Understanding Clinical Metaphors from an RFT Perspective

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Journal of Contextual Behavioral Science 3 (2014) 305–313

Contents lists available at ScienceDirect

Journal of Contextual Behavioral Science

journal homepage: www.elsevier.com/locate/jcbs

RFT for clinical use: The example of metaphor

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Why this Type of Analysis is Important

- A key challenge for Contextual Behavioural Science (CBS) is to draw together understanding and developments in RFT and ACT

- Hayes et al. (2012) suggested a reticulated model as a way to do this

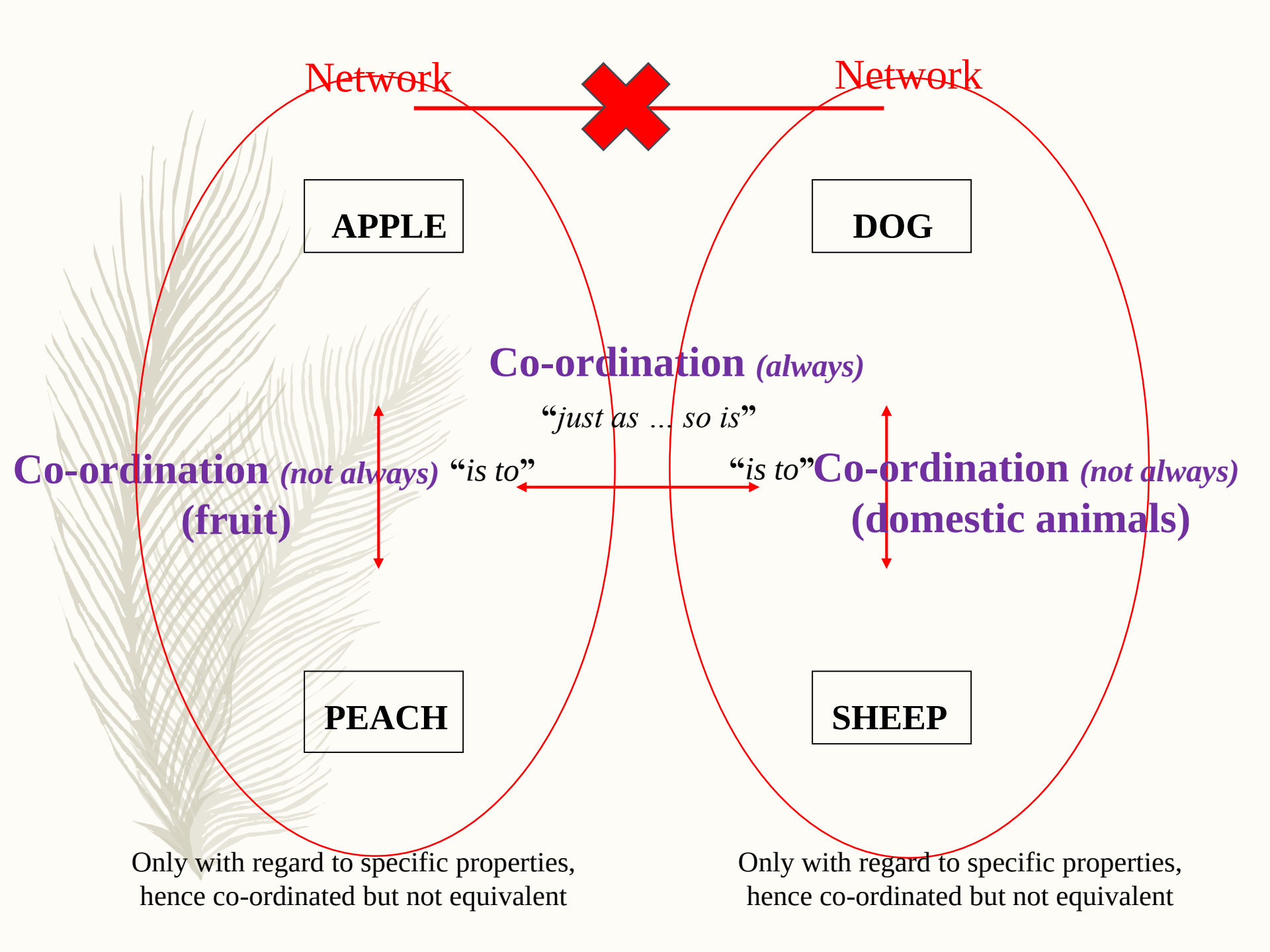
- But the necessary experimental work in RFT is not yet in place (e.g. no empirical basis for an RFT account of fusion and there may never be)

- Foody et al. (2014) argued that a *fourth* generation of RFT research is necessary for this, the *application* of RFT's conceptualisation of analogy and metaphor is part of this agenda

