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PSYCHODYNAMIC PSYCHOTHERAPISTS' PERCEPTIONS OF AND USE OF METAPHOR IN ADULT PSYCHOTHERAPY

A research report submitted in fulfillment of the requirement for the degree

Master of Arts in Clinical Psychology

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Abstract

Exploration of the topic revealed significant coverage of individual psychoanalyst's views on metaphor supported by in-depth case studies, which have come to the fore primarily over the past ten years. There appeared then to be an opportunity to undertake a comparative research piece in which therapists' opinions could be collated and combined with a view to unearthing both commonalities and differences between them. Semi- structured interviews were conducted with eight psychodynamic psychotherapists, the aim being to explore therapists' understanding of the significance of metaphor and its usage in adult psychodynamic psychotherapy. Transcripts of the interviews were analyzed qualitatively using an interpretive style of analysis with the hope of generating a thorough understanding of how therapists think and work with metaphor. The focus was particularly on understanding the extent and the diversity with which it is used by therapists and patients. This included the question of its usefulness and in what ways, if any, therapists perceived it to be significant regarding the impact on therapy in determining outcomes or as a facilitator in the process of therapy.

Despite metaphor being difficult to isolate in terms of its capacity to determine outcomes, it was found to be a useful and beneficial part of the process of therapy. It appeared to be used quite extensively by therapists and their patients as an expression of difficult feelings and emotions and as a playful, yet serious means through which to unpack and elaborate on these. The research hoped to contribute in particular to the debate surrounding the theoretically controversial issue of therapists' generation of metaphor and related to this, therapists' repeated use of preferred metaphors. This included the question of therapist countertransference as an influential factor regarding these issues. The limitations as well as the benefits of working with metaphor were explored together with the factors contributing to the circumstance of it not being that useful any longer.

Reflections on the researcher's tendency to be seduced by language and the impact of this on outcomes, together with important reflections by therapists on cultural and historical influences, point to an interesting way forward for research in this area.

Declaration

I declare that this research report is my own, unaided work. It is submitted for the degree of Master of Arts in Clinical Psychology at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other university.

Signed this_____day of _____ 2008.

_____

Tracey Rainier

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CHAPTER 1

INTRODUCTION

1.1 RATIONALE

There was found to be a surprising lack of mainstream psychoanalytic literature written on the concept of metaphor prior to the mid 1990's while currently there appears to be a renewed vitality in the exploration of the topic (Babits 2001). This is mainly concerned with individual analyst's views of metaphor followed by their presentation of in-depth case studies to support their beliefs. There appears therefore, to be an opportunity to conduct a comparative research piece in which therapists' views are combined and collated with a view to unearthing both commonalities and differences in opinion.

Metaphor refers to a specific set of linguistic processes where aspects of one object are carried over or transferred to another object so that the second object is spoken of as the first (Arlow, 1979). Psychoanalytically, "experiencing one kind of thing in terms of another" (Lakoff & Johnson, 1980, p. 5) becomes "in terms of another time" (Borbely, 1998, p. 925).

The great psychotherapist Rudolph Loewenstein (1956, as cited in Arlow, 1979) spent much of his professional life trying to understand how therapists understood their patients and how they communicated this knowledge in the most effective way. He felt that speech was the most fundamental means by which meaning and understanding could be achieved. In trying to unearth what patients were concealing (Freud & Oppenheim, 1958), he considered it important to look beyond words themselves, being sensitive to how, what and when things were said, to the emotional tone but also to the use of figurative words such as metaphor.

This study has attempted to fill the space left in the literature through its contribution of therapists' perceptions of and use of metaphor in adult psychodynamic psychotherapy. It felt important to address in addition, the limitations of metaphor, indications of which were scant in the literature.

As the work progressed an interesting debate began to emerge from the literature concerning the generation of metaphor by therapists. This debate appeared to imply an evolutionary trend occurring within psychoanalysis where some analysts were being drawn to present their patients with metaphors generated by themselves. This seemed surprising and contrary to traditional psychoanalytic belief where therapists are typically thought to play a less active role (Babits, 2001). Despite this Arlow (1979) reported that the spontaneous production of metaphor by analysts was probably not that uncommon, if not useful at times. Indeed, if one looks at the progression of psychoanalytic thought since Freud, then perhaps this evolution in thinking and practice is not that surprising and to be expected (Fonagy & Target, 2004).

The opportunity to explore this issue further presented itself in this study, where an attempt was made to add to the body of knowledge concerning under what conditions and for what purpose the use of therapist-generated metaphor was most beneficial (Martin, Cummings & Hallberg, 1992; Rasmussen, 2000). This included therapists' countertransferential issues as influential in their generation of metaphor. In addition, the study explored therapists' use of preferred metaphors with patients, which appears to be an as yet unexplored avenue in psychoanalytic literature.

The obvious enthusiasm and fascination with which the study of metaphor was reported on by psychoanalysts induced the researcher to examine her reasons and intentions for embarking on this study. Ogden's (2007) viewpoint in this regard appeared most striking. In it he stressed that it was not the techniques that a therapist had acquired that would determine the nature of the therapeutic environment but her particular style of working that was influential. He included the uniqueness of her personality, the way she thinks, listens, and uses metaphor, irony and humor.

Most certainly the researchers own love of language, in particular poetic language and a creative way of thinking and viewing the world, drew her to research this topic. There was a curiosity as to how it was worked with psychodynamically and in what ways, if any, there were benefits to its usage with patients. This has perhaps enabled the work to be engaged in at greater depth but has also challenged her to present an unbiased view, which appears to have been equally difficult for other writers in the field.

Finally, the outspoken views of Spence, Schafer and Mitchell in which they accuse psychoanalysis of being more of an art than a science through its definition of theory with the use of metaphors, such as Freud's archeology and Winnicott's mother/infant metaphor, opened the door to a more scientific approach to the study of metaphor (Adams, 1997).

To this end, the study attempted to focus on the personal accounts of therapists' experiences in their work with their own and their patients' metaphors and the conditions influencing this in the moment. This was consistent with, and has hopefully contributed in some way, to Adams's (1997) call for a theory of metaphors in therapy rather than metaphors as theory.

Throughout this study theorists and clinicians' use of metaphor to language the psyche, is held in dynamic tension with the metaphors that are used by patients and therapists within the therapeutic context to explain, elaborate on, and make meaning of experience. It is not only the potential space that is metaphoric, for example, but also the metaphors that are employed by patients and therapists as containers of difficult material that are metaphoric (Babits, 2001).

As such, the focus of this study is on metaphor and on its usage by patients and therapists in therapy. It will only be those theoretical metaphors associated with the development of the capacity to symbolize, as the foundation to the metaphoric languaging of the psyche that will be discussed and elaborated upon.

1.2 RESEARCH AIMS

The research aims to explore therapists' understanding of the significance of metaphor and its usage in adult psychodynamic psychotherapy. Its intention is to transcend the seductive nature of metaphor in the provision of a holistic account of its use and limitations.

With this in mind it is important to understand the extent and the diversity with which it is used by therapists and patients. This includes the question of its usefulness and in what ways, if any, therapists perceive it to be significant regarding the impact on therapy in determining outcomes or as a facilitator in the process of therapy.

1.3 THEORETICAL FRAMEWORK

1.3.1 Qualitative Research

The complex and intricate nature of the concept of metaphor became apparent to the researcher during the perusal of the literature. A qualitative approach to its study therefore appeared to provide the appropriate vehicle for the exploration of the concept because of its focus on the acquisition of in-depth material that would lead to the refinement and elaboration of this complex phenomenon (Ragin, 1994).

Qualitative research attempts to understand the actions and experiences of people living within their own particular context and to represent the issue under review from the perspective of those most closely associated with it (Elliot, Fischer & Rennie, 1999). To this end, individual in-depth semi-structured interviews were conducted with psychodynamic therapists at their places of work. This allowed for a rich and holistic approach to the study of metaphor within the specific context of their therapies, and in this way the data revealed the complexity of metaphor and brought it to life in an authentic manner (Miles & Huberman, 1994).

The researcher understood that it would be challenging to set aside her own beliefs completely but trusted that through self-reflection she was able to set aside the influence of these and that of pre-existing theory in order to understand and represent the issues being studied in a meaningful way (Elliot, Fischer & Rennie, 1999).

By using a qualitative method for this study, the hope was for the attainment of some new insight into how therapists and patients use metaphor but also to test existing hypotheses, that is, to see if predictions that had been made by the literature were sustainable (Miles & Huberman, 1994). The research hoped to meaningfully and usefully answer the questions it initially set out to answer bearing in mind that it did not attempt to contribute to an ultimate reality concerning metaphor but to contribute to the continued dialogues around it (Elliot, Fischer & Rennie, 1999; Ezzy, 2002).

1.3.2 Method of analysis

The data was analyzed using an interpretive style of analysis in order to generate a thorough understanding or a "thick description" (Terre Blanche, Durrheim & Painter, p. 321, 2006) of how therapists think about and work with metaphor within the context of psychodynamic therapy with their adult patients.

The process of data analysis, that is, the active immersion in content and the identifying of patterns and themes, began with the researcher's first transcription and continued as she progressed through the others (Ezzy, 2002; Terre Blanche, Durrheim & Painter, 2006). The aim was that, in the end, an analysis would be presented within a context that was familiar enough to the reader to be considered authentic while at the same time dissimilar enough to offer an alternative viewpoint (Terre Blanche, Durrheim & Painter, 2006).

1.4 OUTLINE OF CHAPTERS

The current chapter serves as the introduction to the study and outlines the rationale, aims and structure of the research presented. This is followed by Chapter Two where an understanding of conceptual metaphor from a cognitive linguistic and psychodynamic perspective is presented, followed by a comparison of the theoretical frameworks of Freud, Winnicott and Bion. A review of the thoughts and work of current thinkers in the psychoanalytic field as it relates to metaphor and finally a presentation of the current debate concerning therapist-generated metaphor will follow.

Chapter Three gives an outline of the method. Chapter Four is a presentation of the results of the analysis with a focus on therapists' perception of the concept of metaphor; metaphor as part of the communication process including therapists' understanding of the role metaphor plays in communication and as a therapeutic language; the therapeutic relationship as metaphoric encompassing what is done in therapy, therapists' generation of metaphor and associated countertransferential issues together with therapists' use of preferred metaphors; and finally metaphor as part of the therapeutic process which covers what is done with metaphor during the therapeutic process, its efficacy, the progression towards the capacity to metaphorize, creativity as part of the therapeutic process and the conditions under which metaphor becomes less useful. The final chapter attempts to consolidate the results and discuss them in terms of the issues raised.

CHAPTER 2

LITERATURE REVIEW
METAPHOR

A comprehensive review of the literature will be presented in keeping with the aim of the research, which is to explore psychodynamic therapists' understanding of the significance of metaphor and of how it is used in adult psychodynamic psychotherapy.

A brief understanding of *conceptual metaphor* from the perspectives of the linguist George Lakhoff and the philosopher Mark Johnson will be elucidated upon as they are the most widely quoted writers across the psychoanalytic field relevant to their area of specialty, as cognitive linguistics. They are particularly renowned for their seminal work, "Metaphors we live by" published in 1980. General psychoanalytic definitions of metaphor and a comparison of the theoretical frameworks of the psychoanalysts, Sigmund Freud, Donald Winnicott, and Wilfred Bion as they refer to the concept of metaphor will be discussed following this. The intention is to compare the concept of metaphor as an innate capacity available to all, as asserted by Freud, with the view that metaphor is a significant developmental achievement, which is in keeping with the views of Winnicott and Bion. Finally, a review of the current literature where analysts present their thoughts on metaphor as it is experienced in psychoanalytic work will be followed by an exploration of the impact on the therapeutic process of therapists generating metaphor on behalf of their patients.

A psychodynamic perspective informs the study itself, the literature however being quoted primarily from writers from the psychoanalytic school of thought. The term, *psychodynamic* refers to "the study of mental processes from a dynamic point of view" (Campbell-Arthur, 2002, p.1), that is, with interest in the dynamic or conflictual elements of the psyche. It may therefore be used to refer to classical psychoanalysis or any of the

movements that developed out of classical psychoanalysis which refer to the dynamics of the mind.

Theorists that inform this study are all of psychoanalytic orientation and would therefore all fit into the psychodynamic paradigm, distinctions however need to be made between them, as they differ in some fundamental ways. Psychoanalytic theory is not constituted by a finite body of knowledge but is constantly evolving. This is why one has seen a move from Freud's classical model, concerned with the role of instincts in the development of psychopathology, to object relation's theory of which Klein and Bion were major proponents. The latter veered away from Freud and took the focus to the exploration of the relationship between real external people and the internal representations they become and this impact on psychic functioning. Winnicott on the other hand, was part of the Independent School of the British Psychoanalytic Society made up of individual analysts. They explored the impact of the mother-infant relationship further and made a significant contribution to the role played by the earliest environment in facilitating or disrupting the child's move from total dependence to mature independence (Fonagy & Target, 2004).

2.1 Conceptual Metaphor

As the topic was researched it became evident that while everyone appeared to be talking about the same thing, that is, about metaphor as it appears in the language of everyday life and in the language of therapy, they appeared to be using terminology such as *symbol* and *metaphor* interchangeably which was at first confusing. It became apparent that some of this confusion might have been as a result of things being lost in the translation from the original German of Freud's works. One of the first to realize, that for example Freud's word *Ubertragung* originally translated as *transference* had identical meaning to metaphor was the philosopher of language, Richards in 1936 (Campbell & Enckell, 2005).

To further the aim of bringing clarity to the meaning of the concept metaphor as well as the concepts of symbol and *simile*, definitions of each will be offered as they appear in the content of this review.

It has become evident, and it will hopefully become clearer through this discussion on metaphor, that the mind is seen by psychoanalytic writers to function in a metaphoric way most of the time. This becomes apparent in the way that the psyche uses non-verbal metaphor in the form of images to establish links and organize mental contents observed for example in *dreams* and in the transference (Campbell & Enckell, 2005).

This understanding would appear to be supported by studies in cognitive linguistics that suggest the extensive use of metaphor as part of an individual's daily experience. This is evident in its usage beyond that of language, also constituting part of one's conventional conceptual system influencing the way one thinks and acts. As such the importance of metaphor has been discerned and highlighted as playing a fundamental role in understanding (Lakoff & Johnson, 1980).

The way in which an individual views the world is determined by concepts in terms of their influence on perceptions, the way one relates to others and indeed one's behavior in general. The abstract nature of important concepts makes them difficult to define within daily experience. Understanding is then facilitated through their being linked to other concepts that are more clearly understood such as, for example, one's spatial orientation (front/back; up/down). This allows then for a metaphoric definition within ones conceptual system (Lakoff & Johnson, 1980).

To explain this further, psychoanalysis is as defined by Freud, "depth psychology or a psychology of the unconscious" (Adams, 1997, p. 28). One could describe the *conscious* as metaphorically on the surface while the *unconscious* is at depth. Lakoff & Johnson (1980, as cited in Adams, 1997) would say that the unconscious is metaphorically *down* while the conscious is metaphorically *up*.

Similarly, in order to facilitate understanding and expression of emotion, associations are made between emotions such as sadness and sensory-motor experience. A drooping posture, for example, may form the basis upon which the metaphoric concept is defined. For example, *sadness is down.* The metaphor is derived from bodily orientation, that is, that a drooping posture usually goes with sadness while an erect posture with a positive attitude (Lakoff & Johnson, 1980).

Communication, important not only in therapy but in everyday functioning, is based on the same conceptual system as thinking and acting. Language, therefore, lends important insight into what that system is like. An example of this would be the metaphor *argument is war.* The concept *argument* is constructed from a definition of the basic domain of the experience of argument, together with experiences that are conceptualized and defined in terms of other domains of experience such as *war* (Lakoff & Johnson, 1980; Wickman, Daniels, White & Fesmire, 1999).

This metaphor is represented in everyday language as *don't shoot me down in flames* or *your criticisms were right on target*. Arguments are not just talked about in terms of war but can actually be won or lost. Similarly there is an opponent whose position is attacked while one's own is defended. The battle is verbal and as a metaphor is grounded culturally, this defines how one argues (Borbely, 1998; Lakoff & Johnson, 1980).

Lakoff and Johnson (1980) believe that metaphor is always based in, and should be related back to experience. The core values in ones culture may therefore be expected to reflect the metaphoric structure of the core concepts in that culture. For example, in some cultures the future is in front of you while in others it's behind.

If one understands that therapy is a co-constructed process one realizes then from what Lakoff and Johnson (1980) say, that each person's historical or cultural background may influence the other and that certainly each persons experience of that history/culture may change through being influenced by the other, as is the nature of therapy (Doctors, 2002).

The discussion thus far has involved conventional metaphors that are responsible for structuring the ordinary conceptual system, which is reflected in everyday language. However, metaphors that are outside ones conventional conceptual system should also be considered, metaphors that are imaginative and creative (Lakoff & Johnson, 1980).

These imaginative and creative metaphors make use of figurative language, which may offer an alternative view on both current and past experience. An example of one of these metaphors would be *love is a collaborative work of art.* This may be a highly personal and potent depiction for the individual containing unique cultural and historical influences. It has the potential of lending new insight into the individual's experience of love in the same way that conventional metaphors do (Lakoff & Johnson, 1980).

In a similar manner to conventional metaphors, these new metaphors may also include other metaphors and statements as well. In addition, they may contain references to past experiences and may also help individuals determine the way ahead (Lakoff & Johnson, 1980). In this way metaphor provides a useful means to access the past and may be used in an attempt to alleviate symptoms by metaphorically linking experiences represented in the here-and-now of the transference with the there-and-then of the repressed past (Borbely, 1998).

As such, the insight gained from these imaginative metaphors has the potential to create new realities for the individual concerned, especially if acted upon. Once this happens it changes the conceptual system on which their actions and perceptions are based (Lakoff and Johnson, 1980).

Lakoff & Johnson (1980) warn that the possibility exists, however, that an individual may focus on one aspect of a concept in a metaphor and fail to notice the other aspects of it. It therefore remains for the analyst to complete the "unfinished gestalt" (Arlow, 1979, p. 378) with the aid of the rich multi-layered meanings suggested by metaphor.

Indeed, prominent psychoanalysts have compared the work of analysis to that of the semantic work required in reading a metaphor, in that psychic work is done through the interconnection of representational fields (Campbell & Enckell, 2005).

In light of this, the way in which psychoanalysts define metaphor within the context of their work will be presented and explored.

2.2 Psychodynamic literary use of metaphor

"In a dark time, the eye begins to see,
I meet my shadow in the deepening shade,
I hear my echo in the echoing wood"

Roethke (in Cox & Theilgaard, 1987, p. ix)

Freud used metaphors from social and political life, from the fields of physical dynamics and hydraulics, physiology and natural history, anthropology and mythology, archeology and ancient history, military life and technology, the classics and popular literature, and from other sources in order to construct his theory of psychoanalysis. Drive theory's use of the metaphor *beast* and developmental theory's use of the metaphor *baby* to describe the patient, together with Freud's archeology metaphor, where he compared therapy to an archeological dig, are called *theory-constitutive* metaphors. These metaphors do not elaborate on theory, they rather constitute it and run the risk of simultaneously opening up enquiry in research while also closing it down (Adams, 1997).

The work of the theorists that have been chosen as a basis for this research, have all used metaphor to define their theories and may therefore be criticized by the same argument, particularly by writers such as Donald Spence (1982, as cited in Adams, 1997). His criticism is that psychoanalysis is more of an art than a science, a view which appears nevertheless as contradictory in his writing in that on the one hand he exhorts therapists to work beyond metaphor if psychoanalysis is to be scientific and on the other, feels that

metaphors are indispensable as far as understanding is concerned. He feels that "we will always use them" but should "not be used by them" (Adams, 1997, p.29).

Be this as it may the controversial issue of Freud, Winnicott and Bion's metaphors defining their work will not be the focus of this research. Theoretical metaphors will be used as they appear in theory to aid the exploration of Freud, Winnicott and Bion's understanding of metaphor. In addition, theoretical metaphors will be used to understand how therapists think and work with them in therapy.

Aristotle defined metaphor as "the power of the mind over the possibility of things" (Sims, 2005, p. 528). The word metaphor being derived from the Greek 'meta,' meaning "above and over," and 'phorein,' meaning "to carry or bear from one place to another" (Pearce, 1996, p. 2). It refers to a specific set of linguistic processes where aspects of one object are carried over or transferred to another object so that the second object is spoken of as the first (Arlow, 1979). Psychoanalytically, "experiencing one kind of thing in terms of another" (Lakoff & Johnson, 1980, p. 5) becomes understood "in terms of another time" (Borbely, 1998, p. 925).

