphors and their consequent loss of salience. This study made no judgment of a metaphor's strength or weakness. Yet, this qualitative assessment appears to be important and implies that, even in therapy, not all metaphors have equal valence. As the literature on language indicates, metaphors serve different purposes and have different values at different moments [29]. Thus, certain metaphors may not be viewed as deepening in-session experiencing because they are perceived as idiomatic descriptive expressions, more connected with colloquial use than emotional depth. This raises the question of whether metaphor use can be measured quantitatively in a meaningful way. Perhaps the first task in metaphor research is the development of a valid rating scale to assess metaphor relevance.

Finally, the EXP raters' pre-consensus agreement was quite low at 75%. It may be that the unit of four patient utterances was too brief to be salient or that non-metaphor utterances were not distant enough from the metaphor content to provide discriminatory value. There is no established methodology for investigating this type of patient utterance. While the observance of consistent utterance segments seemed potentially helpful, the distance between metaphors was often unequal due to variation in session content. Furthermore, several pre-metaphor utterances contained an earlier metaphor that may have served as a potential confound for the EXP rating. What can be taken from this study is the need for a more reliable way of extricating met-

aphors from other patient utterances for comparative analysis.

Clinical Implications and Future Research

Finding new ways to research metaphor use in psychotherapy may prove perplexing, but it is a valuable exercise. Neurological studies show that because metaphors link two unrelated semantic domains for comparison, the inference-making process is more complex and requires a higher demand for processing [14]. It appears that metaphors involve heavier cognitive loads. Potentially, a patient engaged in productive therapeutic work may build new semantic associations through metaphor use. Similarly, Rhodes and Jakes [20] suggest that metaphorical thinking might be linked to the development of delusions in patients diagnosed with schizophrenia. The role that metaphors play in cognitive processes is not fully understood and further study is needed.

The results of the current study raise interesting questions for future research. One such question is whether exploring and understanding metaphor usage offers an additional avenue for training novice therapists. In discussing the reflexive nature of therapy, Neimeyer and Stewart [12] suggest that therapists who have an interest in meaning-making approaches will help patients to articulate complexity "even when it moves them and their patients into realms of subtle and tacit meanings that may only be captured in more poetic or metaphoric language" (p. 353). Yet, to capture such meaning the therapist must be open and sensitive to linguistic nuance. By studying how and why patients generate metaphors, therapists may become more attentive to the ways in which patients use this aspect of language in psychotherapy.

CONCLUSIONS

Clearly, there are still complex questions in metaphor research that are waiting for answers. Since some therapists encourage patient metaphors while others ignore them, it would be useful to know exactly what happens when patients use metaphors and what impact this has on the

process and outcome of psychotherapy. Certain approaches, for example, psychoanalytic, narrative, process-experiential, or existential are more conducive to eliciting metaphors than other approaches yet it is not known whether this facilitates the process of psychotherapy. These are questions that need to be explored.

Spence [3] posits that the very process of verbalization itself distorts the representations of experience. Perhaps we must consider whether using empirical methods to analyze metaphor use, which is highly subjective, misses something [18]. It may be that metaphors are not quantifiable, that they reflect the distinctive personality of the user, and that a new methodology for studying them must be developed.

In sum, this study has taken a step in exploring an area that requires careful consideration. The results suggest that a more refined methodology is needed along with precise tools for weighing metaphor involvement in the deepening of a patient's therapeutic experience. At this juncture, it appears that there is much left to learn concerning the reasons why patients choose to use metaphors and what role they play in therapeutic processes.