Understanding Analogy & Metaphor

- For RFT, the concept of ***relating relations*** is the basic process underlying the understanding and construction of analogies and metaphors

- As early as 1997, Barnes, Hegarty and Smeets proposed a model of analogical reasoning that involved responding in accordance with equivalence-equivalence relations (i.e. the relating together of derived co-ordination relations)


Network
Network
APPLE
DOG
Co-ordination (always)
"just as … so is"
Co-ordination (not always)
(fruit)
"is to"
"is to"
Co-ordination (not always)
(domestic animals)
PEACH
SHEEP
Only with regard to specific properties,
hence co-ordinated but not equivalent
Only with regard to specific properties,
hence co-ordinated but not equivalent

Analogy vs. Metaphor

- Often used interchangeably
- For RFT, analogy is denoted when two networks not normally co-ordinated are co-ordinated
- But remember that in analogies, functions do not transfer from one network to the other (e.g. functions of fruit do not transfer to domestic animals)

Analogy vs. Metaphor

- Whereas metaphor is denoted when one network is used to represent or highlight specific features of another network (e.g. cats are like dictators)

- Hence, features of one network are transformed in accordance with features of the other network

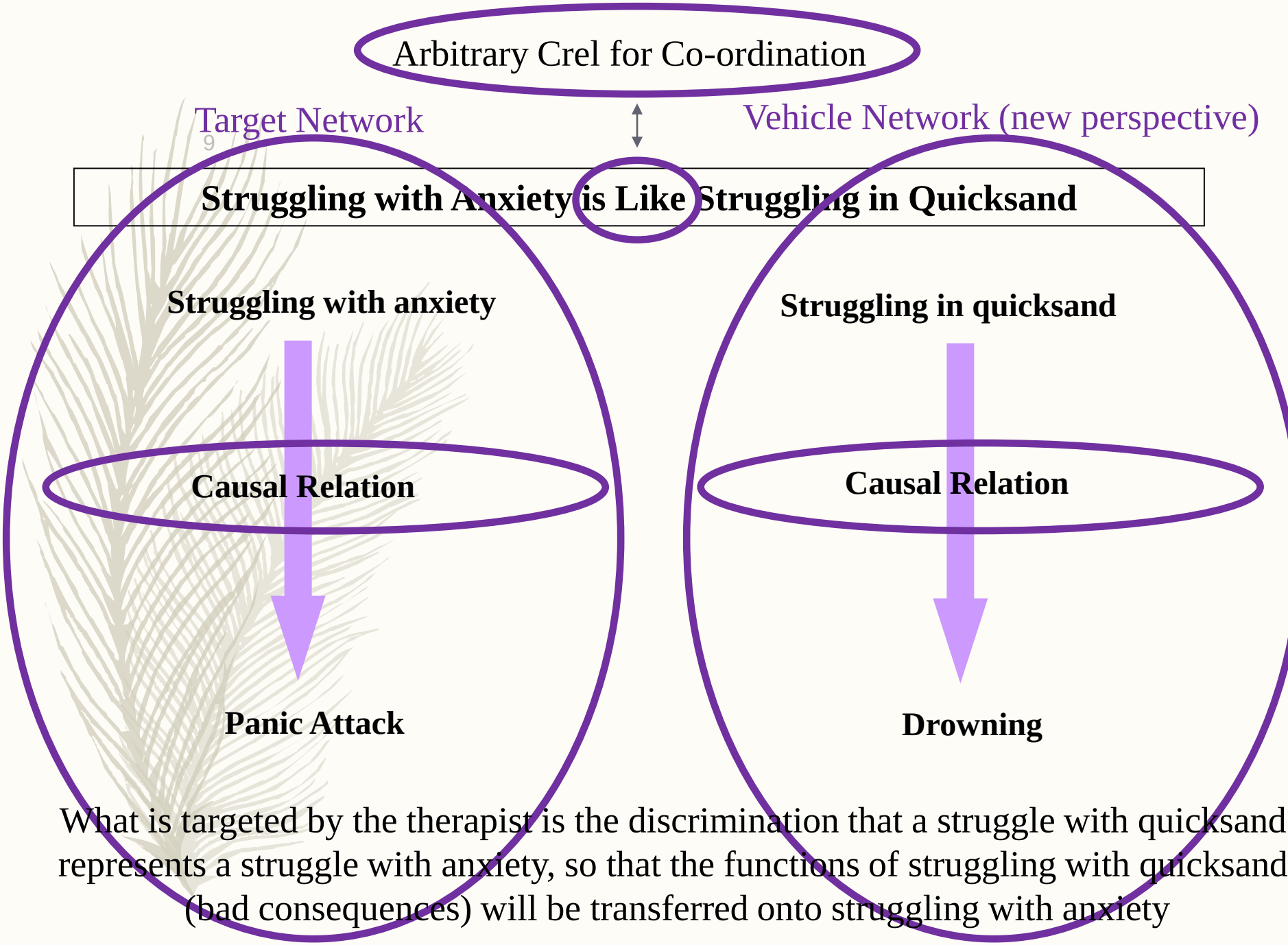
- This suggests that the relations in a metaphor are more complex than in an analogy