In attempting to understand these linguistic processes better, Loewenstein (1956, as cited in Arlow, 1979) spent much of his professional life in the exploration of therapists' understanding of their patients and the transmission of this understanding in the most effective way. He believed the therapeutic encounter to be a special kind of communication between two people with speech as the most fundamental means by which meaning and understanding could be achieved.

Arlow (1979, p.367) states that metaphor is considered to be the most "fundamental form of figurative speech." Figurative language, on the other hand, is a system of significant symbols, which challenge conventional literal usage of a word. Figurative speech is therefore the way in which people access and express language. Metaphor, used in figurative speech, is the means by which literal meaning, normally associated with one object, is transferred to another in order to gain new, wider, special, or precise meaning.

Freud and Oppenheim (1958), encouraged analysts to challenge that which the patient presented in speech, in other words, to search for what was being concealed. Loewenstein (1956, as cited in Arlow, 1979) said that this meant looking for meaning beyond words themselves, to be sensitive to how, what and when things are said, to be sensitive not only to the emotional tone but also to the use of figurative words such as metaphorical expressions.

So, in addition to the understanding that metaphor is not based in language but in the underlying ability to conceptualize one mental domain in terms of another evident in speech (Lakoff & Johnson, 1980; Wickman, Daniels, White, Fresmire, 1999), psychoanalysts assert that the understanding of metaphor should also include it as a fundamental means by which human thought, perceptions, feelings or memories integrate experience and organize reality. It is believed that if they remain attuned in this way, valuable insights into the unconscious could be gained (Arlow, 1979; Campbell & Encknell, 2005).

Freud's approach to the interpretation of dreams will be used to help explore the impact of metaphor on the process of therapy. This is due to Freud's belief that the use of metaphor in dreams, as a vehicle into the unconscious, was invaluable in understanding his patients and their problems (Freud, 1950

Freud used the term metaphor both when referring to images in dreams resembling that of poetic speech and in referring to dream interpretation where he used the word metaphoric to denote the symbolic interpretation of dreams as a whole (Freud, 1952). He implied, therefore that dreams are rich in metaphoric material that may include both images related to poetic speech as well as other forms of symbolic representation. He referred to dreams as being metaphors expressed through metaphoric material.

Arlow (1979) provides very succinct definitions of simile, metaphor and *symbolism*, which may bring clarity to the manner in which the concepts are referred to in this study:

> "In simile A is said to be like B. In metaphor A is described in terms of B. In symbolism B is mentioned and A doesn't appear. In literary symbolism, the component A is understood while in the truly psychoanalytic symbol A is unconscious" (Arlow, 1979, p. 375).

Ernest Jones (1977) expanded on this but was essentially saying the same thing when he pointed out that simile is the simplest form of speech, predating metaphor, where the words *as* and *like* are suppressed but always implied. He believed that there were many similarities between metaphor and symbol, the essential difference being though, that there were no metaphors in the unconscious. He was clear in articulating that metaphors exist instead in the conscious and pre-conscious and function to language difficult affect associated with lived experience, which may be represented in symbols.

A way of gaining some clarity on how these concepts work in relation to each other would be from within the structure and interpretation of dreams where Freud said that representations around the word *like* were simply not found in the dream material. That it was only through the patients associations of the latent dream material that the symbols of the manifest dream were transformed into metaphors of spoken language bringing to conscious awareness that which was deeply unconscious (Arlow, 1979).

Freud called this technique *free association*, which places speech and its associated psychological properties at the center of the therapeutic encounter. Many psychoanalysts have stressed the importance of metaphor as it emerges during this process as a vehicle for gaining insight into the dynamic transformation of unconscious wishes and in the delivery of interpretations (Arlow, 1979; Jung, 1990). This is because metaphors, as the language of the unconscious are representations of conscious ideas, experiences and affects that represent their unconscious counterparts (Freud 1952; Marshall, 1999).

Because dreams provide access into the unconscious, which is indestructible, nothing can ever be brought to an end or forgotten. This makes dreams useful in the work with neurotic patients undergoing psychoanalysis in that triggers that are likely to cause

relapse are unearthed and made meaning of in relation to the real experiences of the patient (Freud, 1938).

It may be remembered that Lakoff & Johnson's (1980) investigation into the nature of metaphor supported Freud's contention that metaphor typically contains associations from the past that may give direction to the way forward for the individual.

Freud (1901, as cited in Freud and Oppenheim, 1958) went further, saying that dreams, as metaphors were transformations of repressed material, indeed the disguised fulfillments of *repressed wishes* or *id instincts*, which were permitted to become conscious, largely in an unrecognizable form by the *ego*. The transformative processes, of *condensation*, *displacement* and the symbolic use of metaphor and simile, were responsible for Freud's "energetic and successful man's" (Holm- Hadulla, 2003, p. 1205) success in turning his wishful phantasies into reality (Freud, 1952).

For the purposes of understanding this core concept, *dreamwork,* Freud's term for the processes required to give access to dream material, the transformative processes of condensation, displacement and the symbolic use of metaphor and simile will be explored further. *Condensation* is responsible for the complex associations between disparate images making up dream-content, and *displacement*, the transference of a thought onto an image which may appear totally unrelated and often trivial, sometimes representing the opposite of the dream-thought upon analysis. He highlighted the transformative role of metaphor and simile, referring to them as gentler more easily understandable forms of expression in dreams. This is despite the more unconventional manner in which thoughts are presented by these means, appearing symbolically in images resembling that of poetic speech (Freud, 1952).

Freud explained that the necessity for transformation was due to the repressed material in dreams being of an infantile erotic nature and as such the public expression of which would be under strict social sanction beyond that of any of the other instincts. He proposed that the only way to escape the disturbing wish was to have it fulfilled within

dream content with the aid of symbol and metaphor. He stated further that the function of the dream was to preserve sleep. He believed that if there was not a way to transform this disturbing material then the mind would not allow sleep for fear of this unsanctioned material slipping out unheeded (Campbell & Enckell, 2005; Freud & Oppenheim, 1958).

If we are to take Freud's contention that dreams are the language of the unconscious and that metaphors are the means by which these repressed infantile erotic wishes are expressed, then it seems pertinent to briefly explore further the origin of this process and the role of the thought conducting agencies of the mental apparatus, the *conscious, preconscious* and *unconscious* (Freud, 1952).

Dreams are generated when thoughts occurring during the day are associated with unconscious inclinations which have been repressed from consciousness but which have been present ever since childhood in the individual. These thoughts pass through a censorship process and may remain in the unconscious or are expressed in an altered form in the preconscious, which become conscious having taken on the guise of a dream-wish, a wish fulfilling phantasy. This is the hallucination or conjuring up of a satisfying image in response to the requirement for immediate gratification of an instinctual need, which would otherwise cause significant pain and discomfort if left unheeded. This maintains mental equilibrium and is a defensive move, which occurs each night in dreams and in a similar way in the production of a symptom (Freud, 1953).

The emergence of symptoms, like that of the dream are both symbolic expressions in which the wish of the id is allowed by being disguised, while at the same time it is not allowed thereby satisfying the *superego*. The symptom and the dream both disguise and reveal the psychic conflict and are expressions of the emotional turmoil the neurotic patient finds himself or herself in (Freud, 1953; Hook, Watts & Cockroft, 2002).

In explaining the mechanism of dream formation, wish fulfillments existing, as preconscious thoughts are able to pass unhindered into the conscious, while unconscious thoughts are able to pass through into consciousness only with the aid of analysis. This is

due to, as discussed already, to the controversial nature of these thoughts. This is why the therapist may initially encounter resistance in the patient during the interpretation of dreams and metaphors but as the analysis progresses material may become more readily available to the conscious mind. It is imperative for the development and maintenance of health that the individual is able to adapt to external reality and it is through the interpretation of unconscious material as it emerges in therapy by means of metaphor that this is facilitated (Freud, 1953).

Art gives the artist permission to express erotic wishes in a socially sanctioned way in that the new reality, which is born out of a reconciliation of the demands of the id and the restraints of the ego, is respected and accepted by society as valid reflections of actual life (Freud, 1953).

Eckardt (2000) feels that Freud was confused when it came to metaphors, fables, symbols and myths. She believes that he has missed the creative essence of these imaginative forms of multi layered emotional expression. By likening analysis to an archeological dig, the challenge for him was to penetrate or decode them, thereby missing the point that they were "representations of the soul" (p.266).

Winnicott and Bion provide alternative views to Freud's in their understanding of what transpires within the therapeutic context. Their individual theories do however give different views of the same analytic experience. Where Winnicott's metaphor of *holding* is primarily concerned with 'being' and its relationship to time, Bion's metaphor of the *container-contained* focuses on the processing of thoughts derived from lived emotional experience (Ogden, 2004). The meaning of these metaphors forming the metaphoric bedrock or framework from which this research will be developed, will be explained further

2.2.1 Patients use of metaphor as an innate capacity versus metaphor as a psychoanalytic developmental achievement

The development of the capacity to symbolize as the foundation to the metaphoric languaging of the psyche will be explored in detail.

Both Winnicott and Bion through the definition of their respective concepts of holding and the container-contained have made significant contributions to psychoanalytic thought. Through the use of these powerful metaphoric concepts they have succeeded in emphasizing the fundamental importance of the early environment in the establishment of the healthy emotional and mental development of the infant and child, an essential component of which is the capacity to symbolize (Ogden, 2004; Winnicott, 1971). Despite Freud's considering the early environment important, he emphasized the role of heredity instead. Winnicott (1971) believed that the reason for Freud's avoidance of the idea of dependence and therefore the impact of the early environment, was because he was not ready to discuss its implications.

For the purposes of consistency and clarity, *him* will be used when referring to the patient or infant and *her* when referring to the analyst or mother.

2.2.1.1 Winnicott and the transitional space

In a similar manner to the way in which Freud's metaphors were addressed, only metaphors that are used to define the theories of Winnicott and Bion as they relate to and explain the capacity to symbolize will be referred to. The manner in which much of their theory was defined around metaphor will not be the focus per se.

Up to now Freud's tentative assertion that the mother has a role to play in the development of the capacity to symbolize has left us to contemplate, perhaps, whether he meant that the creative use of metaphor and symbol might be assumed to be an innate

capacity available to all. For Winnicott (1971) and Bion (1993a) this activity turned out to be a significant psychological developmental achievement.

Winnicott (2005b) was quite clear in his statement about the significance of the early environment in the development of the self where the mother and infant formed a *unit,* similar to Bion's *thinking couple*. For both it was the quality of the mother infant relationship, defined by Winnicott as the *potential space* and Bion as the container-contained, that was a priori requirement for the achievement of the capacity to symbolize and for the attainment of psychological health. Winnicott believed however, that this process had no role in determining the infant's potential. He believed that potential was inherited, but couldn't be realized without the mother's active engagement.

Winnicott was adamant that the infant would not be able to become an *integrated* separate self unless there was the provision of what he called the *good-enough mother*. This was a mother who was successful, most of the time, in adapting to her infants needs (Winnicott, 1971).

As the infant grew, holding evolved from being more of a physical and emotional holding to a metaphorical holding where a psychological place was provided for the infant to gather 'bits' of himself in order to begin gaining a sense of self (Ogden, 2004; Winnicott, 2005a).

It was also during this time that the intellect, or the mind, developed as independent from the psyche. With this as a basis, the formation of memory, logical and rational thought and the capacity to symbolize and make meaning of psychic associations of past, present and future through such means as dreams was realized (Winnicott, 2005b).

Winnicott's concern, however, was the intermediate area of *experiencing* to which both the internal reality of the child and external reality of the environment contributed. This metaphoric area or place that had been provided by the mother represented an intermediate state between the infant's inability, and his growing ability to recognize and

accept *reality*, the area between *fantasy* and reality, which he called the *transitional* or *potential space* (Winnicott, 1971).

This area not only constituted the source of symbolism but the source of symbolism in *time.* It was an *illusory* area whereby the infant *journeyed* from a sense of being one with his mother to experiencing her as separate from him (Ogden, 2004; Winnicott, 1971).

The mother's almost 100% adaptation to her child initiated this journeying, which enabled him to develop the *illusion* that he and the mother were the same person (Winnicott, 1971). At this point there was no need for symbols because during this time of *primary maternal preoccupation* the baby's needs were being met and symbols were only required when there was desire, that is, *wishing* (Ogden, 1993). To this end, the infant began to believe that he might magically manifest the breast or mother whenever he so desired. This conception of the breast in response to an id impulse such as hunger was established on the basis of the mother having been able to actually present the breast over time (Winnicott, 1971).

As the infant's mother began to return slowly to her old life, the space between the mother and baby was paradoxically filled with creative play and the use of symbols. These were now required to achieve the satisfaction of the infant's needs that the mother was failing at times to provide. The initiation of symbol formation was indeed through this *disillusionment*. The mother had to *frustrate* her infant; similar to Bion's mother who temporarily frustrated her child's instinctual needs thereby initiating the capacity to *think*. Disillusionment could only occur following a time of *illusion* where the infant believed that his mother was magically under his control (Bion, 1993a; Winnicott, 1971).

However, in order for the infant to begin making use of the transitional space and eventually develop the capacity to symbolize, he first had to acquire a *transitional object*, which may be recognized as the infant's first symbol and first experience of play. Winnicott understood it to be a symbolic representation of the union of the mother's nurturing breast and the baby. It was located at a point in time and space when the infant

and mother were beginning to separate. Winnicott seemed unclear as to when the infant began to use its first *not me* possession or transitional object stating this to be around the ages of four to six to eight to 12 months and extending into childhood. It may be represented by anything the child found comforting such as his suckling on his own fingers or later on by the possession of a teddy bear (Winnicott, 1971).

The potency of the transitional object, which was now used to alleviate the fears around separation, depended on the quality of the nurturance provided by the real mother who was *internalized*, becoming an internal object. If the mother consistently failed the child then the internal object failed to have meaning for the child and then so did the transitional object (Winnicott, 1971).

Winnicott (1971) compared the transitional space set up between the mother and infant with the therapeutic space between the therapist and her patient. He alluded to this as a highly specialized form of *play*, which was an active process proceeding over time. It was within the metaphoric or potential space where communication between the mother and her infant, and in the therapeutic context between the patient and the analyst, was safe and unchallenged.

If the patient was unable to play in the therapeutic or potential space it was incumbent upon the therapist to create an environment in which the process of play could be permitted unhindered Winnicott (1971). This brings to mind Freud's original concept of free association and his contention that patients should be permitted to bring anything, without being judged or challenged even if the material did not make sense (Jung, 1990). Thus Freud assumed his patients' would be able to play in the space and associate freely. Winnicott (1971) called this the *facilitating environment.* It could be said therefore that the process of play was dependent on the mothers ability to play and the fluidity with which she was able to move between providing what the baby needed at the appropriate time and being able to wait patiently until the baby reached out to her in his time of need, that is, that she didn't *impose* herself on her baby.

Initially the mother was very careful to fit in with the infant's games during play but later on began to introduce some of her own ideas and realized that tolerance for this varied from infant to infant. It was in this way that playing was established within the relationship between the mother and infant (Winnicott, 1971).

Winnicott asserted that the potential space was where the child was allowed to lose himself, to almost withdraw from the world in an unchallenged way. It was a space imbued with metaphoric material, where bits and pieces of external reality were brought and fused with internal psychic experiences in the infant at the time, imbuing the play with a dream like quality. The meaning generated from this symbolic play was dependent on the mother's *reflections*, which were then transferred back thus helping the infant make sense of reality (Winnicott, 1971).

This space was retained throughout life as an area where one was challenged to separate internal from external reality while keeping the two realities inter-related. This may be observed in an individual's interest in art and religion and other forms of creative living, which require imagination (Winnicott, 1971). For Freud culture and art was a compensation for the limitations imposed by reality which in many ways called for a suppression and denial of instinctual gratification while for Winnicott it was the only medium for self-realization (Phillips, 1988).

In a paper presented at the International Congress of 1957 Bion proposed the ineffectiveness of Freud's metaphor of psychoanalysis being analogous to an archeological dig. Bion proposed that the work should not be about the study of ancient and primitive civilizations as the analogy implied, but about trying to unearth what he referred to as that of a primitive disaster. He was referring in this sense to the development of psychoses where the *attack* on the *link* between the mother and infant resulted in the destruction of a capacity for curiosity and the consequent ability to learn (Bion, 1993b; O' Shaughnessy, 1981).

Bion's criticism perhaps highlights Freud's focus on developing a theory that was more conducive to healing the more neurotic patient with what appears to be minimal regard for less well functioning patients such as those suffering from psychoses. A greater perspective on Bion's thinking will be presented which, in many ways, supports his enormous regard for Freud from whose theory much of the foundation of his thinking was derived. His theory incorporated, to a large extent, work done with patients suffering from psychoses into whose world he daringly entered *countertransferentially* in order to understand the extent of their terror and turmoil evacuated through the process of *projective identification* during analysis (Ivey, 2004).

2.1.1.2 Bion's container and the development of metaphoric thought as represented by K

Bion introduced the idea that at the beginning of life and at the beginning of analysis it takes two people to think. It is Ogden's belief, that in contrast to Winnicott, while he considered the mother/infant relationship as significant in the development of pathology, Bion simply used the mother-infant relationship as a metaphor to construct a theory around the unconscious processes occurring in the analytic relationship (Ogden, 2004).

Bion proposed that the development of thinking, or in other words, the capacity to symbolize was dependent on two factors, firstly the development of *thoughts* and secondly, the development of an apparatus in order to contend with these thoughts. He called this apparatus *thinking* (Bion, 1993a).

Bion wrote that the living infant would have to know and experience pain to face the reality of being alive. He was openly indebted to Freud for his contention that the developmental achievement of the reality principle or an individual's adaptation to reality was dependent on the capacity to think. That thinking bridged the gap between the activation of an instinctual wish such as hunger, which was registered as pain by the infant, and the moment of satisfaction of that wish through appropriate action. This instinctual wish could either be satisfied by the wish being achieved or by the activation

of wish fulfillment, which would relieve some of the tension in the psyche. The first mental representation was the hallucinated image of the breast which later became more abstract, represented by words as language developed. Bion did not however believe that the development of abstract thought as complex as it was, could be taken for granted (Bion, 1993a; Ivey, 2004; Ogden, 2004).

Bion felt that what would sustain the infant through this level of pain, which for the purposes of this discussion, we could say was induced by hunger, was a rudimentary form of thought. The acquisition of this would depend either on the experience itself not being too overwhelming or on the infant's ability to resist the urge to avoid the pain. The crux, therefore of Bion's developmental theory of thinking was the infant's capacity to tolerate *frustration*, the frustration of needs not being met. One remembers that the experience of frustration or the incomplete adaptation of the Winnicottian mother forced her infant to find a symbolic or transitional object to help him manage the transition from being one with, to being separate from her, and thus an individual in his own right (Bion, 1993a; Waddell, 1998b; Winnicott, 1971). It may be highlighted, therefore, that for Bion for symbolization to develop, a thinking apparatus was first needed. It may be said then that the capacity to symbolize was developmentally an even later achievement than for the Winnicottian infant.

The infant's ability to tolerate frustration meant that he was able to draw on his own resources, which would then stimulate the formation of a very rudimentary form of thought and thinking apparatus. These resources were derived from the experience of a containing mother who was able to link his experiences and able to tolerate his anxiety and frustration most of the time. In addition he was able to introject this thinking part of her personality from early on, establishing within himself a *thinking couple* (Bion, 1993; Waddell, 1998a).

Bion provides an interesting alternative wherein unlike Winnicott, he relieves the mother of some responsibility, placing some of this responsibility for early development on the personality of the infant. While he acknowledged the importance of the early

environment or indeed the analyst in the analytic situation and stated that health was determined by the infant's capacity to tolerate the frustration of an at times unreliable mother, he also believed that it was the infant's own innate personality features that predisposed him to excessive *projection* derived from the *death instinct*. He referred to these infants as psychotic infants evident in features such as excessive destructiveness, hatred and envy. His focus despite the importance of the mother and infant's roles was on the end result of the failed containment process and not on the origins of the problem. For him it was about the ability to tolerate the frustration of maternal failure and to make meaning of this in a useful way (Ivey, 2004).

The breast or the mother's ability to feed her infant became, for Bion, a metaphor for the mind in which the mother not only brought her loving nurturing self but also her thinking self, a prerequisite, through the ordering of her baby's jumbled thoughts towards a more integrated infant (Waddell, 1998a).

This was achieved through the infants splitting off and projection of his anxiety through the process of projective identification. The purpose of the expulsion of the infant's anxiety-laden perceptions, sensations and feelings into the mother was for her to contain them in what Bion calls her *reverie* (Bion, 1993a; O'Shaughnessy, 1981). This was Bion's term for the mother's state of mind in which she was unconsciously able to receive her baby's expulsion of pain or expressions of pleasure, to *dream* them for her infant and then to return them in a more digestible, understandable form (Waddell, 1998a).

