Sheffield Hallam University

‘Development and Evaluation of a pictorial metaphor technique in Cognitive Analytic Therapy’

James B. Turner
Sheffield Hallam University

Submitted in partial fulfilment of the award of Doctor of Philosophy (PhD) at Sheffield Hallam University on the 27th May 2016

Minor amendments completed 2/11/16

Contents

List of abbreviations

ACAT – Association of Cognitive Analytic Therapy	RRP - Reciprocal Role Procedure
AR - Action Research	RH – Right Hemisphere
BPD – Borderline Personality Disorder	SDR - Sequential Diagrammatic Reformulation
CAT - Cognitive Analytic Therapy	QL - Qualitative
CBT – Cognitive Behavioural Therapy	QT – Quantitative
CMT – Conceptual Metaphor Theory	RCT – Randomised Control trial
FDT- Focused Dynamic Therapy	SEBD – Severe emotional behavioural disorder
LH – Left hemisphere	6PSM - Six Part Story Method
MH – Mental Health	SMH - Somatic Marker Hypothesis
MSSM- Multiple Self States Model	TE - Therapeutic Encounter
NT- Narrative therapy	TP - Training Programme
OR - Object relations	Ucs- Unconscious
Pa – Psychoanalysis	ZPD - Zone of Proximal Development
PM - Pictorial Metaphor	

Abstract

This research has explored and evaluated the use of metaphor and pictorial metaphor (PM) in Cognitive Analytic Therapy (CAT). A four part action research, mixed methods enquiry was designed and administered to explore, qualify and measure the use of a pictorial metaphor technique as part of the therapeutic encounter in CAT. The technique arose intuitively from the author's clinical practice and had received positive feedback from individual patients and CAT therapists. In CAT metaphor is a recognised clinical focus yet there has been no systematic study of the development and effects of working with metaphor and especially PM.

Study1 involved utilising a workshop and focus groups method across the CAT community at a number of regional, national and international conferences. A concurrent review of the available literature following a 'Topical or narrative' review methodology, to capture a wide base of literature, was undertaken. Study2, a Delphi study of expert practice, was managed across the CAT international community. Initial interest was gained from n=101 CAT therapists with a return rate of n=48. Study3 articulated the results of the Delphi and the literature review into a training programme 'resource material' delivered to a number of study groups. Evaluation questionnaires were completed and a follow up reflective questionnaire sent to participants who opted in. The follow up questionnaire was designed to capture responder's reflections on utilising the technique in their clinical work. Study4 involved a pilot of a pre and post training self-assessment the 'MaP-SELF' measuring participant's perceived competence in working with metaphor and PM.

Study1 realised general support for the direction of the research with some preliminary cautions and process considerations to take forward. One of these was recognising working with 'art' is a deliberate step; the therapist being the 'drawer' may be a challenge as art is usually generated by patients. Study2 developed unique insights into metaphor and pictorial metaphor extracting 76 unique statements for rating that considered ways of working with the topic. A number of insights as to the process and function of metaphor were achieved alongside important practice considerations and some answers to dilemmas arising from Study1. Study3 developed, evaluated and refined a workshop and associated training materials that were designed to support therapist's recognition and skill in the application of metaphor and PM in their clinical work. Analysis of evaluations and reflections found that it was possible to extend practitioners skill in this area. Attendees in workshops were better able to recognise and work with PM and were able to generate 'PMs' at the end of the workshop. Importantly Study3 extended the metaphor practice to include a heterogeneous group of counsellors which provided a reference point for the use of the technique in the wider therapeutic community. Study4 provided useful insights into the effectiveness of a self-assessment alongside further workshop evaluation. Analysis supports the self-assessment as a useful tool finding a perceived increase in self-efficacy in the PM technique.

Results support the PM technique as accessible to participants, focussing their thinking as part of the therapeutic encounter. Responders valued metaphor and PM as a way to develop the relationship, generate insights and stimulate recall of problem procedures. Participants rated the workshop favourably and found them encouraging in increasing their skill level. Importantly workshops validated their current practice and increased confidence. The self-assessment had utility as an assessment as well as a guide for best practice.

Declaration

No portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other University or other institute of learning

A note on language

A significant body of literature uses the term ‘patient’ as opposed to ‘client’ or ‘service user’ so patient has been adopted as the descriptor for this research. However, there remain 18 mentions of client within the tables and consent bundles as this was the term the researcher used to communicate with responders.

Acknowledgements

My Supervisors

Ann and Sarah…I remember you saying at one point ‘we are gunning for you’ whilst this has two metaphorical interpretations; one being the support to attain my aims the second being to be more focussed…the way in which you have supported me has been inspiring. Thank you both. To Ann especially, you have stayed the course and I thank you for your honest appraisal and comments on the final thesis as it emerged.

At Work

Andrew Garth, your magical understanding of SPSS and statistical analysis was the rock upon which many torturous hours of data washed…thank you for your generosity of time and your understanding.

Helen Turner, your nimbleness and in-depth knowledge into the workings of EXCEL saved me hours of frustration and pain.

Trish Neilson thank you for the proof read; your attention to detail has been a great resource.

My CAT and CRUSE colleagues

I am indebted to the openness and energy generated by the participants at the workshops and subsequent data collections and wish to convey my thanks for their warmth and generosity of time in generating ideas, understanding, direction and data for this study.

My Family

You lot are just great, a pleasure, fun to be with, a challenge and I love you all dearly…this has been a difficult journey and one fluctuating between having to fit in with you rather than you fit in with this and vice-versa…so it has taken longer than I expected. Thanks for growing up, being so lovely, and recognising the need for me to complete this.

Chapter One: Introduction

Background to researcher's interests

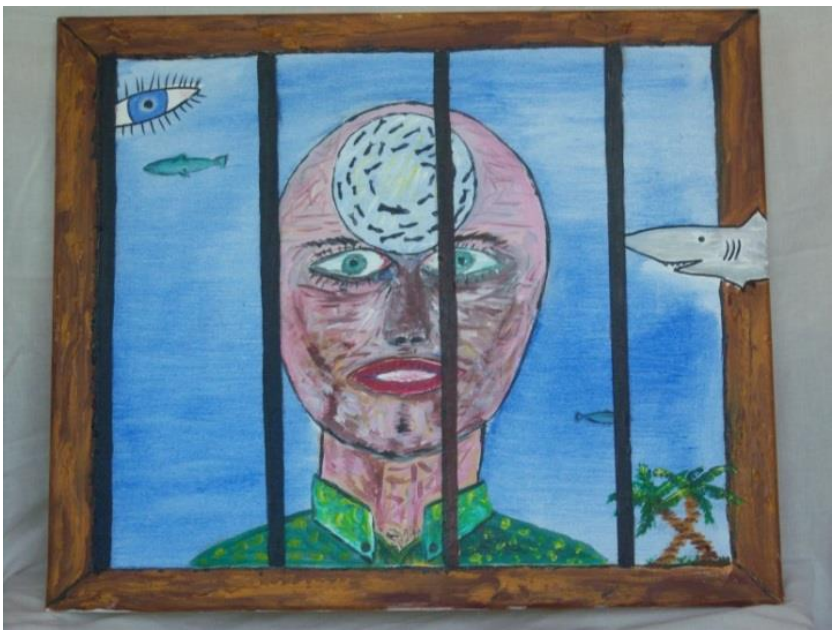
This action research (AR) study is unique, setting out to deliberately explore, qualify, disseminate and measure the use of metaphor and a Pictorial Metaphor (PM) technique as part of Cognitive Analytic Therapy (CAT). This technique has arisen intuitively from the authors' clinical practice and has received positive feedback from patients in 'standard' CAT therapy experiencing a range of mental health (MH) problems/diagnosis. The technique has also been explored in the wider Therapeutic encounter (TE).

I confess I am fascinated by metaphors and PM's. I have spent a third of a century working within the TE and increasingly I find paying attention to metaphors can be beneficial in therapy. However, the more I read and the more I work with them the less sure I am as to how exactly they help and more importantly the steps taken in utilizing them in the TE. In particular, I am interested in the process involved in developing a collaborative metaphoric 'picture' that appears to have saliency for managing the TE. I have an intuitive understanding of how to use metaphors and pictures and manage them, but have never received any training, or prior to this study read in any depth about their use. I am interested in the processes involved in both working with metaphor and with PM and whether one can be 'trained' in this technique.

Case vignettes

From an early stage patients have been involved in the development of the PM as it is their therapies represented in the images and their therapies that have developed the research question for this thesis. Many patients make comments in their goodbye letters on the usefulness of the PM to enable recognition of their problem procedures. Others have generously given informed consent and permissions for their comments and pictures to be used for this research. For their voice to be heard it seems reasonable to provide an explanation of the development of the PM through the patient's voices and pictures.

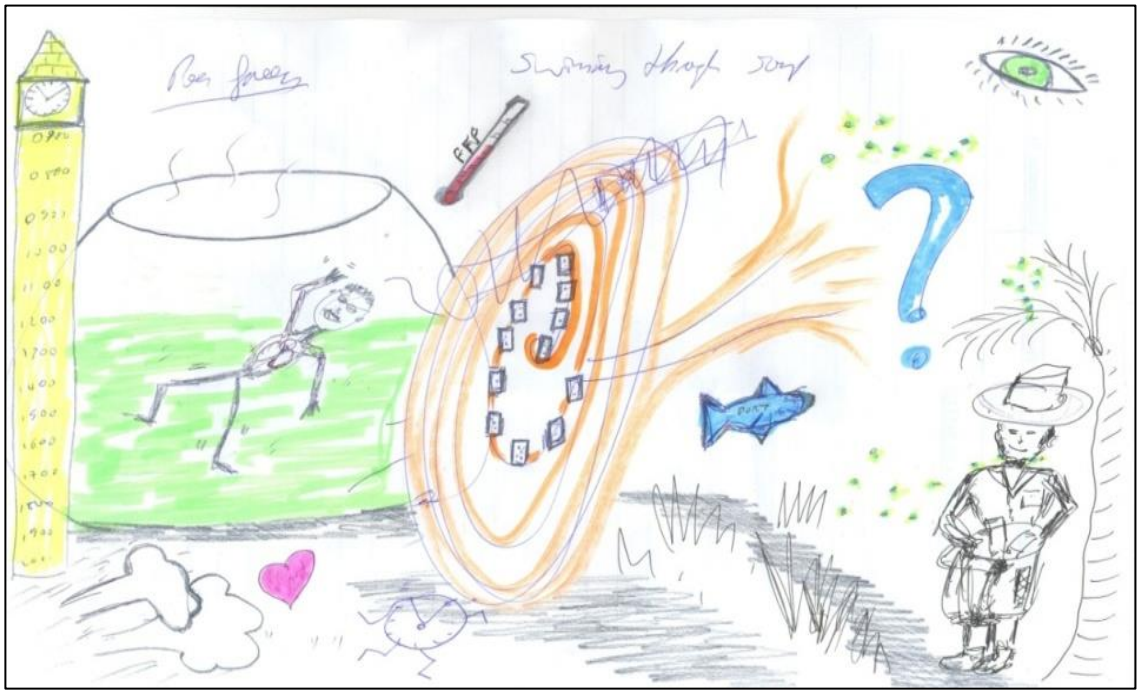
Case example 1 – The ‘Bait Ball’



This picture represents one of the first times I drew with a patient. Reproduced is a scan of a painted example of a ‘PM’ for one patient (they are normally fairly rudimentary sketches). The picture was collaboratively co-constructed in therapy sessions and came to represent the patient’s mental state and defence procedures. The researcher, with the patient’s permission, made a sketch of images based on the patient’s metaphoric utterances that appeared to speak of his psychological distress. He was undertaking a standard CAT for anxiety. The metaphors were generated spontaneously in therapy and appeared to enable him, through the working through of the metaphor and metaphoric images to visualise his difficulties and to move forward and see more clearly how he was reacting to distress. The patient described being trapped in a cage with danger all around, hoping for something better (the palm trees) but spinning in his mind in defence of himself.

We understood his response to the outside world as being dangerous and his automatic response likened to being a psychological ‘bait ball, spinning around in anxiety hoping not to be picked off. He was a keen watcher of nature programmes and in an episode of the ‘Blue Planet’ by David Attenborough he had seen a shoal of herring circle into a tight ball to protect themselves from assault and described this to the researcher as if this was how he was trying to cope. It didn’t seem one had to have any particular skill in representing the metaphor image, just that there was some form of representation agreed between the therapist and patient. This approach seemed to enable therapy and so the researcher added this ‘technique’ to his options in therapy and has subsequently frequently used this PM method with patients to facilitate the TE.

Case example 2 'Swimming through soup'



Patient 4 had significant problems with anxiety. It seems appropriate due to the richness of the patient's voice to explore this metaphoric picture as he generously contributed a commentary to explain his picture…

> *'The diagram 'Swimming Through Soup' came about in the initial stages of my therapy…Jim drew some of the elements that we agreed were strongest images that I used and then added various elements throughout the sessions as we progressed. The central image, for example, came from a description that I used of struggling through anxiety and depression as being like 'swimming through thick soup'. 'The other key element of a vortex, came about when I described feeling as if I was getting sucked into a whole and flung out into an terrifying, isolated place. Added to this were illustrations of anxiety related aspects from my daily life such as the perception that 'time was running away' and a thermometer, based on my feeling physically overheated in situations of perceived anxiety and stress'*

The picture emerged from the space between us, from his words which were drawn. Each week the words led to a new depiction on the paper. The colour was added from the limited pallet the therapist had in his pencil bag. He further noted…

> *'As I progressed through the therapy process I identified some images that described my overcoming of this initial 'swimming through' and these were depicted by Jim and positioned at the 'other end of the vortex'. The image of the fish, for example, came from the idea of a fish that is able to keep on swimming, regardless of difficulties it encounters. The image of an explorer emerged towards the end of the sessions in an answer to a question from Jim as to how I now perceived myself, having gone through the process of therapy; in this case I perceived myself as being ready to venture into the potentially exciting realm of the unknown, complete with a 'toolkit' that I could use to examine and help any psychological problems that I found flaring up in myself.'*

These case studies and my developing practice led me to consult widely on the direction of this research, with CAT colleagues, and the wider therapeutic and nursing community. In dialogue, in a 1-1, or in a group discussion, there seems to be support for their use and benefits (NB: Appendix I outlines publications and conference presentations undertaken as part of this research). There is a significant body of literature noticing and describing many different approaches to working with metaphor and pictures in Therapy. However, whilst there have been a number of research studies looking at metaphor in psychotherapy there appears to have been no systematic study into the development and use of working with metaphor and PM in CAT

My interests in the therapeutic encounter, and the use of metaphor, as a nurse, a therapist and an academic, has led me to my current studies. Over the course of my nursing career I have maintained a keen interest in the effects and application of models of intervention in order to foster and support a TE. I consider my career to have been a novice to expert journey (Benner 1984). Whilst developing as a nurse leader and academic I have progressed as a therapist. I have maintained my focus completing a number of 'academic' programmes and therapeutic trainings including CAT Practitioner programme, Humanistic Counselling, Interactional Dynamic Psychotherapy, Group Analysis and Cognitive Behavioural Therapy (CBT). I have had the opportunity to lead and develop therapeutic intervention services completing research and audit on the effectiveness of these:

- CAT and Community Teams (de Normanville and Kerr 2003, Thompson et al. 2008)
- Clinical Supervision (Turner and Hill 2011, 2011a, Hill and Turner 2012)
- Medicines Management (Turner et al. 2007 and 2008, Hemingway et al. 2012)
- Anger management (Turner and Macintosh 2010)
- Cancer and bereavement Care (Wilson et al. 2015, Turner and Wilson 2016)

My career interest in the creative use of the therapeutic encounter to bring about change, use of exercise and sport, use of humour, use of the relationship and use of creative and art based approaches provides a focus. This distinction is important in the light of current challenges to nursing and therapy education, to be technical and science oriented, rather than art based. As McIntosh and Sobiechowska (2009) note, 'the use of the creative arts and humanities in the education of the human caring professions is being eroded away in favour of technical-rational reasoning' (p295).

Tradition of psychotherapy and creative therapies in Nursing

As a Nurse my therapeutic approach is built on a long tradition and strong foundation in therapeutic and creative interventions based on a number of writers such as Peplau, Lego, Altschul, Barker, Skellern and Forchuk.

Hildegard Peplau (1909-1999) is considered one of the founding 'mothers' of psychiatric nursing and was one of the first published nursing theorists after Florence Nightingale. She revolutionised the scholarly work of nurses, herself contributing greatly. Peplau (1986) noted that nurses have generally recognized competence in counselling due to their professional preparation viewing the relationships as having four stages, orientation, identification, exploitation or working phase and a phase of resolution and termination. Peplau (1952) sees nursing as an 'educative instrument, a maturing force that aims to promote forward movement of the personality in the direction of creative, constructive, productive, personal and community living' (cited Forchuk 1989, p35). What allows this growth is the nurse-patient relationship.

Suzanne Lego (1939-1999), an influential leader in nursing, did not question whether mental health nurses *did* psychotherapy but *how* they do it. Lego (1980) describes the nurse patient relationship as having emerged post 1946 as the 'years of fulfilment' leading to programs of education for psychiatric nursing being implemented. She (Lego 1998) further explores Peplau's contribution to group therapy and is a significant contributor to the importance of the nurse patient relationship over the decades of the evolution of mental health nursing.

Annie Altschul (1919-2001) is seen as one of the pioneers of psychiatric nursing research. Her work into the nurse patient relationships and her confirmation of the importance of attachment theory led to a distinguished career and her influence is maintained today. Altsch8ul led a pioneering contribution into the role of the mental health nurse and incorporating developing knowledge of psychology into the filed (Altschul 1957 and 1962) alongside group dynamics (Altschul 1964) and the process of nursing (Altschul 1978). She is seen as being one of the nurses who developed the core aspect of the nurse as therapeutic agent (Winship et al. 2009). Her existential approach has been developed more recently by Phil Barker who has been instrumental in developing the first recovery model of metal health. His tidal model (Barker 2001) has influenced my practice and his *Craft of Caring* (Barker 2008) is as fine an example of the importance of the therapeutic relationship and creative approaches to supporting patients as one can get.

Eileen Skellern (Winship et al. 2009) is seen as having made a significant contribution to mental health nursing. She contributed significantly on the nurse patient relationship, therapeutic communities and the management of stress in nursing and set up the first ever international congress for psychiatric mental health nursing in 1980 (Winship et al. 2009). The annual 'Skellern' award for life time achievement recognises contribution as to the profession and has led to some notable recipients. Cheryl Forchuk, a recent recipient of the Skellern award, is a current leader in reporting on the nature and value of the therapeutic relationship in Nursing. Her work spans a considerable time period with notable contributions on observing the development and establishing factors in the nurse patent relationship (Forchuk and Brown 1989), bridging the hospital community separation (Forchuk et al. 1998, Forchuk et al 2005), the experience of patients of nurse therapeutic interventions (Coatsworth-Puspoky et al. 2006) and the importance of evidence based practice (Forchuk 2001). She comments that we need to ask questions in order to illuminate our practice (Forchuk 2001) which is what this thesis is attempting to do.

It is interesting to note that each of these authors, in their various writings, have reflected and integrated the work of Peplau into their commentaries, an example of her far reaching contribution to the nurse patient relationship. There are many important facets to managing a positive therapeutic relationship, many being drawn from the Humanist tradition of Karl Rogers and Abraham Maslow. Humanistic perspectives advocate core conditions of empathy, warmth, unconditional positive regard and congruence. Managing these core conditions creates a space for emotional growth, and engender a positive force, a sense of love and belonging to provide motivation for change (Rolfe 1993). Roger's approach clearly identifies a range of interventions but he never lost some of the analytic approaches he initially trained in.

Heron (1993) progressed Rogers' work with his Six Categories of Counselling Interventions describing the therapeutic encounter as 'a structured approach with a range of skills applied in the therapeutic encounter' (p4). Heron's (1993) focus is upon the 'intention' of the intervention, being divided into Authoritative and Facilitative supporting the therapist using confrontative interventions in a supportive relationship, which can enable the patient to change. Humanism is inherent within the development of therapeutic relationships which remains at the heart of mental health nursing (Hurley et al. 2006). These interpersonal skills that communicate a patient is valued and a nurse holds hope that their lives can change, are highlighted as important by patientss (Adam et al. 2003).

The relationship remains such a building block in managing the encounter in mental health nursing. I am, naturally drawn to understanding and exploring this. Our encounters offer opportunities for patients to understand and explore two distinct aspects of their psyche and I am interested in the way that art and creative approaches can enable change. The relationship enables, through the involvement of a benign individual (the therapist), the patient to clarify the confused nature of their internal world. I have a sense that creative approaches may facilitate the patients trust in their self-object. As Fonargy and Ryle (1995) indicate the relationship enables a 'view' and 'understanding' as to the nature of a patient's psychological world by appropriately constructing a formulation of the patients mind.

Aims and outline of Chapters

My foundations in working with and understanding the therapeutic encounter have led to this PhD study. I began my PhD thinking I was prepared for the rigour of the process. In one way I was, with secure foundations in therapy, research and leadership that enabled me to explore this subject. But in another I was wholly unprepared for the intensity and extended focus 7 years of study entailed. I have much to do still in my career and am looking forward to further exploring the topic of metaphor and the therapeutic encounter.

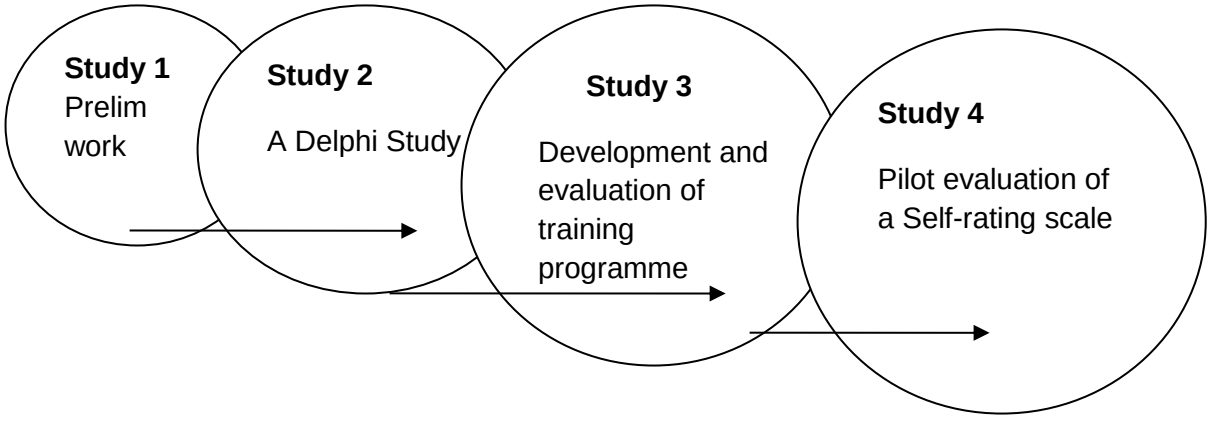
Psychological therapies research, in particular practice based evidence rather than evidence based practice, is seen as an important focus of health and related services research (Pettifer 2003). Change occurs in psychotherapy as naturalistic phenomena, as anomalies emerge, they act as if to undermine the dominant paradigms, because practitioners, not bound to underlying assumptions, ask questions (Hayes et al. 2004). Action research (AR) is about change, change is fundamental and important for humans to develop, understand, and progress and involves emotional processes that can enhance the study of organisations (Walsh 1996). Individuals have differing motivations for change and some have resistance (Dallos and Vetere 2005). Cognitive and integrative models described by Prochaska and DiClemente (1982) and CAT support change, there are steps to take: pre contemplation, contemplation (self and others), preparation, and action. Change needs energy and commitment and can be guided by change management philosophies. For example, '*Who Moved my Cheese'* (Johnson 1998), '*FISH*' (Lundin et al. 2000) and '*Our Iceberg is Melting'* (Kotter 2005) share similarities, such as adapting, generating energy, monitoring, valuing the organisational culture, changing the culture, and making change continue...making it stick.

Change and research meet with this researcher's topic, a number of research statements emerge…

- Is focussing on metaphor and PM a worthwhile therapeutic activity for CAT?
- Can noticing metaphor and working with it be enabling as a central theme?
- Can co-constructing this metaphor into a PM, i.e. drawing the patients problems using images generated collaboratively in therapy, be enabling?
- Can the PM, a representation of the patient's MH difficulties, have a direct relationship to the problem reformulation and SDR diagram?
- Can the patient use the PM as a 'short hand' or 'memorable image' to enable reformulation, recognition and revision of their problem procedures?
- Can this approach be taught effectively in a TP?

This AR has four studies or 'cycles' (Fig1). A 'proof of concept' cycle was initially planned but following advice from supervisors and the University's research community, it was considered post-doctoral work.

Fig1: AR Cycles



Aims

- To set out background considerations, through preliminary workshops and focus groups, as to the use of metaphor and PM in CAT.
- To critically analyse the available literature, context and approaches as to the use of metaphor and PM in CAT and psychotherapy.
- To consider and critique a range of approaches in the utilisation of metaphor and PM in psychotherapy for MH problems.
- To consider and critique a range of approaches in the cognitive psychology of the mind with particular reference to left and right brain influences on therapeutic work

for MH problems.

- To develop and evaluate a consensus through a 'Delphi' study of CAT practitioners internationally as to the ‘best’ use of metaphor in practice.
- To review and refine existing ideas and notions with respect to the PM technique.
- To develop, design and evaluate a TP and materials for CAT therapists into the use of metaphor and PM in clinical practice.
- To make recommendations for practice and future research

Chapter Outline

Chapter Two: Review of the Literature: Relevant literature to help frame and guide the study through a systematic ‘narrative’ review of the available literature encompassing four fields: ‘CAT’, ‘Metaphor in psychotherapy’, ‘PM in psychotherapy’, and ‘Cognitive Neuroscience and metaphor’.

Chapter Three: Methodological Considerations: Methodological and ethical considerations are proposed. A rationale for AR methods is postulated, as are the philosophical, ontological and epistemological underpinnings of the approach to knowledge and understanding.

Chapter Four: Study1 - Prelim work: An evaluation of preliminary workshops presented at CAT conferences with regional, national and international attendance, generated data for the exploration of the topic. Results provided support, guidance and direction for the continuation of this research.

Chapter Five: Study2 – A Delphi study of expert practice: A Delphi study using the CAT community as an ‘expert’ group. Delphi is an accepted method of developing consensus in health care settings and a ‘traditional’ methodological approach has been utilised in this study. A questionnaire from 48 responders generated 76 ‘consensus’ statements. Two further iterations were sent to responders.

Chapter Six: Study3 - TP delivery and evaluation: Methods, results and analysis of the development of a TP. The results of Study1 and 2 were triangulated with the literature and constructed into a ‘TP and materials’. This product was delivered to sample groups, a heterogeneous group of ‘therapists’ (Counselling and CRUSE) and three homogenous CAT groups. Evaluation used qualitative (QL) written reflections and quantitative (QT) questionnaire methods to evaluate the training materials.

Chapter Seven: Study4: From the study statements that achieved consensus in the Delphi, a self-assessment questionnaire entitled, 'Metaphor and Picture Self Evaluation Learning Framework' (MAP-Self) was developed. This chapter discuss the findings of a pre and post workshop administration of the MAP-Self.

Chapter Eight: Discussion and Recommendations: Chapter eight discusses the study, with conclusions and recommendations drawn from the literature, results of the studies, and recommendations made for practice aligned against the study research statements.

Summary and Rationale

Evidence based practice is increasingly in demand within the NHS and professions allied to health. Psychotherapy research has a role to play in informing such practice (Roth and Parry 1997). Metaphors have been explored in Nursing (Hartrick and Schrieber 1998; Wurzbach 1999), Medicine (Domino et al. 1992, Jenny and Logan 1996, Luker et al. 1996), Education (Czechmeister 1994; McAllister and McLaughlin 1996) and the TE (Jacobs 1998, McIntosh 2010). McIntosh (2010) supports the view that metaphor and the nature of metaphor in dialogue, is worthy of study and has utility in the way it is conceptualised from a range of differing theories.

The researcher has set out to explore, qualify, develop, and measure the use of metaphor and PM in CAT. PM's are relatively inartistic and stick like, yet appear resonant of the patient's rich emotional content that the image relates to. A PM incorporates a number of psychological aspects of the patient, some images appear to be felt pain, others experience, and others are change oriented. They are representations of the patients' metaphoric language, images associated with language. This approach is considered a specific and deliberate technique in CAT, an elaboration of the model, and as such this research aims to understand this in detail and contribute to the developing body of knowledge in CAT and hopefully the wider TE. I hope I can shed light on this topic, support and challenge my own perspectives and provide valuable learning for others to critique. Research of this nature is a complex and difficult journey but I feel it is important to understand the steps I, and others are taking in developing and expanding knowledge in CAT and the TE. We need to be sure about what we are doing and continue to do no harm. I am aware findings may or may not support what I am intuitively doing. Either way, what is important is a systematic study and undertaking it in such a way as to be critical of each step and each finding, in order to enable a balanced viewpoint to emerge.

Chapter Two: Review of the literature

Literature review methods

McNiff and Whitehead (2011) suggest that for action research you must show you have reviewed and engaged with the literature, whilst Aveyard (2010) supports a comprehensive review of the literature where it is necessary to undertake a systematic approach. Dallos and Vetere (2005, p30) indicate psychotherapy reviews have four functions:

- What is the contribution of the literature review to the aims of the research, and how will it support the development of the research question?
- What is the main focus of the review and why?
- Where will the review be positioned in the various stages of the research?
- How will the conclusion of the literature review be integrated with the conclusion from the research?

This literature review aims to describe and critique the body of evidence relating to metaphor and PM, to inform and guide the research questions, aims and objectives. A systematic narrative approach to the literature review was adopted as this enabled a critique and summary of the literature noticing any gaps and inconsistencies in the current body of knowledge (Cronin et al. 2008, McCabe 2005). This approach provided a foundation for understanding metaphor in therapy by enabling source materials as well as empirical studies, such as theoretical debates, unpublished work and clinical commentaries, to be accessed, providing evidence relating to the experience of metaphor within the context of informed debate (Hawker et al. 2002; Greenhalgh and Peacock 2005).

A number of approaches to reviewing the literature were examined. Grant and Booth's (2009) typology of literature reviews (Fig2) summarises the strengths and weaknesses of fourteen reviews.

Fig2: Typology of reviews

Critical review	Aims to demonstrate writer has extensively researched literature and critically evaluated its quality. Goes beyond mere description to include degree of analysis and conceptual innovation. Typically results in hypothesis or model
Literature review	Generic term: published materials that provide examination of recent or current literature. Can cover wide range of subjects at various levels of completeness and comprehensiveness. May include research findings
Mapping review/ systematic map	Map out and categorize existing literature from which to commission further reviews and/or primary research by identifying gaps in research literature
Meta-analysis	Technique that statistically combines the results of quantitative studies to provide a more precise effect of the results
Mixed studies review/mixed methods review	Refers to any combination of methods where one significant component is a literature review (usually systematic). Within a review context it refers to a combination of review approaches for example combining quantitative with qualitative research or outcome with process studies
Overview	Generic term: summary of the [medical] literature that attempts to survey the literature and describe its characteristics
Qualitative systematic review/qualitative evidence synthesis	Method for integrating or comparing the findings from qualitative studies. It looks for 'themes' or 'constructs' that lie in or across individual qualitative studies
Rapid review	Assessment of what is already known about a policy or practice issue, by using systematic review methods to search and critically appraise existing research
Scoping review	Preliminary assessment of potential size and scope of available research literature. Aims to identify nature and extent of research evidence (usually including ongoing research)
State-of-the-art review	Tend to address more current matters in contrast to other combined retrospective and current approaches. May offer new perspectives on issue or point out area for further research
Systematic review	Seeks to systematically search for, appraise and synthesis research evidence, often adhering to guidelines on the conduct of a review
Systematic search and review	Combines strengths of critical review with a comprehensive search process. Typically addresses broad questions to produce 'best evidence synthesis'
Systematized review	Attempt to include elements of systematic review process while stopping short of systematic review. Typically conducted as postgraduate student assignment
Umbrella review	Specifically refers to review compiling evidence from multiple reviews into one accessible and usable document. Focuses on broad condition or problem for which there are competing interventions and highlights reviews that address these interventions and their results

*(Grant and Booth 2009, p94-95. *NB: Table partly represented)*

It necessarily follows that all forms of literature review must have a systematic, rigorous and critical approach to inform the research question. Initial searching found much of the evidence was qualitative. Because of a paucity of research in the area and the plethora of narratives, a systematic 'Narrative' or 'Topic' review was undertaken. This approach enabled investigation to support or refute the development of the research question and analysis of findings (Dallos and Vetere 2005).

The author has attempted to identify almost every paper that relates to the topic being researched (Newall and Burnard 2006), using a method that shows the author as demonstrating an awareness of the entire process and a technical proficiency in the component steps (Grant and Booth 2009). There is potential for weaknesses to emerge in a review, such as variation in the quality of assessment, a less identifiable synthesis, or the likelihood of bias being introduced. Potential weakness can be managed through following a structure, in this instance Aveyard's (2010) guidance to develop a protocol, define a question, develop a search strategy and decide on inclusion and exclusion criterion.