- Stewart and Barnes-Holmes (2001) argued that the two stimuli within each network in an analogy are interchangeable (e.g. apple and pear could switch places), but this is not the case in metaphor

- Indeed, these relations typically involve hierarchy within the networks (‘dictators are like cats’ doesn’t work so well)

Using Metaphor in Therapy

- Metaphors (rather than analogies) have long been used in clinical practice
- Three common objectives are as follows:
  - Validate the client's experience
  - Enhance client awareness of her situation
  - Highlight possible 'solutions'
- In ACT, metaphors offer a verbal context that likely minimises the transformation of existing literal functions (i.e. less fusion), but RFT proposes that much more is at stake



What is targeted by the therapist is the discrimination that a struggle with quicksand represents a struggle with anxiety, so that the functions of struggling with quicksand (bad consequences) will be transferred onto struggling with anxiety

Making a Metaphor Work

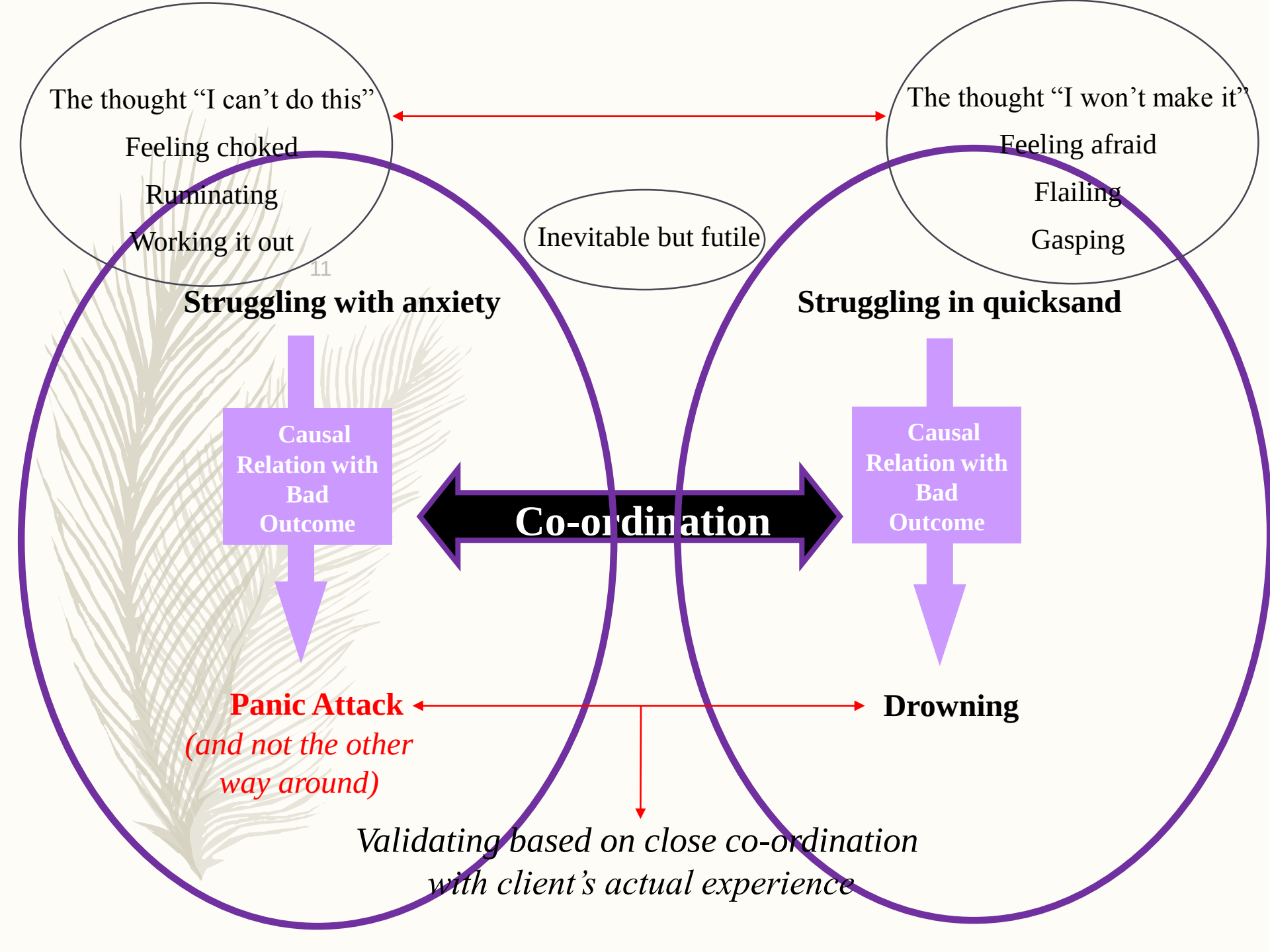
- The client must have a history based on which she can abstract the co-ordinated properties between the two networks (i.e. must know what quicksand is and how it works)