For Bion the development of the capacity to think was therefore an inter-psychic achievement and could not be taken for granted as an "individual neurological development" (Ivey, 2004, p.9).

He believed that this early form of communication between the mother and infant formed a *k-link* between them, which allowed thinking to develop. To *k* was the mother's ability to think about her infant with love, to pay attention and to try and understand her infant's

communications. This could however occur only if the infant was not too envious or felt too persecuted by his own feelings (O'Shaughnessy, 1981).

In this way the mother became the metaphoric container and the baby's fragmented impulses and emotions, the metaphoric *contained.* The successful development of the mother-infant relationship was imperative for the formation of the *alpha-function*. This function essentially existed within the mother and was her ability to transform the raw unprocessed sense elements or *beta-elements* into *alpha-elements*. In essence, the most basic of thoughts derived from the instincts, which could be linked in this form, were transformed into elements of experience, which could then be linked through the process of dreaming, thinking and remembering which becomes the function of psychoanalysis (Bion, 1993a; Ogden, 2004).

The birth of the capacity to symbolize was therefore dependent on the mother's ability to contain her child, that is, the facilitation of his ability to think (Bion, 1993a; Ogden, 2003; Ogden, 2004).

The work that defined a thinking process, which was also elemental to psychoanalysis, that is, the simultaneous viewing of experience from an unconscious and conscious perspective, promoted psychological health (Ogden, 2004).

Bion believed that what an analyst should be offering her patient was the containment of maternal reverie (a dream-like state) whereby the patient's feelings were intuited through their introjection. He felt that this experience could be beneficial to both if the therapist was able to take her time in responding so as to ensure her own stability and health, that she would digest and make meaning of her patients experience, holding and containing it before giving it back (Ogden, 2004).

Growth of the container would involve an improvement in the individual's ability to do the unconscious work necessary for psychological healing. In the analytic space this may involve the capacity for the patient to begin remembering his dreams, or to make

associations that feel real between themselves and their therapist, or it may be indicated by a decline in somatic symptoms and the beginnings of being curious about feelings experienced for the first time (Ogden, 2004).

Growth in the contained may be noticed in the individual's ability to elaborate on and explain at greater depth, their thoughts, feelings and experiences of life. For example, a patient may find that a particular aspect of the past holds greater relevance than ever before (Ogden, 2004).

Dreams have long been understood by analysts to be transmitted through metaphor as a means to explore old conflicts (Shields, 2006). Bion felt, however, that Freud stressed the "negative" or "concealing" (Ivey, 2004, p.10) aspects of dreams instead of recognizing the importance of dreaming in the transformation of disparate experiences, which are held, linked and symbolically represented and which are essential for the development of a more integrated self.

While there is much to be learned from Bion, revered within psychoanalytic circles by many, one is reminded of the intensity with which he approached an intellectual description of what he considered to be the truth. This approach perhaps denied the gentle maternal qualities of the containing space in favor of one that was aloof and cold, more reminiscent of a relationship in which therapist and patient were expected to suffer towards a therapeutic end. This essentially removes any opportunity for the qualities of playfulness or rest inspired by the transitional space (Ivey, 2004).

To this end one may comment that Bion's reverie-container/ contained function differs from Winnicott's idea of the holding environment in that Winnicott's mother is quieter and more unobtrusive in her holding. She mirrors and reflects her baby's emotions allowing the baby to grow as he begins to recognize self in other. Whereas Bion's mother is required to be fully engaged and actively involved in intuiting her infants raw and terrifying emotion with a view to transforming it into something meaningful not simply reflecting it back (Bion, 1993a).

While for both Winnicott and Bion the development of the capacity to symbolize and hence the awareness of self in relation to reality was the consequence of a significant developmental achievement, Freud's contention was that the development of symbolic thought and a sense of self were innate and available to all. In addition it should be pointed out that the Bionic baby had to acquire the ability to think before being able to symbolize indicating a further developmental achievement beyond that required of the Winnicottian infant (Bion, 1993a; Freud, 1950; Winnicott, 1971).

Now that an understanding and a theoretical framework of metaphor has been established, the way in which metaphor is perceived by psychotherapists and used by both psychotherapists and patients within the therapeutic space will be explored and discussed.

As indicated earlier there has been a surprising lack of mainstream psychoanalytic literature written on metaphor prior to the mid 1990's while currently there appears to be a renewed vitality in the exploration of the topic.

Babits (2001) attempts to give an explanation for this, she offers that firstly, this may have been related to the resistance within the traditional psychoanalytic community against therapists playing a more active role in treatment. Secondly its use within the psychodynamic fraternity may be considered to be contrary to psychoanalytic theory as it was originally intended, evidenced in some of the movement's greatest critics within the structural and strategic family therapy movement such as Milton Erickson using it. Babits (2001) says that if the theoretical and technical differences in views between the different groups within the psychodynamic movement were made clearer, metaphor may find its place and be found to be compatible across the field. Perhaps the trend towards its use in the last few years reflects a move towards a broader and more integrative approach to psychoanalysis generally.

2. 3 THERAPEUTIC ENCOUNTERS WITH METAPHOR

"A patient arrives late for a group session:"

"Sorry I'm late. I've been at the dentist. He's going to take my crown off."
"How many crowns have you had?"
"Are you talking about teeth?"
"I'm talking about crowns."
(Cox & Theilgaard, 1987, p. 105)

Lakoff & Johnson (1980) have proposed that metaphors are deterministic in that not only do they represent our lives but may also shape our future. A significant part of psychotherapy is therefore about unearthing these metaphors and examining and exploring the extent to which we unconsciously live by them (Lakoff & Johnson, 1980; Siegelman, 1990). Adams (1997) as does Jung warns that by leaving them in the unconscious there is the risk that we may be lived *by* them.

In many ways the way the analyst talks to his patient and the patient talks to his analyst is through the introduction and elaboration of metaphor by either the analyst or patient (Ogden, 1997). In this way psychoanalysis attempts to alleviate symptoms by metaphorically linking experiences represented in the here-and-now of the transference with those of the there-and-then of the repressed past (Borbely, 1998). One is reminded of Bion's concept of linking that may be understood under the circumstances to mean the therapist's linking of the patient's raw unprocessed feelings/sensations associated with the past to what is happening in the present. The aim of this is to enable him to tolerate his frustration, anxiety and anger in order to develop the capacity to symbolize and to begin thinking for himself (Bion, 1993a; O'Shaughnessy, 1981).

The role of the therapist or metaphoric mother as facilitator in the development of symbol formation and ultimately integration has been discussed at length from the theoretical points of view of Donald Winnicott (1971) and Wilfred Bion (1993a). Siegelman (1990)

is in agreement with these theoretical viewpoints, evident in accounts of her own and others' work. She states that if metaphor is to flourish within the therapeutic space, a strong, safe and containing interpersonal space is necessary that requires little more than a willingness to play.

So it may be said that therapists are generally interested in helping their patients unearth personal metaphors to which the therapist supplies *therapist-generated analogies* in order to draw inferences between the patients metaphors (Barnett & Katz 2005; Borbely, 1998; Ogden, 1997; Pearce, 1996). One is reminded of Freud's view that it is important that the patient is permitted to provide his own associations to his dream image so that all aspects of the dream could be considered (Freud, 1950).

The literature supports an investigation into what appears to be the controversial nature of *therapist generated metaphor* but first the experiences of analysts' use of metaphors during the course of their work will be explored.

2.3.1 An attitude of holding and containing

> *"There is no such thing as a baby. If you show me a baby you certainly show me also someone caring for the baby, or at least a pram with someone's eyes and ears glued to it. One sees a nursing couple."*
>
> Winnicott (1958, p. 99)

Winnicott's famous dictum, so eloquently and simply stated, is supported by psychotherapists' views that it is not techniques, but the quality of the therapist/patient relationship and in particular the therapist's ability to develop and sustain what Winnicott refers to as the holding environment that most influences therapeutic outcomes (Babits, 2001; Levine & Friedman, 2000; Stine, 2005; Zindel, 2001).

The holding environment being analogous to the mother-infant relationship becomes useful in its capacity to both organize and explain many of the concepts that define

psychotherapy such as the love and unconditional acceptance that inspires trust and a sense of safety and security in the relationship. In addition it provides a context, which encourages the evolution of a common language between the patient and therapist which when reflected back, engenders a feeling of having been understood or *held* (Babits, 2001; Shields, 2006; Winnicott, 1971).

A patient's experience of being held due to a good-enough experience of therapy will facilitate this development of trust and subsequently the ability to think and express feelings symbolically (Shields, 2006; Zindel 2001). Thus Winnicott's metaphoric holding and Bion's metaphoric containing relationship are necessary for the potential development to metaphorize. This points to the importance of the personality of the therapist: "Psychotherapy is done in the overlap of two play areas, that of the patient and that of the therapist. If the therapist cannot play, then he is not suitable for the work. If the patient cannot play, then something needs to be done to enable the patient to play" (Winnicott, 1971, p. 63).

In the absence of this potential space there is only fantasy whereas within the potential space imagination develops. In fantasy, "a dog, is a dog is a dog" while imagination involves layers of symbolic meaning" (Ogden, 1993, p. 229).

Developing the argument on trust further, Zindel (2001) refers to trust being established by the analyst's ability to catch his patient's metaphors. This is achieved by the analyst's encouragement and response to the metaphors brought, together with a willingness to use the transitional space in such a way that a transitional language is co-created in which meaning is given to what is generally understood to be the elusive unconscious. It may be said in addition that holding means the communication of a sense of safety that may lead to a deep relaxation at the level of the body, its organs and its innermost functions similar to that experienced by a baby in its mother's arms (Shields, 2006).

Perhaps implicit in Winnicott's understanding of the holding environment is the necessity for the analyst's empathic understanding of their patient. Kohut (1982, as cited in Babits, 2001) uses the term empathy to describe both a "mode of psychological investigation" and a "mode of affective bonding" (p.25). This may be achieved with the use of metaphor, which unites the patient with their analyst in a unique way through the transmission of meaning and emotion within the hidden associations of the patient's material specifically for the purposes of the therapeutic work, perhaps even before the analyst has become aware of the patient's unconscious fantasies (Arlow, 1979).

While holding may generate a sense of aliveness and realness within the therapeutic space, containment facilitates a sense of "reflective wonderment and imaginative thought" (Shields, 2006, p. 1518) instead of merely reacting to sensory or emotional stimuli. It requires of the analyst the ability to sustain a patient's undreamt dreams as they play out in the transference-countertransference over time. These may be held within the analyst's reverie or it may mean the communication of something that is happening within the conscious and unconscious therapeutic relationship that feels appropriate for reflection (ibid).

Shields (2006) proposes that it may be the creation of an environment that contains elements of both containment and holding that would be most beneficial to the patient.

From the discussion thus far it is apparent that the development of the capacity to symbolize is only made possible by the presence of an attuned, empathic trustworthy therapist who is able and willing to dream her patients' undreamt dreams as they emerge within the therapeutic encounter as well as to his ability to play.

2.3.2 Play and Creativity

Winnicott perhaps gave voice to the experiences of many analysts when he said that therapy could not be productive unless both the analyst and patient were willing to play with each other. He described the creativity at work within the therapeutic space where

play evolved, and beyond this felt that play was core to the experience of reality in childhood and in art and culture. That creativity was born out of the *subjective object* gradually becoming related to *objects objectively* perceived, that is, to gradual awareness of a sense of self, based in reality. Creativity as an individual's sense that life is real and meaningful, that it is not simply a work of art produced by an artist, but that it may be present in anyone. It may be found in a baby, adolescent, adult or elderly person who looks at life in a healthy way or does things with committed intent. It may, for example, be witnessed in the prolonged cry of an infant who indulges in it for the pure joy of its musical sound (Winnicott, 1971).

It is within the analytic or transitional space that the analyst gives the patient the freedom to address his creativity (Holm-Hadulla, 2003; Winnicott, 1971). Freud refers particularly to the transference as the playground where the *repetition compulsion,* described aptly by the Queen in "Alice in Wonderland" as "running fast to stay in the same place" (Bernstein, 2005, p. 5) is given complete freedom, an intermediate area between illness and health through which the patient must journey. In this sense one can say that play and creativity, despite being termed fun, a misleading conjecture at times, involves the structuring of internal and external reality as well as the mastery of conflicts (Holm-Hadulla, 2003).

Gargiulo (1998) echoes Winnicott (1971) in his call for analysts to employ playful intelligence within the transitional space through the use of metaphor and warns that if they do not, then the vast knowledge that they have attained over the years will do little to sustain sufficient understanding of their patient. This is because play in the potential or transitional space, as Winnicott (1971) says, is not only the source of culture but also of meaning.

Metaphor is a means through which multiple meanings may be explored putting the patient not only in touch with the issues being addressed in the clinical work but also with the potential way forward, hence the potential space (Babits, 2001).

It may be said, therefore, that the opportunity to play affords the patient the chance to tease out and explore different meanings of self in an unthreatening way. Similarly it affords the therapist the opportunity to deliver interpretations in a more digestible way, which may have been very difficult otherwise. The potential space, the intermediary area between fantasy and reality, is metaphoric but so too are the therapeutic metaphors employed in the space which become containers of difficult material. An example of this might be a patient who describes her depression as a *pit* in order to safely explore the nature of her depression and in so doing ponders the extent to which this is true or not for her (Babits, 2001).

It is all very well to play with metaphor in the potential space but one needs to be aware of the allure of metaphor as disguised playing.

Zindel (2001) confesses to how a particular patient seduces her with metaphor, she describes herself as being *lured* by her patient's symbols and how these at times have *power* over her. She recognizes that her patient uses metaphor when she feels that her analyst is getting bored, *laying traps* for her. It is similar to a "conscious/unconscious game of hide and seek that they play where at times they each want to be found and at others not" (p.7). In the times they don't want to play an unwritten agreement not to enter the space is agreed upon.

Perhaps it is important to think about how a patient's potential is unearthed from the points raised so far and delivered in such a way that clarity is gained for the way forward.

2.3.3 The co-creation of meaning and making links

It has been said that the manner in which the patient communicates his feelings in therapy is inherently metaphorical. This is because the content is largely an approximation of unconscious fantasy, which is structured unconsciously in its presentation in such a way as to invite the analyst to be co-creator of meaning. Arlow (1979, p. 378) refers to the

analyst helping to complete the "unfinished gestalt" with the aid of the rich multi-layered meanings suggested by metaphor.

From our discussion thus far, which includes writers such as Lakoff & Johnson (1980) and many of the psychoanalysts, it has been highlighted that metaphor consists of combinations of words that defy normal logic. The clash of domains or words extends semantic fields, which enables meaning beyond that which would have been achieved with words alone. The dreamer uses idiosyncratic combinations of the day's residues to represent unconscious fantasies, which are not logical on a conscious level. Freud as we know called this *transference.* The transference is constructed as a dream becoming activated in psychoanalytic treatment. The patient constructs a dream about his analyst and in transferring this wish or fantasy into this medium finds representation in clinical situations following which the analyst facilitates meaning (Campbell & Enckell, 2005).

The outcome of this collaboration between the analyst and patient in the illusory area of play is the building of new metaphors. This is both a conscious and unconscious process as conscious and unconscious themes are made meaning of and integrated. This endeavor essentially involves the re-authoring of aspects of the patient's life, which eventually results in the creation of a new life script. This allows for the provision of new opportunities and responsibilities and enables patients to see themselves differently (Winnicott, 1971; Zindel, 2001).

It is important for therapists to bear in mind that there is a multiplicity of meanings interwoven in the rich fabric of metaphor. Freud called this *overdetermination*, which initially referred only to hysterical symptoms but was rapidly expanded to include every psychical product. Overdetermination is at the core of *dreamwork* and in this he meant that there had to be a convergence of several etiological factors before a symptom could be generated (Gabbard, 2007).

Bion calls this skill *binocular vision* – perception from many vantage points simultaneously in order to articulate what is meant by the truth in psychoanalytic terms.

Bion is adamant that the journey one takes with ones patient is about discovery and not creation, but that it is in the discovery that there is the creation of something new. The realization of a new experience of what is true, derived from inarticulate unconscious experience, is achieved through the links made in interpretation. What is very important is to find the words that are true to the lived experience of the individual, expressed as simply as possible (Ogden, 2003).

In the furthering of this endeavor, a therapeutic language is born which may become a sort of shorthand between the therapist and patient. This is useful in the sense that words do not often do justice to affective meaning, which originate in the body (Babits, 2001; Zindel, 2001).

To explain this idea further Lakoff & Johnson (1980) amongst other writers have given support to analysts who have drawn attention to, for example, a child's use of body sensations in cross domain mapping. This is achieved when a domain, which is viewed through a configuration well known to a child and taken from bodily sensations and functions, has helped the child give meaning to internal and external reality. This may be illustrated with the help of an example of a toddler who saw a parcel fall out of a car to which he said, "Car do big!" (Campbell & Enckell, 2005, p. 809). The child had come to configure his world through the scheme of defecation.

Siegelman (1990) believes in the fact that the source of the power of metaphor is in its ability to simultaneously tap into many sensory modalities and into cognition from sensorimotor to concrete to abstract. It is most commonly associated with images or the visual modality, which occupies the largest part of the cerebral cortex but may also include the auditory modality for example, feeling in or out of harmony with the universe; olfactory, as in the staleness of the situations one finds oneself in; and gustatory, the bad taste that something has left in ones mouth, and so on (Babits, 2001).

Metaphor is therefore used by the patient when what needs to be said may be too overwhelming or painful, that is, when conflict is intense and resistance relatively low or

used by the analyst when it is thought that an alternative way of presenting the material would result in opposition from the patient. The displacement element of metaphor is useful therefore as a means to ward off anxiety in, for example, patients who suffer from Borderline Personality Disorder and psychoses. It is particularly useful to use metaphor with patients who are depressed or who suffer from obsessions where it may be used to revitalize their way of perceiving the world, which may appear usually as quite dull and flat (Arlow, 1979; Babits, 2001; Zindel, 2001).

Schoeneman, Schoeneman and Stallings (2004) are interested in patients with similar diagnoses using similar metaphors. They call for research in this area, as they believe that it would not only facilitate a better understanding of that diagnosis but also give clues to possible recovery from it.

Writers go so far as to say that if we do not constantly look for the metaphorical aspect of our knowledge we may slip into a more literal or concrete knowledge of it, mistaking something as the ultimate reality when it is only an *as if*, denying the context from which it emerges (Gargiulo, 1998; Ogden, 2007; Shields, 2006).

2.3.4 Countertransference in the analytic space

Gabbard (1995, as cited in Holm-Hadulla, 2003) refers to the interplay between the multifaceted aspects of the transference-countertransference relationship, where events are experienced in both the patient and analyst's phantasy as essentially a creative process. The therapist may play a strategic role in this creativity that may encourage genuine understanding leading to possible change.

One needs though to address the complexity of this potentially very challenging encounter where every therapist arrives for the therapeutic hour with not only their own unique character structure, the need to preserve their identity, emotional memories and so on, but also with allegiances to authors, supervisors, teachers and to theories themselves (Bernstein, 2005; Gabbard, 2007). Gabbard (2007) stresses the importance of allowing

theory to inform one but not to dictate the process of therapy. This is to allow the patient to reinvent therapy each time he enters the room in such a way that the therapist is able to share in that reinvention as co-inventors.

Winnicott (1971), in addition, reminds us to preserve the individuality of the patient in his declaration that metaphors generated during play should be spontaneous if psychotherapy is to be done at all, and similarly Bion urges therapists to enter therapy "without memory, desire or understanding" (Ivey, 2004, p. 25).

Gabbard (2007) seems to assert that Bion's proposal is unrealistic and that the best one can hope to achieve, as a therapist is to be consciously aware of those areas that seem to inevitably lead to a subjective or countertransferential impact on one's patients.

This is an important consideration to bear in mind as therapists' countertransference may interfere with patients' communication of their unconscious material, or metaphors. This may result in distortions of meaning and lead to patients being driven to either comply or rebel against what they perceive to be their therapist's expectations of them. It may be that the patient's fantasies, transferences, resistances and symptomatic behavior is related to the analyst's enactments, biases and modes of intervening in the hour (Gabbard, 2007).

Despite this not leading to the attainment of insight there may be an initial improvement in the well being of the patient as he identifies with his analyst and his subtle innuendo's in an idealized way. These innuendos may be implicit or unconscious appearing in the interpretation in the form of prohibitions, advice or suggestions relating to the patients reality (Maldonado, 2005).

Analysts may also transmit their own emotional state through preverbal and para-verbal means such as, tone of voice, intonation, rhythm and timing. In this way the patient gains an insight into the psyche of the analyst at the expense of an interest and exploration into his own (Maldonado, 2005).