Develop a protocol

The first step is to review both published, grey literature and bibliographies (Bowling 2009) because important developments and theories can emerge from the literature to inform the progress of a study. Metaphor literature has two main bodies, conceptual or theory based literature and empirical literature, the latter focussing on the patients, or jointly derived metaphor (McMullen 1996 and 2008). This review needs to include both conceptual metaphor to inform the researchers understanding and the empirical to explore the research evidence. Andrew and Halcomb (2009) comment that Researchers need to identify and contrast 'qualitative and quantitative findings to provide justification for the selection of mixed methods design' (p57). These mixed methods or methodological pluralism is a strength of therapy studies (McLeod 1999) and helps to contextualise findings (Dallos and Vetere 2005), so a review needs to include both.

Predefined Question

The research question suggests a number of keyword combinations for consideration: CAT and metaphor; PM and CAT; Psychotherapy and metaphor; Cognitive neuroscience and metaphor. This enables the subject, topic and field to be reviewed in four naturally resonant sections:

- 'CAT and metaphor' – An introductory review of CAT (to inform the reader who may not be a subject specialist) and searching for evidence to support or contradict the use of metaphor and PM in CAT?
- 'Metaphor and psychotherapy' - Is there is any evidence to support or challenge the use of metaphor and PM in the TE?
- 'PM and psychotherapy' – Exploring metaphor as 'symbol' or 'representation'. An exploration into metaphor and art as a medium to facilitate change in psychotherapy seemed the next logical step, drawing on the literature in art psychotherapy may be transferable for this study.
- 'Cognitive neuroscience and metaphor' - Investigating cognition and its link to inarticulate emotions/feelings and inherent complexities in visual and spatial processing (implicative processing).

Concurrent literature reviews in research methodologies were also conducted at key points and remain ongoing. Key inclusion criterion were; Methodological issues (research methods), AR and grounded theory, Focus group methods and Delphi methods.

Develop a Search strategy

Search strategies were designed to enable a broad and comprehensive examination of the literature to protect and enhance the validity of the research (Rogers and Lopez 2002). A systematic search strategy, to identify and catalogue for critique the most relevant literature to inform the narrative and frame my inquiry, was adopted (Aveyard 2010, Cormack 2000, ScHARR 1996).

Through the Universities 'Library Gateway' subject specific databases were highlighted including; psychotherapy, psychology, sociology/social science and art psychotherapy. Relevant databases were PSYCHLIT, SCOPUS, MEDLINE, CINAHL and Google Scholar. Scholar was used alongside traditional search engines as it easily identifies articles, related references and performs citation searches, all of which can easily be exported into Refworks.

Boolean logic was applied using, amongst other key words; 'CAT', 'Metaphor', 'Pictures', 'Psychology of mind' and 'Cognitive neuroscience'. The initial search in PSYCHLIT had the key words with AND/OR combinations on title and abstract search parameters (Fig3). PICO as an anagram was identified to manage keywords where P=Population, I=Intervention, C=Comparison and O=Outcome leading the researcher to use a controlled vocabulary to manage resources.

A PSYCHLIT search (Fig3) yielded over half a million articles requiring the search strategy to be refined, and Wiley Online retrieved over 83000 results (Fig4). Refining the search achieved more productive references, for example, combining metaphor (all OR's) and CAT yielded 11 articles and Metaphor (all OR's) and Cognitive Neuroscience yielded 364 articles. Snowballing, author and SCOPUS searches were managed by searching authors, related articles and citation hyperlinks that were available with each published resource.

This approach led to finding relatively swiftly some of the key writers on the subject as well as the most recently cited published articles. In practical terms journal articles citing other articles and resources may often be one of the main routes of exploring a topic. Alerts were activated utilising Ebsco and Zetoc.

Fig3: Example PSYCHLIT search strategies

Metaphor	**and**	Intervention
Narrative OR Visual Representation OR Pictures OR Linguistic PR Imagery OR Visualisation OR Image laden		Cognitive Analytic Therapy OR Psychotherapy OR Therapeutic Interventions OR Cognitive Therapy OR Cognitive neuroscience

Fig4: Wiley Online searches

83778 results for: metaphor Journals (72335) Books (11423) Database (13) Lab Protocols (7) 6836 results for metaphor in All Fields AND psychotherapy in All Fields 2755 results for metaphor psychotherapy criticism

Inclusion and exclusion criterion

English Language and translated works in languages other than English were chosen. For a broad and established literature field (psychotherapy, linguistics and neuroscience) setting limits to ‘x’ number of years or ‘x’ type of study is complex. Published literature from the last 10 years was actively sought and resources that were older were included if they contributed significantly to the topic.

Analysis of findings

Articles were scanned for relevance and filtered for usefulness, initially from the title and the abstract and critically reviewed (Bowling 2009). A thematic analysis in order to familiarise the researcher with the data set, generate initial codes, search for themes, review themes and refine themes (Silverman 1997). A reflective research journal was maintained and notes made at regular intervals to enable important aspects of the research study to be captured and reflected upon. The review of the literature is presented in four sections: Cognitive Analytic Therapy, Metaphor, Pictorial Metaphor and Cognitive Neuroscience

Cognitive Analytic Therapy

Stopping people from stopping themselves (Ryle 1995)

CAT was developed in the United Kingdom by Dr Anthony Ryle with the aim of integrating the valid and effective elements of psychoanalytic object relations theory and cognitive psychology, especially Kelly's 1956 'Personal Construct Theory' (Ryle 1990, Ryle and Kerr 2002, Calvert and Kellett 2014). CAT is an integrated therapy drawing on recent advances in developmental psychology which stress the actively intersubjective nature of the human infant and its implications for normal growth and learning and also for psychopathology.

The CAT approach is unique in terms of the psychotherapies, CAT combines and blends the development of descriptive formulations of patient's difficulties similar to cognitive-behavioural (CBT) approaches, with a central focus on the therapy relationship incorporating and extending psychoanalytic understandings of transference and counter-transference. CAT supports the patient's early and active engagement in the work of therapy. From its conception within the NHS and due to the acknowledgement of limited resources, CAT was always carried out within predetermined time limits, usually of 16-24 weekly sessions but there is also a 'briefer' therapy of 8 sessions.

CAT training is available in many parts of the UK and abroad. There are 900 registered practitioners in a range of countries including Ireland, Finland, Spain, Greece, New Zealand and Australia. CAT aims to understand and ameliorate chronic and self-limiting patterns of emotional expression/inhibition and tries, among other things, to find the main emotional patterns of relating to self and others and their connection to the patient's presenting problem or apparent distress.

An Integrated model

The 'cognitive' in CAT has a central task in transforming meaning to further the patients goals and help recovery, 'metaphor should therefore be a powerful companion' (Stott et al. (2010, p14). The particular techniques of CAT include the extensive use of written and diagrammatic representations of the patient's recurrent dysfunctional procedures, such therapy tools are created in collaboration with the patient in the first few sessions of the contract. These techniques incorporate complex strands of an individual's felt sense that can be generated into a pictorial representation of both the patients metaphoric language

utilised in therapy but also metaphors from their lives. As Ryle and Kerr (2002) note CAT is good at 'doing with' rather than 'to' (CBT) or 'being with' (Pa). In their introduction to CAT Ryle and Kerr note…

> 'Neither cognitive or analytical models acknowledge adequately the extent to which individual human personality is formed and maintained through relating to and communicating with others and through the internalisation of the meanings developed in such relationships, meanings which reflect the value and structures of the wider culture.' (Ryle and Kerr 2002, P2)

Psychodynamic perspectives focus on the role that experiences in childhood have on psychological problems. Sigmund Freud (1986) is considered the grandfather of analysis. Freud stated that the 'triumph of every psychoanalyst is to succeed in making Unconscious processes Conscious' (Freud 1991, p129). This world view provides important understanding of the role of early life in relation to psychological distress. His exploration of the minds mechanisms have been synthesised and developed, sometimes with great insight and sometimes as he himself has stated with less rigour. Stevens (1993) notes a comment of Freud's…'Oh don't take that seriously I made that up on a rainy Sunday afternoon' (p135). One can see the playfulness in this comment but also it leaves one with a question as to the validity of all of his assumptions.

There are some key principles of a psychodynamic framework that can help therapists and mental health nurses explore emotional and interpersonal components of their work. For example, the notion of transference arises from a psychodynamic perspective and explains the process whereby emotions that have been experienced by a person towards another in their early life are brought out and may be felt towards the nurse. Countertransference refers to the professionals responses to this (Hughes and Kerr, 2000).

Jung, a contemporary of Freud, was interested in symbols. Unconscious processes were primordial, psychic processes transformed into images via symbols and metaphors. Jung taught that the great motivator of life lay in what he called the transcendent function (Olds 1992). Cox and Theilgaard (1987, p95 citing Samuels 1985) note 'For Jung, the crucial function of a symbol was to express in a unique way psychological fact incapable of being grasped at once by consciousness'. They go on to outline the distinction between signs and symbols where 'metaphor sits midway between sign and symbol for one half of metaphor is known to consciousness' (ibid, p95).

A major critique of the psychodynamic approach is the saliency of the Unconscious and Consciousness. Freud and Breur sustain that consciousness constitutes only a part of human mental life, and that the 'logical mode of thinking which we are familiar extends no further than the surface of consciousness' (Freud 1991, p130). Is there not a contradiction here with autonomy and determinism? It seems that the existence of psychoanalysis bases itself on the opportunity for expressing freewill once one has brought the Unconscious processes to consciousness, rather than being determined. Freud (1908) writes expansively on creative approaches likening our play as a child to the representation of this play as an adult in the world of phantasy and daydreaming.

Freud's integrative model of the mind, the Id, Ego and Super Ego provide some explanation. They are not separate but interacting. Ego forces represent the cognitive and perceptual capacities of a person (Stevens 1993, Farrell 1981), the Id represents the instinctual sexual and aggressive drives and the Super-Ego manages the conflict between the self and its desires in a social world. Stevenson (1987) notes, that 'the mind is not co-extensive with what is conscious, or can become conscious, but includes items of which the person can have no ordinary knowledge at all' (p73).

The Ucs has been challenged in many spheres as unscientific (Farrell 1981, Stevenson 1987). Habermas (cited Turner 1995, p38) feels that Freud's attempt to use an energy model to account for psychic behaviour was simply inadequate. Further challenge is based on the theory being an assumption and as a contradiction to freewill. Pontalis' (1968) view is that the 'memory that is lost is only lost insofar as it belongs to a certain region of my life I refuse' (p83). Szasz (1979) also challenges Freud's contention that man has no freewill, believing the argument for determinism is 'scientific dogma rather than self-expression' (p124). Stevens (1993) expands this to 'How can one be blamed for ones' actions without knowing the real reason for the behaviour?' (p136). Mindell (1987, p127) feels that 'we should believe in our experiences and perceptions even though they may cause pain and distress'.

Laing (1990) however, notes that experience is multi-layered. While I am writing this I am also conscious of and thinking of many other events and anticipating events. For example, listening to music and the feelings this evokes, wondering about the thread of this thesis, being aware that the sun is shining, thinking about the next ideas and putting these down on the screen. I do not have total awareness of all these thoughts but they are in play. I

am exercising will and unconscious processes but not being driven by them. Stevenson (1987, p73) believes that 'every event has preceding sufficient causes within realm of the mental'. Dilman (1984) expands…

> 'Where a person be said to exercise his will or agency, he must know what he is doing, have certain thoughts about his actions and environment'.
>
> (Dilman 1984, p63)

However, a number of our actions and thoughts do seem to have an unconscious motivator behind them, as noted earlier when outlining object relations and the importance of early life experiences, we are often invited to dance and enact a behaviour that we developed in order to cope with early life experience. A dance that we are not immediately aware of but just/must repeat. Freud's therapeutic approach is an art, which can enable us to notice these dances and grasp their relative ungraspability. As Freud (1991) notes, instincts 'Can never become an object of consciousness, only the ideas that represent the instinct can' (p151). He argues that these ideas emerge through the exploration of dreams and through free association. The use of art, visual sequences, and dreams is worthy of noting as is Freud's wolf man sketch, which could be an example of a pictorial formulation.

Psychoanalytic thinking views the Ucs has discharging in dreams, with the preconscious mind accessing information to a devolved system of communication between consciousness and memory (Freud 1991). The 'triumph of every psychoanalyst is to succeed in making unconscious processes conscious', states Freud (1991, p129). Pontalis (1968) criticises this view, noting the lost memory is lost only insofar as it belongs to a certain region of my life I refuse. Which leads to concerns over power relationship in psychoanalysis, as it is, as if, analysis denies the power of consciousness.

Wilfred Bion developed both group and individual analysis, Hanna Segal worked with symbolism and psychoses and Esther Bick with infant observation (Sayers 2000). More recently Otto Kernberg has developed a model of development based on object relations (Kernberg 2004) and worked extensively with Borderline Personality Disorder. He also explored sexual love in mature and pathological relationships in his work '*Love Relations'* (Kernberg 1995).

Recent developments in psychodynamic approaches have arisen from the object relations (OR) theory proposed by Melanie Klein (Klein 1997). She identified the need for the infant to integrate their part object world (the paranoid schizoid position), experience the psychic trauma of both loving and hating what becomes the same object and as a result experience loss (the depressive position) (Klein 1997, Mitchell 1991). For Klein, introjection, projection and splitting are the defensive processes used in the 'paranoid schizoid position' and later a more mature and neurotic defensive process are used in the depressive position like, humour, repression, denial and sublimation (Mitchell 1991). CAT is indebted to Klein for providing a hinge between the European school of analysis and the UK school and her work, although critiqued plays an important role in the understanding of object relational early life experiences.

OR views early life relationships between the dependency on mother (breast) and the subsequent split in the humans psyche between good and bad objects. OR are focused on the infant's first relationships with others (Dutton 1998), and exist from the beginning of life (Klein 1997). OR theory has adopted the concept of the internal world consisting of internalised objects that carry powerful affective loadings and seem woven and invested with intentional qualities (Leiman 1993). These internalised subjects are voices that comment (or have a dialogue) on a person's thoughts and deeds (Leiman 1993). OR) provides a more resonant view of interaction for the author in the way that OR describes how people use one another to stabilise their inner lives and helps to understand identification at work (Hirschon 1997). Individuals project their own image of the good into others as if subordinates are like the good parts of themselves (Hirschon 1997). The view is that in early life an immediate and intense transference is formed. In so much as during therapy the patient's inner child, unable to distinguish between inner and outer worlds, attempts to shed the terrified, unwanted parts of the self into the therapist through transference and projection (Thomas 1997).

In contrast to Klein's view Fairbairn's view is gentler, where the single tendency of an individual is object seeking. Individuals seek love and to be genuinely loved as a person and their love is genuinely accepted by the other (Tantum 1998). Fairbairn sees the individual person from the very start to be conceived in terms of dynamic structures based on experience with objects instead of these being derived from unstructured energies (Sutherland 1980). The researcher is mindful of the nature of unconscious enactments and further guided by the more recent integration of dialogism in CAT.

Dialogism and CAT

Vygotskyian activity theory and Bakhtinian concepts of the dialogic self are integrated in CAT (Leiman 1992, 2004). They examine the interplay of social and biological influences on psychopathology and have secured a dialogical perspective on the working of the self (Calvert and Kellett 2014). CAT and Bakhtin's dialogism offers a…

> 'Framework for understanding a simultaneous conversation between different theories and methods of psychological therapy, between different mixes of patient presentation and need, between different processes of therapeutic formulation, progress and encounter' (Potter and Sutton 2006, p3).

Key Vygotskyian (1962, 1978) concepts are internalisation (understood as a transformative process through which early interpersonal experience becomes intrapersonal, so contributing to the social formation of self), the Zone of Proximal Development (ZPD) and psychological tools (understood as sign-mediated cultural artefacts which may influence the mental activity of self or of another). Jerome Bruner's work on 'scaffolding' (an extension of Vygotsky's learning techniques) was an early influence on the development of CAT (Ryle 1994). Dialogue constitutes a key conceptual pivot in human interactions. Bakhtin states…

> 'To live means to participate in dialogue: to ask questions, to heed, to respond, to agree and so forth. In this dialogue a person participates wholly and throughout his whole life: with his eyes, lips, hands, soul, with his whole body and deeds' (Bakhtin 1984 in Potter 2010, p5).

Dialogism emphasises communication as a defining feature of the human self and of the potential of dialogue—talking, listening, and creating meaning—to heal (Hepple 2010). In the TE focussing and managing dialogue is an essential component. The therapist and patient are creating a matrix and co-constructing a reality using signs and words to describe simple to complex phenomena. It is fundamentally important that therapists are attuned to the patients and act accordingly.

Bakhtin's interest is in the processes of authoring, speaking and the responsibility of reaching artistically beyond ourselves (Potter and Sutton 2006). Dialogism views the patient as providing clues about the kind of internalised object relations (Leiman 1996) that can be examined in other activities of the patient and in the transference. Is rooted in object relations viewing the infant as highly dialogic in support of the infant seeking out iteration (Ryle and Kerr 2002, Leiman 2002) and navigating itself by using culturally derived information, skills and understanding through sign mediation (Ryle 2000).

One hears the patient's story through dialogue between any two people. Clues come in the form of signs, a word, picture, a sound, gesture, token, or a story. Signs have lives of their own, carry meaning between voices (Stiles 1997). Signs are reflective of reality and are at the same time part of reality, signs bring earlier experiences that they embody into situations where they are used (Stiles 1997). The sign is not merely a mirror, it is the true carrier of the reality it signifies, 'a sign adopts a mediating position in human activity changes its structure and developmental course, words are signs par excellence' (Leiman 1992, p98). Self is viewed as social from infancy, not an aggressive libidinous drive as Freud (1960) would have it, nor an aggressive frustrated child as Klein (1980) postulated.

A Brief Therapy

CAT offers the possibility of a relatively brief intervention without losing depth of psychological engagement and insight with the patient and his or her concerns. Battino (2007) notes brief and time limited sessions can manage the expectation of patients so they start doing significant work during the closing phase of therapy. His study found an 85% satisfaction rate with patients who had an awareness of how many sessions they were going to have. The CAT model and structure uses a more explicitly educative approach to the helping relationship than many other psychotherapeutic models, it gives the patient a better chance of understanding and collaborating with the purposes and methods of helping with his or her problems. CAT involves doing things with people rather than on people (Ryle and Kerr 2002) whilst offering a corrective emotional and cognitive experience through which the person takes away a stronger sense of his or her own agency in patterns of self-harm or self-care.

Evidence Base

CAT is based on a strong commitment to research (Ryle 1995). An early comparison of CAT with Mann's (1973) approach showed CAT produced more cognitive re-organisation, as measured with the reparatory grid, than did the more purely analytic approach (Brockman et al. 1987). A review by Margison (2000) indicates there are a number of single case study reports but less controlled trials (Holmes and Bateman 2002).

CAT is proposed as a safe and accessible intervention for a wide variety of presenting and underlying psychological and MH problems (Ryle 1990). CAT in particular has been used to work with groups with hard to help problems such as eating disorders and personality disorders. For example, in cases of Borderline Personality Disorder (BPD) CAT has

proved effective (Chanen et al. 2009). CAT has been theoretically and clinically supported by the elaboration of the Multiple Self States Model (MSSM) (Ryle 1997, Ryle and Kerr 2002) which offers an understanding of the phenomenology of BPD. CAT-based skills level training for workers in community MH services and in-patient psychiatric services have been evaluated (Bennett 2003, de Normanville and Kerr 2003, Thompson et al. 2008). Many features of the current model arose out of early process and outcome research by Ryle (1995) who continues to be an active and strong proponent of the model (Bennett and Parry 2004).

The formal evidence base so far is largely naturalistic although several controlled trials are currently underway. The features of the model, especially its pro-active and collaborative style with its focus on the therapeutic alliance, conform to generic features of successful models of therapy (Ryle and Kerr 2002). They also appear to contribute to its success in engaging and retaining difficult and personality-disordered patients in treatment (Ryle and Golynkina 2000). Results from research trials have contributed to CAT evidence base (Chanen et al. 2009) notably via:

- The demonstration of patient-therapist work and research based formulation methods (Bennett and Parry 1998).
- The development of an empirical model of practice through the process of Task Analysis (Bennett and Parry 2004).
- The development of a research instrument (Competence in CAT–CCAT) (Bennett and Parry 2004a)
- An approach involving BPD patients in guided introspection and reformulation guied by the Multiple Self States Model (MSSM) (Bennett and Ryle 2005).
- Chanen et al. (2009) the evaluation of CAT with adolescents an early intervention service for borderline personality disorder
- A model of borderline personality disorders has been developed and views such disorders as arising from chronic developmental deprivation and/or trauma, generating a tendency to dissociate into different self-states each characterised by different reciprocal roles (Ryle 1997, Ryle and Golynkina 2000, Leiman 2004).
- Kellett (2004, 2005) the treatment of dissociative identity disorder with CAT: experimental evidence of sudden gains.

Critical review of CAT

As a developing therapy there is naturally criticism from more established therapeutic interventions, notably from the psychoanalytical perspective as the time limited nature of CAT challenges the open ended practice of analysis. A search on 'Wiley online' found 2218 sources with the key words 'cognitive' 'analytic' 'therapy' 'critique'. 1923 journals articles, 260 books, 34 web databases and one lab protocol were cited.

The most recent and comprehensive review of CAT research has been published by Calvert and Kellett (2014). They note that CAT, whilst being a popular therapy, lacks wider credibility of its evidence base due to having largely bypassed the rigours of the controlled phase of the hourglass model of psychotherapy evaluation (Salkovskis 1995). Margison (2000) points out the large number of CAT case reports and small uncontrolled trials and the existence of a large theoretical literature. The CAT evidence base is dominated by small-scale practice-based studies in typically complex and severe clinical population, 44% were focal to the treatment of personality disorder. Although the quality of extant CAT evidence is generally sound (52% of studies were high quality), the depth and breadth of the evidence base is currently limited (Calvert and Kellett 2014).

Norcross and Goldfreid (2005) comment that RCT evidence in CAT is limited with some studies showing less favourable results, while Brockman et al. (1987) in a small RCT for depression and anorexia compared CAT with focused dynamic therapy (FDT) finding a significance effect for CAT as opposed to FDT. Dare et al. (2001) comparing CAT with FDT, family therapy or treatment as usual, found all treatment groups improved but the CAT group showed non-significant benefits over the other forms of intervention. Mace et al. (2006) findings suggest training experiences that pay most attention to common, transferable psychotherapy skills, are best provided before work with more derivative models is undertaken.

Fozooni (2010) suggest that the most promising development in CAT is the (relatively) recent import of Vygotskian and Bakhtinian ideas such as the zone of proximal development (ZPD) and dialogic interaction. Fozooni's critique does not appear to be a reductionist approach to CAT but rather a suggestion of a therapy finding its feet, whereby areas within CAT such as the dialogic can be explored and understood in more depth.
Mulder and Chanen (2013) note research in CAT is limited despite its wide appeal…

> ‘It remains untested whether intervention at the service system level, such as teaching the basic principles and relational skills underlying structured interventions such as CAT to a broad range of clinicians, might change their interactions with patients with personality disorders to the extent that at least clinicians and services will first do no harm’ (ibid, p89).

Calvert and Kellett (2014) find that where comparisons with other modalities are available, CAT appears largely unequivocal. There is a particular need for further CAT outcome research with common MH problems. They note for future examination that CAT can be an effective intervention across a range of MH difficulties, and practitioners should consider a 24-session CAT contract for those patients presenting with complex and severe difficulties and practice research networks could make a significant contribution to the CAT evidence base.

Despite these criticisms CAT continues to be considered as one of the interventions of choice amongst those in the MH field, it has a strong TP, it has not suffered significantly with the economic downturn, and it maintains a research and developmental focus.

The Model and practice of CAT

CAT makes use of psychological tools such as co-constructed reformulation letters and diagrams aiming to summarise, in a top-down manner, the problems with which patients present (conceived of as reciprocal role procedural enactments) in the context of a narrative account of their psycho-social developmental origins. A patient’s dialogue is the focus of therapy (including the use of metaphor) and has a representation of reciprocal roles (Leiman 1992). The therapist listens with the ‘third ear’ to the signs in the patient’s speech. Their speech can illustrate a procedure through finding the patient’s inner voice which comments on their thoughts and deeds. Sometimes these voices are cherished even when they are persecutory or blaming (Leiman 1992).

CAT offers a scaffold of concepts and tools to explore this inner voice and dialogue. Through support the patient is allowed space to explore and be enabled, what has been described as the ZPD (Vygotsky, 1978, p86). The ZPD is the gap between what the child can do unaided and what it can do with the provision of appropriate help from a more experienced other (Ryle 1995). However, the ability of the young person’s learning, the ZPD, is related to imitation of adults or peers (Phillips and Soltis 1998). The metaphor of the scaffold has proven particularly useful in this effort. Scaffolding is described as a

process that enables a child or novice to solve a problem, carry out a task, or achieve a goal that would be beyond his unassisted efforts (Wood et al. 1976). In building the possibility for change and providing a frame to climb, scaffolding, like a child's climbing frame, should be ideally adjusted to the individual's current capacity where learning takes place on two levels the first external the second internal (Ryle and Kerr 2002).

The CAT relationship is active collaboration, the notion of doing therapy 'with' a patient rather than 'to' a patient (Kellett 2012, Ryle and Kerr 2002). A 16 session CAT therapy typically involves three phases of therapy, a) engagement and reformulation, b) the working phase involving recognition and revision of procedures, and c) a phase of termination. These are the three R's of CAT; **R**eformulation, **R**ecognition and **R**evision, these phases aid the patient to internalise both the person of the therapist and the conceptual tools used.

Engagement

CAT aims to understand and ameliorate chronic and self-limiting patterns of emotional expression/inhibition and try, among other things, to find the main emotional patterns of relating to self and others; their connection to the patient's presenting problem or apparent distress. Sessions 1-5 are generally accepted as the engagement and initial reformulation phase, where the therapist and patient mould their relationship and begin to understand the patient's problems and context**.** Initial sessions of any therapy are crucial.

Early sessions collect information through active listening and checking out thoughts and feelings, developing an interested other, hearing what the patient says not just in words but in the signs and utterances of dialogue. Information gathering is a threefold task; being aware of subtle interpersonal qualities in discourse and hypothesising of reciprocal role procedure (RRP); transforming emerging interactions into working alliance; and receiving a full account of the patient's main complaints, symptoms and personal life (Wood 1997).

Reformulation

The importance of a formulation or mind map to guide the therapeutic process is a shared task in CAT and Cognitive Behaviour Therapy (CBT). In CBT, as in CAT, the formulation offers a clear conceptualisation of the patient their concerns and present circumstance. This includes the assessment of the patients 'key problem areas, together with relevant factors from the person's upbringing and social circumstance' (Williams et al. 1997, p262).

For CBT formulation read ‘CAT Reformulation’ a bridge between assessment and treatment (Aveline 1980) with some evidence that (re)formulation has a useful predictive value (Høglend et al. 1992, Tillett 1996).

A reformulation describes past and present relationships, including the evolving therapeutic relationship and also the patient’s relationship with himself, thus simultaneously attending to interpersonal and to intra-psychic processes. Within this overall understanding, particular problems may be addressed by a range of therapeutic techniques. The ‘reformulation’ is jointly arrived at by the patient and therapist in a collaborative way being represented in both a written and diagrammatic form. Reformulatory activity includes the use of mapping, self-rating scales and psychotherapy self-evaluation questionnaires (Potter 2010). It has a narrative component, a re-telling the patient’s history, and a descriptive one, describing current damaging procedures. It is used throughout therapy as a basis for patient homework, problem recognition, and as a guide to, and description of, transference-counter-transference interactions (Ryle 1995b). Identifying in the patient’s language a memorable and shorthand description of the patients underlying dynamics, symptoms and mental problems (Leiman 1994).

Included are rich person-centred descriptions of the psychological and inter-personal processes underlying patients’ difficulties. Such input indicates to the patient that integration of personality fragmentation is an explicit aim of the therapy. Ryle and Kerr (2002) comment…

> ‘Letters summarise the often jumbled narrative told by a patient, they summarise key events in the past and suggest, in a non-blaming way, how the negative patterns learned from early experiences are being repeated or how alternative patterns have developed in order to avoid those early ones have themselves become restrictive or damaging.’ (Ryle and Kerr 2002, p10)

In coming to a reformulation one must listen to the utterances of the patient and the signs being passed over. For example, when a patient speaks of her/his abuse they often speak in a quiet voice and move on quickly to another subject, in a sense recreating his/her long term coping strategy, of bottling up and coping alone with her/his problems. Equally repetitive ways patients have in session such as ‘admiring’ and ‘hands off’ roles bring examples of a more general pattern that nearly always elicits other parallel examples, which confirm or modify the pattern (Ryle and Kerr 2002).

Caution is required with a reformulation that states such powerful life experiences and restrictive and damaging roles (Ryle and Kerr 2002) because links exist between abusive early experience and later problems in psychological development, maladaptive coping strategies, and a resulting personality structure which is fragile and which encourages rejection from others. Reformulation letters provide clarity to feelings often unsaid in dialogue and express a clear and chronological representation of a patient's life, their difficulties, and their coping mechanisms. They are also transitional, parts of the therapy that can be taken away and internalised at the patient's own pace.

Reciprocal Roles

The aim of CAT is to identify, in a language that the patient can share, those mental constructions, and underlying repetitive problem procedures that underpin the patients symptoms and difficulties and his inability to change (Ryle 1990). CAT looks for the bigger picture of the patient's psychological world and explains it in clear, user friendly ways which, in many cases, allows the person to feel less trapped, more able to care for themselves and do their own psychological self-help outside the session.

CAT emphasises the relational and social origins and context of most human psychopathology. At the heart of the bigger picture is an understanding of the importance of sympathetically identifying reciprocal emotional roles which are exacerbated or perpetuated by a variety of long established and emotionally driven coping procedures for the patient. These coping procedures are maintained because despite their contribution to distress, they were once effective solutions (albeit maladaptive) in providing relief from damaging childhood and adolescent experience. RRP's are developed typically in response to the manner in which the parents or caretakers parented the child (Kellett 2012) and lead to procedures described by Ryle (1995) as 'Traps', 'Snags' or 'Dilemmas'.

Procedures are cognitive ideas integrated with object relations illuminating developmental dynamics related to behaviours and are intended to elicit appropriate reciprocation. Traps, snags and dilemmas seem to address the Freudian notion of repetitive compulsion (Freud 1973), or the return of the repressed (Leiman 1994), based more on object relations rather than any instinctual foundations. For the patient non-reciprocation of these procedures may lead to modification of procedures but is often met with effort to force the others to play the expected role (Leiman 1994).

- Example a – ‘Abusing to Abused’…an abused child may learn the abused adult role which could, according to Stiles (1997), lead the patient to enact the abused or abusing role or recruiting others to do it for/to him.

- Example b - ‘Neglecting to Neglected’…neglect being a core experience of the child from his caretakers may lead to a pattern where he is led to be needy or equally dismissive of his needs. These needy or dismissive patterns or procedures are representative of how the child managed their early experiences of neglect.

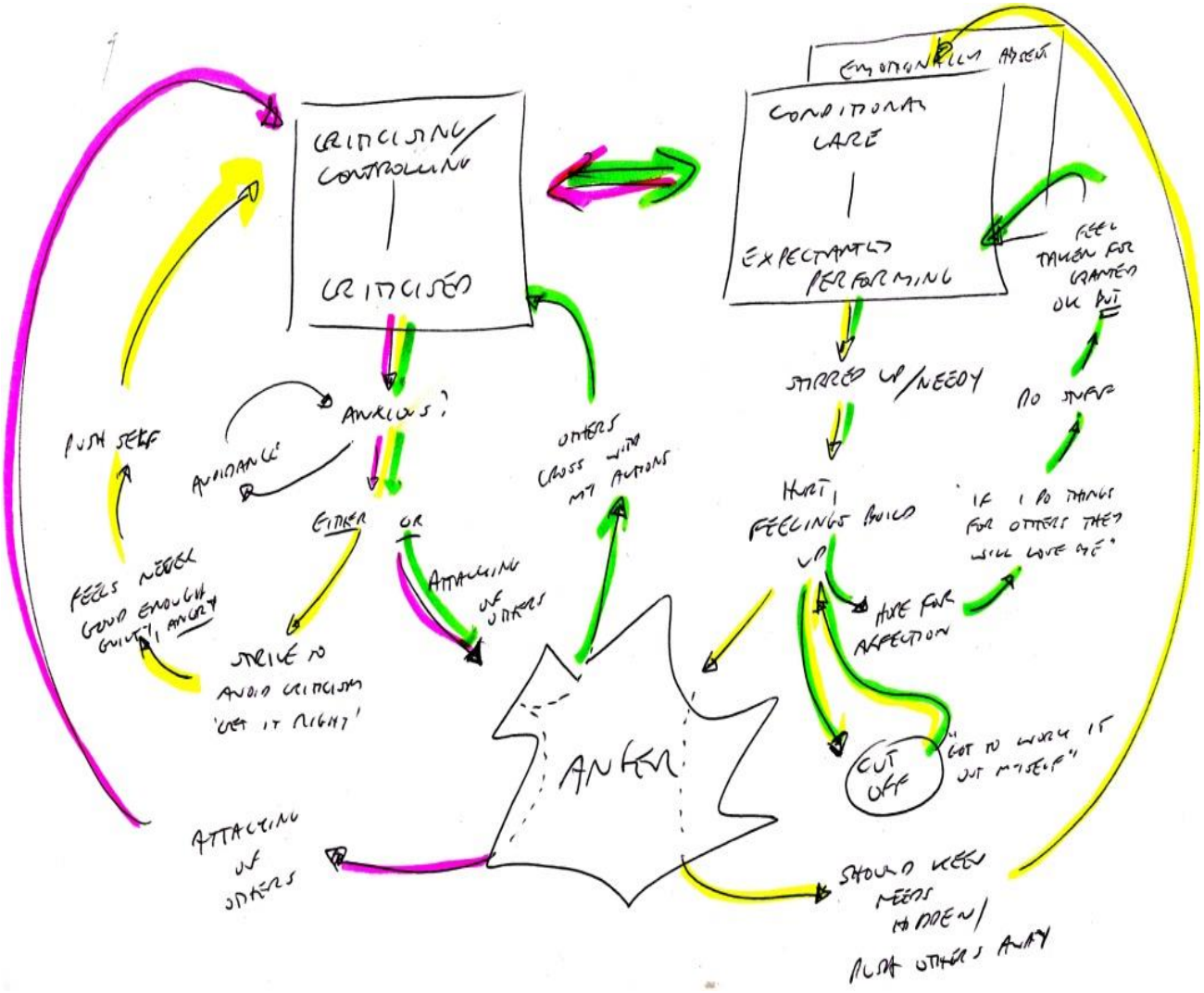
These procedural emotional roles are also prone to be enacted in the therapeutic relationship with the therapist and it is the non-collusion with and working through of these re-enactments which is at the heart of effective therapy. As these will usually be manifest within the therapy or treatment relationship it is important to notice and work with the in session enactment lest they undermine or sabotage treatment. CAT therapists are alert to the invitation to reciprocate (or collude with) these various role enactments by patients (for example ‘needy victim’ or ‘vengeful attacker’).