- The target behaviour must be very salient (this metaphor is about how you react to anxiety and not about the feelings themselves)

- The therapist must be able to specify clearly what she means by the metaphor "working"

- For example, the quicksand metaphor could be used initially to introduce the client to a novel focus on reacting to anxiety (i.e. just drawing the parallel between anxiety and quicksand), rather than exploring anxious feelings

- Or, this metaphor can be used to draw the parallel and to add to this the causality relations that can also be specified in this metaphor, when it is used at its most full


The thought "I can't do this"
Feeling choked
Ruminating
Working it out
The thought "I won't make it"
Feeling afraid
Flailing
Gasping
Inevitable but futile
11
Struggling with anxiety
Struggling in quicksand
Causal Relation with Bad Outcome
Co-ordination
Causal Relation with Bad Outcome
Panic Attack
(and not the other way around)
Drowning
Validating based on close co-ordination with client's actual experience

Understanding Analogy & Metaphor

- The initial aim of all clinical metaphors is to point out something not previously seen by the client (i.e. by relating an issue to something it is not typically related to in language or experience)

- In functional-analytic terms, this presents **an alternative perspective** on the target issue and usually on some aspect of the client's behaviour (e.g. struggling with anxiety)

- The extent to which this new perspective also accommodates the client's actual experience is very important

Constructing Good Clinical Metaphors

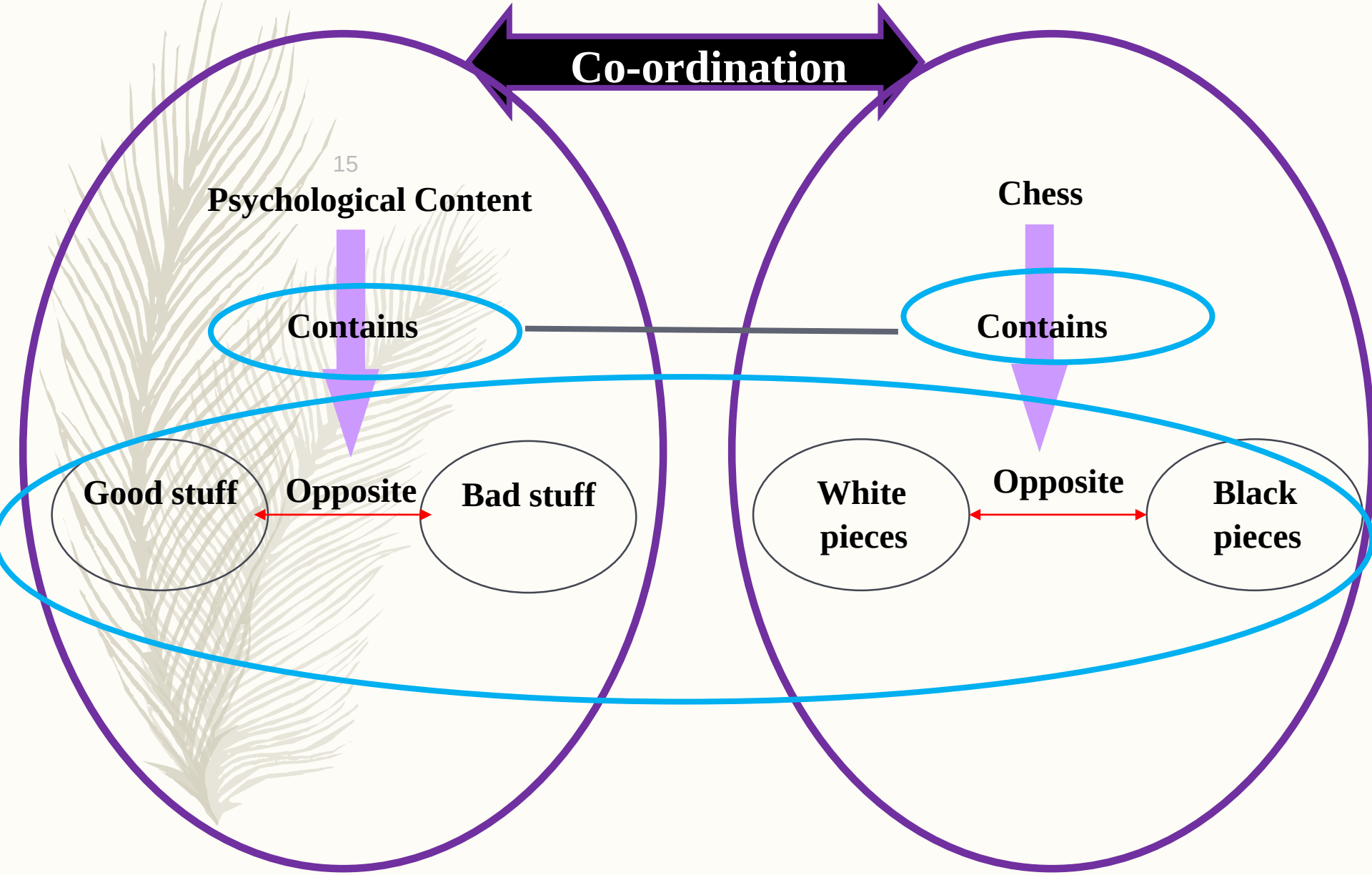
- Many metaphors are designed to simply create a shift in perspective that will thereafter facilitate a change in behaviour