Despite this, countertransference is not necessarily always used and experienced negatively in therapy. Freud and analysts since him described it as an important technical tool (Heenen-Wolff, 2005; Maldonado, 2005). Holm-Hadulla (2003) gives an interesting account of his therapy with a patient in whom it was only by allowing himself to enter deeply into his own psychic creations or to what Bion would have referred to as maternal reverie, that he was able to receive his patient's confused and fragmented material and give it shape and structure. These psychic creations were manifest in moods and in visual images, which had to be carefully examined as distinct from his own conflicts. It was through his willingness to receive his patient's projections, to hold them and transform them into something palatable that enabled him to engage in conscious and unconscious thinking. This was only made possible by his engaging with his own aesthetic material countertransferentailly (Heenen-Wolff, 2005).

The use of countertransference requires the constant self-reflection of the analyst in order to discriminate between the analyst and patient's conflicts and even so, as has been indicated in this discussion, its use may lead to both understanding and misunderstanding (Gabbard, 2007). There is a sensory and cognitive component to this reflection based within the psychoanalytic paradigm together with the wisdom that comes from clinical experience and communicating with others in the field. The use of countertransference enables the patient to find his own creativity but requires the analyst's openness to her own creativity too (Holm- Hadulla, 2003).

In addition, this principle needs to be applied to every dream that a therapist has about their patient as these dreams contain elements of countertransference that need to be carefully sifted through to determine what belongs to them and what belongs to their patients. In this way, dreams to which Winnicott referred to as *healing dreams* have the potential power to inform one of such things as patient's affect. Insights gained in this way can inform the psychoanalytic process (Heenen-Wolff, 2005).

It appears obvious from the discussion thus far that therapists and patients use metaphor spontaneously. However, at some point all metaphors have the tendency to break down which makes room for others (Gabbard, 2007).

2.3.5 Limitations of metaphor

Siegelman (1990) warns against the dangers in exclusively using any particular type of interpretation whether in content or form. This includes the exclusive use of metaphor, dreams, aggression, genetic material or even the transference, which then loses spontaneity and authenticity. This may also include the over use of psychoanalytic terms such as holding, containment and so on. She mentions how easy it would be to be drawn into using metaphor exclusively in interpretations because of the addictive nature of metaphoric language, which has a tendency to draw on creativity and intuition.

We are reminded at this point of the analyst Zindel's (2001) patient who used metaphor from time to time to lure and draw her into the therapy and how it was used by both as a defense when moving on and addressing difficult affect laden issues that had become too overwhelming.

As the patient moves towards maturation and further along the developmental continuum from what Winnicott (2005b) calls, *absolute dependence* to *relative dependence* to *independence*, Babits (2001) says that the power of the metaphors used in therapy begin to diminish. Metaphors are by their nature, reusable, recallable and disposable held by the *good-enough* mother in all these roles, which is never restrictive or finite. They may temporarily serve to structure the psyche of a patient at a particular time, but over time tend to expire due to either a change in the psychic reality of the patient possibly due to the work of therapy or due to changes in external reality, remembering that metaphors are drawn from remnants of the day or current psychic reality (Adams, 1997; Freud, 1950).

While it was clear that writers enjoyed working with metaphor, there appeared from the reading to be debate within the psychoanalytic community on the merits and demerits of

therapists supplying metaphor in response to patients material. While there seemed to be general consensus on metaphor being quite a seductive means by which to work, some therapists seemed wary in supplying metaphor in therapy due to the contrariness of this from a traditional psychoanalytic point of view. Therapist generated metaphor, as a proposition will now be explored and debated.

3. THERAPIST GENERATED METAPHOR

> *"In the psychoanalytic situation the interaction of the analyst and analysand is an enterprise of mutual metaphoric stimulation in which the analyst, in a series of approximate objectifications of the patient's unconscious thought processes, supplies the essential metaphors upon which the essential reconstructions and insights may be built."*
>
> Arlow (in Siegelman, 1990, p. 99)

Arlow's statement deserves attention as it implies the analyst play an active role within analysis, which seems contrary to traditional psychoanalytic thought (Babits, 2001). Our concern is perhaps amplified by Winnicott and Bion both warning that a pathological state exists when balance within the dialectical process is not maintained for whatever reason (Ogden, 1993).

In terms of the analyst's role, it is Siegelman's (1990) view that a therapist who is in touch countertransferentially will no doubt be thinking metaphorically most of the time. It becomes pertinent then to decide whether to share these spontaneous images or words or to keep them in mind as clues while awaiting verification of their authenticity.

Therapists are cautioned against knowing too much and feeling pressured to deliver the correct interpretation. This may be in an attempt to help a patient make meaning of their experience but may instead foreclose an opportunity for the patient to make sense of their own internal world (Ogden, 2007).

Bion reminds us that psychoanalysis is about entertaining and containing the psychic truth as it emerges in the therapeutic encounter. He exhorts the analyst to this end to abandon all "memory, desire or understanding," as an essential discipline required of the analyst. He warns that failure to achieve this will result in a "steady deterioration in the powers of observation whose maintenance is essential" (Ivey, 2004; 25). He refers instead to the understanding as it emerges in the therapy that is slowly cultivated by what he calls the *selected fact*. This refers to the therapist's sudden realization of what is going on in the space, when all the *bits* obtained from the interactive experience with a patient that are loosely held in mind, fall into place and form a coherent new and important understanding. This may indicate a therapist's shift from a state of bare *attention* to being able to hone in on a selected fact. Coltart (1992, as cited in Ivey, 2004) points out that this moment should be accompanied by the "gift of communicating an insight in appropriate language" (p. 30).

Appropriate language is perhaps the essential feature of this communication in that in psychotherapy a metaphor delivered that is not relevant to the content and richness of the patient's material equates to indoctrination, which if repeated generates compliance. If a therapist errs in this regard, in isolated instances, it may result in the emergence of resistance and confusion in the session. Repeated maternal failures of adaptation or impingements force a person to react to their environment instead of allowing them to be. In a patient with a fragile ego, being repeatedly forced to react destroys being (Winnicott, 1971).

Similarly, a therapist repetitively supplying inappropriate metaphor would be like the Bionic mother's inability to transform her infant's thoughts into something more digestible resulting in the infant re-introjecting not a fear of death made tolerable but a *nameless dread*. Contact with this mother is perceived to be life threatening and as such the infant is forced to sever all links or ties between them which makes all future learning and growth impossible (Bion, 1993b).

Thus instead of projective identification where the infant's anxiety is projected, and as such becomes an important form of communication between the mother and infant and results in thought, the infant whose existence is threatened, evacuates the psyche which is opposite to thought and is termed *anti-thought.* Anti-thought becomes evident in attacks on the link with the mother because she is associated with a mental space where thoughts can happen and where links between experiences are made which are too terrifying to comprehend because of the nature of the thoughts introjected (Ivey, 2004). Bion (1959, as cited in Ivey, 2004) gives an example in his paper, "Attacks on Linking" where a patient begins to stammer in response to an interpretation he gave. This he proposed was an attack on the link between him and his patient in that their ability to communicate in the session had been arrested. If links are attacked symbol formation becomes impossible because objects cannot be brought together without their similarities and differences being confused. This results in the use of *symbolic equation* where one thing is not *like* another but *is* the other (ibid).

In the absence of symbolism, thoughts are actions and so in thinking that one hates or is angry with someone, a person suffering from a psychosis literally feels as though they are attacking that person. Phantasies are reality, not thoughts about reality. This is why it is so difficult to induce people with a psychosis or with Borderline Personality Disorder to own their feelings, as one is able to with a neurotic patient. To re-introject projected destructive parts of the self is terrifying for patients because it feels as if they are being attacked and invaded by aggressive foreign objects. So patients often cannot take their therapist's words because it feels like the therapist is trying to force something alien and toxic back into them. The therapist's understanding is perceived to be persecutory (Bion**,** 1993b; Ivey, 2004).

Despite this theoretical background, it has been proposed that the analyst actively stimulate the patients associations by using specific metaphoric expressions. These may represent an intuitive understanding of the exact way the patient appears in the analyst's mind, using metaphor generated by himself to interpret that which the patient has brought (Arlow, 1979; Ogden, 1997). This is because the patient is often unable to express

emotion in words and it is usually through an activation of affect and imagery within the therapist countertransferentially, that imagery is activated in the patient, often in the form of metaphor (Barnett & Katz, 2005; Bucci, 2005; Ogden 1997; Reed 2003). Babits (2001) is of the opinion that clinical advantage is generated where metaphors supplied by or developed by the analyst facilitate understanding,

In his important paper, "Metaphor and the Psychoanalytic Situation," Arlow (1979) seems to contradict the view he expressed in his earlier paper quoted above, appearing critical of therapists' evocation of a patients' associations through the provision of metaphor. This view may stem from his psychoanalytic roots based on Freud's assertion that it is inappropriate to burden one's patients with one's own associations of their dreams and that it is the analyst's job only to facilitate the interpretation of dreams (Freud, 1950; Siegelman, 1990). Arlow (1979) concedes, however, that the practice by therapists of spontaneously producing metaphors is probably not uncommon and may indeed be useful in certain instances.

Perhaps what Arlow wants us to remember is Freud's emphasis on the individuality with which interpretations should be delivered. Freud's concern was that while there are universal symbols in dreams that may be interpreted by the analyst, there are also those that are generated from the individual's deeply held ideational and original material. He pointed out, however, that symbols were useful as an aid to the analyst when the patient's associations were insufficient or broken down altogether (Freud, 1950). This view fits with Winnicott's (1971) belief that metaphors generated during play should be spontaneous and unique to the individual, if psychotherapy is to be done.

Part of the spontaneity of play or therapy is in the manner to which the patient is allowed to *be* in the space, the degree to which relaxation, based on the trust and acceptance of the therapeutic relationship is encouraged. It appears important for the therapist to permit something akin to what Freud intended by his concept of free association. It is about giving the patient permission to deliver material in an unstructured form without forcing

them to produce a coherent story, which would be fraught with anxiety and defensive in itself (Winnicott, 1971).

The differing views proposed seem to validate the emphasis that has been placed on research to determine under what conditions and for what purposes the use of therapist-generated metaphor is most useful (Rasmussen, 2000; Martin, Cummings & Hallberg, 1992).

Where Siegelman (1990, as cited in Adams, 1997) appears to encourage her patients to explore the metaphors that she has encouraged them to bring, Murray Cox and Alice Theilgaard (1987, as cited in Adams, 1997) are provocative in that they believe that the goal of therapy is change. But where Siegelman (1990) believes the agent of change to be more the psyche of the patient than the input of the therapist, the others believe that being confrontational in one's intervention as an analyst is what is important (Adams, 1997). Siegelman's (1990) view is that the translations that patients give of the symbols they have generated verify what the therapist has often observed in the unconscious interaction with the patient. In this sense the therapist is freed of the responsibility of having to be suggestible, trusting that the patient is able to do the work required.

Cox and Theilgaard (1987) believe that introducing an element of surprise is fundamental to the attainment of effective therapy. So it is not only through the encouragement of the patient to use metaphor but also in a sense through the inciting and shocking of the patient with metaphor that they believe change is induced.

This appears contrary to Winnicott's assertion that what is most significant in therapy is that the child surprises himself or herself and that it is not about the clever interpretation by the therapist in that moment (Winnicott, 1971).

Kopp (1995, p.xvi) introduced the term "client versus therapist generated metaphor." He believes, like Siegelman (1990), that it is preferable for patients to generate their own metaphors, which are then explored and transformed, with the help of the therapist.

Kopp's (1995, as cited in Adams, 1997) concern with therapist-generated metaphors is that they may fall outside of the patient's psychic reality and be instead invasive, off the point and unempathic. He will, at times, very tentatively produce metaphors for his patients but this is never done coercively. Of interest is that he proposes the transformation of metaphors, that is, the production of new metaphors to replace the old in order to expand the power of the metaphor on a conscious level.

Psychoanalytically this poses a problem in that this view may interfere with what has been alluded to as the integrity of the unconscious processes within the patient, that is, respect and trust in the process of therapy (Adams, 1997).

It appears that the provision of metaphor is indeed not necessarily an uncommon one Arlow (1979). What appears important across all views is the timing and sensitivity with which metaphor is delivered, together with the relevance to the patient's material (Cox & Theilgaard, 1993; Kopp, 1995; Siegelman, 1990). What is perhaps being highlighted as important is not whether the patient or analyst generated the metaphor, but that it was co-created (Babits, 2000; Rasmussen, 2000, Zindel, 2001). This then leads to reciprocal handling and development of the metaphor and to the bridging of the gap between self and other (Babits, 2001). This reminds one of all that is evoked in the overlap of the play areas between the patient and the therapist in the potential space (Winnicott, 1971).

Adams (1997) prefers Siegelman's (1990) practice of the exploration of metaphors with her patients in that he believes that this is less manipulative. He differs, however, from her and the others' view that the role of the therapist is to induce and facilitate change. He believes that whether change occurs or not, it is ultimately the responsibility of the patient themselves. He prefers to take as his point of departure the idea that therapy is about the patient having an experience, which involves talking, and thinking about their psychic realities and being witnessed in doing this. Attending to the metaphors of the unconscious is, he believes, one-way of providing this experience.

Bernstein (2005) presents a view beyond the idea of therapeutic change when he refers to the outcome of therapy being cure. Where he is in agreement with Adams (1997) is that he believes that it is not the psychoanalyst who is responsible for the cure but that it is the process, the experience of therapy.

It appears from the research that while metaphor is experienced as useful and has the potential to make therapy more interesting for both analyst and patient, there are also limitations to its use. Over time metaphor may become less potent due to psychic changes occurring within the individual or due to changes in the patient's experiential world. It appears that while therapists do generate metaphor in certain instances they are cautioned to consider the timing and sensitivity of their delivery and also the relevance of the metaphor to the patient's material.

CHAPTER 3

METHOD

3.1. RESEARCH DESIGN

The researcher engaged in an explorative study in keeping with the qualitative research tradition. Therapists' own views on their perceptions of and use of metaphor in adult psychodynamic therapy were invited. First hand accounts of therapists' experiences within the specific context of psychodynamic therapy, where examples were given of metaphor that had been generated in therapy, lent richness and depth to the data. This facilitated an understanding of how metaphor was used in their therapies and the extent to which it was used, and bearing this in mind, the role it played to a therapeutic end (Terre Blanche, Durrheim & Painter, 2006).

The researcher attempted to remain as non-directive and as open minded as possible during data collection, which was attained through the use of semi-structured interviews. This was in an attempt to allow for new possibilities to be elicited that may have elaborated on and refined what was already known about the concept of metaphor (Ragin, 1994). In order to achieve what could be called a more holistic understanding of the concept of metaphor, the researcher immersed herself in the collected data from which the complexity of the concept and its interrelated parts began to surface and from which new insight in certain areas were attained (Ragin, 1994; Terre Blanche, Durrheim & Painter, 2006).

3.2. RESEARCH PARTICIPANTS

For the purposes of this study, the employment of a purposeful sampling method was considered appropriate in the selection of psychodynamic therapists as a unique and specialized group, representative of others in their chosen field. The richness of their

experience made allowances for the varied possibilities in which metaphor may have been elicited over time in their work (Ezzy, 2002; Guba & Lincoln, 1989; Neuman, 2000; Terre Blanche, Durrheim & Painter, 2006).

Eight participants were used for this study in that the sample was largely homogenous and the interviews were in-depth enabling the researcher to report her findings in a general way. In addition, although not part of the original criteria for selecting this sample size, the interviews reached a point of saturation and were therefore considered as meaningful by the researcher (Terre Blanche, Durrheim & Painter, 2006).

No distinction was made regarding the gender or cultural differences of participants. The researcher worked from a list of possible interviewees supplied by her lecturers and supervisor as well as people she had met professionally who worked in the psychodynamic field. The researcher phoned potential participants in private practice from the greater Johannesburg area where she introduced herself and explained the nature of her research with the purpose of gaining informed consent.

Potential participants were made aware that the researcher was a student studying a Masters in Clinical Psychology at the University of the Witwatersrand and that she would greatly value their participation in her research.

In elaborating on their participation, participants were informed that this was voluntary and that it would involve being interviewed for approximately an hour by the researcher at a time and place convenient to them. They were informed of the topic and the general aims of the research and a few of the questions that the researcher was interested in exploring were introduced. They were also informed that they might be asked to generate examples from their work. This was considered important in that confidentiality is understood to be a fundamental ethical principle of psychotherapeutic work and as such being asked to offer examples in this way may have placed therapists in an uncomfortable position in terms of their work. The way in which this introduction to the research and to the researcher was presented, and developed, was important in that it may have

influenced their decision to participate in the research. It was during one of these telephonic discussions with a therapist that he admitted to being uncomfortable with having to give examples of patients' metaphors. He was otherwise happy to grant the interview and it was decided to continue as there were many aspects of metaphor that could be discussed in an in-depth but more general way without having to rely on information about specific cases (Banister, Burman, Parker, Taylor & Tindall, 1994).

3.3 INTERVIEW PROCEDURE

For the purposes of this research, an in-depth semi-structured interview was conducted. An open-ended interview schedule (see Appendix D) was developed from a study of the literature and was consistent with the aims of the research (Terre Blanche, Durrheim & Painter, 2006). The prior formulation of questions did not inhibit a response to, and a follow up of issues brought up by the interviewees, including those not thought of by the interviewer, which allowed for greater depth, richness and diversity in the research. Therapists' pointing out the difficulties associated with working cross-culturally and giving examples of their work in this area is an example of how therapists contributed something the interviewee had not addressed in her questions (Banister et al, 1994; Ezzy, 2002; Ritchie & Lewis, 2003).

Most of the interviews lasted between fifty minutes and an hour while one lasted 90 minutes. They took place in therapists' private practices and offices, which were preferred venues in that they were free of interferences from sound that could disrupt recording.

Prior to the interview therapists were asked to sign consent forms for the interview (see Appendix A) and for the recording of the interviews (see Appendix B) where it was explained that this was to allow for close textual analysis of the data and to alleviate distraction from note taking (Banister et al, 1994; Terre Blanche, Durrheim & Painter, 2006). The details of these contracts will be covered under Ethical Considerations.

The interview began with a short introduction to the nature of the research followed by an open-ended question that involved their understanding of what metaphor was, to aid the process and help develop rapport. It was the researcher's intention to involve the interviewee as a co-enquirer rather than as a research subject to encourage their interest and commitment to the combined exploration and gathering of pertinent information. The interview ended with an enquiry as to whether the interviewee had anything more to add (Banister et al, 1994; Terre Blanche, Durrheim & Painter, 2006).

During the transcription insights were gained. These related firstly to her own performance, where perhaps she missed following up a valuable comment or interrupted the interviewee prematurely, secondly, she was induced to think about interesting new ideas that had emerged and could follow these up in future interviews and thirdly by being immersed over many hours in one interview, themes and theories related to the concept began to emerge and in this way the analysis had already begun. The idea of questions developing in this way may be explored through an example whereby the researcher asked about the limitations of metaphor. Interviewees responded that some people simply could not symbolize, giving the example of concrete thinking people. This began a process of thought within the researcher related to, amongst other things, what facilitated the process of symbolization. This later constituted part of one of the major themes to emerge (Ezzy, 2002).

3.4 DATA ANALYSIS

There are various means by which qualitative data may be analyzed (Ritchie & Lewis, 2003), it seems as though however, there is no one agreed upon way (Woodhead, 2006).

Terre Blanche, Durrheim and Painter (2006) provide two basic methods of conducting qualitative analysis. The one is based on interpretive assumptions and the other on social constructionism. They caution that fundamental to conducting sound interpretative analysis is "to stay close to the data, to interpret it from a position of empathic

understanding," the outcome of which should be a "thick description" of the results (p. 321).

There are many different traditions that fall under the interpretive style of analysis such as phenomenology, grounded theory and thematic content analysis. These range from using pre-determined categories and codes that are applied to the data in a mechanistic way to yield quantifiable results, to becoming immersed in the data, reflecting on it and writing an interpretation based on an intuitive sense of what is happening. They suggest a series of five steps that may be useful in conducting qualitative analysis that fall somewhere between these two extremes (Terre Blanche, Durrheim and Painter, 2006).