Sequential Diagrammatic reformulation (SDR)

During reformulation, a diagram, the SDR, is developed, a visual representation of the patient’s behaviour and maladaptive ways of thinking (Treasure et al. 1995). Dunn and Parry (1997) assert an SDR enables identification of the problem procedure and keeps their understanding at a psychological rather than personal level. This helps in the wider context of the patient’s life and in recognising enactments in sessions.

An SDR is a visual and useful tool for noticing role procedures and for the tracing of exits to procedures in a strong and meaningful way. When developing an exit, cutting through the procedural sequence, is visually powerful and representative. The SDR (Fig5) summarises the patient’s problems, how they were developed and how they are maintained, similar to a case conceptualisation (Freeman and Dattilio 1992) where schemas, behaviours, thoughts and actions are understood in the individual’s psychological context.

Fig5: Example SDR



The boxes indicate the patient's reciprocal role procedures. For example, the one on the left is 'criticising to criticised' arises in response to a critical early life experience from their caretakers (parents initially). In these respect patterns of coping emerged as a way to manage the tension caused by the expectation of criticism, that every time they did something it would be picked on and deemed not good enough. The experience leads the patient into a state, anxiety, where they can either strive to avoid criticism, to get it right or can become angry and be critical and attacking of others. In so doing, adopting a response to criticism or being the one who is seen as critical, the 'self-self' and 'self-other' aspect of object relations. Either way the patient is left feeling not good enough by the response of others to continue to expect them to do better or is critical of themselves for lashing out at others. Another response is avoidance, keeping one's head down as if the pressure would go away, but this just leads to a maintenance of anxiety or others but this never feels good enough where and conditional care to expectantly performing.

The Therapeutic relationship

As sessions progress applying the reformulation to the recognition, monitoring and modification of underlying dysfunctional procedures creates a scaffolding of support (Ryle 2003). Creating a learning place in the ZPD, where the therapeutic relationship becomes one factor in change, enabling patients to understand their problem development and supporting them in making changes to the harmful patterns they use (in coping with a number of situations) 'once trust is established within the ZPD partly hidden and painful signs/words can be gradually rediscovered' (Fozooni 2010, p129). New, jointly created signs/words will emerge, facilitating comprehension (Leiman 2001). The therapist has to have multiple awareness of one's own snares the heal all, know all, love all invitation (Watts and Morgan 1994) so that the alliance becomes a crucial protective role; protecting patients from their strong negative feelings.

Alliances are fostered through creating a space for dialogue (Kerr 1999). Whilst creating this space one must be aware of the patient's self-protection procedures and the therapist must manage and dilute the influence of these reciprocations by jointly working with the patient to recognise them by enabling an increased ability for self-reflection (Kerr 1999). CAT accepts there are unconscious (Ucs) processes behind everything we do. Ryle (1995) notes 'we do not have to have a theory about them because this is difficult to get, but its process will be manifest'. The concepts of projection and projective identification, how people induce their feelings in others, encouraging others to have those feelings and act on them are manifest. Stiles (1997) comments, 'If I feel your feelings and motives because I want to, that is identification. If I feel your feelings and motives because you want me to, that is projective identification' (p172).

The relationship enables, through the involvement of a benign individual (the therapist), the patient to clarify the confused nature of their internal world. Subsequently facilitating the patients trust in their self-object, their own capacity to comprehend the nature of their psychological world, by appropriately constructing a vision (reformulation) of the patients mind (Fonargy and Ryle 1995).

Therapy is about dialogue in the way words and communication is carried across between individuals, dialogue can represent a patient's reciprocal roles (Leiman 1996) because as patients speak repeated ways of coping and managing situations become apparent.

Listening for signs like being ‘in a rut’, can illuminate a procedure by asking for the patient’s inner voice. The inner voice is one that comments on a person’s thoughts and deeds, sometimes these voices are cherished, even if they are persecutory or blaming (Leiman 1993). Often these descriptions will use a metaphor to represent core pain or psychological distress, for example ‘stuck in a rut’ is a well-known utterance to indicate a psychological state.

I am often thinking of the dialogue in my encounters with patients, how dialogue constitutes a key conceptual pivot in human interactions. Language, writes Bakhtin 'lives only in the dialogic interaction of those who make use of it’ (Cheyne and Tarulli 1999, p7). In the dialogue a therapist and patient are co-constructing a reality using signs and words to describe simple to complex phenomena. It is important that therapists are attuned to the patients and act accordingly.

For example, an abused patient near the end of therapy commented on our relationship to the effect that there was an attachment made, ‘*not in any homosexual way’* he explicitly said but as if *‘I was holding him with a father/mentor role’*. I was hearing here his vulnerability in male relationships based on his early experiences. Working with this patient I was very aware of not reciprocating many of the roles he has experienced before, unconcerned distance for example, or being busy, as he would have had an expectation of me filling one of these roles. As Ryle and Kerr (2002) advise that some patients have an expectation of, or wish for, or attempt to elicit, one particular outcome, namely an acknowledgement and reciprocation or a role.

Observation and monitoring (revision)

Rating problem procedures is part of CAT, consider this example of a procedure…

> *‘Experiencing others as criticising and controlling left you feeling upset and alone with your problems, you coped with these feelings by coping alone (soldiering on) as if I am in control then things will be OK, but your feelings don’t change and you feel more alone, becoming self-critical’.*

CAT would encourage observation and monitoring of this on a weekly basis using rating sheets and/or a diary to facilitate recognition and revision. Each session would normally close with a discussion of how the session felt for the patient, points considered and expectations for the week ahead.

The phase of termination and follow-up

Ryle (1995) notes that termination is often a moving and profound experience for both patient and therapist so an awareness of the ending is important and should be noticed throughout sessions. Mann (1973) considers the last third of therapy beginning the process of termination whereby a good ending can enable the patient to internalise the therapist as a replacement for previous ambivalence. However, even with a focus on an ending the reality can still be experienced as uncomfortable by patients as a form of betrayal or desertion (Ryle 1995).

Care must be taken so that therapists do not collude with responses that might mask painful separation anxieties and may sustain a degree of idealisation while others find it difficult to appreciate how important they have become for the patient (Ryle and Kerr 2002). Ending is supported by another CAT tool, the goodbye letter, aiding the therapist and patient to acknowledge termination issues and work completed so far (Pollock 2001). The letter states clearly these feelings which are acknowledged and understood so it may be more likely that the patient will be able to hold onto what they have learned (Ryle 1997).

Regarding metaphor

A literature review of the CAT repository and literature using a keyword search was undertaken. Metaphor was used as the keyword which unearthed 57 *Reformulation* (the journal of ACAT) commentary's/articles and a further 14 related matching articles (n=71). A breakdown of the papers reveals 51 commentaries, seven case studies, six research papers, four book reviews, two editorials and a literature review. The research papers were a mixture of reporting on the Six Part Story Method (6PSM) (Dent Brown 2011), this study, and research into attachment and CAT. Overall 517 comments were found utilising a keyword search of each paper using the term metaphor. Publications by Jefferis (2011), Kirkland (2010), Hughes (2007, 2011) and Dunn (1997) were particularly resonant and articulate of metaphor use in CAT.

A number of themes emerged from the analysis of the literature, metaphor as part of language, the nature of CAT, case examples, functionality of metaphor (including transference), 'process' aspects of utilising metaphor, and images.

As part of language metaphors were used to describe an evaluation of a meeting (Bennett 2004, Dunn 2005), supervision (Gil-Rios and Blunden 2012), in a book review (Burns-Lundgren 2004) where the magic and meaning of symbols and imagery/metaphors and, specifically words and their development were noted, and as review of conference (Bermingham 2006). Bermingham commented on the use of metaphor in a classical way, as in literature, helps to internalise the content in much the same way as the use of metaphor does in CAT therapy. Ryle (1975) notices the way metaphors provide every day accounts of themselves such as 'he is hard on himself'.

Jefferis (2011) notices the nature of CAT which has welcomed development and creativity in therapy paying particular attention to narrative, language and dialogue in meaning making. Vygotsky's use of 'scaffolding' as metaphor (Cheyne and Tarulli 2007, Fozooni 2010) and 'object relations' as a metaphor to describe Stern's infant observations (Dunn and Ryle 1993). Gobfert and Barnes (1995) note the therapeutic relationship can be described as a 'secure base' whilst Pollard (2004) notes the 'overgrown garden' when describing the field of therapy.

Metaphors of 'traps, snags and dilemmas' (Ryle 1997, Leiman 1997a, Jefferis 2011) to describe mental mechanisms come to mind, whereby therapists can be observed to habitually use metaphor and analogy as are helpful in explaining certain concepts and experiences to a patient (Jefferis 2011). Mitzman (2010) notes the contextual reformulation building on the patient retelling their narrative from the patient's unique language which would include their metaphors. This reformulation mapping is a cornerstone of CAT enabling the recognition of procedures going forwards. Potter (2004) draws our attention to the process involved whilst mapping whereby 'the patient and I map out a procedural sequence we will listen out metaphorically for a dialogical voice: attacking, rubbishing, overly rescuing or the like' (p6). Scott Stewart (2001) notes reciprocal roles give helpful ways in which to sustain the therapy and the patient. Appendix III provides a number of useful case examples extracted from the literature, a few of which are reproduced here to support comprehension.

- Ardern (2004): An individual can act as a metaphorical Thames barrier, holding back the tide so to speak.
- Beard et al. (1990): A patient might be a ship of fools but you can be the captain.
- Buckley (2002): 'One woman brought me a drawing of herself portrayed as a small

> figure of uncertain gender being crushed by an enormous boulder, and was surprised by her creative associations to it. Another brought me poems, which at times expressed very beautifully her yearning for a spiritual rebirth' (p92).

Functionally Anderson (2009) noted their usefulness as part of a metaphorical group matrix. Other observations on the function of metaphor as diffusion are found. Foir example a sense of managing thoughts in that once the thought can be seen as just a thought then the person is free to choose a direction in accordance with their core values and so find an exit from the trap (Carroll et al. 2005). Dunn (1997) comments on the heart as Jung's feeling function allowing metaphoric expression, whilst Pollard (2003) draws our attention to Bakhtin's (1984) metaphor of the cartwheel in Rabelais' world where the wheel revolves between the head and body. Dunn (1997) notes the complexity of the use of metaphor, suggesting...

> 'Metaphor is the best way to convey feeling and that without it therapists become prey to over-thinking. The debate for me is more about the place and uses of metaphor in the practice of CAT- when is it most effective, how much or how little, whose metaphors'. (Dunn 1997, p.x./online)

What seems to come across is the process of utilising the patient's own metaphors, a shared language, to envision aims and exits (Nehmad 1993, Dunn 1997, Turpin et al. 2011, Wilde McCormick 2012). Fitzsimmons (2000) comments on metaphor process as breaking down her old patterns and recognising them.

Hayward and McCurrie (2008) describe the importance of metaphor as a vital therapeutic metaprocedure where they may promote an increase in the recognition and understanding of emotional states, acting as an aid to exploring exits from the patient's problems. Metaphors can work with unmanageable feelings through 'images, metaphor and description, and revising the conclusions and meaning derived from experiencing this state' (Bristow, 2006, p7). This is congruent with Dent-Brown's (2011) method and Toye's (2003) cultural awareness, where patients describe their own experience through metaphor, that can lift the story from the particular to the general enabling patients to reflect on the metaphor without being caught up in it, furthermore the metaphor can be an exploration of themes through accessing a number of perspectives (Coulter and Rushbrook 2010 and 2012).

Hayward and McCurrie (2008), on discussing metaprocedures in therapy, note the use of metaphor and story to manage affect with individuals who might intellectualise their problems. Continuity between sessions was important in Rayner et al.'s (2011) research finding patient's view continuity as valuable and keeping it real inferred an externalisation on the internal world of the patient. They (ibid) noted techniques like using metaphors, supplementary written material, and other practical suggestions, were important and useful tools easily accessed and remembered. Hepple (2011) explored the role of transference and counter transference, a complex area within the therapy relationship, whereby metaphor can help describe the relationship. He uses an example of a game of tennis where someone serves the ball, which can be viewed as projection, and the receiver returns it as a human exchange.

Images and drawing metaphors are mentioned in a number of articles (Nehmad 1993, Leiman 1997, Hughes 2011, Kirkland 2010, Wilde McCormick 2008) with the narrative being drawn and noticing the nature of images. In fact the SDR is viewed as a visual representation (Walsh 1996). For example, Leiman (1997) notes that reciprocal roles can be condensed and formulated as a rule using a metaphorical phrase within a diagram. Wilde McCormick (2008) offers a useful guide to working with metaphor using an exercise of a box of old cards as 'a picture can help stimulate the imagination'. She notes…

> 'The idea is when you have found the metaphor or theme around the procedure and separated it; you have more time to think about it and how you want to write it. It also allows us to write in small steps, rather than become overwhelmed by thinking of the whole letter.' (ibid, p17).

Buckley (2002) notes the importance of using a patient's own metaphors and also, if appropriate, to encourage her to express herself in ways other than language. Jefferis (2011) extends this to the use of films, books and fairy tales as metaphor which allows the particular challenge to be approached and thought about, and the unrealistic nature of fairy tales allows this process to flow more smoothly than if the tale was a realist one. Metaphors become adaptive…

> 'Making new sense of the previously dysfunctionally regulated states, by finding new explanations and meaning with the help of another. This helps develop the capacity to sense and reflect on strong emotions by representing them in images or words, or by using metaphor and analogy.' (Bristow 2006, p6).

Complexity exists within the review as it is suggested that metaphors are to be avoided with those with Asperger's (Murphy 2008). Yet with patients whose ability to imagine is impaired they are useful (Dent-Brown 2011). Kirkland's (2010) consideration when working with learning disabled individuals noted the misuse of therapists power when working with metaphor with three mistakes that may encroach on the usefulness of metaphor, identified from Milioni (2007) as using metaphor as a silencing device, the high-jacked metaphor and the signifying environment.

The silencing metaphor concerns the therapists' metaphor as more prominent, the high jacked was where the patients metaphor was overly noticed and the signifying environment the effect of the room, for example, perhaps full of books and certificates suggesting the knowledge and power of the therapist. Steele (2013) reinforces these cautions as certain metaphors might resonate with the therapist more than others and more weight might be unwittingly given to one metaphor over another. The caution to draw from this intriguing article was that collaboration and co-construction were important so as not to render the metaphor unrecognisable by the patient. As Pollard et al. (2006) eloquently note…

> 'The concept of the dialogical self is itself a complex metaphor, made up of a number of different (and conflicting) primary metaphors. From such shared experiences emerge shared meanings and importantly shared values that can enable people to live together in conditions of relative harmony.'
>
> (Pollard et al. 2006, p 22)

Metaphors and psychotherapy

The literal meaning of metaphor (μεταφορά – metaphora) is a transfer, in rhetoric transference of a word to a new sense, is language directly comparing seemingly unrelated subjects. It sometimes seems that metaphors are the only way of talking about many things (Palmer 2006) with traditional interest being focussed mainly on the linguistic metaphor. In the last three decades there has been an increasing amount of attention paid to metaphors, most notably the refreshment of metaphor theory by Lakoff and Johnson (1980) who have sparked considerable debate. Lakoff and Johnson's define metaphor as something relatively more concrete or conceivable, which stands for something more elusive. Their Conceptual Metaphor Theory (CMT) where metaphors are considered to be cross domain mappings based on similarity is now well established (Dorst and Pasma 2010). Their research is compelling and their attention to detail has established them as leading theorists on the conceptualisation of metaphor.

Metaphor and language

Metaphors have been an essential feature of human communication from time immemorial (Barker 1985). They are mental constructs, shaping our thinking about the world and reality (Saban 2006), and are considered an indispensable structure of human understanding through which we figuratively comprehend our world (Hermans 2003). Metaphor, it is argued, is a primary or first order development of the mind, that not only enables language to develop, but it is through metaphor we come to understand the world (Siegelman 1993). Lakoff (1997) and Lakoff and Johnson (1980) write that we are not simply given our world but it is constructed through the way we make meaning of our perceptions and thoughts. Lakoff and Turner (2009) suggest that conscious knowledge is commonly understood through metaphor 'knowing is seeing, when we see something in a new way, we know it in a new way' (cited Siegelman 1993, p5).

Lakoff, Turner and Johnson's work acts as a cornerstone in metaphor theory exploring the importance of managing a language which is familiar and at the same time once removed supporting individuals in the complex nature of meaning construction and associated emotional responses. For example 'noticing that we use our basic bodily understanding of places, movement, forces, paths, objects and containers as sources of information about life' (Eynon 2002, p399).

Attempts have been made to compartmentalise metaphor. For example, Mills and Crowley (1986) have described eight types of metaphor…

1. Major stories
2. Anecdotes and short stories
3. Analogies, similes and brief metaphorical statements
4. Relationship metaphors
5. Tasks and rituals with metaphorical significance
6. Metaphorical objects
7. Artistic metaphors
8. Cartoon therapy

Fabregat et al. (2004) and Kovecses et al. (2010) describe a number of 'meaning' metaphors which incorporate Mills and Crowley's list. They are:

- **Emotion**: express emotions. For example '*I am torn up'*
- **Ontological** (or normative): Arise from basic bodily experience or from comparison with objects or things. For example '*I feel like an empty cistern that must be invisibly refilled.'*
- **Orientation:** Give the idea of movement, pointing to different directions; on top, over, under, in front, behind, here, there, past, or to come. For example '*I was totally under pressure.'*
- **Creative:** Compare abstract concepts, like love, freedom, death and can be ontological and orientation metaphors. For example *'My husband is an octopus; he takes my vital space. I need a little room to grow.'*

(Fabregat et al. 2004 p151-152)

Fabregat et al.'s (2004) work is rich and empirically valid however the focus is on the facial expression and metaphor rather than the use of PM. Their metaphor descriptions or categories are congruent with Lakoff's (1997) source domain (the realm of our body experience) and target domain (the emotion of emptiness for example).

Function of Metaphors

Suzanne Langer characterises metaphor as 'our most striking evidence of abstractive seeing, of the power of the human mind to use presentational symbols' (cited Siegelman 1993, p5). The functional aspects of PM appear to involve a number of considerations, as a way of understanding a history, as a way of understanding emotions, as a way of managing the TE, and as a way of developing recognition and revision of problem procedures.

As a way of understanding a history

Witztum et al. (1988) considers metaphors as a kernel statement, expressing something essential that enables complex constructs to be managed by the mind (Serig 2008). They provide a language of flexibility (Billow 1977) linking complicated thoughts, feelings and emotions, as if simplifying them into a memorable event, at the same time reducing the infinite possibilities available to the mind. This kernel, the beginnings of and potential for growth, can be linked to metaphorically structured long term memories (Gibbs 1992). Muran and DiGiuseppe (1990) note they are 'active and directive and that they accurately acknowledge the nature of metaphor as an heuristic and epistemic device' (p69).

The function of metaphor suggests deeper meaning than here and now management of thought and emotion. They are not simply instantiations of temporary, ad hoc categories but reflect pre-existing conceptual mappings in long-term memory that are metaphorically structured (Glucksberg and Keysar 1990). Fabregat et al. (2004) view their function as a linguistic structure or trope, conceived as a matrix' or bridge furthering the working through of thoughts and affects in their symbolisation before effects appear in language as conscious speech.

Martin et al's. (1992) study on the intentional use of metaphor, noticed three constructivist functions of metaphor, mnemonic, epistemic and motivational that might be important factors in promoting patient change. They critique the limited number of empirical studies exploring such theoretical suggestions (e.g. Angus and Rennie 1989, McMullen 1985) where, up to 1992, there had been no published studies using any form of experimental manipulation to these three aspects or indeed their clinical impact (Martin et al. 1992, p143). Rasmussen and Angus (1996) explored metaphor with borderline and non-borderline patients. Martin and Stelmaczonek (1988) and Martin et al. (1990) found elaboration using metaphor was distinguished by the patients as therapeutically enabling events. Of interest it was the therapist offering the metaphor that stimulated recall.

As a way of understanding emotions

Words contain important figures of speech (Fine et al. 1973). McMullen (2008) indicates that there are parallels in both metaphor and emotion as well as metaphor and conceptual. We use metaphor intuitively and unconsciously to understand the mind, emotions and all other abstract concepts (Eynon 2002) in so far as the metaphor enables us to understand unembodied things, such as the mind for example. Metaphors, being capable of evoking emotion, manifest both operant and latent content working on both cognitive and emotive strata. As these factors are common to psychotherapy it seems useful then to pay attention to metaphors in psychotherapy (Fraser 1998). In Kovecses et al. (2010) work, metaphor and emotions are seen to be entwined, have an intrinsic force tendency toward action. Fine et al. (1973) suggest metaphor use when a patient has a discrepancy between what they are feeling and the available words to describe this feeling state…'without some sensitivity to metaphorical usage, it is all too easy for a therapist to miss the sometimes unconscious appeal that is being made by his patient' (ibid, p88).

Lakoff and Johnsons (1980) research identifies metaphors as more than merely linguistic expressions, because it follows that we would expect different linguistic expressions to be different metaphors…'we have one metaphor (they use an example of 'love is a journey') and this unified way of conceptualising love metaphorically is realised in many different linguistic expressions (ibid, p209). Recent authors have expanded the model of the metaphor to be more constructivist, including memories, feelings and dreams (Skarderund 2007). Ortony (1993) expands the constructivist view of metaphor, noting three general hypotheses as to why individuals use metaphor so widely, the inexpressibility hypothesis, the compactness hypothesis and the vividness hypothesis.

Inexpressibility hypothesis

Metaphors, by enabling people to understand one thing in relation to another, by focusing on similarities and analogies between the two phenomena, can be considered as instruments of discovery (Saban 2006). Their value lies when the metaphor is interwoven into a story, as if it mirrors the patients situation reframes meaning and suggests methods for resolution (Larkin and Zabourek 1988, Heiney 1995). Larkin (1990) discusses Erickson's (1901-1980) therapeutic storytelling, where 'talking in metaphor is an indirect way of offering therapeutic suggestions' (ibid, p11).

Metaphor 'condenses complex and even opposite feelings, needs, wishes, fears and experiences, it does so with great economy and apparent simplicity' (Fraser 1998, p142). Barker (2000) uses the metaphor of water to describe the variable and irregular patters (of the mind) that never repeat themselves. He illustrates the complexity of 'I' the mind...'something solid, like a tablet upon which life is writing a record. Yet the 'tablet' moves with the writing finger as the river flows…so that the memory is like a record written on water' (Barker 2000, p53). These descriptions provide the reader with a rich seam of knowledge and imagery. Neimeyer (1999) writes eloquently on this subject…

> 'To move beyond the constraints of public speech, we need to use words in a more personal way, and draw on terms that are rich in resonance and imagery. Speaking of our loss metaphorically can help us accomplish this, sometimes leading to surprising insights unavailable to us when we think of it only in more conventional 'symptomatic' terms' (ibid, p78).

Compactness hypothesis

Serig (2008) notes that metaphors can unearth buried affect and provide insight by making the past present and the unconscious conscious. Metaphors link complicated thoughts feelings and emotions, simplifying them into a memorable event whilst at the same time reducing the infinite possibilities available to the mind to try to fathom out our conceptual mappings and understandings.

Strong (1989) noticed metaphors of the 'greatest significance are those expressed without consciousness…are part of the patient's language, or in dynamic terms 'outcroppings of the unconscious' (p203); as if, working with metaphors brings a heightened consciousness and involvement in and with the metaphor (Siegelman 1993). Long term memories may themselves be metaphorically structured (Gibbs 2008), in a significant study by McMullen (1989) she notes…

> 'Descriptive analyses revealed features of patients' figurative language that were more consistently present in the successful than in the unsuccessful cases, namely, the elaboration of major therapy themes via bursts of figurative language or development of a metaphor over time, the existence of a central metaphor(s) as evidenced by the use of several conceptually related figures that fit the metaphor(s), and the expression of some positive personal change in figurative language.' (McMullen 1989, p203).

Vividness hypothesis

Metaphors can seemingly be utilised to get to, explore and understand a person's inner, psychodynamic representations of the world (Domino et al. 1992), they can reduce defensiveness and provide 'aha' leading to insight and change (Pernicano 2010) and may play a substantial role in identifying how patients cope psychologically with their illness (Spall et al. 2001). Metaphors work on an interactive level, having a shared language, creating meaning within a literal system; both the speaker and listener have to understand the current meaning and at the same time have referent appreciation based upon their existing understanding of the phenomena in which the metaphor is applied (McIntosh 2010). Metaphors offer dynamic and dramatic views beyond the surface of things into their deeper significance (Fraser 1998). McIntosh (2010) reviews the literature extensively, noting research over time from 1977 to the date of authorship of the last Cambridge Dictionary of Metaphor and Thought. In her review she cites key works as represented in Fig6 as a matrix.

Fig6: Review Matrix – Functions of metaphor in psychotherapy

Author	Point 1	Point 2	Point 3	Point 4
Cirillo and Cryder (1995)	Making a point vividly	Accommodating disparate interest through multiple meanings	Changing perspectives on a topic	Using novel combinations to create or reveal something new
Lyddon, Clay and Sparks (2001)	Being sensitive to patients metaphors can convey understanding of the patients ways of 'knowing' contributing to a shared language	By symbolising emotions that have not previously been explored can assist in constructing new meanings	May enable patients to access new information about themselves in indirect ways	May facilitate discovery by facilitating awareness of patients previously unknown aspects of the self
Guerin (2003)	Communicate as they assist in the development of a shared language over the course of therapy	Represent or symbolize emotions	Language using metaphors refer to views of the self	Express that which is difficult to put into words and to speak

As a way of managing the therapeutic encounter

Language in psychotherapy has been found to use metaphors extensively and when expressed can facilitate insight providing new solutions and to enhance communication and the working alliance (Angus 1996, McMullen 1985, Levit et al. 2000). During the therapy encounter metaphors arise and, if noted and used, become educational tools. Metaphors thus can begin to extend (and broaden) the boundaries of beliefs about thinking (Abbatielo 2006) and broaden 'the concept of cognition to include the imaginal and metaphoric forms of cognition' (Kopp 1995, p133). A number of important facets are engaged in managing a positive alliance, where the core conditions derived from Humanistic counselling theory and practice are a cornerstone. The relationships foundation rests on a successful alliance whose quality depends on the extent the patient and therapist agree on tasks, achieve goals and the quality of the bond developing between them (Keijser et al. 2000). Change is greatest when the skilful therapist provides trust, acceptance, acknowledgment, collaboration and respect for the patient in an supportive and risk aware environment providing maximal safety (Beutler and Harwood 2000).

Holmes and Bateman (2002) address these common factors of the alliance where patient's emotional involvement in therapy was positively correlated with outcome. Four components of a successful alliance are observed…

- The ability of the patient to work purposefully in therapy
- The capacity of the patient to form a strong affective bond to the therapist
- The therapists' skill as providing empathic understanding
- Patient therapist agreement on goals and tasks.

(Holmes and Bateman 2002, p8)

The relationship starts from day one, from a secure base metaphorically, as a supportive function (Gobfert and Barnes 1995). Kok et al. (2011) in a recent qualitative study, using discourse analysis and observation, find the poetic nature of metaphor can create a TR with patients as space was created within language to allow new construction of meanings to generate changes. Their findings include the contextualised culture of the patients. The study revealed inner struggles and interpersonal relationships. Whilst this is a Malaysian study the findings appear to be translatable.

Roth and Parry's (1997) findings consider the alliance an indicator of a positive outcome in therapy. CAT, because it maintains a focus on the interpersonal, pays attention to this rather than leaning too heavily on technique in the absence of the alliance. Nevo and Wiseman (2002) further note 'the importance of the developmental life-span approach, time limit, focusing on the working alliance, quick assessment, having a central focus or theme, active and directive counsellor participation, therapeutic flexibility, and dealing with termination' (p228) is important in time limited therapy. One of the researcher's research statements for testing is whether a focus on metaphor and PM can enhance the alliance when working constructively with metaphor in the encounter.

As a way of developing recognition and revision of problem procedures

Metaphors have decades of tradition in psychotherapy and are used by clinicians of diverse origins (Witztum et al. 1988, Sharp et al. 2002). They help make meaning of the problems of living, invariably expressed through complex metaphors used by our patient's (Barker and Buchanan Barker 2005). The use of metaphor is well documented (Kopp 1995, Abbatiello 2006, Barker 1996, Welch 1984 and Palmer 2006) and is an often used

utterance in all therapeutic and social encounters (Leiman 1994). Early psychological pioneers, such as Freud (1908) and Jung, recognised metaphors give rise to emotions and reveal hidden meanings (Fox 1989).

Subsequently Erickson (1935 and 1944), Kopp (1995), McIntosh (2010) and McMullen (2008) have made significant contributions to the understanding of metaphor as part of a psychotherapeutic approach. Recently Stott et al. (2010) published a useful work on metaphors and CBT and Battino (2002) notes 'if you work within your patients own metaphoric imagination, then you are closer to their internal being' (ibid, p22). Strong (1989) notes the use of and acceptance of metaphor as a genuine form of patients' experience and communication could provide counsellors with viable medium for effecting change.

Battino (2007) further notes that we all like to listen to stories viewing their influence as a direct route to the unconscious. Metaphor has a range of uses in stories (Salka 1997) for example drawing on classic stories such as the '*Wizard of Oz'* can be helpful in therapy where Dorothy learns that all along she had the ability to return home. In current culture the use of films and cinematic metaphor can be valuable. Consider the characters in '*Finding Nemo'* for example. Each provides commentary on ways of managing anxiety and decision making.

Bettelheim's (1989 and 1998) tales of enchantment explore how a story has to truly hold a child's attention, it must relate the child's experiences without belittling them and at the same time instilling confidence in their agency and ability to manage the future. Bettleheim (1998) notes how fairy tales enable the child to make coherent sense of the complexity and turmoil of their feelings. Rustin and Rustin's (1987) book '*Narratives of Love and Loss'* explores children's fiction. They note that children's fiction is a genre of broadly metaphoric writing whereby metaphoric ways of representing experiences can function as poetic containers of the life experiences of the reader. The metaphor is the bearer of emotional meaning through symbolism and the story itself (p4). For example, in '*Toms Midnight Garden',* metaphors of stages of emotional development can be observed and more widely in children's literature these metaphors are often a crucial part of the fiction (p37). Enabling us to understand metaphor allows us to grasp the ungraspable (Spall et al. 2001) or even describe the nature of the interaction, as in the dance of therapy (Pistole 2003).

Winship (2011) draws our attention to the work of Samual Beckett's psychotherapy alongside Wilfred Bion's analytical contributions during 1934-1936. He explores this work as an exploration of chess and schizophrenia guiding us towards an understanding of Beckett's' work and the context within it arose from his relationship with Wilfred Bion. Ewart (2015) provides further commentary on the role of Beckett's '*Murphy' (1938)* describing the way the novel challenges views at the time of disability and institutionalisation. The role of therapy and integration of psychoanalysis within the therapeutic encounter has been noted in the section on leaders in nursing but it is worth noting that this creates an uneasy alliance as Winship (1995) again observes. His paper draws our attention to the importance of thinking and not just doing in psychiatric nursing, a position that the author of this research finds essential to his practice.