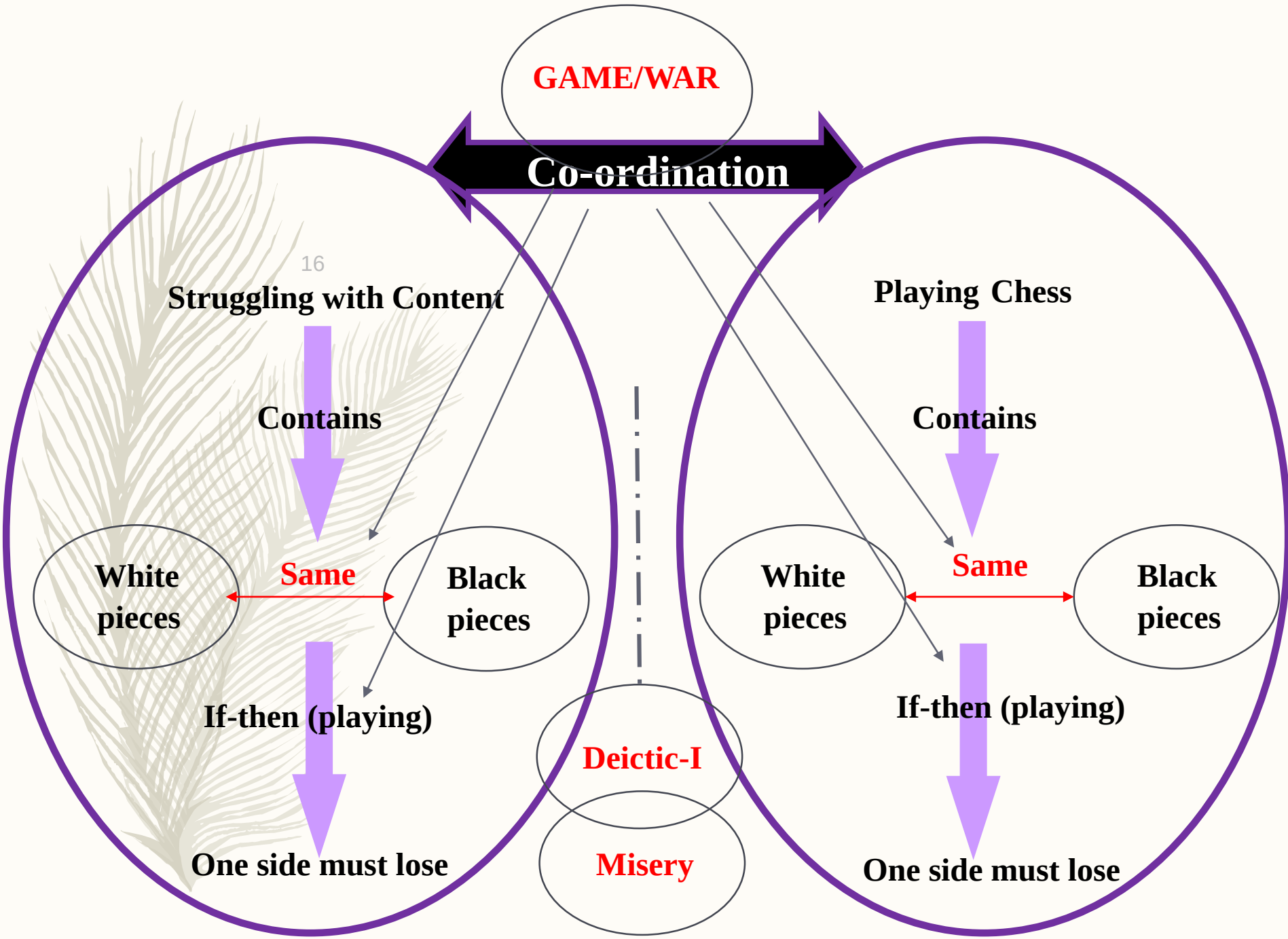
- In these cases, the metaphor does not contain ‘a solution’ (stopping struggling may or may be derived from the quicksand metaphor, especially not initially)