REFERENCES

1. Labov W, Fanshel D. *Therapeutic discourse: Psychotherapy as conversation*. New York: Academic; 1977.
2. Rizzuto AM. Paradoxical words and hope in psychoanalysis. *Psychoanal Psychol*. 2004, 21:203—213.
3. Spence DP. *Narrative truth and historical truth: Meaning and interpretation in psychoanalysis*. New York: Norton; 1982.
4. Watzlawick P. *The language of change: Elements of therapeutic communication*. New York: Basic; 1978.
5. McMullen LM. Use of figurative language in successful and unsuccessful cases of psychotherapy: Three comparisons. *Metaphor and Symbolic Activity*. 1989, 4:203—225.
6. Strong T. Metaphors and client change in counselling. *Inter J. Advanc. Couns*. 1989, 12:203—213.
7. Neimeyer RA, Mahoney MJ, editors. *Constructivism in psychotherapy*. Washington, DC: American Psychological Association; 1995.
8. Kopp R, Eckstein D. Using early memory metaphors and client-generated metaphors in Adlerian therapy. *J Ind Psychol*. 2004, 60:163—174.
9. Wickman SA, Campbell C. The coconstruction of congruency: Investigating the conceptual metaphors of Carl Rogers and Gloria. *Couns Ed Super*. 2003, 43:15—24.
10. Martin J, Stelmaczek K. Participants' identification and recall of important events in counselling. *J Couns Psychol*. 1988, 35:385—390.
11. Martin J, Cummings AL, Hallberg E T. Therapists' intentional use of metaphor: Memorability, clinical impact, and possible epistemic/motivational functions. *J Cons Clin Psychol*. 1992, 60:143—145.
12. Neimeyer RA, Stewart AE. Constructivist and narrative psychotherapies. In: Snyder CR, Ingram RE, editors. *Handbook of psychological change: Psychotherapy processes and practices for the 21st century*. New York: Wiley; 2000. p. 338—355.
13. Seiden HM. On the "music of thought": The use of metaphor in poetry and in psychoanalysis. *Psychoanal Psychol*. 2004, 21:638—644.
14. Rapp AM, Leube DT, Erb M, Grodd W, Kircher T T J. Neural correlates of metaphor processing. *Cogn Brain Res*. 2004, 20:395—402.
15. Dapretto M, Bookheimer S. Form and content: Dissociating syntax and semantics in sentence comprehension. *Neuron*. 1999, 24:427—432 .
16. Levitt HM, Korman Y, Angus L. A metaphor analysis in treatment of depression: Metaphor as a marker of change. *Couns Psychol Quart*. 2000, 13:23—35.
17. Klein M, Mathieu-Coughlan P, Kiesler D. The experiencing scales. In: Pincus W, Greenberg L, editors. *The psychotherapeutic process: A research handbook*. New York: Guilford; 1986. p. 21—72.
18. Pasztor A. Metaphors: A constructivist approach. *Prag Cog*. 2004, 17:317—350.
19. Sims PA. Working with metaphor. *Am J Psychoth*. 2003, 57:528—536.
20. Rhodes JE, Jakes S. The contribution of metaphor and metonymy to delusions. *Psychol Psychoth: Theory Res Prac*. 2004, 77:1—17.
21. Schoeneman GJ, Schoeneman KA, Stallings S. I had emerged into light: New sources and uses of metaphors of depression and recovery. *J Soc Clin Psychol*. 2004, 23: 354—358.
22. McMullen LM, Conway JB. Conventional metaphors for depression. In: Fussell SR, editor. *The verbal communication of emotions: Interdisciplinary perspectives*. Mahwah, NJ: Erlbaum; 2002. p. 167—181.
23. Styron W. *Darkness visible: A memoir of madness*. New York: Random; 1990.
24. Sewell KW, Williams AM. Broken narratives: Trauma, meta-constructive gaps, and the audience of psychotherapy. *J Construct Psychol*. 2002, 15:295—218.
25. Derogatis L. *Symptom Checklist-90-R: Administration, scoring, and procedures manual*. 3rd ed. Minneapolis, MN: National Computer Systems; 1983.

26. Battle CC, Imber SD, Hoehn-Saric R, Stone AR, Nash EH, Frank JD. Target complaints as criteria of improvement. *Am J Psychoth.* 1966, 20:184—192.
27. Merriam-Webster's collegiate dictionary. 10th ed. Springfield, MA: Merriam-Webster; 1997.
28. Kopp R. Early recollections in Adlerian and Metaphor Therapy. *J Individ Psychol.* 1998, 54:480—486.
29. Lakoff G. The contemporary theory of metaphor. In: Ortony A, editor. *Metaphor and thought.* 2nd ed. Cambridge, England: Cambridge University Press; 1993. p. 202—251
30. Lambert MJ, Hill C. Assessing psychotherapy outcomes and processes. In: Bergin AE, Garfield SL, editors. *Handbook of psychotherapy and behavior change.* 4th ed. Oxford, England: Wiley; 1994. p. 72—113.