3.4.1 Process of analysis

The process of data analysis, that is, the active immersion in content and the identifying of patterns and themes began with the researcher's first transcription (Ezzy, 2002; Terre Blanch, Durrheim & Painter, 2006). Braun and Clarke (2006) criticize researchers using words such as *emerging* to describe the identification of themes. They say that this negates the active role of the researcher who is interested in reporting on themes that they have isolated as important. Terre Blanche, Durrheim & Painter (2006) propose a five-step model to analysis:

Step 1: *Familiarization and immersion*

By this stage the researcher had already developed a broad understanding of her data and of the more prominent themes. She then immersed herself again, reading and re-reading the transcripts, making process notes of each transcript in order to gain an overview of each from a thematic point of view and also to facilitate knowledge of where to find information to support the inferences she'd made and if this would indeed support what she had inferred (Terre Blanche, Durrheim & Painter, 2006). An example of this was inferring early on that therapists appeared to generate metaphor on behalf of their patients relative to their patient's material.

Stage 2: *Inducing themes*

General themes were sought from specific instances referred to in the data. In furthering this aim, the process of searching for what lay beneath that which was more obvious was sought after, for example in answering the question, 'Do you find yourself using favorite or preferred metaphors with a number of patients and if so what are these?' may fall under the theme, 'therapist generated metaphor,' and link to one of the questions that the research is asking, that is, 'How are metaphors used by psychodynamic therapists?'

Firstly, the specific language of the interviewees was used in defining categories.

Secondly, content was thought of in terms of processes, functions, tensions and contradictions.

Thirdly, an optimal level of complexity was sought as this would entail attaining a balance with regards the number of themes and sub-themes that were defined to ensure the development of rich and interesting research.

Fourthly, the themes were linked to what the research was asking.

Stage 3: *Coding*

Coding was done at the same time that themes were being deduced. This involved numbering certain parts of the data, that is, phrases, lines, sentences or paragraphs as they related to one or more themes. The coded pieces were gathered under a code heading which was analyzed as part of that grouping and in relation to other groupings. This was a dynamic process in which themes constantly changed and merged, an example was that under the heading, 'conditions for therapist generated metaphor' were coded in instances where therapists used words and phrases such as, 'spontaneous' and 'attuned.' This was then linked to other sub-themes under 'therapist generated metaphor' such as 'countertransference' which had its own grouping of coded words such as 'seductive' and

'beautiful.' Countertransferential issues however could also have been placed under the heading 'communication.'

The transcripts were co-coded by an independent person with experience in qualitative research. The results were discussed in order to reach consensus on themes before the interpretation phase was entered into (Miles & Huberman, 1994).

Step 4: *Elaboration*

In steps 2 and 3 material that was separate and not seen to be connected before, was brought together in themes. During this stage the researcher became aware that data clustered under a code may have different meanings in that sub-issues and sub-themes began to emerge. An example of this process was, 'I find myself using metaphors related to water' (therapists' use of preferred metaphors) was part of another sub-theme, 'Countertransference,' related to a main theme, 'therapist generated metaphor.' Countertransference was by this stage moved from being a sub-theme of 'communication' to a sub-theme of 'therapist-generated metaphor' of the major theme, 'therapeutic relationship- mothers and infants, therapists and patients.'

Step 5: *Interpretation and checking*

The final stage was the writing up of the findings, that is, the researcher's interpretation of the findings using the defined thematic categories. The interpretation was checked for contradictions, over interpretations and prejudices. The researcher also reflected on how she could have colored the results in any way, for example her own bias towards the use of metaphor to further insight and understanding in therapy and might have contributed to a slant in this direction.

3.5 PRINCIPLES OF GOOD PRACTICE IN QUALITATIVE RESEARCH

Terre Blanche, Durrheim and Painter (2006) report that traditionally research has been associated with the determination of truth and that consequently since the advent of qualitative research there has been a "crisis of legitimization" (p. 371). This is because qualitative researchers have not been able to rely on traditional positivist epistemology. These writers feel that the crisis is not over as there seems to be little consensus on what constitutes scientifically adequate research.

Elliot, Fischer & Rennie (1999) have laid out seven principles of what they consider to be good qualitative research practices, which serve the function of:

1. Legitimizing qualitative research;
2. Ensuring more appropriate and valid scientific reviews of qualitative manuscripts, theses, and dissertations;
3. To encourage better quality control through more focused self and other monitoring
4. To encourage further developments in approach and method

The following principles were adhered to throughout the study:

1. *Owning one's perspective involves* researchers being open about their theoretical orientation and their personal anticipations regarding the research. This openness to their own values, interests and assumptions prior to the research and as it evolves helps them understand any impact that these may have on understanding. This openness also helps the reader understand the background from which the results were interpreted and enables them to be open to other possibilities (Elliot, Fischer & Rennie, 1999). The researcher's own theoretical stance, as in choice of theorists within the psychodynamic frame upon which the research was based, and from which she would choose to work as a clinician was in keeping with that of most of the participants interviewed. There was therefore a congruence of thinking and the

concern that this may have foreclosed on other theoretical viewpoints coming to the fore despite her not consciously leading participants in this direction. In addition, the scope of this research did not allow her to take on more of a meta-position whereby the use of the metaphors that define the theory that frame her research could be questioned. She was also aware that she chose a topic that greatly interested her and that clinically she enjoys working with, which may have given a more biased slant to the benefits of working with metaphor. A possible advantage however of having this interest and an understanding of the concept may have allowed for an exploration of the concept at greater depth.

2. Situating the sample implies a description of the sample being provided in order for the reader to be able to judge the generalizablity of the results (Elliot, Fischer & Rennie, 1999). It was impossible to give a more detailed description of the backgrounds of the participants due to the constraints of confidentiality, where the priority was to safeguard the identities of both therapists and their patients.

3. Grounding in examples requires the author to provide examples from the interviews that elaborate on the analytic process and the author's understanding of the results, it enables the reader to establish the fit between the two and allows them to come up with possible alternatives (Elliot, Fischer & Rennie, 1999). The safeguarding of patient and therapist identities became a priority over a possible slight loss of meaning as a consequence of no direct quotes being permitted in the results section of this study. This was a concern and as such the researcher endeavored to remain as close to participant's choice of words and phrasing as possible so as not to change the essence of what they were trying to convey while attempting to maintain the richness and uniqueness of their examples.

4. *Providing credibility checks* involves the checking of categories, themes and accounts by various means (Elliot, Fischer & Rennie, 1999). A co-coder was used to verify the most prominent themes. Our combined results were discussed which

facilitated a more comprehensive and in depth approach to the analysis and discussion of the results.

5. *Coherence* refers to the understanding of the data fitting together to form an underlying framework to the concept or phenomenon under study (Elliot, Fischer & Rennie, 1999). The interlinked nature of the themes became apparent while conducting the analysis, at the time this made them a little more difficult to differentiate but ultimately facilitated the telling of a more integrated "story."

6. Accomplishing general vs. specific research tasks involves putting the appropriate specifications in place related to whether one is trying to gain a general or specific understanding of a concept and includes the limitations of extending this understanding to other instances (Elliot, Fischer & Rennie, 1999). Due to the contextual frame in which qualitative research is done there are usually strong limits to the generalizability of the results (Terre Blanche, Durrheim & Painter, 2006). Perhaps the saturation point that was reached during the collection of data together with the homogenous nature of the sample may indicate some transferability of the findings (Terre Blance, Durrheim & Painter, 2006) but would exclude the broader cross-cultural application.

7. Resonating with readers implies that the manner in which the research has been written and conducted adequately represents in the reader's opinion the topic under review (Elliot, Fischer & Rennie, 1999). Every attempt has been made to authentically capture therapists' work with metaphor by not embellishing their language or experience in any way despite the seductive nature of metaphor.

3.6 ETHICAL CONSIDERATION

The Human Research Ethics Committee (Non-Medical) of the University of the Witwatersrand granted ethical approval for this study. Factors considered particularly pertinent to this research were issues of confidentiality due to the nature of the material to

be discussed, and consequently the need for informed consent regarding the granting and recording of interviews. In addition consideration had to be given to there being no risks or benefits to the interviewees.

Prior to each interview each participant was given an information sheet (see Appendix C) and encouraged to discuss any issues that may concern them pertaining to the information on this sheet or anything else. The information sheet outlined the nature of the research and its ethical concerns. It included the time requirement for the interview and that with their permission the interview would be recorded. It was brought to their attention that participation was voluntary and as such they would not be advantaged or disadvantaged from withdrawing from the research at any point. The issue of confidentiality was raised and the researcher confirmed that she would make every effort to ensure the confidentiality and anonymity of the participants and the information that they divulged concerning their patients. To this end no information that would identify either themselves or their patients would be included in the report and only pseudonyms would be used. They were also informed that they could refuse to answer any of the questions if they so desired (Banister et al, 1994). The researcher was sensitive to the instances where therapists were torn between expressing their thoughts regarding the complex nature of metaphor coherently, while at the same time having to maintain patient confidentiality.

Consent to the interview was then signed which included in addition their own responsibility to safeguard the confidentiality of their patients and that the researcher would undertake to include no direct quotes in her study. It is for the purpose of safeguarding patients' metaphors that there are no transcriptions included as appendices. To further the aims of maintaining confidentiality, the consent to the interview being recorded included the assurance that recorded material would be safeguarded. In addition that access to the material would be restricted, which ultimately involved scrutiny by only my supervisor, my co-coder and myself. It was made clear that all data would be destroyed on completion of the study and that no identifying details of themselves or their patients would be included in the transcripts.

The researcher left her contact details with interviewees in the event of their wanting to withdraw from the study, to facilitate a response to any comments they may have or to answer any queries (Banister et al, 1994).

Participants were offered copies of the study once it was completed and were informed that the final document would be housed in the archives at the University of the Witwatersrand.

CHAPTER 4

THE PROCESS OF ANALYSIS: THERAPISTS PERCEPTIONS OF METAPHOR AND OF ITS USEFULNESS

4.1 Introduction

It became evident while conducting the interviews for this research, that while the concept of metaphor, on close examination appears to be a somewhat intricate, complex and emotive phenomenon, psychodynamic therapists use it pervasively and unselfconsciously in their work. It was therefore difficult for them, at times, to extricate it from their work to be examined in isolation and at depth.

Despite this, therapists generously granted the researcher entry into their therapeutic worlds, particularly as it referred to the rich and textured use of metaphor as it emerged in their work with their patients.

4.2 Analysis of transcripts

Four themes were isolated each with their own sub-themes. The aim was to capture the essence of metaphor with the hope of facilitating the development of a rich and textured research piece. It will be observed that the themes and sub- themes may be inter-connected, not necessarily fitting into one category alone but perhaps at times interfacing with a few. This is perhaps not surprising in that metaphor, as we have already discovered from the theoretical views reported in Chapter 2, is about making associations or to quote Bion about linking experiences.

The major themes and sub-themes to be covered are:

- Therapists' perceptions of the concept 'metaphor.'
- Metaphor as part of the communication process in therapy-including therapists understanding of the role metaphor plays in the communication process and metaphor as a psychotherapeutic language.
- The therapeutic relationship-mothers and infants, therapists and patients- covering the patient/analyst relationship and what is 'done' in the space, together with therapists' generation of metaphor. The latter will include therapists' countertransference in relation to their generation of metaphor and their use of favorite or preferred metaphors with patients.
- An exploration of metaphor as part of the process of therapy- will include what is done with metaphor within the process of therapy, its efficacy as part of the process, the progression towards the capacity to metaphorize, creativity as part of the process and finally at what point metaphor loses its usefulness.

To ensure confidentiality pseudonyms will be used at all times and for the purposes of furthering this aim and in consideration of the delicate nature of the material discussed, it was decided that none of the material would be quoted directly. This was stated openly to therapists being interviewed and it was on this condition that they shared information about their patients with the researcher. It has been endeavored despite this restriction, to remain as close to therapists' words, intonation and phrasing as possible attempting at all times to not add words to fill in gaps or to explain things more concisely or clearly.

4.2.1 Therapists' perceptions of the concept 'metaphor'

Because metaphor appears to be used interchangeably with concepts such as dreams, symbols and simile in the work, in journals and in everyday conversations, it was interesting to explore therapists' understandings of the concept, especially as each of these concepts, has been found under rigorous scrutiny to have its own definition despite being linked in some way. In addition to some individual thoughts on metaphor, the majority used the concepts dream, symbol and simile when referring to metaphor

Interviewee 3 felt that *psychology* itself was metaphoric suggesting that metaphor takes on various forms and also appears to be comprised of different levels. At a meta-psychological level psychoanalysis may be considered to be a metaphor. This is because one is working at the level where experiences and everything else in psychology is as if they were something else.

In addition to this view, half the interviewees were in agreement with Interviewee 3 that metaphors are *as if* representations where something is like something else but was not actually that thing as would be the case if one were to apply Hannah Segal's concept of symbolic equation as pointed out by **Interviewee 1.** He assumed that the interviewer was using the word simile as a synonym for metaphor because in his experience, when people are trying to describe a situation, event or experience as another, they will use metaphor or simile and refer to it as being like that situation or, in other words, that the situations are alike in some way.

The following example may be an indication of a person working towards the as if: -

Interviewee 2 described a patient who is very bright but too concrete to bring anything that is as if and think about it in an as if kind of way. She does, however, do things for example she made an effigy but could barely talk about it except that it was about life and death. She could make no associations and could not internalize any of the therapist's associations which fell flat, met by silence, so instead the therapist explained in the interview that she just remained interested and curious and held the object in her own mind.

All therapists identified *dreams* as metaphors and admitted to working with them as an important means of accessing their patients' internal worlds. The following is an interesting account of a patient's dream: -

Interviewee 5 felt that metaphors are offered in the therapy as dreams when people are trying to describe something. She described a dream presented by a patient in which the

patient's partner's child appeared as living very happily in a beautiful home but began without warning to run around in circles. The patient knew that the child was in danger and needed to get to the child but could not. The patient had a sense that the child was going to turn into a toy and when she got there it was a toy and the head came off. The child became a metaphor for the patient who, in trying to find happiness, would instead get bogged down in the complexities of life and feel, as a result, that the life was being sucked out of her.

Meanwhile, two interviewees mentioned that they dreamt about their patients either in the room during therapy or outside of it. They provided the following examples: -

Interviewee 4 said that she might dream about her patients during or after the therapeutic encounter, which allowed communication to happen with her patient. She said that at times the image could be spot on but at other times appear to be a riddle which would leave the therapist wondering why that particular content or picture arose in that moment.

Interviewee 2 gave an account of having dreamt about a patient for 22 days in a row during a time of crisis in her patient's life, which for her, represented the extent to which she had to hold her patient's rage and stand by her until she recovered.

While **Interviewee 3** mentioned the role of dreams in the reduction of anxiety, giving the following explanation: -

He said that patients bring dreams that are coded representations of what has happened during the day or in their lives in general, which enables the mind to continue without waking. This is because dreams are responsible for the reduction of anxiety, that is, keeping it in equilibrium by redistributing emotional energy.

In addition, six interviewees referred to metaphor as a *symbolic representation* of their patients' material and whether represented in images, dreams, a drug trip or symbolic

drawings, facilitated the understanding necessary to make meaning of patients' experiences. Some of these instances provided by therapists follow: -

Interview 2 said that metaphor is often a visual symbol, more than a concrete thing. It is three-dimensional in that it's beyond visual also encompassing tactile and auditory sensations. She gave the example of a patient who longed to be at the sea. This image evoked for her a sense of the sand under her feet, which is both concrete and tactile, a feeling of being grounded but also a sense of being free as she stood next to the sea. She could feel both the coarseness and the comfort of the sand under her feet as she talked about the image. She went further saying that metaphor is multifaceted in that it's not just something that equals something else. It is broader capturing different aspects of oneself because it is experienced, or one feels it, or imagines it, engaging all the senses.

Interviewee 5 spoke about patients who explain things symbolically through their dominant senses. Some were more visually based, artists for example, where she would have a tendency to ask them to visualize something.

Interview 7 felt that metaphor appears primarily in the form of dreams and in the stories people tell of themselves. The therapist reported how, over the years, patients had said that there was no other way of telling their story unless they became this or that thing. She reported a very unusual presentation by a patient, which required, due to the level of symbolic representation, a type of dream analysis that was found to be very useful in the therapy. The patient, who was in the habit of taking a number of drugs quite irresponsibly, brought one of their terrifying "trips" to therapy. Its content was related to the therapeutic work, deeper aspects of which, he had not been able to access before. It was also useful in that it involved symbolic representations of new issues, which were then explored for the first time.

Three interviewees experienced metaphor as a means for patients to articulate feelings that were experienced *somatically*, for example: -

Interviewee five felt that people used physical metaphors because so much of peoples' experience, taking depression as an example is experienced somatically.

While finally, two interviewees highlighted the general understanding that metaphor is manifest in the *language* that people bring to therapy, for example: -

Interview 6 said that metaphor might appear in the form of a phrase or an idea that comes up. The example given was of a person who found themselves to be quite needy but dismissive of peoples needs in general and also quite greedy. The person described how they wanted lots of things from different people but could not have them because this would hurt the people involved. The patient reflected on how it reminded them of their childhood and that they were possibly one of those children that wanted all the sweets to themselves at a party. This metaphor of being the needy greedy child was very traumatic for the patient to deal with but enabled her to access some empathy for herself over time.

Interview 8 felt that it appears in the language people use particularly in the emotional descriptive words they use. She offered an example of a patient with a tendency to over eat. At the same time she was also very concerned with appearances and how things looked and about hiding her unhappiness from the world under a happy exterior. The patient brought the metaphor of a beautiful vase of flowers sitting in murky water, full of messy dirty stuff. No one could see what was happening through this from the outside, but sometimes therapy made the water clean.

4.2.2 Metaphor and the communication process

In this section therapists' thoughts on the role of metaphor as part of the communication process in therapy will be addressed. This will include aspects such as metaphor as a facilitator of the expression of difficult emotion, the means by which patients use metaphor to communicate indirectly with their therapists and the use of the metaphor generated by therapists as part of their interpretations. In addition metaphor as a language

in itself, as a language of the unconscious and as shorthand will be supported by accounts by therapists.

4.2.2.1 Therapists' understanding of the role metaphor plays in the communication process

Five therapists felt that metaphor facilitated the *articulation of difficult feelings* in patients. One therapist gave an example of where metaphor had been used by her patient enabling him to *own* his feelings: -

Interviewee 6 spoke of metaphor in an example she gave as an expression of something that popped into the session, which then became something quite emotional for her patient because it expressed how he was feeling so well without him having to talk about it in a more literal way. This was particularly relevant because he struggled to know how he was feeling; always having had to be what others wanted him to be. His metaphor of being in quicksand helped him own his own feelings, as he was able to visualize himself in that situation, which moved him from the typical view of himself, which was an external position to an internal position. The metaphor relaxed him a bit more as it expressed his dread in a less dreadful way and made his experience less all encompassing. It was all in all a powerful means of communicating his feelings.

While an alternative view was provided by other interviewees who felt that metaphor was useful in that their patients *didn't have to own* their feelings in that moment which made them less threatening. The following example is an expression of this belief: -

Interviewee 7's patient found it easier to express things during times of significant change within, through the use of metaphor where he referred to a little or big version of himself. He used metaphor to express certain ways of being in the world and certain feeling states that he didn't have to own directly. Despite his being very articulate he found it hard to be emotionally intense especially with the level of trauma that he was trying to describe and metaphor made this easier for him to do. Metaphor had perhaps

helped him articulate his experience for the first time in a different kind of way instead of his usual manner of expressing it through acting out. It was also the means through which she tried to understand her patient.

Alternatively, two therapists had patients who *communicated indirectly* with them by means of referring to their journals in sessions, which alleviated the threat of expressing feelings and experiences verbally. The one example offered was of a patient who was suffering from Schizoid Personality Disorder, who brought his journal representing his internal world to therapy, as he'd not been able to work out how to talk in therapy, the other is represented in the following succinct account: by -

Interviewee 8 who felt that metaphor is a way of speaking about difficult things in a less threatening way while at the same time not evading issues. She referred to a patient who communicated indirectly by means of her journal in which she referred to images that had been discussed in therapy.

While half the therapists observed that metaphor *facilitated understanding*. The following examples give a clear idea of what therapists' experience: -

Interviewee 1 said that he thought that metaphor was about explaining, elucidating or elaborating an experience or emotion but primarily an emotion. Helping a patient communicate what certain feelings/experiences are like, whether these were about living with a difficult husband or wife, to a sensation that they can't quite name to refining an experience over time to which the therapist may add his own metaphor or simile. The purpose of using metaphor is to try and understand those experiences and feelings through the patient and therapist finding ways to communicate their individual minds

Interviewee 4 found that metaphor is a simple, succinct yet potent form of communication through its capacity to clarify, explain and give words or a picture to something. She gave the example of a woman who brought the metaphor of *The Ugly Duckling*, the communication of which facilitated understanding of where she was at, for

the patient and therapist. The patient began to understand what it meant when she was the ugly duckling and when she was one of the ducklings and when she would put herself in these positions and how she would reflect on the reflection of herself. Also in the transference as to what she thought the therapist was seeing, and when she couldn't hold the outcome of the story the therapist could, and so it worked on many levels.