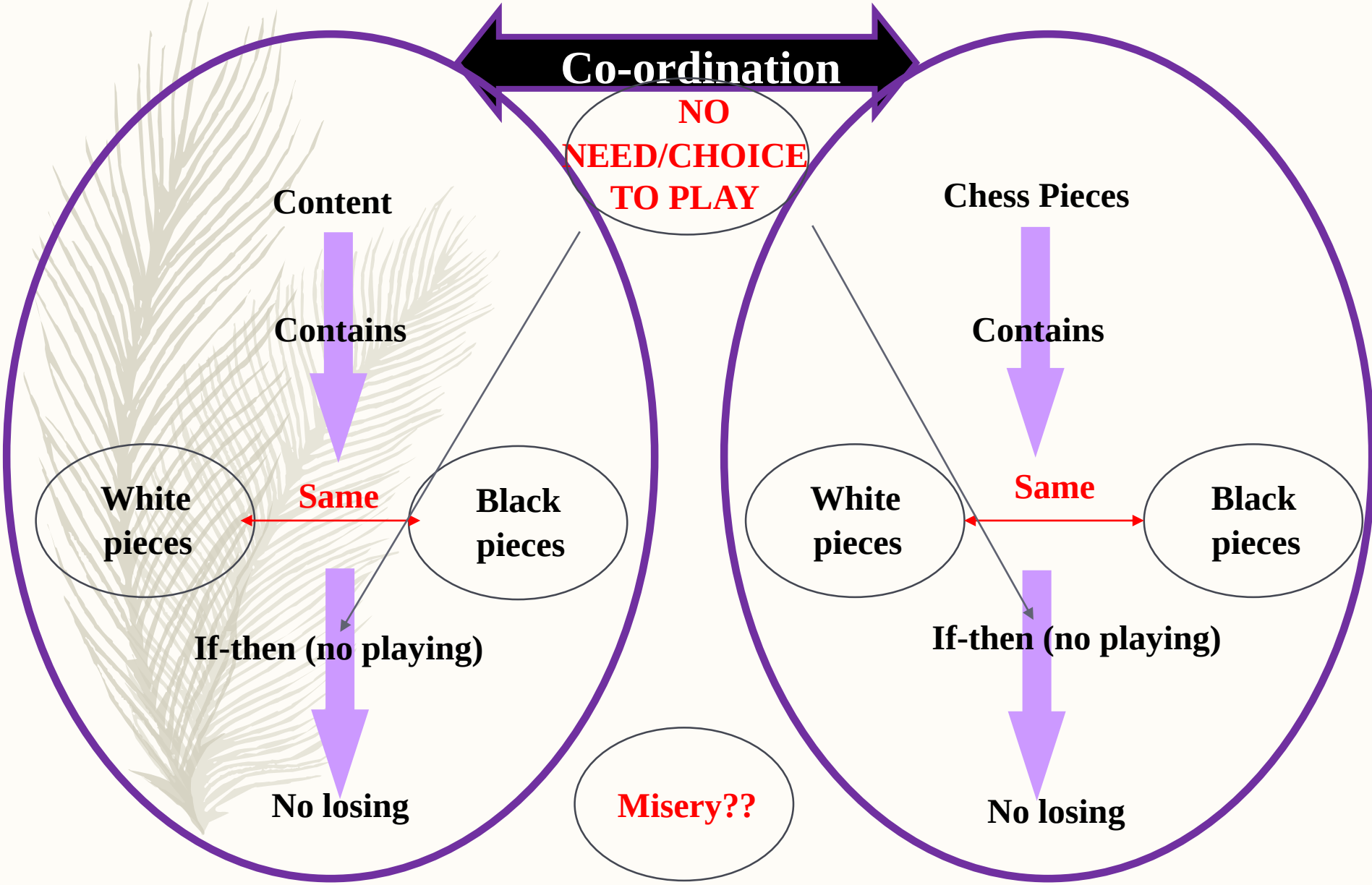
- Some of the more complex metaphors, like the Chessboard, have both a shift in perspective (playing either black or white is still damaging and miserable) and a solution (you can operate at board level and not play even when you hold the pieces)