Bion (1977) thought that metaphor as part of the therapists 'dreamy reverie' could be an expression of the patients' unconscious and that reverie facilitates a noticing of metaphoric associations. Modell (2009) comments that these technical components of the therapist's encounter increases awareness, expression and communication of metaphor, he concludes that 'the salient function of metaphor is in the establishment of empathic contact with our patients' (p10). Bion cites chess as a metaphor for therapy and subsequent writers have explored and/or adopted this understanding. It is interesting to note that others have progress to the 'actual' role of chess in therapy, as Fadul and Canlas (2010) have explored, citing Albert Ellis as a notable therapists who played both checkers and chess with his patients. They (ibid, p7) notice that the Persian physician Rhazes (AD 852-932) is understood to have played a game similar to chess whilst counselling his patients according to metaphors of chess related to real life situations.

This use of cinema as therapy, promoting change through specific 'movies', acting as novel metaphors for therapeutic change between sessions, has been documented (Sharpe et al. 2002). Pollio et al. (1977) note how employing novel metaphors to talk about problems in a new and unusual way can serve to make explicit what has previously been implicit, thereby facilitating problem description and resolution (McIntosh 2010, p398). Metaphors it seems can be used to describe therapy, both the patient's spontaneous productions, or the therapist's choice of words. The process of psychotherapy can itself be explained metaphorically like in the interests of developing the treatment alliance (Blatner 2006). In fact therapy itself has been described in metaphoric terms as a journey (Hall 1997) and like the student teacher relationship (Michels 2007).

Patient or therapist derived

Barker (1996) observes that family therapists may offer metaphors for strategic direction whilst Searle (1985) reinforces the importance of meaning in metaphor; it is always the speakers meaning that is important. Kok et al. (2011) researched patient derived metaphors where 68 trainee therapists were advised to pay attention to metaphor initiated by the patient. Each therapist was to conduct 3-5 sessions, metaphors were noted down and a narrative account was used in a case conference. The researchers generated a long list of metaphors, mostly related to emotions, covering the range of bodily sensations, descriptive of their current lives, reflective of culture, having multiple meaning's, and how metaphors can promote change. They recommend further research to explore the complexity of the relation between language and psychological factors.

Martin et al. (1992) noted that patients tended to recall therapists' intentional metaphors approximately two-thirds of the time, especially when these metaphors were developed collaboratively and used repetitively. Patients rated therapy sessions in which they recalled the therapists' intentional use of metaphors as more helpful than sessions in which they recalled therapeutic events other than therapists' intentional metaphors. Their research is supportive of training therapists to be 'attentive to and utilise metaphor in practice whereby experienced therapists were coached to use metaphor intentionally' (ibid, p143). The training was 3 hours in duration and included the nature of metaphor and its possible effects on the patients experience and awareness were discussed, explained, illustrated and modelled (ibid, p144) Whilst this was a small study of three therapists 41 episodic memory questionnaires and audiotaped sessions were completed. Patients recalled therapist derived metaphor in 66% of occasions. The authors notice limitations to their research, never-the-less it is an important reference point for further study and this study in particular.

A number of models specifically notice or incorporate metaphor, and it seemed important to examine the practice oriented literature or 'models' of psychotherapy that did so. Appendix IV provides additional detail on the therapeutic approach defined as part of some of the following models. Nineteen models incorporating metaphor were found. These Models have many references to metaphoric language, Figure7 shows a breakdown of the key aspects of each model, process, and function and some suggested dialogue. The models indicate metaphors can be patient derived or therapist derived with patient derived metaphors generating an understanding of the patient's inner world.

Fig 7: Analysis of 18 models incorporating metaphor

model	process	function	Example dialogue
Aeolian mode	Attend – witness – wait…metaphors confrontativley interventive	Challenge beliefs	I wonder why that should be?
Acceptance and Commitment Therapy	metaphors as 'tools'	Establish new belief systems	When you have a headache like that it might be better to put down the hammer
Action Learning	Metaphors/imagery to connect emotionally to past events	Bring about change	What would that emotion look like?
Cognitive Therapy	Generation of helpful ways of thinking	Reflect on alternatives	You have the heart of a lion yet feel like a mouse?
Clean Language	Discover personal symbols and metaphors	Explore metaphor to convert metaphor to an alternatives	What does the rut look like?
Ericksonian Psychotherapy	Strategic use of metaphor by the therapist	Liberates both the patient and therapists from preconceived notions	It seems to me as if the metaphor is describing…?
Focussing	Connecting to the sense and experiencing it and uses imagery and metaphor	Coming to a new understanding of felt sense	What feelings come to mind when you think about this metaphor?
Freud	Free association	Help surface repressed thoughts and feelings	What images come to mind?
Guided Affective Imagery	Consider ten scenarios	Seeks to lead to desirable changes in both affect and attitudes towards life situations	Consider this scenario?
Jung	Unconscious processes transformed into images via symbols and metaphors	To express in a unique way psychological fact incapable of being grasped at once by consciousness	Tell me more about the Metaphor?
Narrative Therapy	Generate and evolve new stories and ways of interpreting events	Reflection through renaming and the use of metaphor	Run the image as if you might run a movie
Neuro Linguistic programming	Humans form cognitive maps	Patients to 'hear' or 'see'; the problem	What do you see/hear/experience when you think of this metaphor?
Person Centred	Therapist has a metaphor to mind it is proposed as a metaphor not imposed	to explore, and transform	I wonder what this ,metaphor mean for you?
Conversational Model	therapist expresses a more active involvement	use of metaphor and interpretation	It seems to me as if the metaphor is describing…?
Winnicott	Enabling 'playing' to offer a holding environment for discovery	In playing, and perhaps only playing, the child or adult is free to be creative	Let's see what this looks like as a picture if that's alright with you?
Reasoning by Analogy	Involves comparing two objects, events or people based on relevant but not obvious similarities	Metaphors are the patterns that connect	Why is it that you are taking that elevator down?
6PSM	story' is generated by the patient that becomes a metaphor and incorporates metaphor	to help the individual reach self-awareness whilst improving internal and external dialogue	Draw a story with six pictures including a character, a task, obstacles, helps, climax or action and aftermath
Transpersonal Psychotherapy	The melding of the wisdom	organising information and facilitating new understanding	Metaphors explain what is wrong with the human condition…

NB: This list is not exhaustive as there are over 500 documented therapies but these appear to be influential.

Stott et al. (2010) view the process of metaphor working as having five aspects; Metaphor activates an intact conceptual structure in the patient; Perception and reality can be divergent, such as the metaphor, '*I am in a dark place'* indicates an emotional sense rather than an actual reality; A suggested non-permanence of the predicament, light can be brought into darkness; A mental model is then activated that is non-blaming, as if it's a problem with darkness rather than the individual. The patient can then accept responsibility for creating the light.

Metaphors within this five aspect approach create vivid imagery that crystallises the new perspective that can facilitate speedy recall, 'a hook upon which to hang piece of therapeutic work and/or homework' (Stott et al. 2010, p15). All models reviewed utilise metaphors based on the assumption that patients recall metaphor, therapist's intentional metaphor as well as their own. Key points for consideration appear to be:

- Modifying metaphors - '*when you have a headache like that it might be better to put down the hammer.'*
- Utilising metaphors to connect with past distressing events, the felt sense
- Reflecting on core beliefs through metaphor.
- Identifying metaphors for particular events seeking a preferred metaphor response, explore the steps to achieve this preferred position.
- Strategic use of therapist derived metaphor to facilitate change *but* these have to be proposed not imposed.
- Guided imagery, either imaging a scenario or describing a story as in the 6 part story method.
- Exploration of the metaphor as a sensory image can draw this image out, agree not to intrude but to create and explore.
- Be prepared to play. Playing occurs in that space where our imagination is able to shape the external world without the experience of compliance, climax, or too much anxiety.

Within these suggestions there are reciprocal limitations, not to over use metaphor, and to be prepared to alter the approach as it is the individuals understanding that matters. Metaphors can contain affect but also stimulate effect, so it is important to maintain the common factors of a successful TE.

Cautions and limitations

McIntosh (2010) suggests some limitations to metaphor use. She questions the nature of research and the decontextualized nature of metaphor study, as metaphors need to be understood not in terms of their content but when and whereby the content arrived in the highly contextualised nature of metaphor use in therapy. She (ibid) notes that the 'focus on words has taken precedence over a focus on talk, on talk as a form of situated action' (p402). Because of their importance in all communication it is difficult to find literature denouncing metaphor, but there are cautions to their use. Schroots et al. (1991) state that…

> 'There are better or worse metaphors, more or less useful or effective metaphors, but no right or wrong ones. Metaphors always involve the highlighting of certain aspects of phenomena and the obscuring of others' (ibid, p3).

Neimeyer (1999) considers that it is the individual's interpretation that matters…'the nature of metaphor itself that it is once removed, it is not literal language in metaphor but a felt sense, figurative language is much more fluid and protean' (p81). There are occasions where affect is hard to reach, as in the case of conventional or automatic metaphor and times when metaphor is used defensively as a way to avoid affect (Siegelman 1993). There are also occasions where there are parts of every metaphor that do not and cannot fit the object the metaphor represent (Lakoff and Johnson 1980, Moss et al. 2003).

Muran and DiGiuseppe (1990) recognizes the potential harm of metaphor and reiterate the importance of explicitness and shared understanding according to communication theory (p69). Stern (1985) cautions about fitting metaphor into an expected format because it is logically consistent with a developmental theory 'psychopathology may, but does not have to, have a developmental history that reaches back to infancy' (p260). Henzell (1984) in Chapter 2, 'Art as Therapy', discussed a framed metaphor whereby it is open to inspection and an unframed metaphor that is closed. He later cautions that 'pictorial imagery avails itself to over determination and may become a repository of many meanings' (ibid p20). It is rhetorical dialogue that can transform a symptom into a metaphor from unframed to framed, from one to the other.

There is discussion within the literature about dead and alive metaphors….novel metaphors are considered live and conventional metaphors dead. Falck (2010) comments on Cornelia Muller's position in that they are actually sleeping or waking rather than dead or alive. The researcher would lean towards this view as both dead or sleeping metaphors when explored contextually with a patient can provide current meaning. The problem is when the listener hears the dead metaphor and assumes s/he knows what it means without seeking clarification. Falck (2010) supports this with a view that metaphors work on their level of use rather than primarily on the level of linguistic systems. Barker (1996) applies seven pitfalls when working with metaphors:

1) 'Attempting to use metaphorical methods before adequate rapport exists.
2) Offering a major metaphorical interventions before proper assessment has been completed.
3) Choosing a story or activity to which your patient has unpleasant, fear filled or otherwise negative associations.
4) Overlooking the importance of some aspect of the real life situation to which you intend to apply the metaphor.
5) Allowing insufficient time for delivery of the metaphor.
6) Starting before clear therapeutic goals have been agreed upon with your patients.
7) Failing to choose the right metaphors and overlooking metaphors that patients are offering.' (Barker 1996, p132-135)

Metaphors, pictures and pictorial representations

Pictorial metaphor/pictorial representation

Images and imagery are all around us and are worthy of exploration. The SDR picture enables the creative mind to see problem procedures. The pictorial method is the study of the self's spatial and temporal dimensions as an adjunct to narrative. In many ways images speak but without the narrative how can one interpret collaboratively? The researcher is interested in whether pictures can be used to explore interpersonal and relational dynamics but not in the absence or replacement of a dialogue.

The pictorial image, that embodies many meanings, has a long tradition of illustrated literature; texts with accompanying pictures. Silverman (2006) notes the aim of researching the visual image is to examine the work that they do and to understand how they do that work. Consider your early introduction to reading and relatedness through

comics and children stories. These and more complex dialogue, such as the work of Dickens or Thackeray, are often supported by illustrations, providing visual explanation and ironic commentary on the text through a subtle system of related metaphors (Kennedy 1994). Figure8 is an illustration from Thackeray's work…Mr Osborne's welcome to Amelia!

Fig8: Mr Osborne's welcome to Amelia

Metaphors are part of an individual's dialogue. In fact there is generally no disagreement as to the existence of linguistic metaphors (McGuire 1999), with some sentences regularly including up to four metaphors (Tompkins and Lawley 2002). Forceville (2008) notes that if metaphors are essential to thinking, then they cannot be confined just to language, but also occur in music, static and moving images, sounds, gestures, and to our senses. Lakoff and Johnson's (1980) CMT leans towards language rather than other mediums and has been challenged by researchers to be expanded to include visual images (McIntosh 20101). The researcher is mindful of the role of movie, drama and poetic references (Carroll 1996, Carswell and Magraw 2003) within the TE. These mediums can be resonant of the patient's experience alongside the dialogic nature of signs where the image is viewed as a concrete form of abstract themes (McIntosh 2010).

Psychotherapy literature often presents pictures and metaphors to represent core pain, or hoped for changes, in patient's difficulties (Wilde McCormick 2012, Dunn 2007, Billings 1991). This use of a picture in therapy is not novel, in fact pictures can be seen as a foundation in the psychotherapies being based on the importance of visualisation and imagery (Siegelman 1993, Rubin 2001). However, there is considerable debate around whether there is such a thing as a PM (McGuire 1999).

The answer, according to Serig (2008a), is unavoidably pluralistic. As Sedivy (1997) suggests, their existence is based on the belief that pictures possess a propositional content...there are metaphoric pictures…metaphoric pictures do not possess metaphoric content…therefore there can be no theory of pictorial metaphor. I disagree, in answer to this line of logic a number of authors in Art research have made a contribution to the field:

- Virgil Aldrich (1968): all art is metaphor.
- Noel Carroll (1996): visual metaphors identify or link disparate categories by means of homospatiality whereby two objects can share the same space.
- Cathy Dent (1990): 'one thing is depicted in terms of another that that is different in kind, but bears an actual resemblance to the first object (Dent and Rosenberg, 1990, p984).
- Carl Hausman (1983): visual metaphor is internal to the work of art.
- Susanne Langer (1948, 2009): every new experience, or new idea about things, evokes first of all some metaphorical expression (cited Siegelman 1993).
- Joy Schaverien (1999): Art Psychotherapist and Jungian analyst, also writes about the 'revealing and embodied' image (Hughes 2011).
- Rita Simons: wrote a number of books about the meaning of various artistic styles in pictures (Hughes 2011).

Metaphor, art and language

Our cognitive flexibility, the minds ability to deal with complexity, ambiguity, anomaly and even absurdity drives our desire for reorganisation and leads us to use and create metaphors (Serig 2008). Using language (words) to describe metaphors appears to be helpful yet can there be words and language without images? Mother, is a word describing one's primary caretaker but also embodied with this word are images of 'Mother' and emotions arranged around the images and word. Using images, extending metaphor to works of art that represent emotions or devising various means to express this inner life through music, painting, the arts and literature is a human trait (Turbayne 1962). Susanne Langer (1948 cited Siegelman 1993) studied the symbolism of reason ritual and art in her work and describes the acquisition of new knowledge primarily through the metaphoric process, describing the comparison of one thing in terms of another, a new thing is born. Furthermore, Hermans (2003), notes image schema and their metaphorical use are central to a patient's imagination and can be explored and extended in therapy.

Metaphors, deriving from the imagination and dialogic nature of the individual, the dialogue that occurs within, between, and without, can be expressed in pictures and such visual metaphors can be noticed (Dent and Rosenberg 1990). Their (Ibid) study investigating the development of the individual's ability to comprehend visual metaphors (as indicated in corresponding verbal metaphors) investigates young people's ability to manage and comprehend metaphor and visual imagery. They note aspects of drawings that express 'emotion or mood' among other attributes. Their explanation of PM is very clear…

> 'In pictorial metaphor, one thing is depicted in terms of another thing that is different in kind, but bears an actual resemblance to the first object. Some properties of the vehicle object must be present in the depiction of the topic object in order for the depiction to be metaphoric, but the complete vehicle object is not depicted. The metaphoric ground or resemblance is highlighted in the visual metaphor, the topic-vehicle interaction is explicit. Thus, pictorial or visual metaphor is analogous in structure to verbal metaphor, although in the case of pictorial metaphor no words are used'. (Dent and Rosenberg 1990, p984)

Within this explanation, the verbal metaphor becomes the visual and visa versa. In fact the absence of words is difficult to accept fully as there are words when language is developed associated with activity, and so there would be an inner dialogue of words used whilst forming the PM. Dent and Rosenberg's conclusions were that visual expression of metaphor can trigger verbal metaphors.

Function of pictorial metaphor

Black (1998) comments, that a metaphor is strong when it is both empathetic and resonant. Art, as a medium, has inherent strength, and can introduce alternative perspectives for both the patient and the observer (Riley 2004). In Freeman and Dattilio's (1992) discussion around conceptualisation in cognitive therapy, their case examples begin with a sketch made by the therapist to represent the core problem. They comment that 'the sketch not only identifies the plethora of rules, but the possibility of therapy' (ibid, p21). The PM can facilitate transformation of mental representations that lead to maladaptive behaviours (Francis et al. 2011). Using art techniques suggests that change happens because of the transference of verbal information into visual form offering an alternative means of meeting need (Gentile 1997).

The picture is bringing the metaphoric image back to life (Witztum et al. 1988) which can lead the patient to developing transformational plans for life, plans to change if you like, arising from the developing imagery. The functional aspects of PM appear to involve a number of considerations…

- As a way of understanding a history.
- As a way of understanding emotions.
- As a way of managing the TE.
- As a way of developing recognition and revision of problem procedures.

As a way of understanding a history

Gentner et al. (2001) note that metaphor is like analogy and Salka (1997) notes that experience based metaphors, is an approach, where one…

> 'Gathers information from a patient's telling of his or her direct experience, a specific, individualised story or analogy often emerges...through the patients identification with this metaphor rapport with his or her unconscious mind is deepened' (ibid, p23).

These analogies in visual depiction, like utterances, can intend to convey specifics, thus we can acknowledge the meaning of an artist's metaphoric image/representation, especially if this was the specific purpose of a picture to re-present a metaphor.

As a way of understanding emotions

The process of development incorporates both the specifics of the utterance and the way in which it was given (McGuire 1999). This is an important clarification, as with any utterance it is both the conveyed and the conveying content that are important…

> 'When a patient or therapist introduces a live metaphor, as it emerges, it allows the patient to shape his or her own conscious experience, thus new meanings and new sensations are experienced' (Fraser 1998, p139).

Metaphors in this respect help us to focus attention and organise our thinking as well as help others do the same (Rosenblatt 2007). When seeing there is always the object and then an interpretation where content emerges, a fusion (or function) of the object and interpretation, the result being that there is commonly occurring metaphoric understanding within created objects (Aldrich 1968). Art gives an external voice to emotions (Lacroix et al. 2011) and becomes part of the healing process within the therapeutic alliance (Hughes 2007). It is as if the exploration of images is dynamic and therapeutic, McIntosh (2010)

explains this well…

> 'the images that I have presented, and the way we can work upon them suggests that we can approach them uni-dimensionally, either as metaphors or as a dialogic, but we can also approach them inter-dimensionally by utilising both of these approaches alongside one another – a kind of mixed methodology' (ibid, p165).

As a way of managing the therapeutic encounter

Working with and managing metaphor in the encounter 'can be the framework, context and terms of reference for the therapeutic hour' (Fraser 1998). Moon (2007) notes that the 'making and sharing of visual metaphors promotes rapport between the art therapist and patient' (p11). He adds 'when we communicate with patients through their own visual metaphors, they create opportunities to support, inform, engage, offer interpretations, provoke thought, and gently confront patients in a safe, psychologically non-threatening ways' (ibid, p12). There is permission inherent in these guidelines for either the patient or the therapist to deliver the metaphor, what is important is the collaboration, the patient introduces the metaphor and the therapist follows, or the worker can introduce the metaphor and the patient claims it. In either case, as Fraser (1998) notes the 'therapist is no longer the agency of treatment but a fellow participant in a process of individual development' (p139).

Witztum et al. (1988) also allude to the 'image evoked in the therapist….he told the patient a story about this child *(image)* to serve as a matching metaphor' (p6). Spall et al. (2001) in their focus group study of metaphor and palliative care note 'we believe that, should professionals initiate metaphors, they need to be relevant and within the experience and understanding of the patient' (p352). These authors seem to corroborate the proposition of there being both **strategic** approaches when utilising a single metaphor throughout the course of treatment and **tactical** approaches that might use metaphor for a limited purposes within the wider treatment frame.

Angus and Rennie (1989) and Martin et al. (1992) note that in some therapies a single fully and collaboratively developed metaphor can act as a central theme. For an example, I had a patient who described his emotion state as a 'Washing Machine,' because this was used as a strategic metaphor in that session (and subsequent sessions), at the end of each session I asked '*how is your washing machine now*? This elicited the answer '*you know there's less water in it!'*

There is evidence for both strategic and tactical uses of metaphor, as spontaneously derived, from either the patient's dialogue or the therapist dialogue. This is a delicate issue in psychotherapy and may speak of the power imbalances between a patient and a therapist whereby the therapist may be seen as the expert. CAT, as a co-constructed and dialogic therapy, is mindful of these complexities and it would argue that as the participation is usual and inherently collaborative the 'push and pull' (Potter 2010) of the relationship is more visible. Potter is talking here about his therapist led activity…

> 'Admittedly I am the one holding the pen so far…but the map is hers as much as mine. Her hands are on it…Her words and stories traced by it.' Furthermore he is looking to 'hand over shared activity and authority over the emerging diagrams as soon as possible' (ibid, p3).

This dialogic relationship can be represented through the image, where the image, as a form of self-expression can access the interpersonal structure and relational dynamics (Meira and Ferreira 2008). Falck (2010) quotes Muller in noting 'two realms of metaphorical structure may be active at the same time, a verbal one with a rich image, and a higher level one (conceptual) that is accessed through the specific semantics of the verbal metaphor' (p115). Imagination has the power to hold images from years ago which lie hidden, recalling and visualising these images can come through art making(Wilde McCormick 2012). Naumberg (1966 in Francis et al. 2011) emphasised that putting mental representations in graphic form can create a space for the expression of the patient's important qualities, strengths and struggle, what is often embodied in a patient's metaphor. Siegelman (1993) supports the process of metaphor working through exploration, towards evocation and elaboration, rather than interpretation.

Lakoff (1993) notes the 'source' term in a metaphor is often visual (as the visual is our most developed sense) giving the metaphor a concreteness, through the senses, and enabling the abstract to create resonance with the world of sense and lived experience (Siegelman 1993). Art introduces alternative perspectives for both the patient and the observer (Riley 2004). The PM becomes a logical extension of Lakoff and Johnson's (1980) constructivist position whereby metaphor is primarily a matter of thought and action and only derivatively a matter of language (Forceville 2002). Images as signs in CAT can be likened to our mnemonic language. Perhaps as far back to Neanderthal man, signs and pictures have formed the basis for representing more of the world and have enabled the development of man and subsequent complex language (Ryle 2010). One cannot ignore the impact of pictorial representations, as therapy is more than words (Schore 2008).

Recent research in metaphor and cognitive neuroscience by Gibbs and Matlock (2008) found that 'mental re-enactments reveal that metaphor understanding actively evokes images, which in turn are closely tied to bodily actions' (cited Dorst and Plasma 2010, p99). It is, as if, bringing the image to conscious awareness can alleviate the conflict through the therapeutic relationship (Lacroix et al. 2011). Wilkinson (2010) states that art, if produced by (and with) patients, especially in the emergence of metaphor, can be psychologically enabling. Levine (1996 in Lacroix et al. 2011) suggests that art is a gesture that transforms the self as well as the world, the body reveals the problem but also meaning and conflict and a new perspective from which to observe it (Lacroix et al. 2011). Art techniques also have the ability to enable expression of and containment of feeling responses that the patient may have no other safe area to cathect (Hughes 2007). As Hass-Cohen and Carr (2008, p 298) note…

> 'Art therapy enhances opportunities for shared non-verbal communication. In the light of ideas developed from attachment theory and neuroscience, it can be concluded that…the creation of art in the presence of a supportive therapist provides a context for reparative attachment work'

Pictures may represent a subject but also can include many different images. The important distinction here is the clarification with the patient of what the PM embodies from their perspective. Pictures have propositional (can represent a subject and characterise that subject in some way) content. Of course, any picture can have multiple interpretations, but if it is co-constructed then the meaning rests on the collaborative understanding. An observation reinforced by Siegelman (1993) noting that metaphors are unconsciously determined figurative expressions that can have vivid sensory connection and generate potential for affective charge.

As a way of developing recognition and revision of problem procedures

Working with verbal metaphors as discussed is well documented (Kopp 1995, Cox and Theilgaard 1987, Barker 1985, Siegelman 1993). In terms of understanding the process an example the researcher has paraphrased from Siegelman might elucidate…

> 'A patient says 'I feel like I am a butterfly' when this is heard one's own metaphoric 'antennae' go up and an image is often seen, perhaps of a butterfly alighting then flying off. The seeing is a crucial part of my response; I am attempting to see what the patient sees. My initial image –to be corrected by what he says next- depends on my own associative net…He shifts the image… 'a butterfly half way out of its pupae case – now the association changes, I see an image that relates to birth (infants emerging from the birth canal).' (Siegelman 1993, p17)

Witztum et al. (1988) note that metaphoric statements represent metaphoric images, plans of action, that can assist patients 'bring their metaphoric images back to life which stimulates them to further develop these plans of action and eventually implement them' (p2). Barker (1996, p116-117) sets out a number of prerequisites for successful delivery of metaphors:

- There must be an adequate level of rapport between therapist and patient.
- The patient must be prepared for the use of whatever category of metaphorical message it is that you plan to use.
- The therapist must have confidence in the therapy plan. A half-hearted or semi apologetic introduction of a metaphor is unlikely to meet with success.
- There should be an agreed or implied contract to use indirect methods, such as metaphor, with the patients concerned.
- Any appropriate steps should have been taken to ensure that the patients are in as receptive a state as possible.
- Timing is an important consideration. You should consider carefully just when to introduce your metaphor and how to pace its delivery.
- The continuous assessment of the feedback your patients are offering you is essential. As your (the) metaphor is being delivered, you should constantly assess the response, principally the non-verbal ones, and what you deliver.
- Thought should be given whether it may be best to offer a metaphor based on fact or on fiction.
- You should be clear whether you are aiming to make a single point or to embed multiple messages in what you deliver.

The researcher has a tension with this list as it *assumes* the metaphor is not patient generated and that all metaphorical 'strategic plan' are therapist delivered. The literature suggests that the collaborative nature of therapy should recognise the patient's metaphor but also allows the therapists to introduce metaphor as a joint activity.

Pictorial metaphor process

Art therapists have made much contribution to the literature on image making and therapy. This thesis is in essence a multi-modal attempt at integrating some practice from art therapy within CAT. Art therapists have contributed to the dialogue as supervisors and as commentators on published articles as well as integrating and being guided by their

literature base. Notably Riley (2004) argues for the role of art in therapy…

- ‘Image making offers the patient and therapist an advantageous means to achieve therapeutic goals.
- Art therapy invites personal metaphors into the conversation and allows the patient to make changes safely within the art product.
- Art teaches therapists to listen (with their ears and their eyes) as participant-witnesses.’ (Riley 2004, p90).

Diane Waller has contributed widely on the theme of art and therapy, spanning a range of ages, Child (Waller 2006) to adults (Waller 2013). Her work contributes to supporting art making for Dementia (Rusted et al. 2006), Schizophrenia (Laurent et al. 2014), addictions (Waller and Mahoney 2002) and physical illness (Waller and Sibbett 2005). She notes the importance of art making to facilitate positive change through the therapeutic relationship, engagement and using art in a safe environment. She notes the fundamental principles of art therapy are that…

- ‘Visual image making is an important aspect of human learning process
- Art made in the presence of an art therapist may enable the child to get in touch with feelings that cannot be easily expressed in words’

(Waller 2006, p217)

As noted I am mindful that I am not an art therapist and that other therapist’s may not be also, so it is important to take the structure of an established approach. Forceville (2008) suggests four major factors that play a role in art metaphor…

- Art metaphor is apprehended differently to verbal counterparts.
- They cue similarity between target and source of the metaphor differently to language.
- As music or pictures they have more cross cultural access.
- They have a stronger emotional appeal than verbal metaphors.

Where the images emerge and are generated, there are multiple interpretations and they can engage us in multiple possibilities leading to implicative elaboration. Stott et al. (2010), acknowledge an artist who skilfully brought to image some of the metaphors described

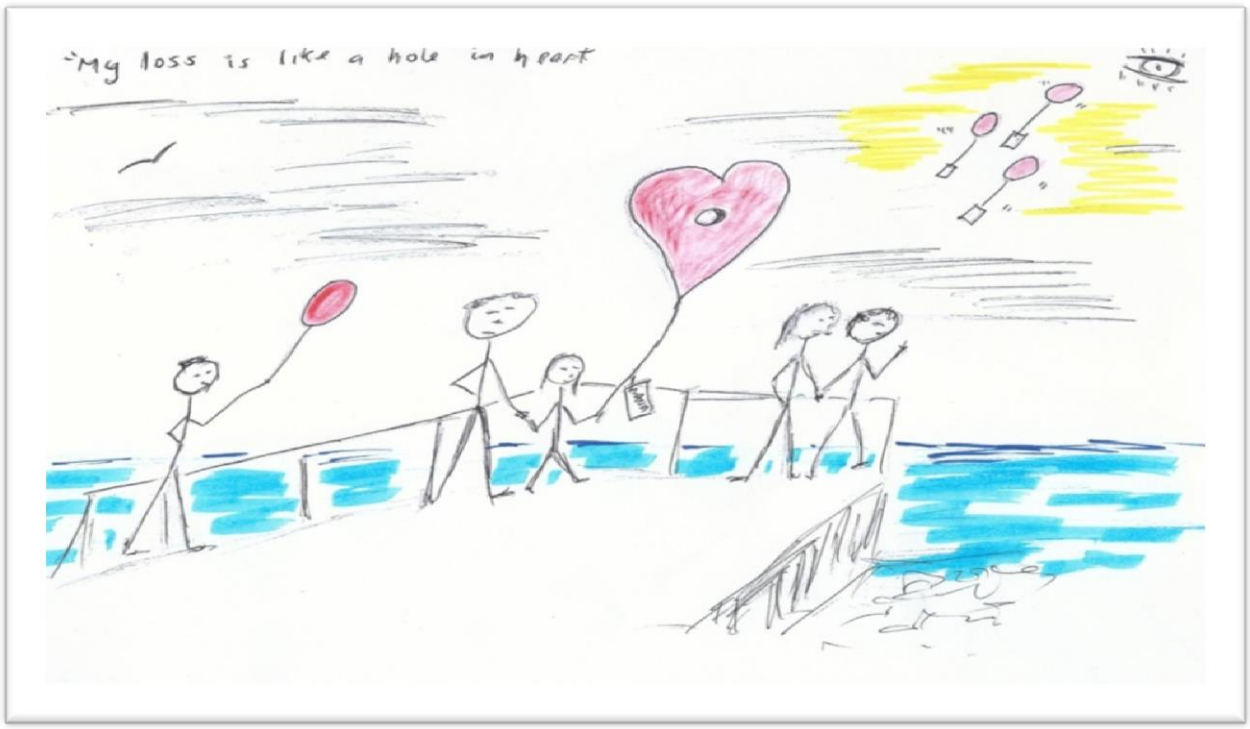
within text, the metaphors were able to bridge the verbal and imaginal. They are in effect symbolic and can re-present other phenomena. Moon (2007) regards the patient's metaphoric artwork as being akin to parables. In that there is a juxtaposition of the physical objects, the picture representations, with the life experiences they bring to therapy. Moon is working with art generated by the patient, rather than art generated collaboratively by the therapist with the patient which is a focus of investigation in this thesis.

The visual extends to bringing into the room references to film and other creative mediums. Carroll (1996), on film metaphor, notes that 'visual images, needless to say are symbols' (p814). Many therapists frequently use metaphoric illustrations in actively discussing with a patient their day-dreams about the patient which occur to them while listening to their dialogue during therapy (Yamaguchi and Todoroki 1974). This noticing becomes an initial step to working with metaphor and representative images.
Bayne and Thompson (2000) argue a place for pictures with three therapist responses: explicating what is implicit in a metaphor; therapeutically extending or modifying it; and the counsellor creating and delivering a therapeutic metaphor. These responses unearth new understandings as Henzell (1984) comments…

> 'Psychotherapy of this kind might aptly be compared to an art, an art that by imaginatively, perceptively and tactfully offering the patient deferent schemata and alternative perceptual domains uncovers the trajectory of his unconscious thoughts and feelings so they can be fully owned' (ibid, p21).

Siegelman (1993) outlines the importance of the image laden metaphor that as novel is usually born out of intense feeling 'the need to communicate something never communicated in that way before, to make others see what you have seen, and often to state psychological states that can only be approximated in words' (ibid, p6-7). A novel metaphor incorporates a 'topic' a 'vehicle' and a 'ground'. For example, '*my loss is like a hole in my heart'* (as expressed by my daughter about her Nana's death). The topic, what the metaphor is about, is loss and death, the vehicle *'a hole in my heart'*, being the relationship of the topic to another object loss which is the ground (the similarity between the vehicle and the topic). One thing is likened to another. The fact that the topic and vehicle referents are different is critical, without this there is no metaphor (Dent and Rosenberg 1990). The image below is a pictorial representation of a goodbye ceremony that my daughter asked us to facilitate where we let go of a balloon each with a note for 'Nana' written on it. Here we can see my daughter's balloon being represented as a heart with a hole.