And finally two interviewees referred directly to their building on patients' metaphor as part of the *interpretation* process where things that may have been hard for their patients to hear, were reframed and in that sense were made more tolerable. The following example given by a therapist highlights how metaphor was used to soften her confronting of her patient's rage: -

Interviewee 5 said that people speak in metaphors when they are trying to understand something, that it is the patient's way of communicating how they see the world. She also found that it is a useful means for the therapist to communicate something back to the patient in terms of their experience and in the reframing of things. It also softens the confrontation. She gave the example of a woman who has had to endure one trauma after the other this year and how she in the past had brought a dream representing her anger, of a tiger attacking her husband and all it required of him was to take a pillow to frighten it away. Five years later, due to the level of trauma being experienced, the metaphor has evolved into one that is more serious and is now a lion and a bear that she is running with, representing an anger that cannot be chased away with pillows. The therapist explained how it had become much easier to talk about the patient's rage and envy through the symbols of the tiger, the lion and the bear than by using other forms of therapeutic language.

4.2.2.2 Metaphor as a psychotherapeutic language

Interviewees 1, 2, 3, and 7 referred directly to metaphor and language, more than half referring to it as a language of the unconscious. Interviewee 1 and 3 agreed that it was a common language that developed between patient and therapist, 3 and 7 that words in

themselves are metaphors while interviewee 2 felt that metaphor was more than language, that it was three dimensional. The following are examples of therapists' opinions regarding metaphor as a *language*: -

Interviewee 1 said that it's about trying to find a language in therapy for the mental correlate associated with sensory bodily experiences, which one struggles to convey one to the other, and this is where metaphor comes in. Metaphors that are generated in therapy become a specific language that both therapist and patient understand.

Interviewee 2 felt that metaphor offered a way for things to be constellated in ways that language could not do on its own, that it was three-dimensional

Interviewee 3 highlighted that what was really important for him was that there was coherence between himself and his patient which comes about through the process of linking, that both people in the room understand what is being talked about, that there is a common language being developed. He pointed out that symbols are about language and that words are metaphors in themselves.

Interviewee 7, in thinking about metaphor before our interview, had thought that so many of her sessions were about symbol, used the instant people language and therefore felt that languaging was metaphoric in various ways.

Five interviewees referred to metaphor as the language in which *unconscious* processes may be articulated. The following examples each contribute something different to this understanding: -

Interviewee 1 said that as psychodynamic therapists we are trying to access the unconscious and there are no metaphors in the unconscious. It is therefore the words associated with like that become symbolic representations of the unconscious.

Interviewee 5 reported that particularly in relation to the patient who brought the dream of running with a lion and a bear that these metaphors provided a nice language to work with where internal aspects of self could be accessed. She also reflected on her sense that dreams were about the unconscious integrating something.

Interviewee 6 in referring to her patient's response to her bringing metaphor said that it may be picked up in a moment or not and that that will be the end of that and then its not really a very useful one. She said that she supposed that it was like unconscious material because that is true for metaphor in that it would come back if it was important.

Interviewee 7 felt that metaphor is about having a rich internal world and being able to language that internal world and this is why people who are more concrete and who struggle with language will struggle to give words to their feelings.

While five therapists referred specifically to the development of a specific metaphor as *shorthand* in therapy to be used by both themselves and their patients when referring to issues relating to the patient. Two referred specifically to it facilitating understanding through its use in this way, while one felt that it softened confrontation where it was used instead of the normal language of therapy. It was also highlighted as a limitation by a therapist who felt that if left unchecked, patient and therapist could be talking at cross purposes (see 4.2.4.5). The following examples give a clear explanation of how metaphor as shorthand is worked with by patient and therapist: -

Interviewee 4 said that metaphor could become a shared language that develops between patient and therapist and a shorthand where for example the patient will say that they feel as though they are in that unsoothable baby today, a feeling immediately understood by both. She also referred to the metaphoric language of dreams becoming a useful short hand with patients. She gave the example of a man who found himself stuck in a road between a squatter camp on one side and children throwing stones at an elephant on the other side of the road whose back was burning. In therapy the language became shorthand for which side of the road he found himself on at a particular time or on a particular day.

Interviewee 6 felt that her patient's metaphor of feeling that he was sinking in quicksand and that things were sticking to him and drawing him down had become a useful shorthand for many things that had already been talked about in therapy. It became a fixed shorthand and when he brought it, he knew that she understood what he was talking about and over time it became elaborated on to the extent that he was able to talk about stepping in and out of it.

4.2.3 The therapeutic relationship - mothers and infants, therapists and patients

Therapists' description of the therapeutic relationship and what this allows to be done within the space is considered first, followed by therapists' thoughts on their own generation of metaphor within the therapeutic context. Whether this is influenced by their own countertransferential feelings and if so, to what extent this is so, is followed by the use of, and their opinions of, using their own favorite or preferred metaphors with patients when conducting therapy.

4.2.3.1. The therapeutic relationship and the essential features of 'doing'

Winnicott (1971) says that what happens in the therapeutic space is work, things are done and that playing is doing. This theme is explored through an examination of therapists' understanding of the therapeutic relationship and of what is done in the therapeutic space. Therapists refer to the therapeutic relationship, the concept of 'doing' in terms of the work done with metaphor in the space and the space itself as being metaphorical.

Interviewees, in essence, described the therapist's role as active in the room encompassing aspects such as thinking, metabolizing, linking and playing while at the same time being nurturing, caring and sensitive to their patients processes. All the

interviewees used terminology to describe the therapeutic relationship derived from the thoughts of Winnicott and Bion while a couple referred in addition to the work of Freud, and briefly to Green and Klein.

The following examples are indicative of therapists' sentiments regarding the therapeutic relationship and what is *'done'* in the space: -

Interviewee 1 talked about the therapeutic relationship in terms of what transpires in the transference. He explained how he referred back to a metaphor a patient had frequently referred to in the past about his father as a figure who felt shadowy, did not have any features, who was dark and ominous, and used it to link the patient's suddenly feeling scared in the therapy room. The patient agreed that it was as if he, the therapist, had become a shadowy figure. In this way an experience in the person's life had been linked with something in the room that helped his patient feel understood.

Interviewee 2 with reference to her patient who brought an image of being in a pool that felt very comforting and soothing and in a real sense her patient's witnessing of tots being taught to swim with moms by a very strong, solid and containing mom in warm water, felt that it was important for her as the therapist to be curious, share it and notice it. It was also about making links between what was happening in her patient's body at that time and what she might be imagining for herself in that moment. The link between the water all around being holding and containing almost like the therapy space where she could be the tot in water, that there was 'an other' with her keeping the space safe. The sharing of something vulnerable that was held collectively was very important for her because she struggled to connect with people and in this way she was experiencing a relationship on a deeper level that involved feelings.

Interviewee 4 said that her role as a therapist was to help her patient's think and dream, by metabolizing their beta elements through the maternal alpha function. This would ultimately enable the patient to feel contained and open spaces for something creative to happen. She also referred to her dreaming of her patients, the symbolic content of which

she could choose to keep to herself or to share with her patient, she reflected that inviting her patient to think with her had proved particularly useful.

Interviewee 5 felt that if one is asking a patient to get in touch with their vulnerability within therapy then there had to be a relationship to contain it, a safe space in which they could genuinely let go. She said that metaphor could be the container of a person's experience and of their frustration. She said that she liked to take her patients' metaphors and play with them, deconstruct them and give them alternative interpretations that tapped into her own creativity and facilitated thinking in her patients. She also enjoyed the banter that ensued as they discussed the metaphor.

Interviewee 8 felt that the therapeutic relationship was about helping a person stay with difficult emotional experiences in a way that felt more containing and safe. It was about developing a therapeutic relationship and finding ways to work with and think about what went on inside and how one made sense of that. Its was about processing those elements and trying to get them back into a digestible form so that they felt really understood and also provided something tangible for them to hold onto.

4.2.3.2.Therapist-generated metaphor

Therapists' thoughts on generating metaphor for their patients and their patients' responses to this, where relevant, will be explored followed by the links between metaphor generation and therapists' countertransference. Finally therapists' views on the use of favorite or preferred metaphors will be examined.

Where therapists brought metaphor they were clear in stating that it had to be related to the patient's material. Some mentioned specifically that it should be unique to the individual. A couple of therapists mentioned that despite the possibility of therapist generated metaphor being questioned from a theoretical perspective, they still used it because it was useful. One therapist felt that it was important to hold back on her own metaphors until her patient offered something, for fear of imposing them on her patient.

From the results it appeared that patients responded in a very individual way to therapists metaphors, some metaphors would be picked up on with relief and others ignored, therapists giving different accounts of why this was so. Examples relevant to these points follow where: -

Interviewee 2 said that metaphors come in the images that a patient brings and in associations she might find to what the patient brings. Her images do not come from anything concrete but from another substrate she is coding, that it's useful to offer something that is three-dimensional, out of the usual ambit of language. They are always related to where the relationship is at and very much what the patient is working with.

She reported that when this occurs in the room, patients are interested and may take her metaphors in a different way to what she has been thinking and that is interesting for her, or people will skip right over. It's very individual in that no one has ever said that she should not have said something or not come back because of it. If her patient is quiet, she reported that she is interested in that and if they say they are thinking about what she has said then she just waits.

If they gloss over what she brings its not meaningful for them, she said she could say its resistance but she doesn't think it is because metaphors are things you offer almost like a something and you see what people do with them, they may move on because it's not meaningful to them or come back to them later.

Interviewee 3 said that, technically a therapist, giving metaphors could be questioned but that he found it quite useful. He said that when he comes up with a new association for a patient that he has not thought of before, he needs to be alive to his associations because they could be quite wild, he said that he needed to be available to the patient's mind. The association could feel quite foreign to the patient but they are often willing to mull it over. The patient may say that his association is totally opposite to what they are thinking but he said that that is ok because you as the therapist have helped open up another line of thought.

Interviewee 4 made it clear that when giving a metaphor it should be related to the patient's life or the life of the therapy. She offered that sometimes she uses a metaphor because it can make an interpretation a lot more powerful. She likes to work with what comes up, that is quite surprising and insightful in a dreaming kind of way, she may keep this to herself or invite the patient to think with her, which she finds very useful.

She gave the example when working with a child, which has been included because it gives a very good idea of what it means to dream in therapy and how this is offered to the patient in an attempt to make meaning of their difficulties. Despite this example being of a child, it has the potential to be applied to work with adults too. While working with a child with severe issues of loss, the source of which by that time had not become apparent, the therapist found herself awakening from a dream during therapy talking of *Cinderella*. Upon asking the parents if there were any issues regarding stepmothers or stepsisters in the family she found that the mother had experienced a terribly painful history of a stepmother in that her own mother had committed suicide and she lived with the guilt of responsibility for that and her father remarried a month later. She and her brother clung to each other and every time they separated the little girl, her patient, got into a state, she was carrying a lot of that and it was so unspoken that it was transferred in a dream within the therapist in a beta element kind of way.

Interviewee 5 reported generating metaphors spontaneously for her patients but felt that holding back with a metaphor generated by herself is important, not to impose but to wait till they brought something which was then played with, engaging her own creativity. She felt that she needed to get to know a person and to understand how they would use the space before bringing her own metaphor.

Interviewee 6 said that theoretically she supposed that it was more important to work with the metaphor that the patient brought but that she also found that she used metaphors, sometimes deliberately because it would help the patient access something they were struggling to access and sometimes it would just pop out spontaneously and

she would forget about it but the patient would bring it back the next week and use it. She felt that the ones that worked were a little bit different, unique and quite surprising.

In explaining what patients do with her metaphors, she said that patients may pick up on them or not, if not then it was not really useful, she said that perhaps it was like unconscious material that if its important it will come back.

Interviewee 8 explained how she listened to her patients' language, the way they verbalized their internal struggles and difficulties before bringing a metaphor.

She stressed that timing is very important when offering a metaphor and people can receive it with a lot of relief, it can leave them feeling understood, an image to hold in mind and that can make some meaning. She said that she was constantly reminded of Bion and the capacity to make links and to think.

4.2.3.2.1 Therapists' accounts of their countertransferential issues in relation to the generation of metaphor

All therapists reported the possibility of *countertransferential feelings* influencing their generation of metaphor. Three therapists issued warnings about responding to a patient's material in this way. Some examples of therapists' thoughts follow: -

Interviewee 3 said that in therapy one is continually trying to filter out the way the therapist might be seeing the patient, that one is trying to find them rather than impose a meaning on them that is coming from ones own experience which is not easy as one is talking from ones own experience. Supervision and therapy should give one a clearer idea of oneself and ones biases but it is something one is trying to sort out all the time. So it is important to distinguish and link in ones own mind what is meaningful and what are the metaphors of ones own life. We can impose so easily because of our lives that are furnished with theoretical biases and prejudices, its much easier if one has a theory in a

box and one can say that one knows that this is this rather than living with the uncertainty.

Interviewee 4 gave an extreme example of a physical countertransference during a session with a woman whose mother had emotionally abandoned her frequently. It was in a session with her after her having experienced a severe loss in her life where the patient felt that she was going to disintegrate, that the therapist felt that someone had taken her hair and was swinging her around in her chair. In trying to make sense of this the therapist thought that it might have represented the patient trying to hold herself together by holding onto something like a mobile and that in the moment she became that in the countertransference. She kept this to herself waiting to see what came up in later sessions and feeling in that moment that it was about her having to understand something.

Interviewee 5 said that she offers the metaphor of the infant and mother when she has more empathy for the patient than they have for themselves, so that is a direct countertransferential thing, it's about clear concern. It's spontaneous in the moment. It's about how the between space feels in the moment and where that feeling is coming from and then to put that into words.

Interviewee 6 reflected that if metaphor came to her that touched her life then she would be more careful about editing or censoring it because it would feel like it had come too much from her, but she said that this was an almost impossible one to call.

Interviewee 8 said that it was important to not use trite overused metaphors but that the metaphors used should have some significance for the patient so that it was not the therapist's stuff that was imposed. She warned that one needed to be quite careful of what one was doing. She gave the example of a patient whose particularly punitive superego was depicted in her sense that harsh eyes were on her. She reported that at times she felt quite frustrated with this patient because she didn't seem to have been able to move on. She said that she had to be careful not to bring up that image when she herself was feeling exasperated, that some images could be very powerful and evocative, sadistic and

damaging, that hopefully one would know when one was having sadistic urges but if you were bored with a person you had been struggling with for a long time one needed to be careful of not giving something of your own.

While in addition, seven therapists specifically spoke of their *enjoyment* in working with metaphor that might induce them to use it more often in response to their patients' experiences and feelings: -

Interviewee 2 described metaphor as light, not heavy things that were kind of gifts that one unwrapped that were either carried through or left behind in therapy.

Interviewee 3 referred to his delight in the creative use of metaphor and spoke about those times when using metaphor like Pans Labyrinth when there were breakthroughs in therapy, through the wall, that he experienced as a kind of high.

Interviewee 4 felt that in general terms, not specifically related to her own countertransference that it was the personality of the therapist that determined to what extent metaphor was used, she reflected on her tendency to think in pictures and that metaphor therefore helped her get across her thoughts and at times helped her speak

Interviewees 5 reflected on how fortunate she was that so many of her patients were creative and expressed themselves symbolically.

Interviewee 6 spoke of her love of language and a turn of phrase and that this had many meanings in terms of her life and that she had to think about the fact that perhaps she preferred beauty to ugliness and that metaphor in therapy may help her feel more comfortable, to sanitize in a way.

Interviewee 7 reflected on the patient who was able to play in therapy, speaking of the enormous joy and the pleasure she would take in his creative intellect, she said that she liked him bringing clever and new ideas to therapy and she said that she thought that was

about her, that he had a doting mom in therapy that had been nice for him. She described his metaphoric use of language as quite beautiful at times.

Interviewee 8 reported that she found metaphor very appealing and interesting and that it hooked her, she felt that she had to watch that she did not go there for her own gratification.

4.2.3.2.2 Therapists' use of favorite or preferred metaphors

Where therapists brought their own preferred metaphors related to specific examples or to more general themes, they all emphasized that they had to be related to the patients material, a couple mentioned specifically that they should be unique to the individual. Interviewees 3 and 7 brought specific examples of metaphors they used more frequently with patients while interviewee 4, 5, 6, 7 and 8 presented metaphors that they used related to specific metaphoric themes. These themes related to mothers and infants, children, pasts and presents and water. Interviewee 2 did not use preferred metaphors at all and Interviewee 1 could not remember a specific example but thought that it was possible that he did use preferred metaphors. The following examples are an indication of the nuanced ways in which therapists use *preferred metaphors* or alternatively *metaphoric themes*: -

Interviewee 1 reported that he did not use favorite or preferred metaphors that he was aware of but he suspected that he might because one has an unconscious and that may induce one to pick on certain words and metaphors. He said that if he used one too often he would question himself because he may be talking about an aspect of himself rather than what the patient was trying to describe. He felt that the metaphor would lose its individuality that the whole point of therapy especially analytic therapy is to search for the uniqueness, the thumbprint of each person. It's each person specific meaning of Oedipus.

Interviewee 2 said that she did not use her own same one because there was nothing creative about that and so if she did she would start to wonder about it.

Interviewee 3 gave two examples of metaphor he uses with patients, the following is one of these that he uses with some patients who find it hard to enter an inner world or to have a conception of one. The metaphor comes from the film *Pan's Labyrinth* in which Filio, the little girl, goes into an underworld in which she can feel safe and contained but it is also a place where there are some dark and frightening images. The fawn gives the little girl the chalk and says to her that when she wants to enter this world she must draw a door on the wall. This is symbolic in that what he is saying to his patients is that he cannot take them into that underworld unless they are willing to go there and he is supplying them with the chalk to draw the door through which he will travel with them when they are ready. He emphasised that it is about realizing where the patient is at and about trying to help the patient move from the concrete to the symbolic.

Interviewee 4 said that she uses the same metaphor in terms of what a child needs, things like lap time, baby metaphors because that is a lot where her thinking in her work is at, around infant parent dynamics the unsoothable part of the self.

Interviewee 5's favorite metaphor that she comes back to is the metaphor of the infant and the mother. Helping a person to see a mother doing something to a child and getting the patient to imagine what it was like for them as the child, to have empathy for themselves and to see how it impacted on them then and visibly in what they are doing now. She would use this once she has got to know the person, and to understand what and how they use the therapy space and what kind of stuff they would bring. When a high degree of trust had been established.

Interviewee 6 said that she did not necessarily use preferred metaphors as for her its quite unique for different patients, that the ones that worked were a bit different, individual, she supposed that there were some common metaphors, thinking of the needy/greedy child, metaphors about children, and pasts and presents and things about that. She said that she would not necessarily offer them at first to her patients as metaphors but as reflections and interpretations and then to see where they grew. They come spontaneously and were directly linked to the patient's material.

Interviewee 7 spoke of using the metaphor that she said we were all taught when learning to do trauma work, the one of it being easy to give the headlines but that its much more painful to tell the whole story. She said that she thought she would also bring metaphors when trying to help people understand that therapy is difficult and protracted work

Interviewee 8 does not use her own preferred metaphors and apply them to her patients but rather listens and tries to connect more with the patient and work out what metaphors would have meaning for them. The only thing she felt was that when overwhelming emotion was being talked about there were normally lots of water images that would emerge.

4.2.4 Metaphor and the process of therapy

Examining what happens to metaphor once it has been generated in therapy by either the patient or therapist will be explored in this theme. This is followed by therapists' views on the efficacy of metaphor within their work. The development of the capacity to metaphorize as a therapeutic process is taken into consideration by therapists, as is metaphor as a creative product of this capacity. Finally therapists' opinions on where metaphor fails in its purpose or loses its usefulness are examined.

4.2.4.1 What is done with the created metaphor within the process of therapy.

Five therapists felt that once metaphor had been introduced into the therapeutic space it could be *elaborated* upon over time. Some referred to it being brought back by the patient and others by the therapist. The purpose of this could be the possibility that it enabled the patient to hold difficult material which could be worked with, a couple of therapists felt

that this could be done in a dynamic kind of way. The following examples are given as a means to elaborate on this idea further: -

Interviewee 4 reported that metaphors can be added to but often the core meaning stays the same, that they may be often revisited, that a patient's stuckness is revisited in this way.

Interviewee 5 said that dynamically she would take her patients back to their metaphors in other sessions to help them unpack them. She said, in referring to the patient who initially dreamt of the tiger attacking her husband, and five years later it was not about the tiger anymore but her running with a lion and a bear, that her traumas had shifted her metaphor and her sense of the extent of her own rage, it has been nice to work in this way because they had been able to enter a deeper level and she has been able to own the fact that she was angry because it was almost easier to hold in metaphor. She said that therapy is about shifts and so the question is how to bring that in a palatable form for the patient. She said that she likes to do it in metaphor because it personalizes it, it's their metaphor, their dream, their image.