The Chessboard

It's as if there's a chessboard going out in all directions *(covering all psychological content).* It's covered with black and white *(opposition relation)* pieces that work as two teams *(opposition relation),* where the white pieces fight *(strong language)* against the black. Think of your thoughts as these pieces, they hang out in teams too. For example, "bad" feelings (e.g. anxiety) hang out with "bad" thoughts. Same with the "good" ones. The way the game *(describes how client reacts to content)* is played is that we select which side we want to win *(implies that one team will lose)* and put the "good" pieces (e.g. feeling self-confident) on one side and the bad pieces on the other. Then we get up on the white queen and ride to battle, fighting to win the war against "bad" content. It's a war game *(language intensifies opposition relation)* and huge portions of yourself are your own enemy *(language intensifies opposition relation).* Sometimes the more you fight, the bigger the pieces seem to get *(causality relation).* So you try to knock them off the board, to dominate them instead. Except your experience tells you that the opposite happens. You have a sense that you can't win. Yet living in a war zone is a miserable way to live.

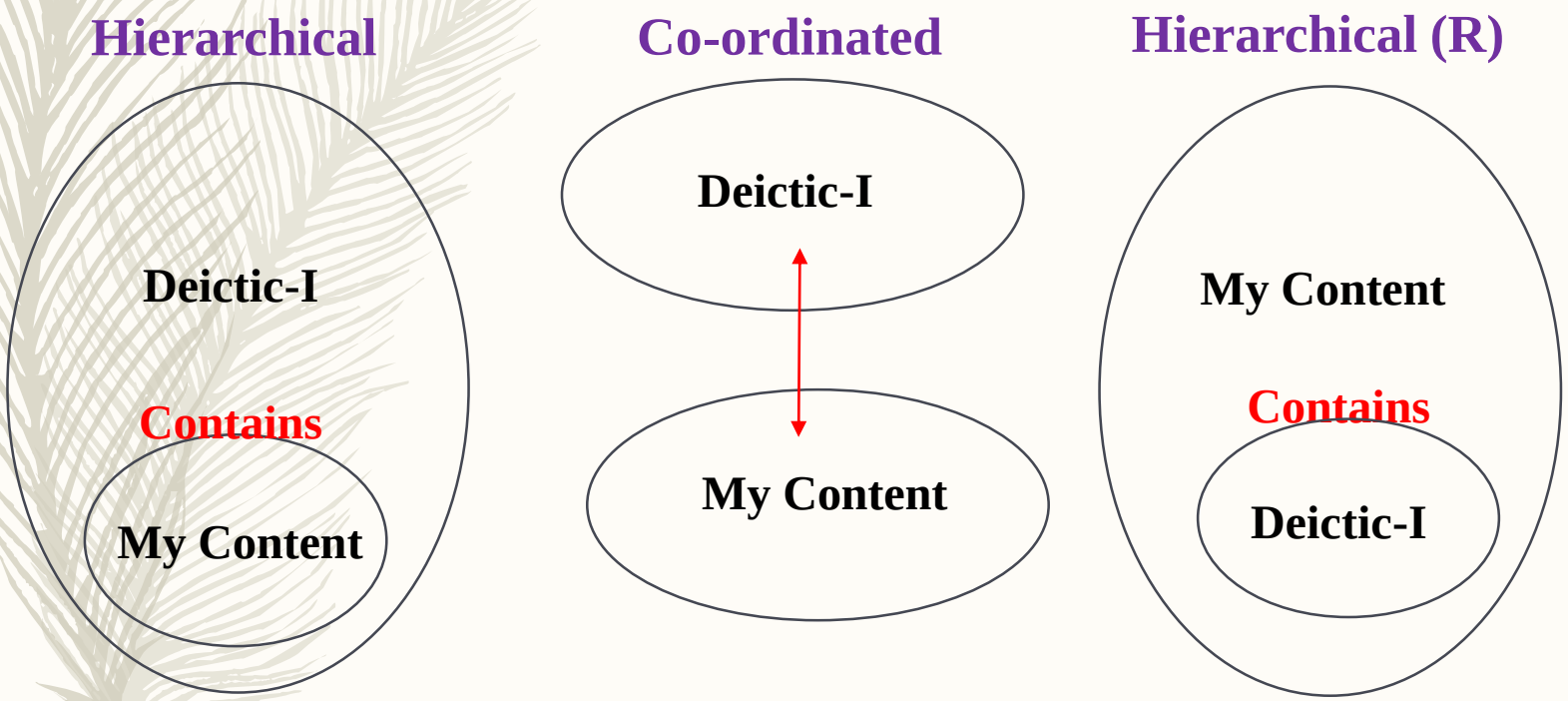

Co-ordination
Psychological Content
Contains
Good stuff
Opposite
Bad stuff
Chess
Contains
White pieces
Opposite
Black pieces