Fig9: My loss is like a hole in my heart



Whilst this image is resonant and connects to a recent grief experience, mental images can also represent and make connection with the early life experience. This embodiment of experience within the image can support the individual's current self-healing capacity in recalling and working with the image in verbalisation. As if, the 'shift from the visual to the linguistic heralds a new capacity for symbolisation' (Wilkinson 2010, p194).

McIntosh (2010) directs the artist and therapist to realise the importance of colour when using visual metaphors. In '*The colours of my day'* (which is a picture of a flag with bands of colour rising from the base on a white background with the bands (or stripes) being green, black, yellow, red, then black again) she explains that 'colours are reflections and metaphors themselves, the blackness is interspersed in the late afternoon with stars that evolve into yellows and pinks' (ibid, p161). The colours are intertwined with words to create meaning. In his example the colours have an index: white=calmness, green=nausea, black=anxiety, yellow=blissful, pink=fun/laughter and black (again)=fear. In this respect the colours of the day not only represent thinking but also emotions.

What seems important from this example is not only to pay attention to colour if it is used, but also to notice the narrative of the patient. Because, 'in becoming an image maker and a writer, the author has created a 'zone' in which it is safe to write about the personal' (McIntosh 2010, p162) which in turn opens the door for other writing and emotions to be expressed.

Cognitive neuroscience, CAT, metaphor and pictures

> 'You, your joys and your sorrows, your memories and your ambitions, your sense of personal identity and free will, are in fact no more than the behaviour of a vast assembly of nerve cells and their associated molecules'
>
> (Crick 1994, p3)

Neuroscience, attachment and CAT

Research into neuroscience is providing a more focussed approach to psychotherapy (Fonargy 2004). Developments over the last 10 to 15 years in cognitive neuroscience provide compelling evidence to support the importance of metaphors (and PMs) as a means to help patients manage early relational attachments and subsequent attachments (Greenwood 2011, Wilkinson 2010). Attachment is seen as important to the healthy development of the psyche and has been well expressed in the work of Bowlby, Schore, Stern and Siegel to name a few.

Essentially the central idea is that the quality of the early child/caregiver relationship is important in determining the child's ability to establish a secure base from which to explore the world in a confident manner (Greenwood 2011). Of particular importance to psychotherpy are the developments in neuroscience and attachment, studies of orbitofrontal cortex activity suggest a strong relationship to the emotional regulation systems in the mind.

Schore (in Hermans 2003) argues that 'the capacity to make transtitions from negative to positive states of mind, and to realize a certain level of adaptive continuity of the self, is seriously reduced in forms of insecure attachment' (ibid, p107). The CAT approach to attachment seeks to understand how attachment patterns determine reciprocal roles in early object relations with the significant other (usually mother). It may be some patients have problems of utilising language (mediating self-dialogue) as opposed to actions for self-efficacy and whether bringing the right brain to the fore in therapy through metaphor can facilitate change rather than focussing more on the cognitive change processes.

Wilkinson (2010), in summarising the internal workings of the mind and attachment, directs us to view the working mode of attachment as being stored in the right hemisphere, the early developmental brain dealing with affect regulation for coping and survival. Relationships to the later developing left hemisphere are subsequently developed

characterised by verbal, conscious and serial information processing (Greenwoood 2011, Wilkinson 2010). To illustrate, psychotherapy is generally accepted as an enabling experience, setting the conditions where this mediation can occur. When working with someone who has a traumatic childhood the use of gestalt techniques, such as opening a dialogue through an simulated empty chair exercise with both the 'abuser' and the 'abused' can be helpful, integration of the emotions and feelings of childhood can be worked through. Allowing the adult mind to come to terms with, manage and revaluate the effects of early life experience. CAT therapy would approach this through the model's three accepted phases of therapy…

- The reformulation phase whereby a shared understanding is come to;
- A recognition phase, whereby the patient is supported to notice the ways they act and react in relation to their reformulation;
- A revision phase whereby alternative ways of acting and reacting are managed.

Learning occurs when individuals establish 'alternative ways of harnessing their thoughts and emotions (Carter 2003). Rose (2003) comments 'cognition cannot be divorced from affect, try as one might'. Psychotherapy has been found to 'significantly change functions and structures of the brain, in a manner that seems different from the effects of psychopharmacology' (Fuchs 2004). One way that change in therapy and emotional learning can be explained is by Damasio's (2003) Somatic Marker Hypothesis (SMH)…

> 'When a person comes across a novel situation that requires a response, the bodily, emotional aftermath of the response is retained and becomes a 'somatic marker' … 'later when the person meets a similar situation the SMH is recreated, thus guiding the person to make an appropriate response based on the emotions that were felt previously' (Carter 2003, p229-230)

The SMH provides a link between neuroscience and psychotherapy, in therapy the somatic marker, or reciprocal role in CAT, is being worked with. Barker (1996) notes the metaphor applies an outflanking manoeuvre on the unconscious where the message of the metaphor bypasses the logical functioning of the brain (Sharpe et al. 2002). The question remains…'does utilising metaphor make a link between the right brains emotional regulation function and the left brains time, place and memory function enabling the frontal cortex to make different decisions and reconstitute feelings and emotions from the past? A complete review of neuroscience, brain function and emotion is beyond the scope of this thesis so the focus will be on what current neuroscience can add to our understanding of how metaphor may function.

Current Cognitive neuroscience perspectives

Current psychology of emotion seems to be distilled into one key question: How do emotion and cognition relate? This question is at the front of my mind when searching for evidence for or against the use of metaphors in therapy. There is no definitive view as often the debate for synthesis degenerates into polarized views ‘Mind vs Brain’, ‘Holism vs Reductionism’, ‘Top down vs Bottom up’ (Toomey and Ecker 2009). Literature regarding emotion seems divided into two camps, the *Separatists* and the *Integrationists.*

The Separatists

The separatists emphasise the idea that emotion is evolved, functional, and, crucially, rather separate of cognition. The key evidence for this camp is response to threat. Responses to threat reveal the separation of cognitive circuitry from emotional circuitry. Emotions are, at root, simple, functional, switch-like, hence Ekman's (1992) basic emotions which remain attractive. Emotions and cognitions can relate, but this is likely to be displacement or interference. Key names in the area include:

- Ekman (1992): Discrete basic emotions that are functional.
- Maclean (1990): Atavistic emotion - the limbic brain is reptilian, cortex is mammalian, evolution is a bodge job with these two separate modes of response interfering with and displacing one another.
- Panksepp (1998): The need for a separate affective neuroscience that is separate of the cognitive approach.
- Rolls (1999): Consciousness is not a property of animal minds. Rolls studies the affective representation of taste that is important as a means of advancing our understanding of the neural mechanisms for the regulation of food intake. As well as the mechanisms underlying emotional processing in the brain (Rolls 1999).
- Öhman (2000): ‘Snakes in the grass’ things that are threatening pop out at us from visual displays like the functioning of an automatic mechanism that pushes cognition around.
- LeDoux (2003): Components necessary for emotion include an emotion system, a memory system and a feeedback system from the body.
- Bowers (2009): For the attempt to make emotion into a kind of cold cognition, which can't work and thus makes it look from the start that real emotion can’t be anything to do with cognitive theory.

A tension within this research is that the separatist movement often focuses on the amygdala and threat, or emotion and taste, rather than the amygdala-frontal cortex relationship as a means of understanding the underlying emotional relationship.

The other camp – Integrationists

Integrationists emphasise that emotion is integrated with cognition. Damasio's (2003) famous patient *'Elliot'* indicates that (cognitive) decision making doesn't work when emotions are impaired. Thus emotion and cognition are built to work together, they have evolved together, and the view that they are separate/interfere with one another is insufficient. This is the prevailing view at the moment, steering away from the old prejudice that emotion is irrational. Some people think this makes things far too jolly and panglossian (Blindly or naively optimistic), and we end up forgetting about the (moral psychology) problems that come with emotion.
Key names in the area include:

- Damasio (2003): Perhaps the principle researcher in the field. He gets expansively philosophical so that the Patient Elliot/orbitofrontal cortex explanation becomes the way to get to the heart of the matter.
- Gray (2004): Is important as he establishes the principle that emotion and cognition are highly choreographed in their activity (i.e. a highly functional relationship and interplay, and that they are more designed than the accounts that suggest that emotion just pushes cognition around or that the two just mix in some way).

More widely, integrationists suggest that evolutionary neuroscience, evolutionary psychology and neurobiology can be viewed as a gestalt, since animals deployment of aggression/emotion is highly selective, and humans' limbic systems, are biologically meshed with the frontal lobe (cognition). The conclusion has to be that human anger/emotion is deliberate, and about getting a reward or pay-off.

The convergence

The convergent and consequence of separatist and integrationist thinking can be illustrated by LeDoux (2002), who looks at the bottom end (biology), and finds that emotion and cognition are split, but only for a brief moment. In contrast Damasio (2003) looks at the top end (decision-making), and finds that emotions are absolutely crucial to

effective thought. Thus, from top to bottom, emotion and cognition are linked. The frontal cortex represents the expansion of emotionality in humans. The orbitofrontal cortex activates very reliably and consistently during emotional reactions (Damasio 2003) and particularly where reward contingencies are involved (Rolls 1999). The amygdala and frontal cortex are very strongly linked biologically (Damasio 2003, Lane and Nadel 2002, Rolls 1999) and the importance of the orbitofrontal cortex is underlined by the result that damage to emotionality entails problems for cognition (Damasio 2003). Toomey and Ecker (2009) argue that clinical symptoms involve implicit memory and that a selective depontentiation of implicit memory has the broadest efficacy, implicit memory being the regulation of social behaviour by the amygdala-orbitofrontal relationship. There is no consensual view as yet so the debate continues.

Brain development and hemispheric function

It is interesting and important to note that psychotherapy and medications have similar effects on neurotransmitters in some cases (Fuchs 2004, Cappas et al. 2005), whereby learning and plasticity are improved by both processes. Both papers cite Kandel's (1998) research 'insofar as counselling and psychotherapy are effective… it presumably does this through learning, by producing changes in gene expression that alter the strength of synaptic connections' (cited Cappas et al. 2005, p374). This leads to the position that learning has a measurable impact on the brain therefore successful therapeutic interventions should equally lead to measurable change (Beutal et al. 2003).

The right hemisphere (RH) is more mature than the left hemisphere at birth, and grows more quickly. It contains the amygdala, so processes the earliest experiences of the primary caretaker (especially the face and emotions). The amygdala is on line at birth, its function involves the nature of good and bad, safety/danger, the startle reflex and is sensitised to trauma (Carroll 2005). The amygdala is pivotal in processing threat and paralinguistic (e.g. facial) emotional stimuli (Beutal et al. 2003). At three months the anterior cingulate is preparing the infant for socialisation, motivation to communicate is suggested, with the child needing contact and acceptance (Wilkinson 2006, Carroll 2005).

At this stage psychological proximity binds the infants interpersonal relationships (Bowlby 1969). The corticolimbic and orbitofrointal regions of the brain are also associated with the regulation of emotion (Cappas et al. 2005). If there are problems with the responses of others at this crucial stage, and as the brain is developing these circuits the infant is necessrily vulnerable to environmental experiences, both positive and negative. At ten

months the prefrontal cortex matures enabling the baby to experience a more mature kind of relating, leading to self regulation, and to deal with experiences and shame. Procedural or implicit memory is held here and encompasses automatic performance, disposition and non verbal habits (Fuchs 2004).

Wilkinson (2006) notes the RH is deep and negativistic, its function is to store emotions and appraise associations of thoughts and ideas with an developing ability to be self-reflective. She comments the RH is dominant for awareness of the physical and emotional self and for a primordial sense of self. Finally, that the RH plays a key role in recognising self from others, like empathy and identification with others, our subjective processes, which are understood to be among the first mental processes to develop.

The left hemisphere (LH) matures later, a child by two to three years old has an increased linguistic and analytic ability, functions that are exclusivley of the LH. It enables experience of agency, relating and of separateness. The development of the hippocampus enables explicit or declarative memory. Fuchs (2004) notes that the hippocampus is involved in a life long remapping of cortical networks according to the individual experiences. The LH holds explicit or declarative memory, recording single experiences (ibid). Long term memory processes are involved in the medial temporal lobe and prefrontal cortex. Cappas et al. (2005) decribes the memory's action as 'an event takes place or information is learned, the hippocampus begins processing that information…information then becomes dependent on this structure until it becomes old knowledge, at which point it is organised in the neo cortex' (p376). For example the:

- Dorsolateral prefrontal cortex – considers thought and feelings, working memory, if you like assembles current and past experiences for working in the immmediate moment.
- Anterior cingulate and hippocampus – tag time and place to memory and assist in storage and retreival, thus developing the role of social self

It is important to note that the LH cannot achieve these functions without support from the RH. Each brain develops in response to its interaction with that which is felt inwardly in the body and that which affects the person from outside. Carroll (2005) considers that all mental functions are necessarily correlated with interruptions, displacements, and distortions in the organising processes of the body. In order for change to happen and produce lasting effects, therapy must not only help develop insight but 'should arrive at

restructuring neural networks, particularly in the sub cortical limbic system' in order to alter motivation (Fuchs 2004, p480).

Furthermore as memories can be modified when stored and retrieved (Cappas et al. 2005) it is 'possible to shape the manner which painful experiences are remembered and integrated' (p377). Cappas (ibid) goes on to discuss Narrative Therapy (NT), whereby a dialogue is a thread that weaves events together with the intention to revise these narratives though the process of therapy. The CAT reformulation offers a representation of this dialogue in the form of a letter setting out problematic procedures similar to NT whereby the dominant dialogue or story is reconstructed to a more adaptive account.

The prefrontal cortex – 'The Thinking Cap' acts as the emotional executive of the right brain as it has strong neural connections into the emotional systems located in the RH. The orbito frontal cortex organises from 10-18 months in two phases. Firstly acting as an interface between cortex and sub cortex between the other (especially eye contact) and internal bodliy senses. Secondly, it enables the individual to recover from disruptions of state to integrate a sense of self across states allowing for continuity of experience (Carroll 2005, Carroll et al. 2003). Fig10 helpfuly denotates here…

Fig10: Left and right cortex functions

Left Cortex	Right Cortex
Language, structure, analysis Meta level: thinking about, organising abstract concepts, using logic Left brain as interpreter – constant labelling and assigning casuality Capacity to modify (dampen autonomic response) on the basis of insight and reflection	Grasps content, tone and global intent Processing emotional information about relating Capacity for regulation (only RH can generate autonomic response)

Metaphors and the Mind

It has been suggested that the way metaphors work in the mind is on the divergence between the left (rational) and the right (creative) brain (McGilchrist 2009). It is as if metaphors have a mnemonic property...in that metaphorical phrases last longer than literal phrases (Ryena 1996) and can be a conduit to material that has been buried alive (Bayne and Thompson 2000).

Goncalves and Craine (1990) suggest that at the deep/tacit/unconscious levels, knowledge is represented in analogical and metaphorical ways. The use of metaphors is suggested as a therapeutic tool in order to access and change tacit/unconscious levels of cognitive representation. Some patients, and indeed some therapists, theoretically lean towards one or the other.

What appears important is to recognise a person has the ability to 'span the logical objective and analytical as well as the metaphoric, imagery, synthesis and totality and that working with this duality can lead to growth and positive mental health' (Welch 1984, p13). Furthermore, Samples (1976) acknowledges that when the metaphoric mind is accepted and celebrated, 'there is no longer a distinction between rational and metaphoric minds there is only mind' (Welch 1984, p13). Metaphors can emerge to capture and convey our earliest experiences (Wilkinson 2006, 2010) contain sensory, imaginistic, emotional and verbal elements and as such can activate multiple brain centres (Pally 2000). But evidence suggests that metaphors are likely to only be processed in the right hemisphere (McGilchrist 2009, Wilkinson 2010). For example, Marshall and Faust (2008) note the right hemisphere processes metaphor particularly when novelty, creativity and imagery are involved. Ortigue et al. (2004) find the right hemisphere specialises in early processing of emotionally charged words. Mitchell and Crowe (2005) note that some language functions, including metaphor, are mediated by the right rather than the left hemisphere.

As metaphors hold rich meaning, by relating one sense to another, levels of experience are therefore considered important in the TE. Much research into hemispheric action indicates that the LH has superiority for most semantic processing tasks whereby figurative meaning is activated in the RH (Marshall and Faust 2008). There is again a special role for novel metaphors in the right hemisphere (Wilkinson 2010) and metaphor retrieval may involve the 'retrieval of alternate, distantly related and even unrelated interpretations in order to process unusual or unfamiliar word associations' (Marshall and Faust 2008, p 103). The implication is that the LH and the RH differences enable complexity in comprehension in effect a gestalt. Although language is located in the left hemisphere considerable weight is being placed in research on the role of the right hemisphere in metaphoric processing especially when novelty, creativity and imagery are involved (McGilchrist 2009, Wilkinson (2010).

Pictures and images and the mind

> *'*A mental image is a pictorial representation, akin to a private photograph, from which one can derive information as to what it is an image of by observation.' (Bennett and Hacker 2008, p43)

People are in a daily dialogue with themselves in an attempt to create meaning through expression. One way of doing this Loock et al. (2003) argue, is through the contents of their artwork. As images and art can be an insight into a person's projections and personal perceptions utilising creative expression could be applied as a non-threatening problem identification experience (Loock et al. 2003). CBT, CAT and other therapies can, and do, utilise imagery, referring to the capacity to imagine an object. It necessarily follows that a metaphor can generate an image, a metaphor in a pictorial form is an image. The LH and RH mediate integration of imagery and emotion, building a bridge in effect between the iconic mode of the right and the linguistic mode of the left (Cox and Theilgaard 1987).

Various forms of imagery utilise distinct neurological pathways but in general use similar pathways to perception (Cappas et al. 2005). Again it follows that the brain in processing non-verbal activity can effect emotions. Problems with imagery and location in the mind are less controlled and more difficult to interpret (Beutal et al. 2003). Wilkinson (2010, p193) notes 'the making of such pictures indicates a dawning ability to move from the concrete acting out of old trauma thought the transference to a more symbolic way of experiencing'. In neural dialogue this reflects closely the views noted previously of reworking the minds response to remembered trauma and relationships and enabling a different response and action. She (ibid) further notes…

> 'It is this capacity to integrate early right hemisphere traumatic experience, which often emerges in visual fragments, with later developing left hemisphere capacities, that marks recovery.' (Wilkinson 2010, p194)

McGilchrist (2009, p115) seems to tie this together when stating that 'metaphoric thinking is fundamental to our understanding of the world, because it is the only way in which understanding can reach outside the system of signs to life itself. It is what links language to life' and later 'metaphor embodies thought and places it in a living context' (p118). Although these are bold affirmations the evidence seems to suggest significant importance in the role of RH activity in metaphor with associated imagery being a vehicle to transport meaning across the hemispheres.

Literature Summary and discussion

There are a number of approaches to reviewing the literature and a number of strengths and weaknesses in any one approach. What is accepted is the need to conduct as systematic a review as is possible to inform the topic. In choosing to structure a review around a systematized approach with a robust search and review strategy the researcher has been able to capture a broad range and scope of literature in order to inform this study. Utilising a critical appraisal of available resources alongside a systematic search strategy with 'alerts' enables the researcher to keep abreast of the subject and can enhance the rigour of the review.

The psychoanalytic and OR aspect of CAT represent a balanced focus on early life experiences and enactments alongside a cognitive process. Therapy enables the patient to notice these early patterns and how they may be affection them in a self-limiting ways as an adult. One way this is achieved is through the development of the SDR which encompasses experiences in early life having laid down patterns of thinking and behaving.

Often therapies are very focussed on cognitive processes, especially cognitive and behavioural therapies, and yet the use of metaphor is well documented (Kopp 1995, Abbatiello 2006, Barker 1996, Welch 1984 and Palmer 2006) and is an often used utterance (Leiman 1994) in all therapeutic and social encounters. Holmes and Bateman (2002) consider metaphors 'inherently integrative as they coalesce a number of complex strands of thought into a single memorable image. Metaphor and language speak of many issues. Modell (2009) comments on the discovery of mirror neurones noting that their presence provides an objective explanation for the inter-subjectivity inherent in primates. He (ibid) suggests that metaphor can immediately be understood by metaphoric gestures and body language due to the existence of our mirror neurones. He further goes on to note that 'we unconsciously interpret our affective world by means of metaphor in preparation for action' (ibid, p8).

CAT incorporates aspects of acceptance and commitment therapy (Hayes et al. 2004) which also has a deliberate noticing of metaphors to support change in a patient's MH. Patients who have engaged in this metaphor work have not deviated from the CAT model nor the accepted time limited pathway. The model is important as it provides a holding experience for the therapist and the patient. Nevo and Wiseman (2002) note…

> ‘The importance of the developmental life-span approach, time limit, focusing on the working alliance, quick assessment, having a central focus or theme, active and directive counsellor participation, therapeutic flexibility, and dealing with termination’ (p228)

Wilde McCormick (2011) also notes…

> ‘We might work with the body, with metaphor, with pictures and dreams, but it is our presence that helps the revision of stuck patterns and painful procedures to feel safe and to loosen their hold’ (p37).

One can see here the importance of the dialogic in the interaction as well as managing time and expectations within the TE. Adams (1997) explores the role of metaphor in psychoanalysis and their location in the practice of analysis, finding they are present and useful in the consulting room but there must be more than metaphor for therapy to be effective and that they are ultimately dispensable. What Adams is alluding to here is similar to Spence’s (1987) view that we should use and continue to use metaphors but not be used by them. Adams (1997) goes on to argue not for ‘metaphors as theory but a theory of metaphors in therapy’ (ibid, p29)…‘the issue is how on a case by case basis, the unconscious employs specific metaphors that aptly render the psychic reality of particular patients’ (ibid, p36).

It is clear from the literature metaphors have a place within therapy and can reach unconscious material. As a central theme they have been noticed to be helpful. Levit et al. (2000) found, although little is known about how metaphors evolve over the course of therapy, patients in successful therapies develop a core metaphorical theme in relation to the main issues. Lakoff and Johnson’s (1980) CMT, as one thing likened to another, provide us with a rich and complex structure within language. Metaphors can embody emotion and provide a one step removed position to help individuals manage complex emotional issues. Their utterances can be emotional ontological, orientating and creative.

Attempts have been made to categorise metaphors into major stories, anecdotes, analogies, relationship metaphors, tasks and rituals, objects, and artistic presentation. This provides a range of mediums for metaphors to be utilised in communication. In psychotherapy metaphors can be utilised in understanding a patient’s history whereby the metaphor is a beginning and understanding spreads out from this ‘kernel’ though exploration.

It is strongly suggested that we learn through metaphors and they work as a heuristic and epistemic device, having salience for here and now emotions but also understanding past events. The nature of metaphor, expressing the inexpressible emotion easily, their memorability and the vividness of imagery they bring to mind, are suggestive of their conceptual usefulness. Whilst debate exists as to the nature and representation of PM there does seem to be enough evidence to support this approach as part of the TE. Images would include art making, as well as reference to existing images and movies.

A number of authors support art and pictures within therapy where the same rules apply with metaphor verbal as do metaphor pictorial. Images appear to come 'unbidden' to the mind's eye in relation to a narrative or utterance. Images like metaphor can represent emotional states, historical events and current experiences. It was interesting to read Kennedy's (2008) chapter in the '*Handbook of Metaphor and Thought'* whereby in a study blind individuals arrived at the same interpretation of the 'spinning wheels' as a sighted individual.

Art as a medium has strength and depth and can represent complex phenomena, what seems important is the individuals interpretation, whilst some is shared if it is a collaborative constructing within a narrative there should not be interpretation but a co-constructed reality and shared understanding that can facilitate exploration and change. Riley's (2004) roles suggest a strength and possibility here in focussing again on the common factors within the therapy relationship of having a shared goal, making changes and active participation. Within this active participation there is evidence to suggest that the therapist can 'offer' a metaphor. If this can be managed verbally why can it not be managed visually, as we explore metaphor with a patient and we ask '*what images come to mind*?' The researcher intends to address this topic in follow up research questions to the pilot and experimental group arising from the proof of concept aspect of this research. What remains important is that the metaphor is relevant to the experience of the patient.

One of the unanswered questions in this research is the nature of each pictorial representation of metaphor how much of the picture is metaphor and how much is literal representation. The author believes that this is a study to be taken forward as post-doctoral understanding as a 'review' of images generated within therapy. For the purposes of this research there does seem to be evidence for the use of art techniques in CAT as in the TE.

A number of cautions within the literature have been unearthed, not the least being the careful management of the encounter and power implications of drawing for and with the patient. There is an assumption and a limitation within the research presented here that the therapists is willing and able to engage in image development, either as a creator or as a supporter. Not all therapists are comfortable with the idea of deviating from a model, yet creative therapies are supported and have a clear place in many therapeutic interventions. Whilst metaphors and image laden metaphors can incorporate significant emotional material, their ability to be one step removed could enable therapy.

Hughes (2011) has noted a number of concerns with art within this study that the author has attempted to incorporate within this review. She (ibid) comments 'the whole is more than a sum of its parts. To reduce the use of pictures in CAT to linear narrative metaphors may be useful, but it is also limiting' (p25). She has concerns about potential transference issues involved in joint picture making that cannot be straightforwardly paralleled with joint formulations in other aspects of CAT as well as constructing a training programme as if there is one method of creative art use in CAT. This is not the authors intention but to add to the developing dialogue in CAT and enable therapists to increase their repertoire of tools available to them to support patients in managing their distress. Her main concern is the art psychotherapy position of non-directive art making where the image is not directed in any way, and this approach in this study does that in albeit a collaborative and co-constructed way. She notes that some art therapists do share image making, in groups for example, but only where there is disability or isolation that make shared work efficacious. Yet there is a strong place for art within therapy and corresponding support within neuroscience. The evidence from cognitive neuroscience seems to suggest that creative methods in psychotherapy can engage right brain activity. What has been explored is the nature of metaphor and art as an enabler, utilising structures in the right and left brain to find a way forward for individuals in mental distress, enabling emotional management.

As I have read into the subject I can see how an increased knowledge in cognitive neuroscience provides the therapists with an additional way of conceptualising change for patients. For example, like Wilkinson (2006), I recently had a patient who was struggling with change, we discussed the relationship of change to the way the mind works based on this review, this discussion seemed to 'enable' the patient to move forward as he had reassurance (and hope) that change can 'as if' make physical alterations in the brains connections.

It seems as if metaphor has many positive functions and can activate multiple brain centres. Equally art and visual metaphors utilise distinct neurological pathways. Based on this review it would seem that there is support for incorporating metaphor and PM and visual representations within therapy but with a number of cautions which this theses will aims to explore. Metaphor has support within the literature as a way of getting to unattainable places and art has been supported as a means to achieving this. As noted there are limited studies that explore metaphor and pictorial metaphor in the TE so this study will provide a focus on the topic and data and analysis of data should provide useful evidence for the ways in which this technique can be utilised as part of the TE.

Chapter Three: Methodological Considerations

Philosophy

Creswell (2003, p5) notes three questions central to the design of research enquiry…

1. 'What knowledge claims are being made by the researcher (including a theoretical perspective)?
2. What strategies of inquiry will inform the procedures?
3. What methods of data collection and analysis will be used?'

This study is unique in that it seeks to develop an understanding of the application of known theories in a different and particular way. There is a significant body of knowledge pertaining to metaphor in the TE and a valid research base in art psychotherapy. There are psychological interventions that focus on metaphor as well as linguistic theories regarding metaphor. The researcher is drawing upon these traditions to create new understandings in the use of metaphor and PM in CAT and in the wider therapeutic community.

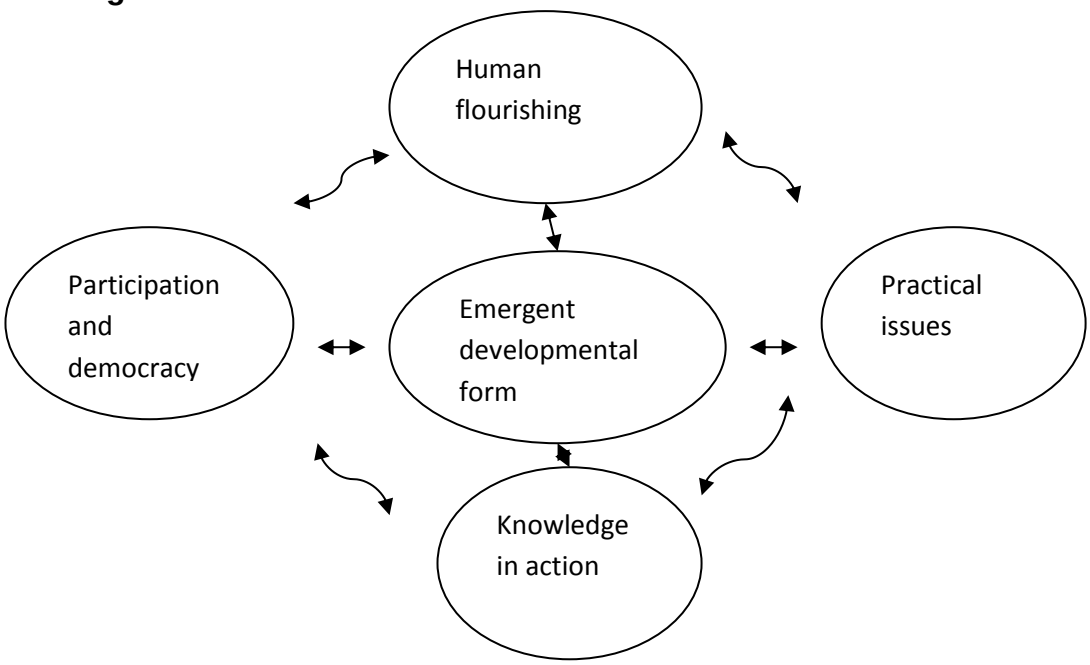
Arising out of a teachers as researchers approach and based on an extensive career as a teacher and researcher John Elliott is a respected academic and leader. In 1990 he wrote of the importance of reflective practice and practice based research, citing three important studies. Elliott (1991) sees action research as a cultural innovation with transformational ability. He encourages teachers as researchers of their own practice. He suggests that researcher needs to cite the practical interest and personal motivations that inform researchers decision. The author has included this as part of the rationale for the study.

Elliott (1994, p136) further expresses support for an action research approach, noting that AR has a pedagogical aim to incorporate an educational ideal, in this case the skills training in pictorial metaphor. Change in practice is supported as does gathering evidence that measures inconsistency or inconsistencies to the aims. Furthermore it involves identifying inconsistencies and practice problems, involves stakeholders and has a level of reflexivity. He notes that change fundamentally involves the collaborative reconstruction of professional culture through the development of discursive consciousness. (Elliott 1993).

The most suitable research philosophy for this study is Action Research (AR). AR is 'learning based upon doing' (Silverman 1997) combined with a rigorous process of enquiry aiming to 'describe phenomena and to develop explanatory concepts and theories' (Bowling 1997). The researcher considered other methodologies such as 'grounded theory' because its aim is 'to produce innovation theory that is grounded in data collected from participants on the basis of the complexity of the lived experiences in a social context' (Faugier 2005). As the researcher is articulating a body of existing therapy theory and knowledge to the topic, it seemed more appropriate to choose AR on this assumption.

AR approaches are increasingly utilised in changing practice and have a developing portfolio in nursing (Whitehead and McNiff 2006). Nursing (and therapy) needs to have strong foundations in theory within a 'fluid' and arguably 'unstable' environment. AR creates 'a living theory' whereby the researcher, as he/she practises, observes what he/she is doing, reflects upon the experience and ultimately takes steps to make sense of it (Whitehead and McNiff 2006), contributing to development of theories which challenge the status quo and have significance for practice (Marshall and Rossman 1999). AR has similarities with the characteristics of pragmatism associated with mixed methods (Phillips and Davidson 2009). Figure11 sets out the key characteristics of the AR approach, noticing the human development element built upon active participation and collaboration. The emergent form comes from this collaboration and the synthesis of a practice problem with available knowledge.

Fig11: Characteristics of AR



(Reason and Bradbury 2001)

AR is responsive and readily incorporates dynamic mixed methods, enabling an array of issues to be considered, such as impacts of interventions, observation of interactions, associated issues and planned actions. Often AR projects are problem oriented, in this study the research is seen more as an living appreciative enquiry (Ludema et al. 2001) whereby the researcher is 'drawn to affirm and thereby illuminate the factors and forces involved in organising that serve to nourish the human spirit' (Cooperrider and Srivastva 1987, p131).

A powerful lever in AR is the normally educational nature of the 'change' as it is associated with 'people' who are members of 'social groups.' Therefore, focusing on problems within a specific context is pro-active (Hart and Bond 1995). As people are involved, the skills needed to facilitate AR are collaboration and reflection to justify and enhance service provision (Clark 2000). This AR is exploring and observing the use of metaphor and PM in CAT as the intervention, reflecting on findings, and subsequently taking steps to make sense by developing and refining a tool to support therapists in utilising PMs in therapy practice.