Interviewee 6 said that metaphor is returned to sometimes quite frequently once introduced and can be elaborated upon over time. Initially her patient's quicksand metaphor was external, something he got stuck in while later on it was about him stepping in and out of it and how he could do that, so that there is that dynamic stuff that happens around it.

Interviewee 8 said that some patients who refer back to metaphor would take it, expand on it and bring it to life while others will use it to make sense at times but do nothing with it.

While one interviewee drew attention to the *dynamic tension* existing within the patient therapist relationship: -

Interviewee 7, when referring to a particular patient, said that when he was particularly stressed he would revert to using metaphor and that she was very careful of referring back to them herself because they carried heavy emotional weight for him.

4.2.4.2 The efficacy of metaphor as part of the therapeutic process

Therapists offered differing views on the efficacy of metaphor within the therapeutic process. The following excerpts are indicative of a couple of therapists' views that it is *difficult* if not impossible to isolate the effectiveness of metaphor: -

Interviewee 1 said that this was almost impossible to say because therapy is made up of a combination of so many experiences, references, interventions, interpretations, the therapists regularity, whether you would own up to a mistake you made. He said that he just knew that he used it rather unselfconsciously and that he knew that it was an important communication tool.

Interviewee 5 said that it was really hard to judge what effect people take away with them because when she asked them to reflect it was often opposite to what she thought.

The following therapist felt that metaphor was *not instrumental* in moving the process forward: -

Interviewee 2 said that not much has to be done to make metaphor happen, that its part of the human capacity for imagination, for pictures and visualizations and so it happens, differently for different people. She said that she did not know if it could determine outcomes, that she did not see it as instrumental in moving the process forward but rather as a river that flows and it might be part of the driftwood that might be there.

Interviewee 3 said that it was a crucial part of the process of making links and creating coherence.

While five therapists found metaphor to be a *useful* part of the process. They expressed views such as; it possibly having an effect on the process in delivering interpretations in a non-persecutory way, it being a useful tool in terms of communicating back and reframing things, it definitely helping outcomes and it being an interwoven and beneficial part of the process. The following is presented as an example of one of these views: -

Inteviewee 6 felt that metaphor was an important part of therapy that she worked with it quite a lot along the way. She felt that metaphor could move a process of change very powerfully but also allow one to see what change is happening in the way that people engage with metaphor about their lives and how those metaphors change over time and how they embrace different parts of oneself or incorporate different feelings or reject certain ways of being that have been troublesome, they can be a vehicle for change as well but not in their own. Outcome is determined by the meaning people make of themselves and their lives so maybe it works here too.

Alternatively, the following therapist pointed out that there are some patients with whom the use of metaphor is *not useful*: -

Interviewee 8 felt that metaphor was interwoven with the process and could be quite a beneficial part of the process although it was hard to single out. She said that she definitely felt that it added value in its richness and depth but that with particular patients she was quite hesitant. In addition, she said that it was something her patients could hold onto and draw on.

Of interest was that more than half the therapists either directly or indirectly referred to metaphor as a *transitional object*, which as such facilitated the process in some way. Excerpts are provided as examples of this understanding: -

Interviewee 3 said that symbolization was very important, a crucial part of the process of making links and creating coherence. He said that what one was trying to do was to help patients create a space in their minds that represented the therapeutic space, not confined

to time and place, where they could go to think and process their experience like the idea of Winnicott's transitional object in their mind, that they could use the object. He said that, as one knows, the transitional object is made up of part me and part the other and so the patient has a sense that the images that have been created and can be held onto as a resource are something that has come about from both the therapist and patient.

Interviewee 5 felt that the process may be affected by the therapy being a container for their patients experience, for their frustration because it's not just the hour in which they hold themselves but that they take some of the things that have been said in the hour away with them to latch onto in a crisis.

4.2.4.3 Progression towards the capacity to metaphorize

Six of the eight therapists referred specifically to *developmental issues* having arrested the capacity to symbolize and more than half mentioned that everyone has the capacity to symbolize unless there are severe cognitive deficits. The following excerpts explore these thoughts: -

Interviewee 3 said that what one was trying to achieve was to move the patient from the concrete to the symbolic because the function of the symbolic is linking and the redistribution of ones emotional life. Patients came thinking concretely, partitioning their experience and dealing with their experience as if for the first time and one was trying, in keeping with Freud to move from the thing represented to the word represents.

Interviewee 5 said that she had had experiences with patients who had so little internal world that they were almost pre-self. One could judge what they felt but they can not put it into words. She said that she found these patients difficult to work with, as she was quite a creative high-level thinker. She said that it was important to bring herself back down again and to remember that what they were bringing was very important to them, having someone pay attention was almost a metaphor of containment. She felt that unless there was a severe cognitive deficit or impairment most people no matter what the

baseline start to develop in terms of therapy. The inability to symbolize was possibly due to patients having been discouraged from thinking, from having feelings, simply to have the space no matter how awkward and strange

Interviewee 6 brought the example of a patient who could not symbolize because of an emotional process, so that she could keep herself safe. She said that she thought that everyone was born with the capacity to symbolize but that perhaps what interferes with it was some kind of intrusion or a defensive process of blocking. That all people would be able to symbolize but differently, a poet maybe completely differently to a packer at Checkers but that it is something we can all do.

Interviewee 8 said that she thought that some people do have the potential to use metaphor and others do not. She described how people who were not that bright or people who were verbally literate but emotionally cut off, whose defenses kept everything battened down, couldn't bring metaphor and would see you as loopy if you suggested something. In others it depended on their internal world and how it was structured, resistance or a particular idea about themselves. She felt that a sense of trust and the therapeutic alliance could facilitate the ability to symbolize, that as they felt safer they could slowly start to feel curious about themselves. People are born with the capacity and then there is a relationship or attachment that fosters and nurtures that, people that have more severe attachment difficulties are more concrete emotionally.

While one interviewee gave an interesting example of a case where the cause of her patient's inability to dream was, she felt, due to a *developmental arrest of thinking*. This was due to the trauma he had faced in his life rather than due to defensive intellectualization as she felt that he had been able to symbolize prior to the trauma: -

Interviewee 4 suggested that people who do not bring metaphor to therapy are the concrete-thinking patients who often intellectualize more. She pointed out that these patients were defensive and were different to her patient who arrived in therapy unable to remember his dreams or think in the room, unable to talk, frozen as if in a beta element

place. In his case, he wasn't avoiding something by being overly intellectual, she had always had a sense that he could dream, as she believed all people have the potential to do but that something had been frozen, his thinking had been arrested there. He didn't have that metabolizing part inside him and what shifted him was the containment of therapy.

All therapists except Interviewee 1, possibly because he was not asked directly for his thoughts on the capacity to metaphorize, said that the *therapist /patient relationship* facilitated the capacity to symbolize. The following are provided as relevant examples of this: -

Interviewee 2 gave the example of a patient who, after about two years of therapy, began to bring dreams that were quite concrete, a process of feeling safe, accepted, dropping down into stuff with her had to occur before she could get close to anything imaginative or vulnerable, she had to build up trust and comfort. She felt that it was where the patient was at developmentally.

She brought another example of an intelligent but concrete patient who she said was not near 'as if' but did things in the space, she was the patient who made the effigy but could make no links regarding her experience around it. She also borrowed books asking if she could keep them over the December holidays, the therapist agreed knowing that they were a transitional object but knew that the patient would not be able to tolerate her referring to them in this way. The patient later began cutting roses from her own garden and placing them on her desk at work similar to her therapist's keeping roses on her table in the therapy room. The therapist felt that there was a gentle, genuine, kind and reciprocal interchange occurring between them and that was how the work was done.

Interviewee 6 felt that the containing nature of therapy and the therapist's ability to play a bit because metaphor is playful and to do it in a serious way as well, not just a frivolous way and there is that inside thing that almost comes out of symbolization rather than towards it.

Interviewee 7 spoke about her patient's capacity to symbolize developing because he had been allowed to metaphorize in the room, to represent his experience in a different kind of way. She said that metaphor had brought in an element of play, which was more fun for her patient. Despite part of him being vulnerable when he brought metaphor, he was also quite proud that he had managed to come up with a good representation of his feelings and that was part of the play. She said that it had been the result of a whole lot of active work taking place in the space, part of which was helping him make the links between who he was as an adult and some of the stuff he was doing and what had happened as a child.

4.2.4.4 Creativity as part of the process of therapy

Seven of the eight therapists referred to the creative use of metaphor. Three interviewees spoke about the *creativity of the therapist*: -

Interviewee 3 said that part of the task of a therapist is to be creative. He said that sometimes patients may be presented in therapy with something they can not process like an indigestible food and so that is part of the creativity of the therapist where you realize that the path you are taking isn't working and so you have to find other ways, new ways.

While half referred specifically to the *creativity of their patients* in their use of metaphor:-

Interviewee 4 felt that there was a link in that if something is metabolized, something creative can happen.

As did half the therapists who referred to it being *used by both patient and therapist* in a creative way and as part of their patients process in therapy. The following example covers both of these aspects: -

Interviewee 6 spoke about metaphor in general being a creative way to work. In referring to her patient with whom the needy/greedy metaphor was generated, which then mutated into a dream linked to this metaphor with paradoxical content about an animal who was both terrifying and cute, she said that this patient was a creative person who liked to work in that way

4.2.4.5 When metaphor loses its usefulness

Therapists gave varied views on the *limitations* to the usefulness of metaphor. Some specifically highlighted getting stuck in metaphor when it is used as a defense or when used as shorthand whose meaning has evolved unbeknown to the therapist. It was also mentioned that its demise might be a natural part of the process. Three therapists highlighted the difficulties associated with the interpretation of metaphor when dealing with patients from different cultural and historical backgrounds. While one mentioned the difficulties in working with patients suffering from depression, personality disorders and psychoses, and finally one felt that there were no limitations to its use.

Interviewee 1 said that while the beauty of metaphor and simile is that it can be used as a shorthand, the disadvantage is that one can assume that one and one's patient are talking about the same thing when there has been a development of feeling in the patient and one is stuck three months/ three years back not using it in its fully developed form. It should therefore be checked from time to time. In addition, he said that metaphor might lose its usefulness at a point when one can't stretch the 'like' any longer. Its not a conscious process, it just falls by the wayside. Its demise results from it becoming stale denuded of emotion, a cliché that is not used as a proper communication tool but switches to cognition, becoming part of the defense, so in that sense one could say that metaphor could be used for good or bad.

Interviewee 2 felt that metaphor might fail when it was being used as a tool. She remembered a therapist who used to try and find a metaphor for your life and then work with that, this was incongruent for her, and she felt that metaphors were light, not heavy

things, that there couldn't be one for your life. She said that metaphors could be useful for a time until the person moved on and they evaporated.

Interviewee 3 found no limitations to metaphor, he found it a crucial and very constructive part of the process. He stressed that words have a history of their own and that dreams therefore don't have definitive meaning.

Interviewee 4 thought that metaphor could get stuck if it was being used as a defense like her patient who got stuck in only ever talking about her dreams which made something else impossible.

Interviewee 5 reflected that metaphor was possibly about the therapist seeing something or interpreting a dream in a way that the patient wasn't ready for. She mentioned that timing was very important and that hopefully the therapeutic alliance would hold someone.

Interviewee 6 gave the example of a patient who is very self reflective and told stories about her life and sometimes they were not true and she'd say they were not true. The therapist felt that maybe the use of metaphor here was not useful, as it had become too stuck.

Interviewee 7 said that if metaphor was abused it could provide a way for the patient to avoid issues in therapy. She felt that it was easy to be seduced by metaphor rather than to do the work. She mentioned that she thought that metaphor was about symbol and that it is located in culture and history and that her wariness around it was that we potentially bring our associations around things, how much is it about our way of seeing things and how much the patient's way of seeing things. She gave the example of a patient who was raped and abused by her Scottish father and in working on reintegrating him into her life; she worked on reintegrating the symbols of his Scottish identity into her life. One could project her into all the Scottish stuff and try and understand her character traits based on

that or rather understand that the symbols represented all the things she most loved about her father such as his tenacity.

Interviewee 8 said that despite metaphor being quite beneficial there were patients that she worried about using it with. She had a patient who was quite in love with the idea of being miserable, she really was depressed but had developed a romantic aesthetic around it that was not quite Gothic but *Emo*, Emotional Rock who are into the romance of being depressed. The language can start to feel seductive and the therapists concern around talking about it metaphorically was that it might make the depression sound more enticing, that it may keep her stuck in the beautiful, dark, seductive thing that they both were playing with. With this patient it felt like avoidance about talking about the here and now and she found that she had to talk more directly to avoid becoming too abstract and intellectual. She felt that metaphor was not that useful with borderline patients who struggled with reality testing, that those patients needed more grounding in reality.

She mentioned the challenges of working cross culturally in that one doesn't always know what others' associations are, what may be a benign helpful image for the therapist may not be for the patient. But not only culturally, what is difficult is knowing a person interior world and what is of value and importance and what isn't.

She referred to metaphor possibly breaking down when somewhere in the communication and discussion of metaphor, there was a miscommunication or misunderstaing, which could leave the patient feeling that the intervention, had been a therapeutic failure. She said that this could be worked with usefully in the long run.

CHAPTER 5

DISCUSSION, LIMITATIONS AND RECOMMENDATIONS

5.1 Discussion

The study undertook to explore therapists' understanding of the significance of metaphor and its usage in adult psychodynamic psychotherapy. With this in mind it became important to understand the extent and the diversity with which metaphor was used by therapists and patients. This included the question of its usefulness and in what ways if any, therapists perceived it to be a significant factor in impacting therapy in terms of outcomes or as a facilitator in the process of therapy.

5.1.1 The different ways that metaphor is used in adult psychodynamic psychotherapy

Therapists' accounts of how metaphor was used in their therapies reflected my own perception from the literature of the diverse and complex nature of metaphor. Metaphors were described as *as if* representations of feelings and experience in the study. One interviewee pointed out that on a meta-level psychoanalysis is metaphor because one is working at a level where experiences and everything else is as if it were something else (Arlow, 1979; Borbely, 1998; Lakoff & Johnson, 1980). Therapists used the concepts of dream, symbol and simile when referring to metaphor despite simile and symbol having their own distinct definitions (Arlow, 1979). In this sense, this sample of therapists represented the way metaphor is referred to in the literature and it was not until Arlow's definitions were unearthed that the pieces of the puzzle began to fit in a more integrated way for the researcher.

The research results revealed that significant use of dreams is made by patients and was highlighted by therapists as an important means of accessing patients' internal worlds or in other words, as supported by the literature as a means of gaining insight into the

dynamic transformation of unconscious wishes (Arlow, 1979; Freud, 1938; Jung, 1990). Of interest and perhaps a more unusual occurrence as evident by its limited appearance in the results, was that a couple of therapists dreamt about their patients. Both dreamt outside of therapy about their patients, where the literature hypothesized the dream to contain countertransferential elements that if carefully sifted out may be a highly productive means of gaining insight into the psychoanalytic process (Heenen-Wolff, 2005). One dreamed within the sessions in a Bionic kind of way consistent with Bion's idea in which the mother contained the infants expelled anxiety laden perceptions, sensations and feelings through what he called her reverie (Waddell, 1998a).

Interviewees referred to metaphor as symbolic representations evident in the images their patients brought, used sometimes in the language of therapy or in dream representations or paintings and pictures and in one unusual account in an LSD trip. These metaphors facilitated the understanding necessary to make meaning of their patients' experiences. Arlow (1979, p.378) referred to the analyst helping to complete the "unfinished gestalt" with the aid of the rich multi-layered meanings suggested by metaphor.

There were some instances in the results where metaphor, cited by Siegelman (1990) as the source of its power, was used by patients to access different aspects of themselves by engaging, at times, all the senses in a three dimensional way, constellating these in a way beyond the capacity of language. At other times, one or the other dominant sense was represented in metaphor depending, for example, on whether the patient was more visually based as an artist or auditory based as a musician. This was in keeping with Babits's (2001) view that also stated in addition, that it's usually the visual modality that is used in metaphor as this occupies the largest part of the cerebral cortex. In addition some therapists supported by Campbell & Enckell (2005) experienced patients using metaphor as a means to give expression to physical sensations that could not be articulated in any other way, while another felt that many of her patients drew on and used physical metaphors because in her experience, so many pathologies

were experienced physically and in this way expressing feelings metaphorically was very real for her patients.

All therapists emphasized in some way the importance of metaphor being used to aid communication between therapist and patient. They experienced their patients as using metaphor to explain, expand and elaborate on their feelings, facilitating a more succinct and unthreatening means of expression (Arlow, 1979). An understanding of these feelings could be achieved and worked through, it seemed, by the therapist and patient each bringing something of themselves, through the communication of their individual minds, as succinctly explained by one of the therapists and supported by Arlow (1979) who refers to the analyst as being a co-creator of meaning in therapy.

Perhaps the versatility of metaphor was highlighted by what appeared to be the contradictory views of the interviewees where on the one hand it was felt that metaphor enabled patients to own their feelings, on the other it was felt by therapists that the use of metaphor by patients meant that they didn't have to own their feelings, which made these feelings less threatening.

Some patients who found the expression of difficult emotion impossible at times reportedly communicated with their therapists indirectly through journal writing, often linked to material being worked with in therapy or to important life experiences occurring between sessions.

The elaboration of patients' metaphors for the purposes of interpretation**,** making what could be difficult to hear more tolerable seemed to be considered useful by therapists and is supported by the literature (Arlow, 1979; Babits, 2001; Zindel, 2001).

Therapists experienced metaphor as a psychotherapeutic language that is developed in the room between patient and therapist, a common language that facilitates coherence and therefore understanding (Babits, 2001; Shields, 2006; Winnicott, 1971). They felt that this language became a shorthand that both parties used and were comfortable in knowing

the other understood, and could be drawn upon as a quick and succinct means to articulate feeling states. Babits (2001) and Zindel (2001) felt that this shorthand was useful in that words did not often do justice to affective meaning, which originated in the body.

In addition it emerged that metaphor is the language of the unconscious, clearly articulated by one of the interviewee's when he said that as psychoanalysts one is trying to access the unconscious which has no metaphors, and it is therefore the words associated with *like* that become symbolic representations of the unconscious. The literature elaborated on this a little further mentioning that it was the verbalized conscious ideas, experiences and affects that were representative of their unconscious counterparts (Freud, 1952; Marshall, 1999).

A couple of therapists' felt that words themselves, as symbols were metaphors and that language was therefore metaphoric. Arlow (1979) would state that metaphor is more closely aligned to figurative speech, which is the way people access, and express language, which in itself is a system of significant symbols. This again exposes the complexity and multi-layered nature of metaphor and perhaps points to the reason why therapists in the study, and across the literature use generalities because the specifics are somewhat buried beneath layers of meaning.

Therapists highlighted the therapeutic relationship as being fundamental to the facilitation of patients' capacity to use metaphor during therapy (Bion, 1993a; Winnicott, 1971). They also used metaphor to describe what this relationship was like as well as to describe what was being done in the space.

Therapists most often referred to the containing function of the therapeutic relationship (Ogden, 2004; Shields, 2006). A couple of therapists spoke specifically of the metabolizing function of the therapist where thinking was encouraged by links being made between the here and now of the therapy, if working in the transference**,** or otherwise between what was happening presently in the persons life and what had

happened as an infant. One is made aware once again of the overlaps between Winnicott and Bion and at times Freud's thinking by his (Bernstein, 2005) contention that the transference is a playground in which the repetition compulsion is given free reign, an area between illness and health through which the patient must journey.

Therapists, supported by the literature (Gargiulo, 1998; Holm-Hadulla, 2003) also referred to the importance of their own ability to play within the space and to allow their patients to play which as one therapist pointed out, introduced a fun element into the therapy for the patient. Another therapist in discussing the importance of therapists' willingness to play stated that this is because metaphor is playful but also highlighted the importance of playing in a serious way. Holm-Hadulla (2003) warned in addition that if therapists didn't play then all the knowledge they had gained over the years would be insufficient in their understanding of their patients because play in the potential space is not only the source of culture but also of meaning.

Consistent with findings in the literature, the study identified that therapists have a tendency to generate metaphor on behalf of their patients and that they found this practice to be useful at times (Arlow, 1979). A couple pointed out that theoretically this practice may be brought into question, as traditional psychoanalytic thought upholds the idea of therapists playing a less active role in therapy (Babits, 2001; Freud, 1950). The interviewees felt that despite this, its usefulness was too difficult to dismiss.