GAME/WAR
Co-ordination
Struggling with Content
Contains
White pieces
Same
Black pieces
If-then (playing)
One side must lose
Deictic-I
Misery
Playing Chess
Contains
White pieces
Same
Black pieces
If-then (playing)
One side must lose


Co-ordination
NO NEED/CHOICE TO PLAY
Content
Contains
White pieces
Same
Black pieces
If-then (no playing)
No losing
Misery??
Chess Pieces
Contains
White pieces
Same
Black pieces
If-then (no playing)
No losing

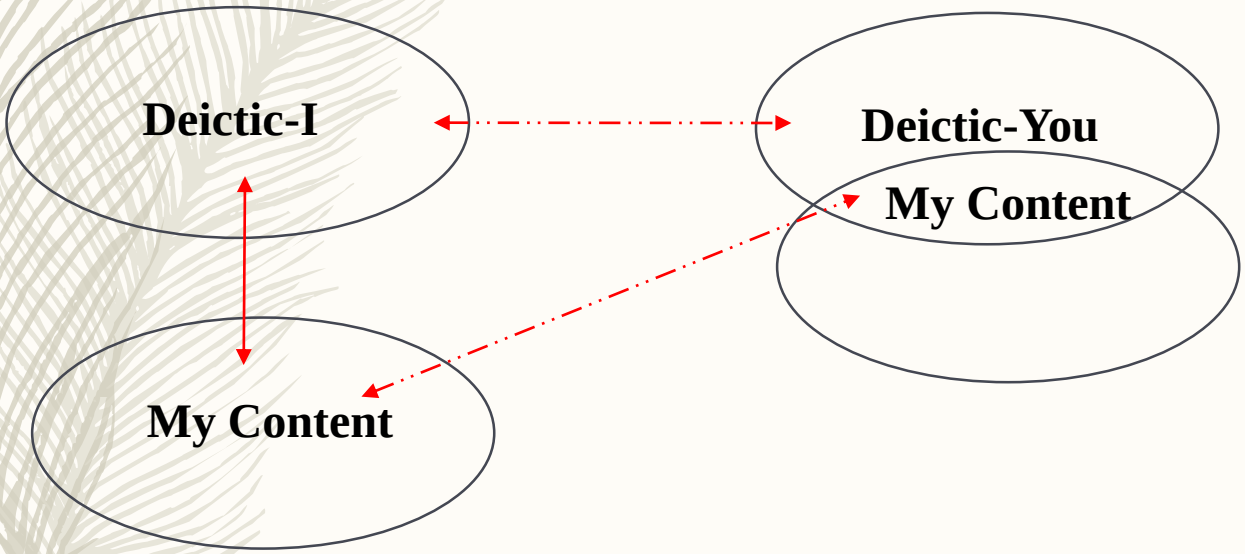
Shifting Perspective with Metaphors

➢Let's look first at the relationship between the deictic-I and one's own psychological content



Shifting Perspective with Metaphors

- We can do a functional analysis of the shift in perspective that occurs in metaphors



- You can see what I see from over there

Shifting Perspective with Metaphors

- If you can see (from there) what I see (from here):
- You and I can be co-ordinated in some way (potentially validating, empathetic, etc.)
- What I have must be something to have because it can be seen by someone else (validates presence of content)
- If I was you, I would see it from over there (different)
- If you were me, you would see if from over here (same, validating reactions)

Do's and Don'ts with Clinical Metaphors

- Do: determine very precisely the target issue/behaviour
- Don't: try to include too many target issues/behaviours
- Do: make sure that your understanding of the target is clear and accurate
- Do: ensure that the client's history will support the target derivation
- Don't: go ahead if you're not sure

Do's and Don'ts with Clinical Metaphors

- Do: determine the new functions that will transfer from the vehicle to the target
- Do: be wary of possible additional derivations/functions that you had not thought of
- Do: be attentive to whether the metaphor had the impact you planned
- Don't: ask clients directly, get them to summarise or try to explain it
- Do: try to expand metaphors that worked well with that client (e.g. adding a resolution/behaviour change piece to an initial discrimination piece)