The approach is a cyclical process focusing on assessment, planning, action evaluation and reflection leading to further planning (Reason and Bradbury 2001), actions that are instrumental in facilitating changes in clinical practice (Meyer 1993). This cyclical process focuses on a holistic philosophy underpinning all the key elements of the AR study (Hart and Bond 1995). AR can contribute to the narrowing of the theory-practice gap (Holloway and Wheeler 2002, Cormack 2000) responding to the necessity to change and adapting current ways of working through evidence-based practice.

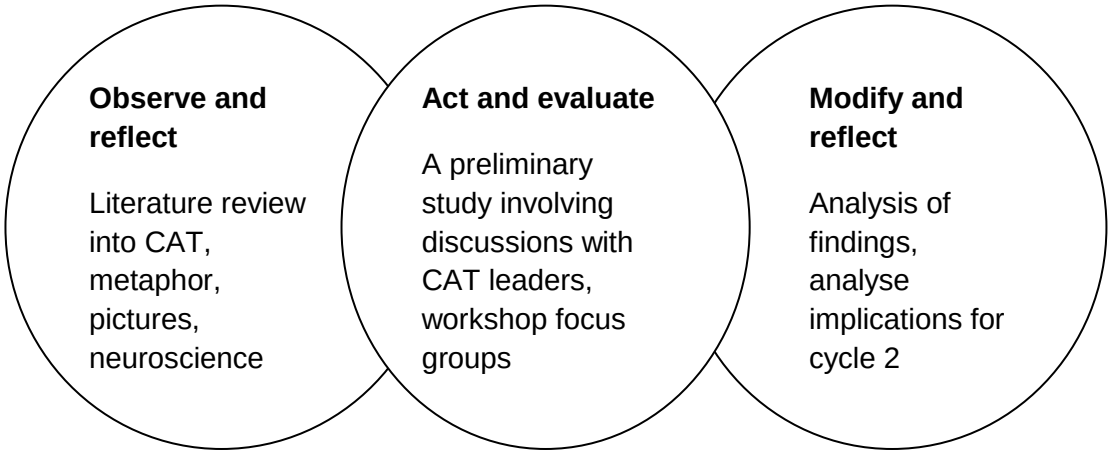
This is exactly the aim of this project to develop and understand the use of metaphor and PM in CAT, enabling a toolkit to be developed and utilised in practice. In fact it has been argued (Campbell et al. 2000) that problems arise because researchers have not defined and refined their intervention prior to implementation, which adds further support to the importance of a phased approach to AR in this study. The end product has a suggestion that deliberately focussing on and developing metaphor and PM, engaging stakeholders in understanding and exploring the topic, can develop on a technique that can be enabling to the patient in supporting change, by utilising creative rather than just syllogistic and cognitive processes (Fabregat et al. 2004).

AR posits if people are involved in the decision making about how their workplace is run (or the way they manage their interventions), following an observe-reflect-act-evaluate-modify approach, they are more inclined to engage with the topic (Whitehead and McNiff 2006). In this study the researcher *observed* a potential elaboration of the CAT model…

- The initial *action* managed a preliminary dialogue and literature review (Study1).
- An *evaluation* proposal was developed in the form of a Delphi study (Study2).
- This led to *developing and modifying* a TP (Study3).
- Leading to subsequent *reflective* and *evaluative* proof of concept steps (Study4).

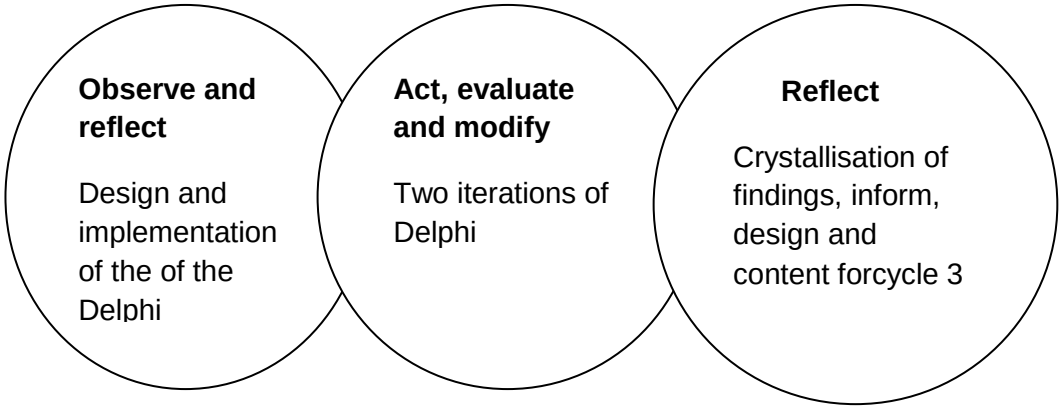
Further studies are anticipated in managing the outcomes and recommendations of this PhD thesis. Figures 12-15 outline the cycles of AR within this research:

Fig12: Study1/Cycle1- Preliminary study



The preliminary work is documented in Chapter four one of this submission. Dallos and Vetere (2005) note that developing psychotherapy theory is a complex and demanding process. Since its development CAT has generated up to 200 research papers in quantitative, qualitative and mixed methods. As the psychotherapies are only just over 100 years old it is important to continue to understand and develop research into their adaptation. Currently CBT holds significant clinical authority over the field of brief psychotherapy. CAT includes significant aspects of CBT in its integration and in CBT there are aspects of working with art and metaphor. The preliminary study supported the impression that the PM technique is of significant uniqueness and that an evaluation is required, an evaluation that contributes to the growing body of literature in CAT.

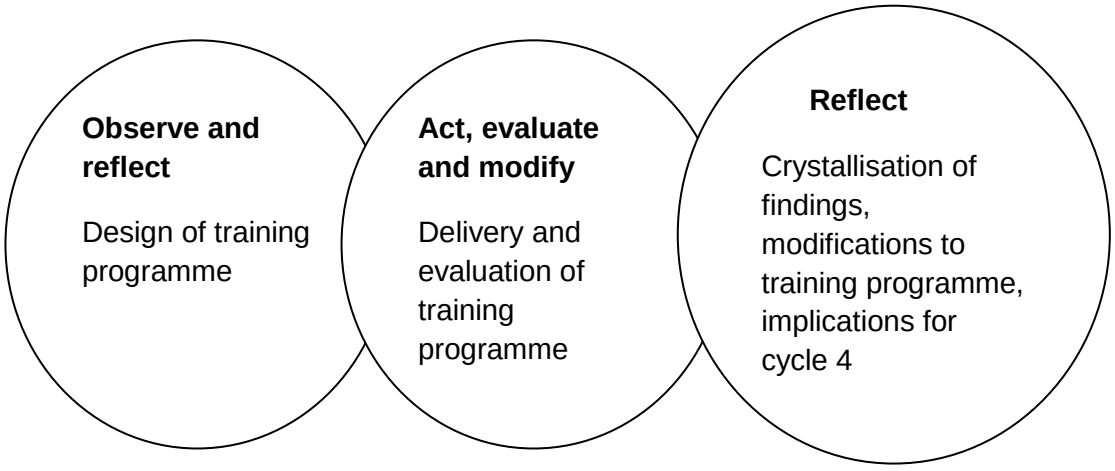
Fig13: Study2/ Cycle 2: Delphi study



Delphi can be used to build consensus among a group of individuals who have expertise in a given topic area (Williams and Haverkamp 2010). Delphi employs a series of rounds where opinions are analysed and voted upon enabling a decision making process to occur among a sample (Delbecq et al. 1975, Williams and Webb1994).

Delphi is increasingly being utilised in nursing (Walker et al. 2000) and health related areas and increasing in popularity across many scientific disciplines as a method of inquiry (Keeney et al. 2001, Kennedy 2004, Cantrill et al. 1996, Walker and Selfe 1996, Duffield 1989, Duffield 1993). In counselling and psychotherapy there is also a developing history as Williams and Haverkamp (2010, p94) note and cite some important studies as evidence of this: Norcross et al. (2002), Norcross et al. (2006), and Thielsen and Leahy (2001).

Fig14: Study3/ Cycle 3: Training programme evaluation

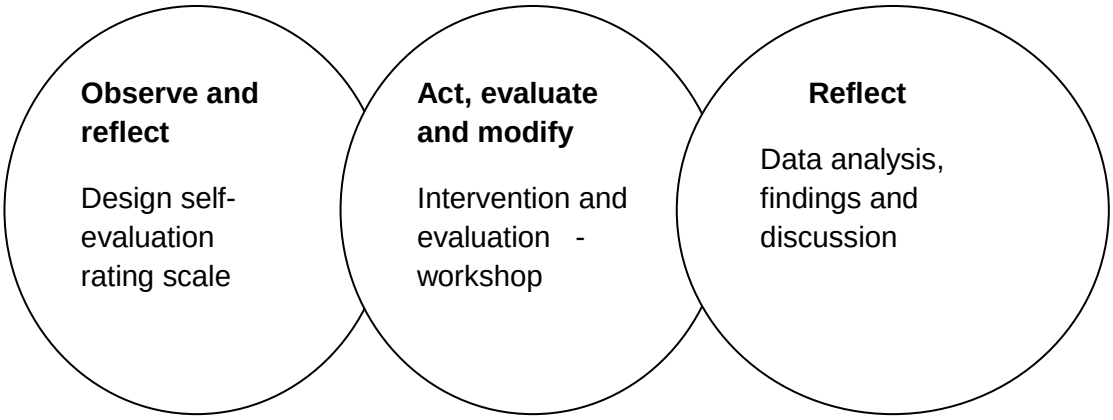


The TP provides a bridge between generating theory and understanding practice. Results from the Delphi, preliminary study and literature reviews are synthesised into training

materials and workshop content in order to support CAT Therapists in utilising metaphor and PM in their practice. Continual review and updating of the workshop format and articulating new and developing knowledge from the AR cycles into the content occurred.

Workshops with CAT groups, a group of counsellors and with groups of CRUSE counsellors were held. This expansion into counselling was opportunistic, based on the work the researcher had completed in sharing his work at conferences and publications. The focus on CAT was maintained and the techniques utility across therapeutic modalities is explored. A follow up questionnaire utilising a reflective model applied to participant's use of the model in practice further extends understandings of the PM technique in practice.

Fig15: Study4/ Cycle 4: MaP-SELF



Cycle 4 is a second product arising from the research, having developed a structured review of the literature, tested this out and correlated it with the results of an expert panel. A 'self-assessment of learning' was then developed as it seemed important to complete the circle to find explore the participants perceived skill development. The self-assessment tool development was informed by a case study design (Newall and Burnard 2006). Case study and Significant event research also has a developing knowledge base in psychotherapy (Dallos and Vetere 2005, Newall and Burnard 2006). This approach is based on a foundation, or belief, that change in therapy is based upon significant events such as the development of a positive therapeutic rapport, a reformulation or capitalising on a central theme. In this respect, the use and focussing on metaphor and PM could be considered a significant event.

Ontology

Ontology from the Greek '*of being'* and '*logia'* (science, study, theory) is the philosophical study of the nature of being, existence or reality in general, as well as the basic categories of being and their relations. In AR ontology speaks of the generation of values that the work is morally committed and that the researcher is perceived to be in a relationship with others and their social context (McNiff and Whitehead 2011). Ontology deals with logical problems about concepts and judgements, these are regarded as ontological theory about values and status. Are these theories objective or absolute values/status, or alternatively are they subjective or relative to the particular feelings of one particular person or most of the people in his society (Raphael 1994).

Ontology is concerned with what we believe is real, what is the essence of clinical problems (Dallos and Vetere 2005, p27). It also involves the theory of being influencing how we view ourselves and others and how we influence research based on our beliefs (Whitehead and McNiff 2006). If we are separate from others we can observe objectively but if we consider ourselves to be integrated then we have to participate with them. CAT is an integrative therapy so it seemed appropriate to study developments in CAT in this manner. The design is genuinely participative, with all cycles grounded in the 'body' of CAT, subsequent developments are based on dialogue with CAT 'experts' and triangulated outside the modality.

An underlying value base of CAT is that that knowledge is interactive and co-constructed. There is an objective reality but this reality is constructed by what we know but is ultimately unknowable. We come to know what we know through interactions with others, who can either confirm, modify, or contradict what we think we know. What we know is a matrix of the interaction between what we know, think and feel and our capacity to integrate this in our self. Knowledge is always partial and evolving and there is no definitive position…knowledge is progressive we can know more and more about something (Norcross and Goldfried 2005). The therapy relationship expands knowing for the patient and therapist, the problem is that there is always another view. There always is another explanation for a person's behaviour. Carruthers (1995) notes the complexity of makeing accurate predictions of people's behaviour on the basis of what one knows (or believes) about their mental states. The same applies to what clinicians do in practice. This study is attempting to reduce these explanations to an accepted consensus through the process of analysis using both a participatory and objective study design.

Concern has been expressed in psychological research about investigator allegiance (Paley and Shapiro 2002). The researcher is aware of his leaning towards metaphor and is mindful of a potential non-wilful distortion of results or bias and has constructed a programme of research that includes a weight of mixed data for analysis. Reflective data and reflection has helped the researcher to maintain the 'Being a stranger in one's own land' position (Dallos and Vetere 2005). Reflexivity allows participants to comment and influence the research process, alerting a researcher to potential risks and ethical dilemmas. Additionally, reflexivity can be a way of thinking which enables the researcher to evaluate the impact a research project has on him/her. Researcher supervision and support for reflection has been maintained (Etherington 2001).

Epistemology

> 'The 'whispering pond'…wherever scientists look and whatever they look at, they see nature acting and evolving not as a collection of independent parts but as an integrated, interacting, self-containing and self-creative whole'
> (Laszlo 1999 in Reason and Bradbury 2001, p 8)

Epistemological assumptions in AR have a foundation on three underpinnings (McNiff and Whitehead 2011)…

1) The object of enquiry is the 'I.'
2) Knowledge is uncertain.
3) Knowledge creation is a collaborative process.

Constructivism is an epistemology, a learning or meaning making theory (Ultanir 2012). From the Greek *epistēmē* meaning '*knowledge, science'* and '*logos*' or theory of knowledge, epistemology is the branch of philosophy concerned with the nature and scope (limitations) of knowledge, essentially what is known and how it comes to be known (Whitehead and McNiff 2006, p23). Epistemology addresses the questions concerned with how we discover, and how and why problems occur (Dallos and Vetere 2005). Essentially two approaches can be identified, the positive, which seeks to set out objective measurement, and the constructivist, whereby knowledge is obtained through understanding, 'I do' rather than 'I think' (Reason and Bradbury 2001). This suggests that our knowledge of the world is generally based on our actions, yet we also need to understand and develop theory that underpins our action. Whitehead and McNiff (2006) consider epistemology to include an understanding of the unit of appraisal, how valid judgements can be made and a logic in the sense of the form that reasoning takes in understanding the real as rational.

The constructivist theory of Bartlett (1932) (cited Good and Brophy 1990) and Neimeyer et al. 1998, Neimeyer and Mahoney 1995, Neimeyer 1999, Neimeyer 2010) is based on the principle that human beings are inveterate meaning makers, weavers of narratives that give thematic significance to the salient plot structure of their lives (Neimeyer 1998 and 2010). The origins of constructivism have been attributed to many (e.g. Jean Piaget, Lev Semyonovich Vygotsky, John Dewey, and Giambattista Vico).

The contemporary growth of constructivism owes much to the work of Jerome Bruner (1966) who advocated discovery learning as an alternative to conventional instruction. Bruner's notion was straightforward—that students *(or patients)* would better learn and retain concepts they discover on their own instead of passively through rote learning and lectures. Constructivists believe that individuals construct their own reality or at least interpret it based upon their perceptions of experiences. An individual's knowledge is therefore a function of one's prior experiences, mental structures, and beliefs used to interpret objects and events. So knowing is a perception of the physical and social experiences which are comprehended by the mind (Jonassen 1991). By this means we arrive at our intersubjective reality, through describing and explaining experience in relation to others (Moss et al. 2003).

Constructivism has a parallel within CAT as it integrates elements of psychoanalytic object-relations theory and cognitive and developmental psychology, in particular the collaborative and dialogical nature of human object relations. The dialogic is integrated into CAT and constructionism though the work of Lev Vygotsky (1896-1934) and Michael Bakhtin (1984). Bakhtin and Vygotsky see communication as where the self is viewed as a dynamic multiplicity of I's (Hermans 2002) and human beings as 'essentially dialogic'. Adults, in this dialogic, communicate using signs and language, Bakhtin states:

> 'Imagine a dialogue of two persons in which the statements of the second speaker are omitted, but in such a way that the general sense is not at all violated. The second speaker is present invisibly, his words are not there, but deep traces left by these words have a determining influence on all the present and visible words of the first speaker. We sense that this is a conversation, although only one person is speaking, and it is a conversation of the most intense kind, for each present, uttered word responds and reacts with its every fibre to the invisible speaker, points to something outside itself, beyond its own limits, to the unspoken words of another person'.
>
> (Bakhtin in Clark and Holquist 1984, p197)

Hermans (2002) cites Bakhtin's (1929/73) metaphor of the polyphonic novel, which allows for a multiplicity of positions among which dialogical relationships may emerge (p147). In Bakhtin's view individual speakers are not simply talking as individuals but in their utterances the voices of groups and institutions are heard (ibid, p149). Collective voices are not simply internalized but reconstructed as part of the self in personal ways. The dialogical self incorporates both continuity and discontinuity. In this respect the 'I' is the continuity of the experience of the self in relation to how it views the 'das Ich' (Freud 1925) or 'I-me' as well as the 'I-Thou' or 'I-mine' combination. There can be discontinuity in that the 'other' may not perceive our 'I' in the same way, so there is in essence, a multiplicity of positions (Hermans 2003). The self thus has a repertoire of two domains, the internal domain and the external domain that refer to those people, objects and environments that relate to 'me' (Hermans 2003).

We only know more about and feel connected to others around us if we engage in dialogue with them or join them on a similar undertaking, a shared position. Potter and Sutton (2006) note Bakhtin's two big ideas. First the addressive, responsive and co-authoring quality of interpersonal communication where communication is only understandable as a joint activity, and the second being the dialogic nature of the different components of culture and society where language genes are in an endless interaction with each other. The dialogical self is a 'theater of voices' (Meira and Ferreira 2008, p293) where 'the voice is multifaceted in time and space, multifocal and dynamic, emerging from the dialogue relationships between 'I-positions' (Ibid, p294).

Assessing the developmental level of a research project includes a further essential tenet in Vygotsky's theory (1962), the notion of the 'Zone of Proximal Development' (ZPD) as described on page 29 and 30 of this submission. The ZPD is supported by the therapist in order to provide a scaffolding of support sequencing, planning, and pacing as well as tools and concepts which are handed over as the child/patient acquires them (Ryle and Kerr 2002). The person in this scaffolding process, providing non-intrusive intervention, could be an adult (parent, teacher, caretaker, language instructor) or another peer who has already mastered that particular function (Kerr 2001). Utilising the ZPD as an approach to research has important implications as authoritarian structures can inhibit the respondent's capacity for discovery and an incomprehensible and incoherent structure can leave exploration undirected. Scaffolding should be ideally adjusted to the respondent's current capacity.

We know that when people face uncertainty and feel at risk, they set up psychological boundaries simply to reduce anxiety (Hirschon 1997) and one of the easy ways to manage anxiety is to cut off or disengage. Hence these concepts are important when engaging research subjects over an extended period of time. In fact, research using constructivism and action approaches can be viewed as akin to the double dialogic where a 'child touches their face and feels the touch on their hand as well as the cheek on hand!' as in the research process where the 'researcher touches the studied and the studied then touch the research'.

Dialogism, has its roots in many philosophical positions for example, Descartes' cogito that suggest both an inside and an outside relationship of the self. This starting point has limitations as if it does not fully embrace the relationships of the self with others. Dialogism both recognizes the 'I' as well as the 'thou' in our interactions with others and within ourselves. Straus (in Hermans 2003) has argued that Descartes cogito implies not only a dualism with the body and mind but also a separation between the self and other (p92). There is much implied in this that we are in some way aware of ourselves but not always aware of the world. This dissonance has been brought together explicitly within dialogism and has been explored in depth by Bakhtin (Clark and Holquist 1984). In Bakhtin's world view the other is pervasive even when the person is alone where dialogue in fact penetrates every word (Hermans 2003). Bakhtin emphasizes communication as a defining feature of human self and of the potential of dialogue (Pollard et al. 2006).

There is some criticism to the dialogical approach in psychotherapy, because the notion that discourse being abstract, may miss occurrences of discomfort and suffering in human experience within ones inner multiple voiced discourse (Bernstein 1989). Pollard (2004) also critiques a theory of human experience derived from a novel in the form of Dostoevsky's writings noting, to what extent can novels represent real life or life as it is lived outside the pages of a book? Furthermore, Pollard (2008) challenges the nature of dialogic in that it underestimates the coercion that is involved in some dialogue so that it is not spontaneous and natural all of the time. It seems to the researcher that whilst these criticism have some face validity the question is to reflect on the nature of the usefulness of the 'I-thou' rather than deconstruct it. From this perspective CAT's orientation and focus on reciprocal roles is one way of guarding against a view of dialogism as coercive or lacking in emotional depth and resonance.

Building on the metaphoric position outlined earlier I want to repeat Lakoff (1997) and Lakoff and Johnson's (1980) comment that we are not just given our world but its construction is based on the way we make meaning of our perceptions and thoughts. The constructivist approach offers an open ended and flexible means of study for fluid interpretive processes and more stable social structures (Charnay 1990).

New learning has generative transformational potential and any new learning holds within itself its own potential for improved learning (Whitehead and McNiff 2006). The Bakhtinian view of the infant as pre-programmed to be communicative and having learning potential combined with the Vygotskian view that knowledge develops in the ZPD has been the central tenet of knowledge acquisition. Language translates ideas, emotions and meaning across time and space. Language is used to describe and divide people into categories and to segregate people into groupings. Vygotsky views every element of man's consciousness having a corresponding word, where language is the sum total of an individual's self as thought and language are inextricably linked (Innes 1985).

Yet is there not more to learning than language? The child initially learns though imagery and right brain activity (Wilkinson 2010). Research has noted that from age five to seven children improve in the ability to understand visual metaphors (Dent and Rosenberg 1990). Language is the vehicle of reason (Boyne 1990), language develops based on learning words in response to images and pictures, is an institution in the present and a product of the past (Lodge 1988). Philosophical thought expands two perspectives 'thoughts and ideas' and 'words/sentences'. They include the thing as it appears in our thoughts 'noumenon,' our immediate lived experience and 'ontology', a science of the existence of man (Hundert 1989, p163). Thus the 'world represented by the language, unobscured by the language, would be perfectly present to the observing subject, who could then speak of what was seen' (Boyne 1990, p91).

Our knowledge of things also divides into direct and indirect knowledge and knowledge through aspects (Hondereich 1995). Individuals create or construct their own new understandings or knowledge 'through the interaction of what they already believe and the ideas, events and activities with which they come into contact' (Ultanir 2012, p195). Knowledge creation is a therefore a collaborative process (McNiff and Whitehead 2011). In this respect constructivism offers an approach to learning that rests on the principle that individuals only construct knowledge based on previous experience and background knowledge (Ultanir 2012).

The object of enquiry is the 'I', the constructivist approach enables the researcher to examine the personal meanings of an individual's experiences of Metaphor, PM and CAT and their interpretation of this knowledge in practice and support this with statistical analysis. We forget that the words meaning depends on its staging, the scene or circumstances in which it is used. What is the difference between trying hard to run faster and trying too hard to think?

Heaton and Groves (1994) believe it is interpretation and observation, but this can only be corroborated in dialogue. Our thoughts and experiences are dialogically interwoven with others and this common linkage is possible by virtue of language and speech (including signs, tokens and words). In communicating 'we assume a common basis for our thought, and our thoughts are made available to others in the same way they are made available to us' (Crossley 1996, p12).

Phenomenology or hermeneutics lie collectively under the banner social action theory, which includes such terms as ethnography, symbolic interactionism and labelling theories (Good and Watts 1997, Polgar and Thomas 1995). Hermeneutic research is particularly interested in how the significance of an action can be understood by its setting and the personal and cultural practices within which it arises (Parry and Watts 1997). To do this, studies concentrate on the individual rather than systems, indeed this is one of the criticisms levelled at phenomenology (Bowling 1997). Karl Popper is often cited when discussing phenomenology through his criticisms of positivism noting its misleading nature and emphasis on superficial fact rather than understanding the underlying mechanisms (Bowling 1997). Karl Popper saw knowledge as being based on a deductive as opposed to constructive view.

Professional competence represents a core value and ethical cornerstone of MH professions and is present in all areas of health intervention. The researcher is mindful of this, as he develops new tools and ideas, it is important that they are based on competence rather than anecdote and assumption (Williams and Haverkamp 2010). The researcher hopes to contribute to a developing body of knowledge in CAT whereby true learning is based upon doing (Silverman 1997). This thesis has multi stages in its construction and consequently a complex methodology.

Researching psychotherapy can be considered to be either idiographic or nomothetic. Idiographic research attempts to understand specific events and nomothetic seeks to set generalisations and create universality (Dallos and Vetere 2005, p25). This research is both setting out to understand a specific process as well as looking for evidence that 'x;' affects 'y' in CAT, effects that might be generalisable.

The complexity in psychotherapy research is that 'one can only make generalisations based on examination of specific cases' (Dallos and Vetere 2005, p26). Concerns are expressed regarding psychological research that basing research on the natural sciences with the premise of refuting the 'null hypotheses' as misguided (Meehl 1978, p187). In psychotherapy we know what we know by understanding the literature, through patient individual contact and through supervision with an expert clinician. Testing and developing this can be gained by following the same route, understanding the literature, consulting experts in the field and then testing this out in individual cases which is the process for this study.

In this respect the main body of this action research thesis is a Delphi study of expert practice. The Delphi technique is an inquiry system that assumes there is a raw data set in the real world and as such one assumes this exists. Conceptualisation of this data set has arisen from prelim review of the literature as well as reflections on clinical practice (Tinstone and Turoff 1975). The results can be considered to be aggregate in that they reflect the complexity of psychotherapy research and include a person's uniqueness rather than general rules that apply to all.

Methodology - What strategies of inquiry will inform the procedures?

Understanding research paradigms is a crucial part of any study because understanding a paradigm enables structure and supports understanding of the research approach (Weaver and Olsen 2006). A paradigm is a world view, a general and overarching perspective on the topic measured in the real world (Polit et al. 2001, Kuhn 1970). Paradigms lead to schools of thought, supporting different scientific communities who share specific constellations of beliefs, values and techniques for deciding which questions are interesting, how one should break down an interesting question into solvable parts, and how to interpret the relationships of those parts to the answers (Parahoo 2014). Paradigms are generally classified into the naturalistic and rationalistic, commonly known as qualitative and quantitative research (Guba and Lincoln 1994).

Quantitative Methodology

The positivist paradigm has a fundamental belief in objectivity, whereby something has happened as a direct result of an event, one that can be identified, understood and determined (Parahoo 1997, Polit et al. 2001). The methods of enquiry employ a hypothesis which through measurement, generate data and following deduction either supports or disproves a theory (Cresswell 2003). The data, numbers and statistics, is favoured by scientists within the positivist method of enquiry (Burns and Grove 2001). Data is frequently presented in charts and graphs with conclusions being drawn following examining cause and effect relationships (Cormack 2000). Through the systematic process of gathering numerical data, to obtain information about the world, testing occurs (Polit and Hungler 1995).

Such quantitative procedures could be questionnaires, random controlled trials, or systematic reviews, which invariably use information in a numerical form and subsequent analysis of statistics (Cormack 2000).

The quantitative approach incorporated within this study, by definition, deals with quantities and relationships between attitudes (Cormack 2000) of normally a large, randomly selected sample (Morse and Field 1996). There is an emphasis on systematic and controlled procedures for acquiring dependable, empirical information (Polit and Hungler 1995). This approach can be described as representing the traditional scientific view of research where anything worth knowing can be objectively measured or quantified and typically represented numerically (Crookes and Davies 2004). The type of research planned has a foundation in quantitative science as well as being influenced by existing knowledge of the research problem (Burns and Grove 2001). Quantitative data was gathered primarily in studies two to four, although an analysis of demographic data was undertaken numerically for all studies:

- Study1 – Preliminary Workshops (Demographic data from questionnaire, EXCEL).
- Study2 - Delphi and iterations (Likert scales analysed in SPSS).
- Study3 - TP pilot and delivery evaluations (Likert scales analysed in EXCEL).
- Study4 - MaP-Self clinical guideline evaluation (Likert scales analysed in EXCEL).

Qualitative Methodology

The naturalistic paradigm can be considered opposite to the above as there is no ultimate truth or falsity because there are different ways of interpreting the data (Polit et al. 2001). The purpose of qualitative research is to describe, explore and explain phenomena being studied (Marshall and Rossman 1995, Lenninger 1985). The approach allows for flexibility, for findings to emerge over the course of the study. Methods of enquiry include interviews, participant observation and conversational analysis, among others. Data is often rich in detail and 'seeks to uncover the understandings and motives that lead to certain actions.' (Cormack 2000, p19). In order to construct a meaningful way forward for the TP, and include the results of the Delphi within this, needs to gain an understanding of the knowledge and experience of the responders. Subsequently, the knowledge and the experience of the students of the training and the utilisation of the training in practice, is important to capture and analyse.

Qualitative methods are associated with the thoughts, behaviour, experiences and feelings of people within their natural environment (Holloway and Wheeler 2002). The participants views and interpretations are the focus, normally utilising interviews and observations as a basis for the measurement tool (Burns and Grove 2001), but in this instance the study will be seeking prose, using words to support the numerical information gathered to answer the study question (Crooks and Davies 2004). Using prose will further dilute the subjectivity of the researcher's own values and thoughts (Cormack 2000). Qualitative research has an established tradition in health care research, and increasingly in nursing research (Morse and Field 1996) and the state of sophistication in the methods of investigation is growing (Good and Watts 1996).

Marrow (1998) and Cutcliffe and Mckenna (1999) have illustrated the benefits of qualitative research in the health and social care setting drawing attention to the benefits of investigating human experiences from a holistic perspective. This in depth approach is well suited to the complex experiences that nurses encounter in practice (Polit and Hungler 1995). Qualitative research in health care provides the investigator with an opportunity to establish evidence and form new understandings related to the issues under investigation.

Qualitative research is guided by the same methodological and ethical principles as quantitative research, involving collecting and analysing evidence and formulating and evaluating theories (Polgar and Thomas 1995, Munall 1988). Through the application of qualitative methods I am able to examine the personal meanings of individual's experiences and actions in the context of their social environments, making detailed descriptions based on language or pictures recorded by the investigator. I am able to be sensitive to and observe subtle changes and nuances which a structured machine-like approach couldn't (Polgar and Thomas 1995).

The data for this qualitative research has been initially generated via focus groups (Basch 1987, Kidd and Parshall 2000, Kitzinger 1995) to inform the Delphi study. In the Delphi study data was generated through the use of a first iteration questionnaire and then refined though subsequent iterations, creating a window on the world (Hyman et al. 1975) into CAT practice. For all four studies responder narrative was coded and analysed in NVIVO and/or following accepted content analysis approaches.

Mixed methods - What methods of data collection and analysis will be used?

The research question, seeking phenomena known by CAT therapists as to their understanding and use of metaphor and PM in clinical practice, seeking a view rather than only a measure of the world, might find a purely quantitative or qualitative study having unanswered questions. In order to address this exploring a mixed methodology where both quantitative and qualitative data is sought seems appropriate. Dallos and Vetere (2005) note a schism in research between the use of numbers and words yet find that in many (or all) situations we use quantifiable statements to support qualitative utterances 'to give meaning to events and experiences' (p46). Mixed methods will enable the researcher to describe phenomena and to develop explanatory concepts and theories (Bowling 1997), as well as providing evidence for change based on statistical analysis.

A mixed approach, with objective and subjective data streams, is a design that can increase reliability in research studies (Reason and Bradbury 2001). Reliability and validity concern the internal data and inferences that can be made from this data and involve issues of replication of a method in observing particular phenomenon (Parahoo 1997). Traditionally tests for validity have arisen from the positivist tradition concerning whether the research truly measures what it set out to do and how truthful the results are (Parahoo 1997, Nahid 2003).

The design and methods in this study of a heterogeneous and homogeneous sample, a structured analysis of data and applying rigorous analysis of data will guard against slippage in reliability and valid of the data and outcomes generated. The main method of data collection in all four studies is a questionnaire therefore inherent content and criterion related validity can be applied. The questionnaires are based on robust examination of the literature and topic, are piloted for congruence and completion and therefore are inherently representative of the phenomena being studied (Parahoo 1997). Triangulation with the literature and pilot data has increased criterion related validity. Methods for each study have been discussed and justified within each methodology and are represented in chapter's four to seven, so are not expanded here to avoid repetition. Essentially Study1 follows a focus group method as applied to workshops, Study2 a traditional Delphi method, Study3 a return to focus group methods as applied to workshops with a reflective follow up survey, and Study4 an initial questionnaire evaluation of a self-assessment scale.