Consideration for the uniqueness of the individual, also thought of as important by Freud (1950) and Winnicott (1971), and relating the metaphor to patients images or to where the individual was at in their lives and in the life of the therapy, were identified as important points to be conscious of when deliberating on what and when to offer patients metaphor (Cox & Theilgaard, 1987; Kopp, 1995; Siegelman, 1990).

The reasons given for this metaphoric generation by therapists related to the facilitation of understanding, being able to offer something outside of the gambit of language, the opening up of new channels of thought, the making of interpretations more powerful,

helping patients to access something they have been struggling to access and the provision of an image that patients could hold in mind and make meaning of.

Countertransferential issues appeared to play a significant role in influencing the generation of therapists' metaphor. What emerged was the importance of being aware of this potential influence due to ones own life experiences, and as one therapist pointed out, ones own theoretical biases and prejudices. Bernstein (2005) and Gabbard (2007) extended this to include the influence of authors, teachers and supervisors. Gabbard (2007) supported the interviewees' caution by stressing the importance of allowing theory to inform one but not dictate the process of therapy so that the patient could re-invent himself or herself whenever they entered the room. Continually self-reflecting despite the inherent difficulties associated with the subjective nature of this was considered important by one of the therapists so as not to impose aspects of self at the expense of the patients' actual experience and feeling (Holm- Hadulla, 2003).

A quarter of therapists interviewed used their own preferred metaphors in relation to their patients' material. It appeared however to be more unusual for therapists to use specific preferred metaphors of their own because they felt that this would negate the uniqueness of the individual, making it more about the self of the therapist and as one therapist pointed out that there was no creativity for her in doing this. Therapists seem instead to work with preferred metaphoric themes. Examples were given of metaphors being generated from themes such as the mother/infant, children, pasts and presents, water, related specifically to difficult emotion, and metaphors related to the theme of the challenging nature of therapy.

5.1.2 The extent to which metaphor is used in adult psychodynamic psychotherapy

It would appear then that therapists in practice use metaphor extensively. This is interesting and appropriate perhaps in view of the current resurgence of interest in the concept. As pointed out by therapists, language in itself is metaphoric but beyond this,

therapists mentioned their understanding of metaphor being the language of the unconscious and considering the philosophy underlying psychoanalysis that one is trying to access the unconscious of the patient then one may consider that therapists are working metaphorically most of the time, a view supported by Ogden (1997). Certainly therapists made extensive use of metaphoric terms such as containing, linking and playing, and mentioned specifically the importance for them in helping patients make links between aspects of their lives in the present with those in the past. This would help them tolerate such things as anger and frustration and in such a way further the development of the capacity to symbolize and to start thinking for themselves (Bion, 1993a).

All therapists referred to generating metaphor for their patients and felt that their own countertransferential feelings could influence the content and timing of these. Siegelman (1990) is of the opinion that any therapist who is in touch countertransferentially is thinking metaphorically most of the time, which implies therapists' emersion in metaphor, which may explain why many of them in the study reflected their difficulty in separating out metaphor from the process of therapy. They reported using metaphor unselfconsciously and spontaneously, that it just happened and that it was engaged with naturally.

One interviewee in particular mentioned that she felt that the personality of the therapist might be influential in the extent to which metaphor is used in general. This is consistent with Ogden's (2007) belief that it is more than technique that one can assume an analyst to have acquired, that it is an analyst's style of working which will determine the nature of the environment in which she works. This includes the uniqueness of her personality evident in the way she thinks and uses metaphor amongst other things.

Therapists appeared to be aware of their own love of metaphor as a choice over the normal language of therapy and some warned about being enticed by it inappropriately. If one looks at the language they used to describe it one becomes aware of its seductive nature (Zindel, 2001). Metaphors were described as gifts to be unwrapped, as quite beautiful at times, as very appealing and interesting, as facilitating the inducement of a

high when there were breakthroughs in therapy, as helping get across thoughts. In preferring beauty to ugliness one therapist expressed how her use in therapy might help her feel more comfortable, to sanitize therapy in a way, while another expressed how fortunate that so many of her patients were creative and expressed themselves symbolically.

5.1.3 The role of metaphor in determining outcomes or as a facilitator in the process of therapy

It was hard for therapists to articulate the role of metaphor in determining outcomes because first of all they were uncertain as to how to define outcomes and secondly it was felt that outcome is determined by the meaning people make of themselves and their lives and this is sometimes at odds with where therapists thought they were, and thirdly because therapy is made up of a combination of so many different factors that may influence an end result such as individual experiences, references, interpretations and therapist regularity and honesty.

The literature appeared divided on whether outcomes were about change or not and if so whose responsibility this was (Adams, 1997; Cox & Theilgaard, 1987; Kopp, 1995; Siegelman, 1990). That the outcome of play was the generation of new metaphors, that patients lives were re-authored which allowed for the provision of new experiences and responsibilities and enabled them to view themselves differently (Winnicott, 1971; Zindel, 2001). Therapists' views of the impact of metaphor in the study fitted along the continuum of not instrumental in moving the process of therapy forward, to it possibly speeding up the process of therapy, to it being beneficial and adding value, to it definitely helping outcomes, to it being a crucial part of the process of making links and creating coherence and in moving a process of change powerfully. Therapists' overriding sense appeared therefore to be that metaphor was a useful and beneficial part of the process of therapy but not instrumental in isolation. It could be used in a moment, left, then brought back, then abandoned.

Its effect on the process was given as being most pronounced when giving feedback through interpretation in a non-persecutory way (Arlow, 1979; Babits, 2001; Zindel, 2001) and also as a container for the patients' experience (Babits, 2001).

In addition therapists referred to a particular metaphor having been generated in the space as a transitional object which patients took away, thought over and processed, held onto and metabolized over time. They also referred to the space itself as being a transitional object, where patients internalized various aspects of the therapy that they could use outside of the therapeutic space in times of crisis for example. An example that comes to mind is the patient who struggled to express herself emotionally but would borrow her therapists books as transitional objects and later began cutting roses from her own garden to put on her desk at work similar to the way her therapist kept roses on her table in the therapy room, this behavior emerging as she began to internalize aspects of her therapist.

These findings were consistent with Winnicott's (1971) understanding that the transitional object represented the union of the nurturing mother and the infant, that it indicated the beginning of the separation between mother and infant and allayed fears in this separation but only if the mother who was internalized was real and alive enough.

Extensive support from the literature has been given for the contention that the capacity to symbolize is a developmental achievement dependent on the quality of the mother/ infant relationship. According to therapists in this study, the extent to which patients used metaphor depended on where they were at developmentally. Concrete thinkers who employed defenses such as intellectualization or whose capacity to think had become arrested through complex and difficult life circumstances benefited from the process of therapy which moved them towards a capacity to symbolize and use metaphor. Therapists felt that all patients had the potential to use metaphor unless they suffered from severe cognitive impairment and that the capacity to symbolize depended on the nature of the therapist/ patient relationship and the consequent degree of containment and holding that was experienced in therapy (Babits, 2001; Bion, 1993a; Shields, 2006; Siegelman, 1990; Winnicott, 1971). Even though everyone has the capacity to symbolize, it was suggested

that this would be done differently in different people, the example was given of a poet who it was felt would use metaphor differently to say a packer at Checkers. From other examples it was shown how people with extreme difficulty of expression such as one of the interviewee's schizoid patient's who made use of non-verbal means such as journal writing to express himself and another patient who made an effigy to express her rage. It was suggested that some of the reasons given for the inability to symbolize were attachment difficulties, the lack of the metabolizing part self, patients having been discouraged from thinking or from having feelings, an intrusion or a defensive process of blocking (Bion, 1993a; Winnicott, 1971).

Therapists unanimously felt that metaphor was a creative way to work requiring not only the creativity of the patient but also that of the therapist. They referred to both their own and their patients' ability to play in the room, to allow themselves to play with their patients' metaphors and to allow their patients to play with their own metaphor, to have a safe and containing space of their own in which to do this. One is reminded that Winnicott (1971) said that the space couldn't be productive unless both the analyst and patient could play. He described play as creative and as the core of the experience of reality in childhood and in art and culture.

In many ways therapists pointed out the usefulness of metaphor but certainly as part of a process the researcher was interested in finding out what happened to the metaphors generated in therapy. She was interested essentially in the limitations to its use if any. Interviewee's opinions were varied and interesting and as such an attempt will be made to include most of them. They felt that the danger in using the same metaphor repeatedly could mean that it could get stuck in some way. If used frequently as shorthand and left unchecked, patient and therapist could find that they were talking at cross-purposes because the patient had moved on. Also if patients always brought dreams for example, this defensive manner of working would not allow the space for other things to emerge. Siegelman (1990) elaborated on this saying that it was dangerous to make exclusive use of any particular type of interpretation whether in content or form mentioning dreams, metaphor or even the transference because they then lose their spontaneity and

authenticity. This use of metaphor as a defense was expanded upon in the study by it being mentioned that metaphor may lose its usefulness when the *like* cannot be stretched any more, when it becomes stale and denuded of emotion. One of the therapists pointed out that there are times when it is not useful with certain patients such as borderline patients where during micro-psychotic episodes they need to be more grounded in reality. The literature however suggested that the displacement element of metaphor might be used to ward off anxiety in for example, these and psychotic patients, which makes for an interesting debate. Especially pertinent to the South African context and not covered much in the literature, was that a couple of therapists found that working with metaphor could be limiting cross culturally. Their particular concern, also pointed out by Doctors (2002) was that one might impose ones own associations from a cultural or historical perspective or offer what one might see as a benign helpful image, not being perceived as such by the patient. Finally, as mentioned previously, in Zindel (2001) and Siegelman's (1990) experience, there was danger in being lured into the use of metaphor due to its seductive nature.

5.1.4 Conclusion

This study has attempted to reveal the different ways that therapists and their patients use metaphor and seems to have also exposed the richness and versatility of this multi-layered, multifaceted concept. Most therapists felt that it was a significant factor in the facilitation of the process of therapy but found it hard to isolate it in terms of its potential to determine outcomes. They were also clear that despite its usefulness in first of all being created as an expression of difficult feelings and emotions and then as a playful means through which difficult issues could be unpacked, elaborated upon, left for a while, then referred back to, there was also a time when it lost its usefulness as patients moved on in their intra-psychic worlds.

Of particular interest, the controversial nature of an aspect of metaphor, first appearing in the literature, was that therapists, despite being psychodynamically trained and adhering in many ways to traditional psychodynamic theoretical beliefs, generated metaphor for

their patients. Traditionally one is reminded that Freud's (1950) analyst is only a facilitator of meaning and understanding because one as the therapist can never possibly get to the deeply held ideational and original symbolic material of the patient. Similarly Winnicott and Balint (Ogden 2007) cautioned the therapist in knowing too much or in feeling pressured to deliver the correct interpretation as this may be foreclosing on the patient's making sense of their own internal world. Finally Bion felt that therapists' "abandonment of all memory, desire and understanding" (Ivey, 2004, p. 30) was an essential discipline, as failure to achieve this would result in the "steady deterioration of the powers of observation whose maintenance is essential" (p.25).

From the study however, and supported by theory was therapists' firm assertion that the relevance of metaphor to patients material and the timing of its delivery had to be considered. If not, we know from theory that this could amount to indoctrination and the destruction of being from a Winnicottian (1971) perspective and the generation of anti-thought and attacks on the link between the patient and therapist from a Bionic (Ivey, 2004) perspective, resulting in the use instead of symbolic equation.

It has been clearly articulated in the literature and by the interviewees that the danger in using therapist-generated metaphor is the extent to which it may be informed by ones own countertransferential feelings which even upon reflection are difficult to discern as they are influenced by the myriad of ones own life experiences, preferences and prejudices and may be largely unconscious. Interviewees were open and honest and aware that the language of metaphor may seduce them and thereby place an unusual emphasis on it in the work with their patients. A few therapists also warned that imposing ones own metaphors or associations on ones patient's material could be colored by ones own cultural and historical beliefs, particularly in the South African context.

Research has begun to explore patients with similar diagnoses using the same metaphors. It has been suggested that further exploration in this area would not only facilitate a better understanding of that diagnosis but also a process of recovery from it (Schoeneman, Schoeneman & Stallings, 2004). This did not appear as a major theme of this study as

interviewees were unable to recall any particular group of patients that used similar metaphors. This is perhaps related to as one of the interviewee's put it, psychotherapists not being that good at categorizing people.

Research to date hasn't focused on therapists use of preferred metaphors and by presenting therapists thoughts on this, perhaps this research is contributing in some new way to the body of knowledge in this area. While a quarter of therapists interviewed used their own specific preferred metaphors with certain patients, the rest didn't. They admitted instead to working with metaphors generated by themselves that were related to certain themes, the dominant theme being that of the mother/infant. I suppose it may be argued that this in itself may limit patients to being in a certain way while foreclosing on the opportunity to re-invent themselves in other ways. Could it be argued then that therapists are in this way allowing theory to dictate rather than inform the process of therapy (Gabbard, 2007)? They certainly seemed to find it useful, as did their theoretical predecessors, to language psychotherapeutic processes using metaphor. Does this not highlight Spence's (1982, as cited in Adams, 1997) concern that one will always use metaphor because it is fundamental to understanding, but that one may also be used by it if one adopts theories that are constituted by it? Of course one could criticize this research in its choice to focus on the individual theories of Sigmund Freud, Donald Winnicott and Wilfred Bion for doing the same thing.

Upon reflection of this research process, it struck the researcher that all therapists interviewed referred to the theorists she had chosen to base her research on to the exclusion to a large extent of others. This despite her as having only mentioned to one interviewee prior to the interview that she was interested in using Freud as part of the theoretical basis for this research.

This realization induced the re-reading of interviews to try and understand how this had transpired, if in essence they had been led on through the nature of the questions, which may have been biased in favor of the researcher's own influence and preference. It was discovered through this exercise that half of the therapists had already referred to Freud,

Winnicott or Bion at the very beginning or close to the beginning of their interviews. While there were a couple of instances where a leading question may have asked by reframing slightly something they had said, in all cases it seemed that the researcher hadn't had a chance to say much by then or hadn't apparently directly referred to any of the theories by hinting at terminology, for example.

The question still remained and forced the researcher to then reflect of her own countertransferential processes during the interviews. Through this process she became aware that seven of the eight therapists had given examples of mother/ infant metaphors generated by their patients. She wondered if the possibility could exist that her own countertransference had induced therapists to comply with what they thought her expectations were of them, just as their countertransference had the potential to instill compliance in their patients regarding the metaphors they brought (Gabbard, 2007). That indeed metaphor is the language of the unconscious, the unfathomable depths of which we will never truly know but are only given a glimpse of through the metaphors we bring in our dreams, the transference and other unconscious processes.

5.2 LIMITATIONS OF THE RESEARCH AND RECOMMENDATIONS

It has been pointed out that adopting a particular theoretical stance that is defined by metaphor may dictate rather than inform, may open up enquiry but also shut it down (Adams, 1997). This is certainly a difficult position to find oneself in as a researcher and perhaps what is important is to be aware that one may be used by metaphor rather than use them (Adams, 1997; Jung, 1990; Lakoff & Johnson, 1980), in a sense that one becomes seduced by them, not allowing for other possibilities to emerge. While the choice of specific theories that certainly are defined by metaphor were chosen as a basis of this research and as such may have been a limiting factor, it was endeavored at all times to allow therapists to express themselves and explain the way they worked in an unbiased manner.

Some of the interview questions may however have been leading at times, related to the researcher's own reading of the literature in an attempt to identify prominent themes. In choosing to use psychodynamic therapists in the study, ethical considerations regarding confidentiality may have become a limiting factor. Due to the sensitive nature of the material that the research required therapists to divulge, none of them were quoted directly, which then required the re-writing of all the responses. Despite trying to remain as close to the phrasing and wording used by therapists, the possibility exists that something of 'them' was lost, the unique manner in which they articulated things that was so much part of who they were was gone. It was also felt that some of the richness of their accounts was lost.

Perhaps the most significant limitation of this research is that it did not address the multi-cultural diversity of working within the South African context. Although this was not a selection criterion, the sample were all white men and women working within the greater Johannesburg area who were culturally very similar to the researcher and therefore metaphorically able to communicate in a way that we all knew and understood. This did not allow for alternative experiences with metaphor to be explored and is a significant limitation to this research. Therapists mentioning the difference and possible difficulties in understanding that would arise in working with people from different historical and cultural backgrounds has however highlighted the potential for the development of new research in this area. Every culture has its own symbols that have been used to express 'eternal truths' and may engender deep emotional responses in individuals, functioning in a similar way to prejudices. They cannot be ignored or dismissed by psychologists, as they are vital components in the structuring of human society (Jung, 1990). To this end, this study has highlighted the sensitivity with which therapists should work, which otherwise might result in therapist and patient talking at cross purposes.

With a view to facilitating this process of communication, future research may add value by exploring in greater depth the extent to which therapists' countertransference may influence patient compliance or indeed resistance on an unconscious level, evident in the metaphors they bring (Gabbard, 2007).

The literature called for a theory of metaphors in therapy appropriate to the metaphors patients bring in dreams, the transference and other unconscious processes and to consider under what conditions and purpose the generation of metaphor by therapists is most useful (Adams, 1997). While this has been touched on in this research, a deeper exploration may or may not give psychodynamic therapists permission to play a more active role in therapy, which appears to be the trend emerging within the community anyway.

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Appendices

Appendix A: Interview consent form

I_____consent to be interviewed by Tracey Rainier for her study exploring how psychodynamic therapists understand and work with metaphor in adult psychotherapy. I understand that:

- Participation in this interview is voluntary.
- That I may refuse to answer any questions I would prefer not to.
- I may withdraw from the study at any time.
- No information that may identify my patients or me will be included in the research report, only pseudonyms will be used and my responses will remain confidential.
- I acknowledge that when talking about my own therapy sessions I am bound by confidentiality to protect my own patients.
- There will be no use of direct quotes.
- There are no risks and benefits to myself

Signed _____ Date_____

Appendix B: Audiotape consent form

I _____ consent to my interview with Tracey Rainier for her study exploring how psychodynamic therapists understand and work with metaphor in adult psychotherapy, being tape-recorded. I understand that:

- All tapes will be stored in a safe place for the duration of the study.
- Access to the tapes will be restricted.
- All tape recordings will be destroyed after the research is complete.
- No identifying information will be used in the transcripts or the research report.

Signed _____ Date_____

Appendix C: Participant information sheet



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Dear

My name is Tracey Rainier, and I am a clinical psychology Masters student conducting research for my degree at the University of the Witwatersrand. My area of interest is an exploration of the understanding of the significance of metaphor and its usage in psychodynamic psychotherapy. This will involve an enquiry into how psychodynamic therapists understand and work with metaphor in adult psychotherapy. I would greatly appreciate your input and participation in the research.

This would entail being interviewed by myself, at a time and place that is convenient for you. The interview will last for approximately one hour. With your permission this interview will be recorded in order to ensure accuracy. Participation is voluntary, and you will not be advantaged or disadvantaged in any way for choosing to participate or not participate in the study. All of your responses will be confidential. No information that could identify you or your patients would be included in the research report and only pseudonyms will be used. You may refuse however to answer any questions you would prefer not to, and you may choose to withdraw from the study at any point. The written material will only include that which has been negotiated and pertains to the research.

You will be asked to sign research participation and recording consent forms if you agree to participate. The tapes used in the interviews will be carefully safeguarded for the duration of the research and destroyed on completion of the research report. The results will be disseminated in a research report which once complete will be housed in the university archives and will be made available to you if you so desire. The research report may be published.

Partaking in the research has identified no risks and there will be no additional benefit to yourself.

If you choose to participate in the study please fill in your details on the form below.

Yours Sincerely

Appendix D: Interview schedule

1. Perhaps it is pertinent to begin with an understanding of the ways in which metaphor has manifested over time in your work
2. Can you describe in as much detail as possible an example from your therapeutic work in which a metaphor emerged that was relevant to the patient's material?
3. How did the metaphor emerge from your interaction with the patient?
4. Did you use or work with this metaphor directly? If so, how, and what effect do you think this had on the process?
5. Do you find yourself using favorite or preferred metaphors with a number of patients? If so what are these?
6. Do you find different patients spontaneously producing similar metaphors? If so, what are these?
7. When metaphors suggest themselves to you, are these in any way related to your countertransference experience? If so, how?
8. Do you have experience of patients who don't produce metaphors in therapy? If so, how do you understand this?
9. a. Do you find that the use of metaphor has a role to play in determining outcomes and if so, what is this role?

   b. Has there ever been a time where the use of a metaphor has broken down? Can you describe this experience?
10. Is there any issue related to the emergence and use of metaphor in psychotherapy that you feel I have not addressed or that you would like to elaborate on?