Triangulation

Whilst generating and evaluating evidence, of particular importance to inference and interpretation, is triangulation (Mays and Pope 1996, Bowling 1997, Good and Watts 1997) whereby the use of other sources to confirm an interpretation is undertaken, commonly described as synchronic reliability. Triangulation can also include the use of a second party to evaluate the data. One of the advisors to this study will inform this triangulation as someone who is familiar with data analysis and CAT. Halcomb and Andrew (2005) state that triangulation within qualitative research is when two or more methods of data collection are utilised in order to strengthen and confirm the research findings. Fig16 indicates the level of triangulation as a relationship of multiple methods, multiple researchers, multiple theories and multiple data sets.

Fig16: Triangulation in action

Ethical Considerations

Ethical issues are a cornerstone of any research project (McHaffie 2000). The objective of an ethical approach should be the avoidance of those dilemmas which people create for themselves, through an inability to observe themselves with any degree of clarity (Barker and Baldwin 1991). AR encompasses complex ethical issues such as intimacy between the researcher and participant and the aim to change practice (Williamson and Prosser 2002) while ensuring and open and democratic process throughout (Whitehead and McNiff 2006). In AR the researcher is closely entwined with the participants (Whitehead and McNiff 2006) as are the ethics of psychotherapy research that use other people's stories to gain academic award (Etherington 1996).

Ethics have their origin in the values, beliefs and attitudes which form the basis of every society (McGee and Notter 1995). Utilisation of an ethical framework as described by Beauchamp and Childress (2001) primary ethical principles can assist in protection of all those participating in any research study (Hek et al. 2002, Polit and Hungler 1993). Teleogical as well as psychotherapeutic ethical considerations apply to individuals in research trials who need protection in relation to their privacy and from manipulation by the researcher (Bowling 2009). Issues of rights and responsibilities, who gains, autonomy, consent and confidentiality, utility, reflexivity and beneficence and/or potential to harm need to be considered.

Ethical considerations in psychotherapy research, such as this one, essentially include issues around informed consent, confidentiality and avoidance of harm (McLeod 1999, Bond 2004, West 2002). ACAT (1995 and 2009), BACP (2009) and UKCP (2008) codes of ethics and research ethical standards have been followed. In psychotherapy there are special considerations not especially power imbalances that ethical process must underwrite and recognise. McLeod (1994) writes…

> 'It is reasonable to conclude that any research design will generate ethical dilemmas. The implication is not that research should be abandoned, but that every effort should be made to examine the effect that a study will have on all of the people who participate in it.'
>
> (McLeod 1994, p168).

The action research design upholds additional ethical issues such as intimacy between the researcher and participant and the aim to change practice (Williamson and Prosser 2002) while ensuring and open and democratic process throughout (Whitehead and McNiff 2006).

In psychotherapy biomedical ethical principles are followed. Including power imbalances that ethical process must underwrite and recognise, Issues of rights and responsibilities, who gains, autonomy, consent and confidentiality, utility, reflexivity and beneficence and/or potential to harm need to be considered (Beauchamp and Childress 200, Bloch and Chodoff 1984). In order to plan and manage these ethical expectations, approvals were gained from all ethical masters (Jenkins et al. 1998). Primarily as this study involved staff learning a technique as part of their normal model and practice the approvals applied to management of individual's rights (Department of Health 2001 and 2005). For each study ethical approval and permissions were gained via proposal (McGee and Notter 1995). Fig17 outlines ethical procedure processes and appendixes V-VIII evidence of approval.

Fig17: Approvals form 'ethical masters'

	ACAT Approval	SHU Approval	NHS/CRUSE	Appendix No.
Study1	Approval gained			V
Study2	Approval gained	Approval gained		V and VI
Study3	Approval gained	Approval gained	Approval gained	V-VII
Study4	Approval gained	Approval gained	Approval gained	V-VIII

- **Study1/Cycle 1-** Preliminary work involved delivering and evaluation workshops within the CAT community at conferences. ACAT approval was granted for this work at the onset.
- **Study2/Cycle 2 –** Delphi study involved approvals from SHU Ethics as well as ACAT ethics and approval gained.
- **Study3/Cycle 3 -** Training programme and evaluation included CAT Therapists, therapists within the NHS and CRUSE, therefore approval was sought from all 'ethical masters' stakeholders where the sample was drawn.
- **Study4/Cycle 4 -** Pilot of MAP-Self-evaluation scale was undertaken as part of approvals for Study3 within the NHS workshop and from National CRUSE council.

Issues of consent, confidentially, justice, beneficence, utility and reciprocity have been considered. Informed consent arises from the principle of autonomy (Mc Leod 1999) and is embedded in many Codes, such as the Nuremberg Code (1949) and exists to protect the exploitation of human subjects in scientific research. All participants in this project will receive information relating to consent and confidentiality as per ethical guidelines (Williamson and Prosser 2002).

Stummer (2009) cites Bond (2004) and Henry (1996) commenting that issues of paramount importance in planning and conducting an ethical research project include protection for both parties, potential risks of the research project, and the use and potential abuse of power. Therefore consent should be discussed not just at the start of a project but during to confirm continued agreement with the research aims described as process consenting (Munall 1988). Consent is predicated on anonymity (Dallos and Vetere 2005) as is informed consent considered a central tenet of ethical thinking (Dryer 1988), involving autonomy and competence. The ability of participants to withdraw their consent to progress with a study is written into all consent and information forms (Bond 2004, Jenkins et al. 1998).

Consent can be a dilemma in action research because projects using this methodology have no predetermined end place, however there are four studies covered within this research and this in effect provides an end point for the participants included. Therapists one should assumes have freewill and understanding, so 'informed' is the central ethical aspect for this research (Barker & Baldwin 1991), hinging on understanding of the research process (Bloch & Chodoff 1984). Therapists are required to clarify with patients the nature purpose and conditions of any research in which the patients are to be involved and to ensure that informed and verifiable consent is given before commencement (ACAT 1995).

At all stages consent has been Asked for and achieved. In each workshop data that was taken and used had an explanatory sheet attached with consent signatures asked for. With regard to patient generated and workshop generated metaphors patients gave their express consent for their picture to be used, and in fact generously commented on their picture for the purposes of this research. This consent was obtained after therapy was concluded to reduce the possibility of a power imbalance being played out (Etherington 1996 and 2001).

Action research involves close collaborative work between participants in psychotherapy so strenuous efforts must be made to guarantee confidentiality and anonymity (Williamson and Prosser 2002) with the researcher working at all times in good faith (McNiff and Whitehead 2006). Confidentiality of all participants will remain intact with participants remaining ‘unnamed’ and allocated a unique code (McNiff and Whitehead 2006). Implicit assurances and explicit guarantees are written in the covering information (Miller and Glassier 1997). Data and codes are secured with a 5* password protected file and/or in a locked file cabinet as does all back up data have the same level of security.

Reflective data will enhance the overall study, whilst attempting to maintain the 'Being a stranger in one's own land' position (Dallos and Vetere 2005). Reflexivity allows participants to comment and influence the research process. This ongoing feedback process can alert a researcher to potential risks and ethical dilemmas during the research. Additionally, reflexivity can be a way of thinking which enables the researcher to evaluate the impact a research project has on him/herself. Reflexivity may involve the use of supervision to reflect on and process issues. As researchers often have strong personal motives for the project they have chosen, it is fairly likely that in-depth involvement with the chosen topic will bring up emotional material. Good supervision and access to personal therapy are of great importance in dealing with the emotional impact the research may have on the researcher (Etherington 2001).

Chapter Four: Study1 - A 'metaphor' research journey

Introduction

Preliminary work for this PhD has been published in '*Reformulation*' the Journal of ACAT (Turner 2011 and 2012). Preliminary work informed emerging research ideas as results were used to guide, explore and validate the study. The author's interest and clinical practice has developed in this area over a number of years having undertaken over a 100 individual patient therapies. I began to 'tune in' to metaphor and then to make a point of noticing metaphor with the patient, exploring its salience for their life and therapy. I then took the step of drawing the images relating to the metaphor in a rudimentary way whilst at the same time checking out with and collaborating with the patient that this approach was acceptable and congruent. The PM work seemed to resonate with patients and appeared to enable change and support the TE. I became aware, from dialogue with other CAT therapists, that I was elaborating the CAT model. I had no recollection of being taught this in any of my trainings or reading anything about it in the literature on CAT.

It seemed important not to just get on with what I was doing but share this approach and explore it with my colleagues. I was interested in whether it was used by therapists in practice, if so how, and was this approach appropriate for CAT. Dr Anthony Ryle commented to the researcher that 'elaboration is progress and can develop and build on CAT as an integrated model'…'if pictures work then use them' (Ryle 2012). Conversations with other leaders in psychotherapy and CAT have helped formulate the research statements and influenced the direction of study. I have been mindful of ensuring that in focussing on metaphor and PM I have maintained the fidelity of the CAT model.

Aims

The aims of Study1 were:

- To obtain stakeholder feedback on the feasibility of metaphor and PM in CAT
- To undertake a pilot preliminary set of workshops and focus groups across the CAT community using CAT conferences on a regional, national and international attendance.
- To generate data in order to establish support for the continuation of this research and valuable guidance regarding the direction of travel and study design.

Method

ACAT was approached and ethical approval via proposal was obtained at the early stages of this study (Appendix V). Prior to the workshops a preliminary review of the literature was undertaken using key words and Boolean operators incorporating ‘metaphor and psychotherapy’, ‘metaphor and CAT’ and ‘CAT, PM, psychotherapy’ among others. A number of literature ‘Ebsco alerts’ were set up using these keywords to supply current citations and articles in the psychotherapy literature on an ongoing basis. The literature has been presented in depth in Chapter Three of this submission.

The researcher had an opportunity over three separate conferences to facilitate a pictorial metaphor workshop and a plenary reflective session at and International conference. A proposal was sent to the conference organisers to facilitate a workshop As part of the programme and this as accepted. Workshops and data collection were facilitated in 2008, 2009 and 2010 at three CAT conferences (a regional, international and a national conference).

In these workshops the researcher was starting out his AR journey (Hope 1998) and testing the direction of travel in metaphor, gathering new knowledge of individuals practice, thus seeking a ‘social-phenomenological position to examine the semiotic or textual structure of every day practical activity’ (Packer 1985 p1086). The researcher viewed each workshop as a subjective not objective experience. One simply cannot expect the same answers to emerge and replicate another’s as they ‘come out of different circumstances of production and reality’ (Holstein and Gubrium 1997). Attendees were given consent and information sheets (Appendix IX) and asked to complete a questionnaire and worksheet (Appendix X).

Each workshop followed a similar format with a blend of didactic and student exercises. Figure 18 shows an outline of the workshop plan. Participants were asked to make process notes (some of which were handed back to the researcher) as well as complete an initial questionnaire on their metaphor use. A flow of lecture format to guided discovery in small and larger groups was managed to develop the technique based on experiential learning.

Fig18 Initial workshop plan

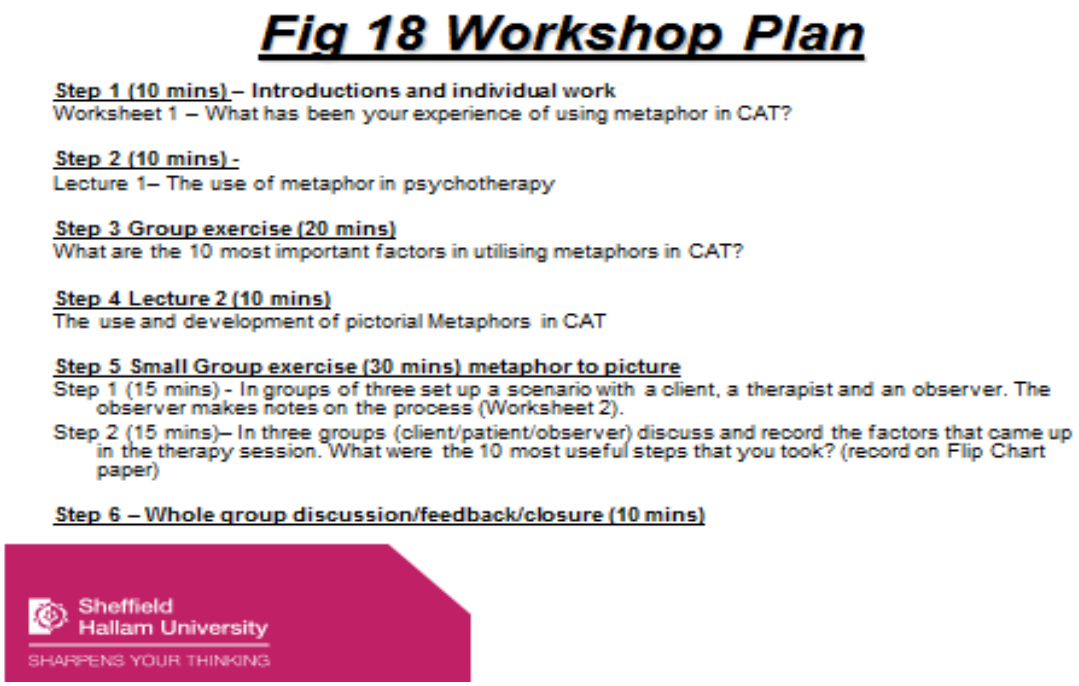


Fig 18 Workshop Plan

Step 1 (10 mins) – Introductions and individual work
Worksheet 1 – What has been your experience of using metaphor in CAT?

Step 2 (10 mins) -
Lecture 1– The use of metaphor in psychotherapy

Step 3 Group exercise (20 mins)
What are the 10 most important factors in utilising metaphors in CAT?

Step 4 Lecture 2 (10 mins)
The use and development of pictorial Metaphors in CAT

Step 5 Small Group exercise (30 mins) metaphor to picture
Step 1 (15 mins) - In groups of three set up a scenario with a client, a therapist and an observer. The observer makes notes on the process (Worksheet 2).
Step 2 (15 mins)– In three groups (client/patient/observer) discuss and record the factors that came up in the therapy session. What were the 10 most useful steps that you took? (record on Flip Chart paper)

Step 6 – Whole group discussion/feedback/closure (10 mins)

Sheffield Hallam University
SHARPENS YOUR THINKING

Data collection

Data collection and analysis was managed within a mixed qualitative and quantitative questionnaires, collecting dialogue as well as some numerical data. Using workshops as a form of data collection is messy but can be made less so by applying principles of questioning from interview schedules and focus groups methodologies. In the first instance keeping to similar questions can help manage the data. The researcher set out to do this by adjusting each workshop based on feedback to continue to obtain some core data but also to respond to the wishes of the group. In doing this, data collection became richer, but more complex to capture. One of the interesting aspects of the data collection was an ‘in conference’ evaluation of data at the international conference where I was asked to feedback at a plenary session the initial results of the questionnaires I had collected.

This complexity can be supported in methodological literature as both Baker (1997) and Silverman (1993) observe. Baker (1997) notes that interviews include from thought to language to themes and are understood to be an interactional event thereby making data rather than data collection.

Silverman (1993) views the primary function of an interview as generating data which gives an authentic insight into peoples' experiences. Denzin (1970) discusses three types of interview, the schedule interview, non-schedule standardised and non-standardised. The researcher managed the focus groups around a non-schedule standardised format because he wanted to provide some structure to data collection and also to gain an insight into the understanding and conceptualisation of the use of metaphor from respondents.

As the researcher is a CAT therapist he can be considered as being in the footsteps of the studied (Perakyla 1997) indicating an intersubjective and reflexive angle as the author was using his own knowledge and experience to explore the topic (Murphy et al. 1998, Hutchings et al. 2006). The researcher has an agenda, the other person may wish to convey a message to the researcher, the end result is access to the meanings people attribute to their experiences and social worlds (Miller and Glassner 1997).

Ethical approval

Ethical approval and ethical justifications have been included earlier in this study. All ethical aspects outlined were managed and maintained (see Appendix V-VI).

Sample

Bowling (2009) notes that ‘any sample is just one of an almost infinite number that might have been selected’ (p197) and is arguably one of the key issues any piece of research (Dallos and Vetere 2005). Whilst sampling error (Bowling 2009) cannot be eliminated it can be reduced to an acceptable level. Attendees were considered heterogeneous in that they share an experience as CAT therapist and homogenous because the groups were all therapists from differing backgrounds and locations (Parahoo 1997). As such they can be considered as representing an appropriate sample of the target population (Hek et al. 2002). The sample technique was considered as opportunistic (Honigman 1994) and judgement sample. Opportunistic, because the researcher mostly used CAT therapist attending CAT conferences, judgement because the data needed to be collected from CAT therapists or other psychotherapists. N=22 therapists completed a questionnaire in two of the workshops and in one workshop N=6 participants provided worksheets. The sample self-selected on the basis of choosing to attend the workshop based on information the conference programme., At each workshop an information leaflet, consent and questionnaire or worksheet were provided for the participants.

In choosing a judgement sample the principles of AR are maintained as well as a strong shared characteristic in the sample. AR should be collaborative, context related, change practice and generate theory (Lyon 1996). This research sets out to achieve these aims. The researcher was seeking collaboration and guidance from therapists on their use and understanding of metaphor and metaphoric pictures in therapy, in order to generate an understanding of current perspectives and develop ideas regarding progression of this research.

Managing validity

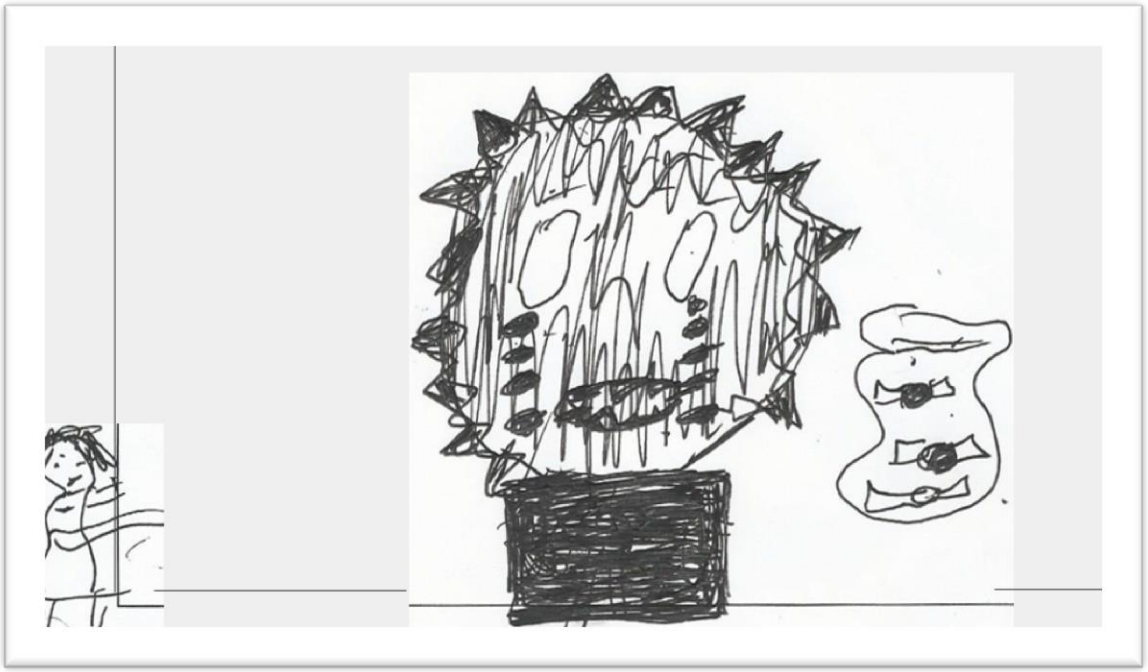
Whether one tries through a structure to control an interview, active interviewing is contamination everywhere, but if interview responses are seen as products of interpretative practice, they are neither performed, nor ever pure. Any interview situation, no matter how formalised, relies upon the interaction between participants. As meaning construction is unavoidably collaborative (Garfinkel 1967) it is virtually impossible to free any interaction from those factors that could be construed as contaminants (Holstein and Gubrium 1997). To ensure reliability and validity the accuracy of recordings and testing the truthfulness of analytic claims needs to be ensured. By using the same semi-structured questionnaire for each workshop an inherent strength to reliability of generation of data is achieved. Included in the preliminary work was a level of reflexivity intertwined with this early scene/stage setting work in relating the researchers own experience of utilising the PM in practice (Murphy et al. 1998, Hutchings et al. 2013, Elliott 1993).

Results and Data analysis

Workshop generated pictorial metaphors

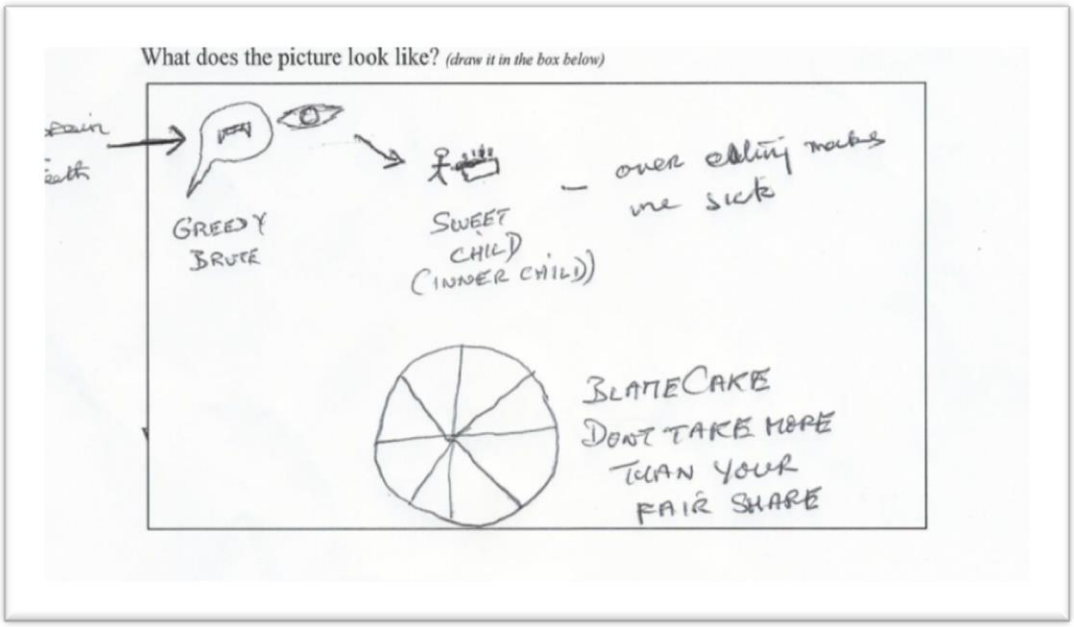
A questionnaire was provided for participants as well as a worksheet. Some of the images developed by the participants were handed in to the researcher for inclusion. These were developed by participants in a group at one of the workshops only in 2009. The reason for this is that the researcher had reflected on the experience of previous workshops and asked the participants if there worksheets could be included in the study which they generously provided. In hindsight it would have been useful to collect in more of the worksheets but the data generated by these four examples is an indication of the application of the PM technique to a case study generated in situ at the workshop.

Fig19: Workshop Example Participant 'a' 'Being scared of own mind made me hide behind the picture'



Unfortunately there is no supporting dialogue for this pictorial representation other than the title. Yet the title has resonance with the small image hiding behind and holding up the picture with the 'scary' head' depicted.

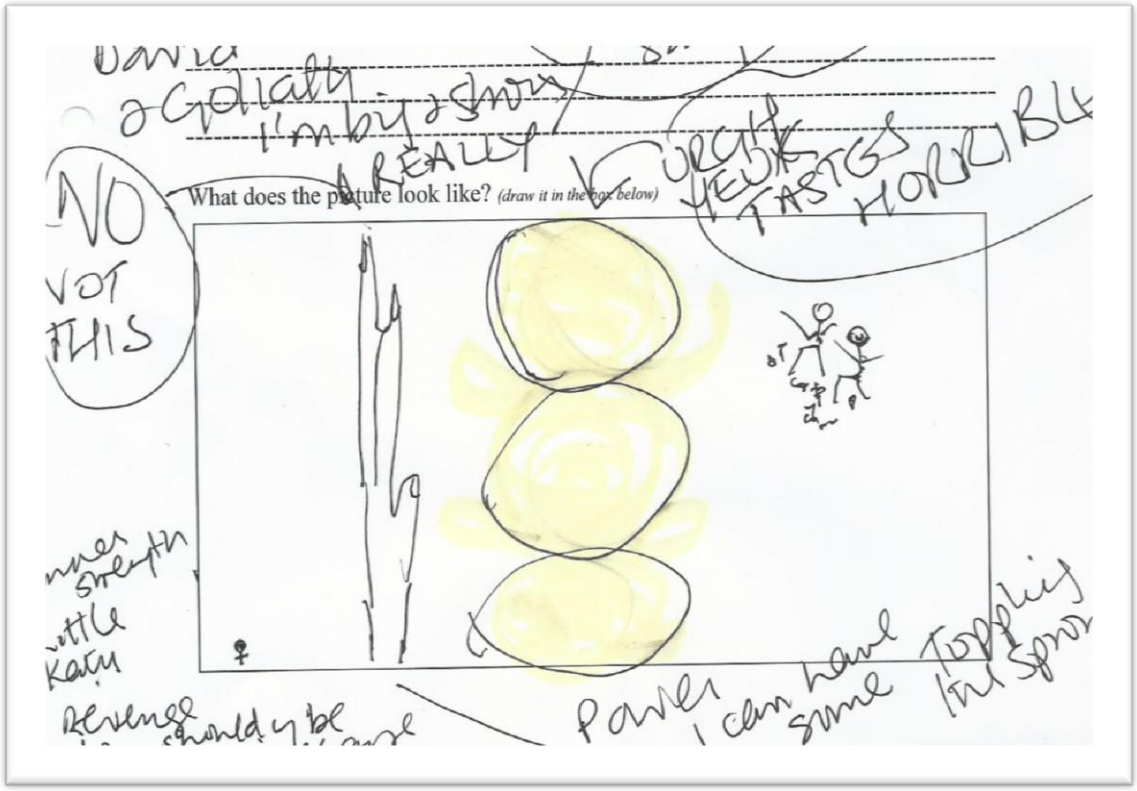
Fig20: Workshop Example Participant 'b' 'Greedy Brute'



Participants notes: *'British female chef (patient) 'afraid of eating my own mind'. Image therapist has is of teeth inside her head. She's diabetic'. The blame cake is a metaphor that led to a discussion as to asking patients to apportion blame, whose portion belongs to whom. Not allowed to eat more than their fair share. Sweet eating child gets sick. Belongs*

to whom.

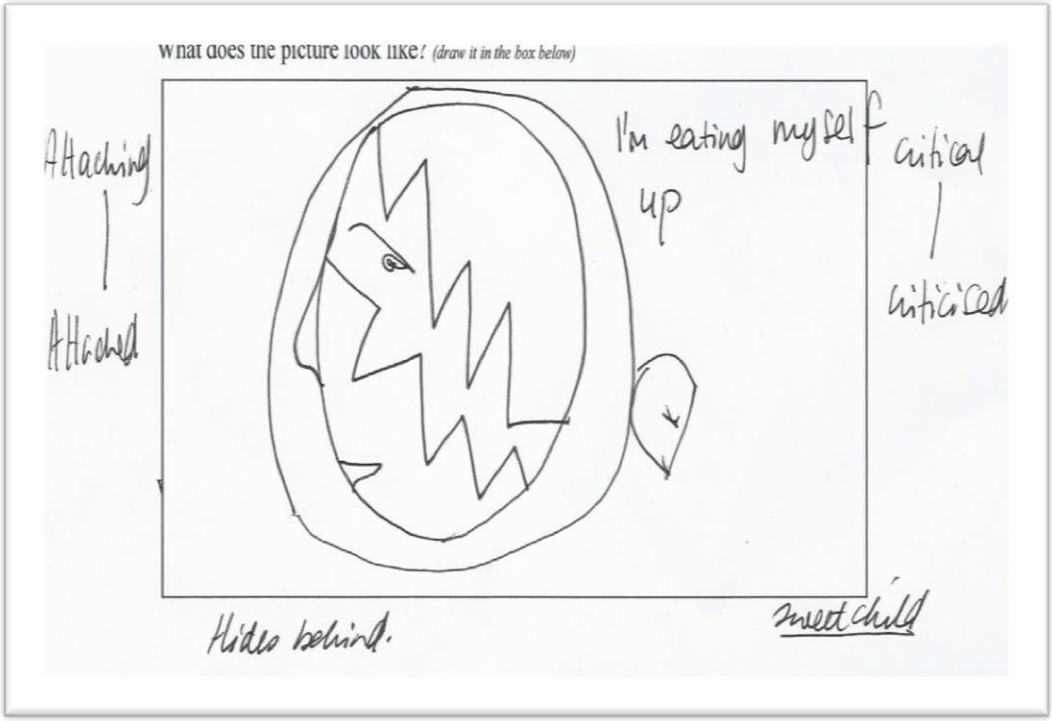
Fig21: Workshop Example Participant 'c' 'tunnel thoughts'



Participants notes: *Lady, depression, parents separated age 3-6, didn't see dad, dad bully, witnesses mother being beaten up. Remarried, scared me for some time. Sunday lunch. Didn't like sprouts age 6 made to sit at the table for 4-5 hours looking at 3 sprouts.*

The picture is enhanced with dialogue, the circles are the sprouts '*urgh yuk tastes horrible*' the hand appears to be a representation of her '*David and Goliath'* position …*'No not this!*' as if the hand has the ability to create agency for the patient. Residing on the left is also dialogue that suggests drawing on her *'inner strength'* in response to the bullying. This is followed by a note about '*revenge'*, and '*why should ? be in charge*?'. The next comment is of a preferred position of *'power, I can have some…toppling the sprouts'*. Without exploring the dialogue and having more dialogue it is left to our interpretation which might lead the reader to think that the energy created by the hand and associated dialogue can lead to the sense of agency that comes with the 'power' comment. This resonates with the function of metaphors as 'change' agents as described within the literature by Cox and Theilgaard (1987).

Fig22: Workshop Example Participant 'd' 'A head and Teeth'



Participants notes: ***Patient:*** *I want not to be afraid of my own mind* ***Therapist:*** *sees a head and teeth*

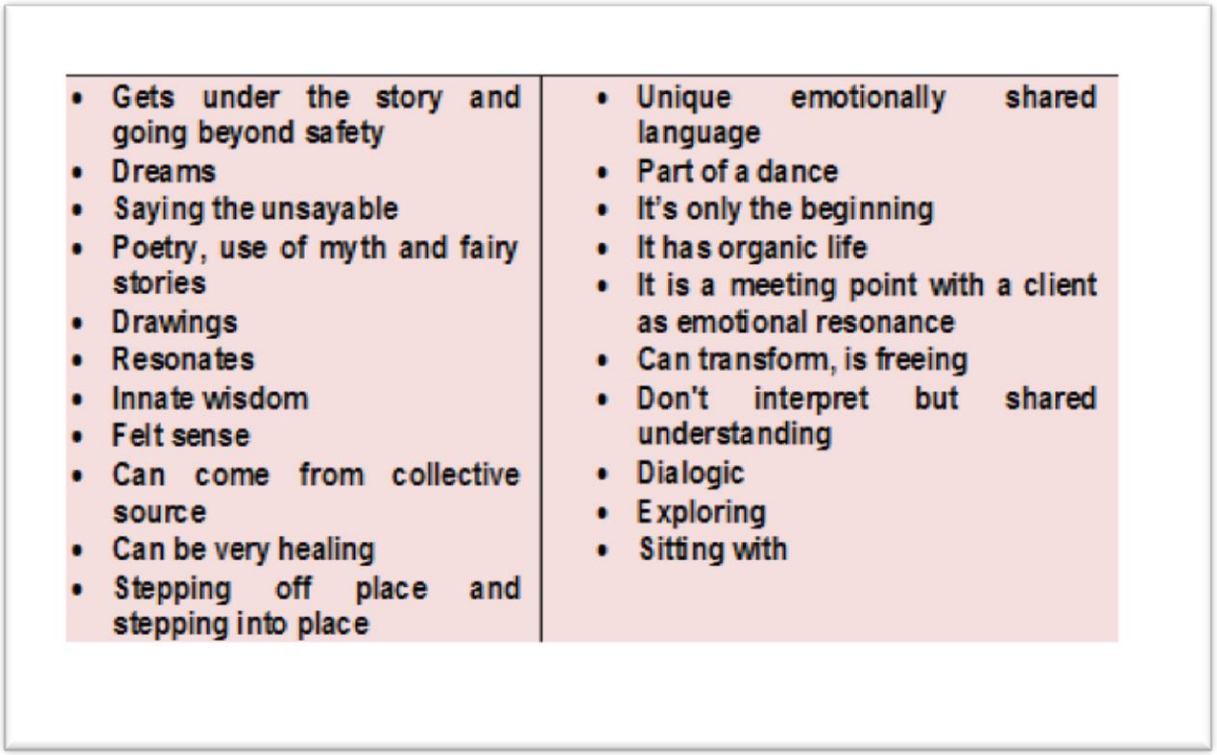
The responder notes…'*Patient is afraid she would 'hide behind an image' when I originally suggested using imagery…so it might help to support an image in session…scribbled out by me'*. It is interesting to note the therapists have all managed to produce a 'picture', even though they are 'scribbles', as one participant described them, they are resonant of the words and metaphors from the patient description of the metaphor. Some of the pictures have dialogue expanding on the picture and some have reciprocal roles embedded as part of the image.

Questionnaire analysis

Quantitative analysis involves a capture and thematic analysis of data from a questionnaire utilised in each international workshop (n=22 responses) and a reflective exercise using the PM in role play at a national CAT workshop (n=6 responses). Attendees were asked to complete a questionnaire I session. Questionnaires were coded to each responder to ensure confidentiality. A fair response rate was anticipated as this is completed 'in situ' workshop/focus group hence encouraging data capture. Participants were asked to generate a list of words that related to their thinking around metaphor and PM in CAT.

There are a number of words that speak of the resonance and influence of metaphors in clinical work the way metaphors are collaborative, illustrate problems and get under the story and as such can become healing in the clinical encounter. Fig18 indicates the range of words and responses given to a question regarding the use of metaphor in therapy.

Fig 23: Group exercise - Collective words that associate with use of metaphors in practice

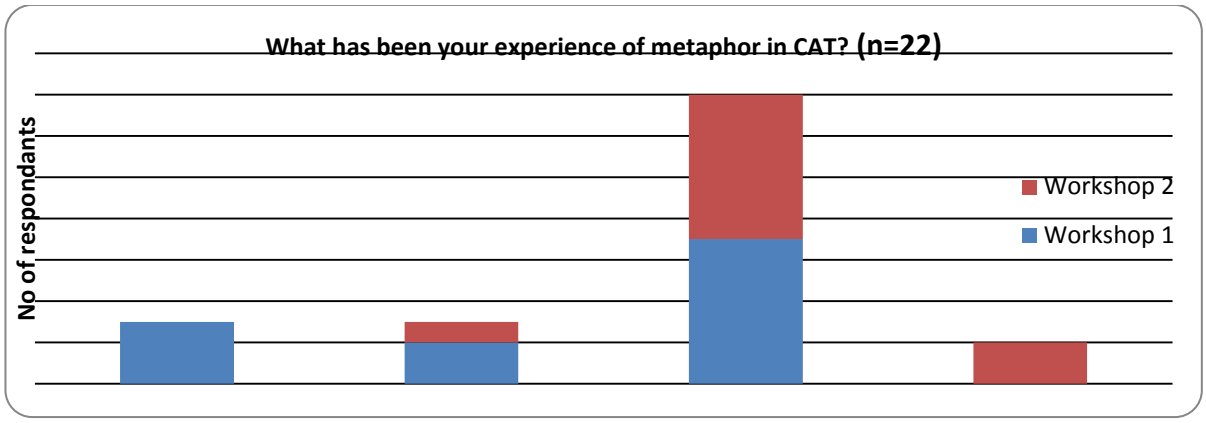


The exercise noticed the use of drawings and stories. Broadly comments fall into four themes:

- Function – saying the unsayable, gets under the story, resonates, innate wisdom, felt sense, healing, organic life, can transform, is freeing, exploring.
- Process –use dreams, poetry, myths and fairy stories, collective source, stepping on and off, part of a dance, organic.
- Therapeutic aspects – unique share language, it's only a beginning, meeting point with a patient, don't interpret but shared understanding, sitting with, dialogic.
- Pictures –drawings.

Although these comments are limited they speak well of the way metaphor can expand understanding provided the therapist explores the context and depth of the metaphor and checks for congruence with a patient.

Fig24 Question 1- What has been your experience of metaphor in CAT



Totals	Workshop 1 12	Workshop 2 10	Total N=22

Fig24 shows responders metaphor experience. Analysis of these figures show that 86% of participants noticed metaphors in their work with 72% often or always noticing/working with them. Qualitative comments were recorded as:

'I do not use metaphor unless it comes from the patient then I might adopt what they suggest'

'I like metaphors and find them very useful but at the same time I am sometimes concerned that my lack of expertise means that I am likely to impose them rather than develop them collaboratively'

'It feels like a fundamental part of finding a shared language'

'I am trained in a method that utilises metaphor – positive psychotherapy'

Fig25: Question 2- What types of metaphor do you use/work with in practice

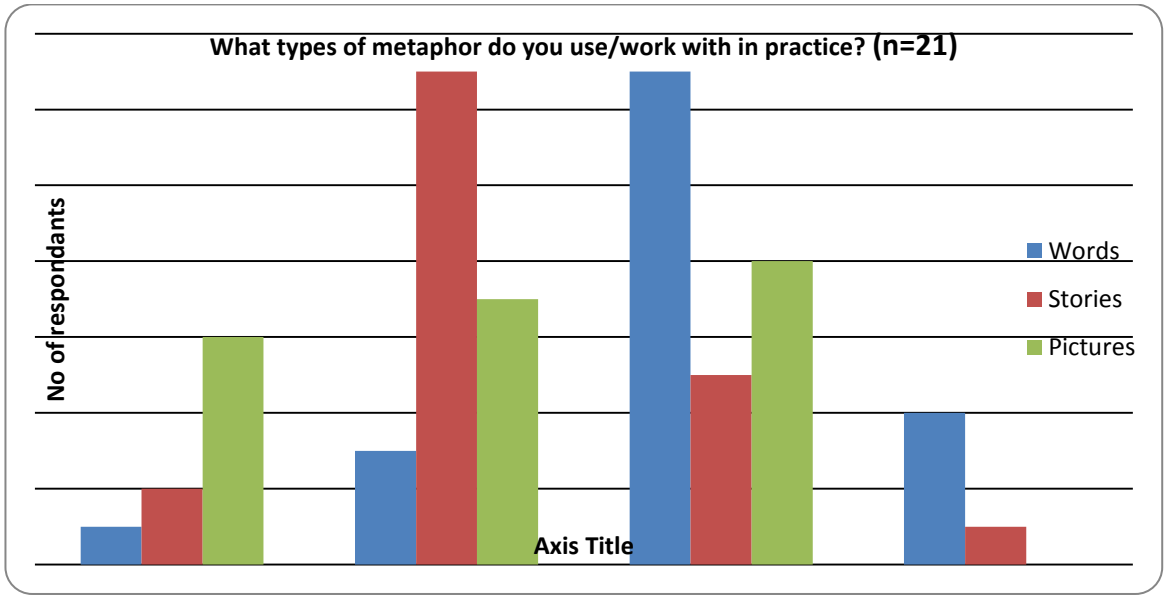


Fig25 provides representaion of a separation between the use of words and pictures. No therapist *always* used pictures on a regular basis but two thirds regularly used verbal metaphors. Some therapists *only occasionally* or *almost never* used metaphor and this is what the author took forward in his later research. Patients stories were used less than metaphors and again one wonders about this approach, although it seemed that the 'story' was within the therapsists repertoire of clinical skills being used across the reponses.

Fig26: Question 3- How useful is metaphor in CAT

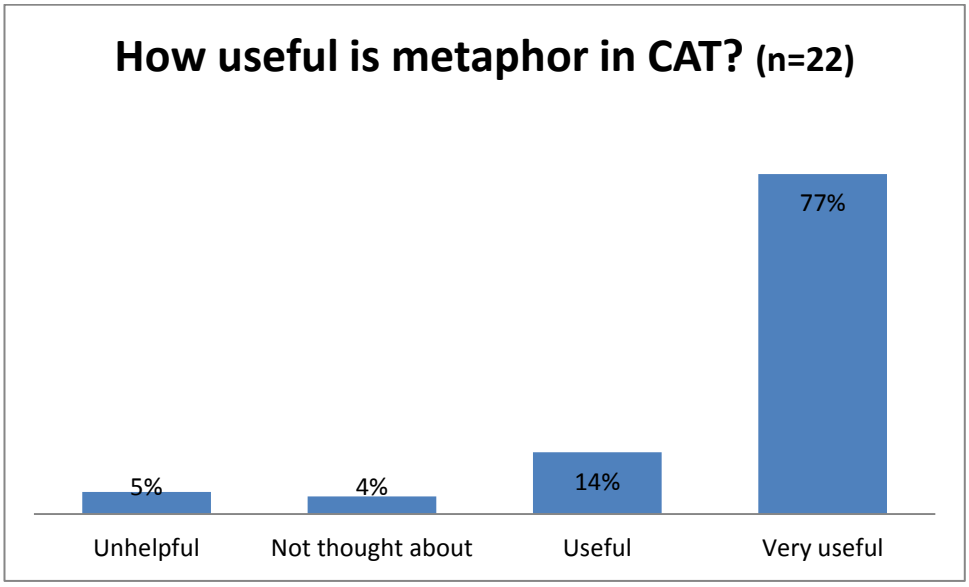


Fig26 shows 77% of responders found metaphor very useful. Mio and Katz (1996, p76) note that 'therapists in good outcome studies develop and carry forward metaphor phrases initially generated by their patients'.

Within the first two workshops 20 of the 22 participants rated metaphor as useful in the consulting room. Individual comments ranged from '*I feel metaphors can give us new ways to describe things/patterns*'; that their '*Creative use can lead to expansion of understanding'*; and '*can be useful in facilitating 'ah ha' moment*'. Focussing on metaphor is a '*way in' that feels safer for the patient to tentatively find and tell own narrative'.*

Participants commented on metaphors as enhancing *'patient's ability to become their own therapist and connect to the therapy'*. It was taken for granted that *'metaphors emerge in the space between us'*. These comments indicate the nature of CAT practice being attuned to patient utterances. .

Discussion

The preliminary work realised rich data into the use and considerations for use of metaphor and PM. This work has been important in setting the scene for an extended study. Data from this small sample indicate the use of metaphor is established in CAT. This is probably down to the nature of the dialogic aspect of CAT, listening with the third eye, noticing the patients language and remaining culturally and contextually attuned to the patient through a focus on the patients language and their metaphors as well as the therapists' primary training in whichever modality they trained in.

Initial issues arose as to whether the picture was to be *'Therapist led or patient led drawing of picture?*' and a '*Therapist led drawing might lead to an enactment of patient wanting to please therapist'.* What we understood was to recognise that the picture is developed collaboratively and in stages and not prepared and 'given' to the patient and as such had a real sense of engagement. On reflection, if this is an enactment of the patient then this will occur in therapy at other times and if this has been noticed, then it can be worked with and applies not only to the use of a picture but the other CAT tools in equal measure. The picture can be likened to a 'gift' of therapy, 'like the Reformulation SDR' and as Gentile (1997) notes through making art 'these individuals were able to gain an internal locus and sense of control.'

Results support the view that as CAT therapists create a reformulation and an SDR, there is inherent permission from this for the therapists to initiate drawing of the picture with them as well. This seemed a positive place to end up and enabling for the therapist. In the four PM examples generated within one of the workshops the images are resonant of the metaphor, are representative of the patient's RRP's, and seem to reflect some 'change and agency' to the patients. The pictures were drawn by the therapist from images that came to mind which suggests that given the right 'forum' these can be taught. I appreciate that attendees at a workshop entitled 'CAT and Metaphor' might already be interested in the topic but still this is a positive perception of the creativity embedded in CAT.

Regarding *'Is there some recognition of transference in the development of the picture'* the answer to this is more complex. Often in the pictures the metaphor is representative of are recognised 'problem procedures' and as such transference may be present. Siegelman

(1990, p99) makes an observation on transference that the ‘therapist image is a valuable counter transference tool’. Pictures are suggested as helpful in a number of ways; as representing core pain and hoped for future; as representing problem procedures; as representing threats; as illuminating counter transference; or as representing other factors. In effect, the picture has much functionality representing at the time an enabler for the patients to access their procedures and reformulation in a creative and imaginative way; taking the patient to the cognitions that underpin the images.

Two further observations were noted. First the collaborative or co-constructed nature of the therapy, and second the process of utilising a central theme though the reformulation and associated SDR. CAT and co-constructionism are congruent as they both share meaning making as a means to understand how humans learn. Both view individuals as creating or constructing their own new understandings or knowledge through the interaction of what they already believe and the ideas, events and activities with which they come into contact (Ultanir 2012, p195).

Therapy is a co-construction with the patient of a new understanding and new possibility, ‘stopping the stopping’ as Ryle (1995) puts it. Through the dialogic, the sense of the inside the res cogitans (self) and the outside, the res extensa (others and interactions with our self) can be understood and worked with. Hermans, notices this with particular reference to the way ‘metaphor, as an indispensable structure of human understanding by which we figuratively comprehend the world, is used’ (Hermans 2003, p 91). He is suggesting that individuals create or construct their own new understandings or knowledge through the interaction of what they already believe and the ideas, events and activities with which they come into contact (Ultanir 2012, p195).

Therapy is built on the foundations of a strong therapeutic relationship (TR). Hubble et al. (2000) note factors in therapy which are, the model (15%), patient’s problems (34%), therapeutic relationship (30%), and placebo (hope) 15% (among other factors). Roth and Parry (1997) suggest that the alliance is an indicator of a positive outcome in therapy. CAT, being dialogic notices and spends time on the relationship, one would argue with perhaps a stronger focus than cognitive therapies, and may better manage alliance ruptures. Successful therapies focus on the relationship and have a central theme (Mann 1973) that can translate across time in session. Mio and Katz (1996) support the usefulness of metaphor as a theme in sessions.

One comment challenged the place of metaphor and pictures in CAT as to whether it is '*a technique to call upon not central to CAT'*. Of course this is the case. All therapist have a set of 'tools' and 'techniques' in their therapeutic rucksack that they can call upon in the consulting room. Focusing on metaphor and using a PM did not seem alien to many of the participants. The use of diagrams is a core aspect of CAT in the form of the SDR and some participants noted the use of art and diagrammatic representation in their work. The SDR picture as mind map allows you to 'structure, organise and integrate the cognitive formulation in a structured, clear and easily adaptable way' (Williams et al. 1997, p 262).

It is as if the PM, like the SDR, can become a memorable image that comes to mind to create a 'full stop a pause even' in a patient's behaviour, an 'aha' moment (Siegelman 1993) opening up other possibilities for action. A metaphor pictorial 'mind map' such as described in this study can be quickly updated and amended representing new information and allowing an active focus. Not all tools and techniques work for all problems. What is important is that one has a range. The PM is designed to be one such tool, to use in cases where it seems appropriate, at the right time, for the right reason and with the right patient. Patients might describe their experience in metaphoric terms, 'I am like a rag doll,' for example that conjures up an image of being tossed around perhaps.

Limitations

Limitations within the study included its exploratory nature where the intention was to 'test the water' and check out if the technique was acceptable to CAT therapists. General support was found from participants and some useful guidance provided. In hindsight the researcher could have set up a system of feedback with participants and followed up practice implications. However, it is debatable how much data this would have generated given the lost opportunity to introduce the longer term follow up material.

Summary and implications for progression of research

The researchers belief is that noticing metaphor and working with it to develop a PM, drawing the patients problems and problematic experiences into a picture by using images generated collaboratively in therapy sessions, is psychologically enabling. The implication here is that the patients right brain is engaged more, allowing the patients creative processes to be drawn upon as well as their cognitions (Wilkinson 2010). The assumption being that the patient is able to access the picture easily in his/her mind's eye, perhaps more easily than a written account of their problem procedures or SDR would be accessed.

This research has a deliberate focus on metaphor as part of the TE and creating a metaphor 'picture' to support the therapy. I am especially interested in understanding the process involved in the articulation of verbal metaphor into a 'picture'. The researcher's practice regularly incorporates 'metaphorical' language the patient utters into a 'picture.' Metaphors are noted early on in therapy and explored and important ones are tentatively drawn into an image and checked out with patients that they represent their metaphor. This happens in the early reformulation stage of therapy and is built upon as the therapy progress if appropriate. Following reformulation the image sits alongside the SDR on the table in the room, reminding the patient and therapist of the problem procedures we are working on. This post reformulation stage in therapy offers opportunities for recognition and revision of problem procedures and it seems as if metaphors and PMs can support this process.

More exploration is needed in this area to understand and establish the key aspects of what, how and why this may be a useful tool for CAT. Based on this preliminary work the researcher developed a protocol for an extended study into the use of metaphor and PM in CAT. In this respect the findings of Study1 are intended to inform and support the development of the research question onto a study of expert practice through a Delphi study. A Delphi will enable the key research statements to be progressed such as exploring the 'who draws' question and further exploration of the function and process of working with metaphor and pictorial metaphor. In particular the initial findings of Study1, albeit from a small sample, have provided a general level of guidance and support for progress. Having searched for an appropriate method to progress this research a Delphi study seemed a robust approach to generating understanding of the topic.

Chapter Five: Study2 - A Delphi Study

Introduction

Based on a preliminary study of CAT therapist at three conferences where early work was delivered and evaluated results indicated support for the progression of this research into the wider CAT community. In order to explore a number of issues around therapist drawing, the functional and processes involved in the use of metaphor and pictorial metaphor and to inform the development of a training programme a Delphi study of expert practice was found to be a promising research method to answer the research aims and objective.

Aims

The aims of the Delphi are based on an assumption that canvassing knowledgeable experts in the field may provide criterion to progress a study designed to:

- Develop and evaluate a consensus through a Delphi study of CAT practitioners internationally as to the 'best' use of metaphor and PM in practice.
- Review and refine existing ideas and notions with respect to the PM technique.

The aims are supported by the following objectives:

- To assist the researcher in identifying issues of best practice.
- To inform the proposed TP in metaphor and PM.
- To provide rich and valuable material to utilise directly in the TP.
- To Inform CAT practice in working with metaphor and PM.
- To inform the wider psychotherapy community of outcomes if appropriate.

Method

Delphi has been selected because it has utility in order to build group consensus across a group of individuals who have expertise in the given topic area (Williams and Haverkamp 2010). Delphi is a proven method of investigation having produced some genuine results (Dallos and Vetere 2005, Baker et al. 2006, Murphy et al. 1998, Mir et al. 2012, Beech 2001, McKenna 1994).

A Delphi study consults expert in the field, engages them in reflection on the topic and establishes consensus, using a number of iterations, regarding the approach being studied (Keeney et al. 2011, Mead and Moseley 2001, Hasson et al. 2000). As a method for managing group communications processes, it is effective in allowing a group of individuals, as a whole, to deal with a complex problem (Tinstone and Turoff 1975). Consensus is predicated on the belief that sufficient widespread agreement from a group of experts generates an empirical generalisation (Powell 2003, Boot et al. 2006, Bowling 2009) or 'N' heads are better than one (Parente and Parente 1987).

Structured consensus methods enable professionals to respond in their own time rather than attend meetings and facilitate the management of influential and powerful people in a group (Cook and Birrell 2007, Beretta 1996) and encourage the frankness of panel members (Mead and Moseley 2001). Delphi studies are generally utilised when there is little previous work in the field, where uncertainly about approach/policy exists, and to develop practice guidelines when there is sufficient evidence (Mead and Moseley 2001).

The Delphi method generates language for analysis, which has salience as ''the way we speak meshes with our lives, is interwoven with our behaviour, actions and reactions. We tend the injured limb but comfort the person' (Hacker 1997, p50). In a Delphi, knowledge, or truth is experiential and has its foundations in Lockean philosophy where the truth of the model does not rest upon theoretical considerations (Mitroff and Turoff 1975). Delphi is in essence an inquiry system, resting on the assumption that knowledge follows from data and the accuracy of the consensus is then correlated via responses from the participants (Parente and Parente 1987). Lockean inquiry systems are considered the epitome of experimental consensual systems akin to the constructivist view.

What distinguishes the Delphi is this ability to gain feedback and the opportunity for participants to modify their judgements based on their reaction to the collective views of others (Mitroff and Turoff 1975). In effect Delphi is an 'I-thou' (Ich-Du) as the development of theory is familiar as well as an 'I-It' (Ich-es) relationship as the familiar is tested in the positivist tradition via the consensus rounds.

Data Collection

An email questionnaire survey canvassing the opinions of CAT therapists in the international community was developed, piloted and administered. Email responses can be improved by paying attention to the design of the questionnaire (McColl et al. 2001) and ensuring saliency of the topic, the numbers of contacts made and self-interest/utility. Relevancy of the survey is important, as irrelevancy will alienate responders from the task (Murphy et al. 1998). Edwards et al. (2002) note a number of factors that can increase a response rate. The most significant factor in questionnaire completion is payment but this is not available for this study, other factors are…

- Make it short and personalised (Keeney et al. 2006).
- Computerised access - survey2 enables this for R2 and R3.
- Contacting participants beforehand – an invitation was sent via ACAT.
- Conference/workshop engagement.
- Follow up non-respondents.
- Questionnaires designed to be of interest and use of colour.
- Questionnaires from universities were more likely to be returned.

Demographic details were collected on the therapists' role, experience in CAT and MH, patient group, level of training, location, age and gender. Demographics enable comparison between responders regarding their expert nature to manage the sample or to make comparisons between professional groups and within groups.

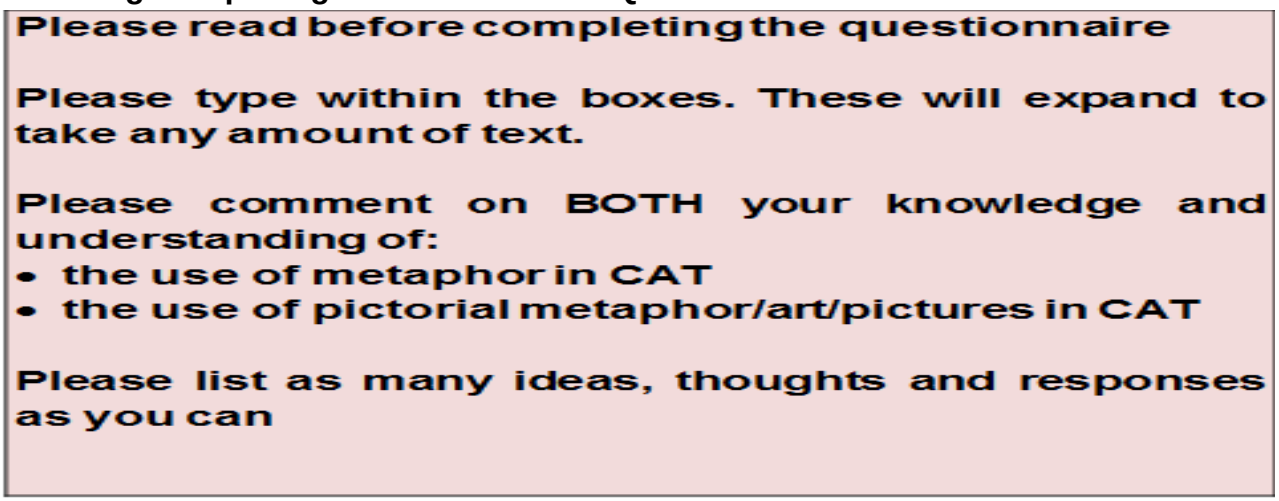
A R1 questionnaire was constructed based on a review of the literature and responses from Study1 then organised into traditional fields of enquiry. Each question was structured to generate data to answer the research aims and objectives. Questionnaires can have varying degrees of structure, and may include open-ended or closed questions. Although closed questions support quick replies and are easy to analyse, conclusions may be distorted due to a limited response. Open questions on the other hand enable the participant to express their feelings, supported by reasoning. Despite these questions being time consuming to analyse (Gillies 2002), richness of data is important, so the questions were deliberately 'open' in this study. Wilkinson (2000) favours Likert type questions which were not adopted in R1 because general information was required rather than specific judgements as to the veracity of subject comments.

Developing the question is one of the most important aspects of any study, 'if respondents don't understand the question data will be inappropriate or the respondent will become frustrated and lose interest' (Delbecq et al. 1975, p86). Delbecq et al. (1975, p94) suggest for the first round the researcher needs to:

- Pre-test questionnaire for usefulness and congruence.
- Summarise a list of the responses identified and comments made.
- Cluster results (qualitative data analysis techniques apply).
- Seek categories and transform comments into sentences.

The questionnaire was piloted with colleagues in academic posts as well as CAT posts. Valuable information was returned regarding the wording of the questions and the overall title of the project and amendments made accordingly. The final questionnaire (Appendix XI) included consent and study information as well as a set of opening statements to encourage engagement and expansion of questions (Fig27).

Fig27: Opening statements on R1 Questionnaire



Questions need to be 'unambiguous and if more than one question each one must tap a different area of concern otherwise there will be repetition of respondents answers' (Mead and Moseley 2001, p6). There are number of ways to structure questions in questionnaires either as probes, main questions, or follow up questions (Bowling 1997). They usually cover six areas: eliciting descriptions (what), opinion or value (why), feelings (how), knowledge (how many), perceptions/sensory stimuli (why), and background (will you).

I have chosen to use structured open questions relating to aspects of CAT and metaphor in order to enable analysis of themes for subsequent iterations of the Delphi. Six study questions were designed to elicit qualitative data (Fig28).

Fig28: Questions designed to elicit qualitative data

Q1 What are the most important principles when working with metaphor in CAT?

Q2 What are the most important principles when working with pictorial metaphor /Art/Pictures in CAT?

Q3 What do you think are the 10 most important factors when working effectively with metaphor in CAT?

Q4 What do you think are the 10 most important factors when working effectively with pictorial metaphor in CAT?

Q5 What obstacles might get in the way of working effectively and developing metaphor and pictorial metaphor in CAT and how can they be addressed?

Q6 What should be included in a training programme for metaphor and pictorial metaphor in CAT?

Questions had prompts, written in italics, to guide responders (Fig29). The use of prompts is accepted practice in questionnaires enabling richer data to be gathered. Some responders may not have experience of working with metaphor so including imagine suggested that their current experience may inform future practice.

Fig29: prompts

Q1 (please include rationale, models you use, when you might work with metaphor ,your views about these and any specific experiences)

Q2 (please include rationale, models you use, when you might work with pictures, your views about these and any specific experiences)

Q3 (If you don't use 'metaphor' in CAT could you try to 'imagine' what would be important when using this technique and answer based on this)

Q4 (If you don't use 'art/pictures' in CAT could you try to 'imagine' what would be important when using this technique and answer based on this)

Data analysis method Round 1

Because Delphi measurement and assessment uses both qualitative and quantitative analysis a large and unwieldy responses may be elicited (Hasson et al. 2000, Keeney et al. 2001). R1 utilises open ended questions allowing freedom of responses (Keeney et al. 2001). As AR relies upon discourse, an understanding of language in use which can bind abstract ideas is sought. Analysis of discourse is guided by Dickerson's (1996) four types of analytic resources; the text; literature; imagination; and intuition.

The text in qualitative data management is initially explored through immersion in the data (Silverman 1997 and 2006, Keeney et al. 2011). The next step is traditionally a content analysis (Keeney et al. 201, Powell 2003), to identify major themes arising from the text. Imagination and intuition on the content is utilised to form the basis of a set of statements for rating in subsequent rounds (Powell 2003) and enables statements to be grouped together into similar areas. Adapted from Newall and Burnard (2006) and Keeney (2011) a 14 stage method of content analysis can be constructed (Fig30):

Fig30: Content analysis

step	activity	step	activity
1	Make notes and memos	8	Each transcript worked through and coded
2	Read transcripts and note general themes	9	Coded sections cut and collapsed together
3	Generate and note as many headings as required	10	All collapsed headings organised into headings (themes)
4	Group categories together	11	Check for congruity with responders
5	Remove repetitive headings	12	File sections for write up
6	Seek independent verification	13	Write up
7	Transcripts (questionnaires) re-read alongside list of categories	14	Integrate literature

Data is intended to be analysed in three stages. Step 1 is a content analysis of all Questions 1, 2, 5, and 6 and reporting of emerging themes. Step 2 is a content analysis of questions 3 and 4 leading to an anticipated hierarchy of importance by frequency. Step 3 is a condensing and collapsing of Step 1 and step 2 data seeking a workable set of statements to progress to Round 2.

Data analysis method Round 2 and 3

Traditionally the final yield from a Delphi is a quantified group consensus achieved from median responses to rated statements (Parente and Parente 1987). Repeated polling following this initial yield has the effect of reducing the variability of responses leading to an increased consensus (Parente and Parente 1987). Wright (2005) lists 20 prominent survey software packages which can manage repeat polling with pros and cons of each. This study used Survey2 due to its unlimited survey, uncomplicated questionnaire design and no cost. The survey is housed on company software with a limit of 1000 responders. Survey2 is utilised often in psychological and health and social care research at Sheffield Hallam University. For R2 and subsequent rounds participants are asked to rate:

- Each statement accurately conveys the meaning which respondents attempted to communicate.
- Review statements and comment on them.
- Rate items in terms of their importance.

Quantitative data analysis utilised standard statistical analysis noting similarities and differences and managed within EXCEL and SPSS. Survey2 has the ability to export statistical data directly into EXCEL and SPSS. Keeney et al. (2011) support using SPSS in managing Likert scales in a Delphi as 'summary statistics (frequencies/descriptives) should be run on the data to determine the number of statements that have reached consensus' (p77). Criterion and standards for judgement arise from subsequent iterations, where responders are asked to rate and re-rate statements.

Likert type scales were the method of choice in this study. Whilst Likert scales generate statistical evidence they have some common problems such as faking good, deviation, the hello-goodbye effect, yea saying, end aversion, positive skew, halo effects and the framing effect (Mead and Moseley 2001b). Mead and Mosely (2001b) discuss options for scaling and whether to use a number or indeed whether to use a visual analogue scale or comparison measures (how much better is 'a' compared to 'b'). The most important factor seems to be how many points should there be on a Likert scale, which vary between 3 and 11, 11 is seen as too many and three or five too few. They recommend 7 which allows for more subtle analysis.

The seven point scale of multiple items (Gliem and Gliem 2003) gives extremes so if a responder rated either 7 or 1 this it was considered a strong opinion. The reason for having the extreme points is that they are not often chosen but when they are they really mean what they say (Mead and Moseley 2001b). Fig31 indicates the Likert scales used, the colours denote green as above the midpoint, orange the midpoint and red below.

Fig31: Likert scale options

AGREEMENT	IMPORTANCE	LIKELIHOOD
• In all cases • Strongly Agree • Agree • Undecided • Disagree • Strongly Disagree • Literally under no circumstances	• Always important • Very Important • Important • Moderately Important • Of Little Importance • Unimportant • Never important	• Almost Always True • Usually True • Often True • Occasionally True • Sometimes But Infrequently True • Usually Not True • Almost Never True

Ethical approval

Ethical approval and ethical justifications have been included earlier in this thesis. All ethical aspects outlined were managed and maintained (see Appendix V-VI).

Sample

Expertness is a key aspect of a Delphi, ensuring the right responses are recruited. An expert is a person who is very knowledgeable about or skilful in a particular area (Soanes and Stevenson 2003), is considered a subset of the available study population (Parahoo 1997, Hek et al. 2002), having relevant experience and theoretical knowledge (Scheele 1975, Keeney et al. 2001, Pill 1970). Representativeness is important in an expert panel (McKee et al. 1991). Bennett and Parry (1998) note, that experience is not necessarily congruent with increased competence.

As this is a complex area I have explored this in some depth guided by a set of questions (Fig 32), derived from Baker et al. (2006, p67), Walker and Selfe (1996) and Mullen (2003), provided a useful examination of the expertness of a panel.

Fig32: Expertness of Delphi panels

What is your definition of an 'expert'?

What type of Delphi is being utilised and what effect has this exerted on choice of expert?

What sample are you aiming for (homogenous or heterogeneous)?

How has the sampling method influenced your choice of experts (snowballing etc)?

What are your inclusion criteria, with justification for inclusion? (Walker and Selfe 1996)

What are your exclusion criteria, with justification for exclusion? (Walker and Selfe 1996)

How do you define knowledge?

What level of knowledge is required and how can this be identified?

How do you define experience?

What level is required and how can this be identified?

If experience has been defined through x number of years, is this defendable?

How do service users/carers/patients feature within the study?

If excluded, why and how will their views be taken into account?

Were non-participants followed up? (Mullen 2003)

How will you disseminate findings to expert panel?

An expert panel for a Delphi is not usually a randomised sample (Keeney et al. 2011) and self-selects in the first instance. An online survey was an appropriate method of contacting experts and subsequently gathering data. A Protocol for a three round E-mail electronic survey Delphi was designed via email and electronic survey. The email request was intended capture available therapists. Accessible through the ACAT member's database, an agreement was gained to utilise a mail shot to recruit the initial sample (Fig 33). Potential respondents were considered to have appropriate and sufficient information on the subject (Horsburgh 2003). As CAT therapists are always qualified in another medium of therapy prior to their training members of ACAT were considered a suitably expert group.

Fig33: Available CAT sample (July 2010)

Trainee	258
Practitioners	329
Psychotherapists	123
Total	901
e-mail server -	745

Rounds 1-3 apply judgement sampling because the data needed to be collected from CAT informed individuals. Purposive or judgement sampling allows for the selection of therapists, based on inclusion and exclusion criterion, who could provide relevant data for this study (Polit and Hungler 1995). A homogenous and heterogeneous sample of CAT Therapists was recruited, homogenous because they are members of ACAT, heterogeneous because they work psychotherapeutically across modalities, professions and international boundaries. For R1 the sample self-selected and demographic data was collected to indicate their level and nature of experience. Following supervision a protocol for R2 indicated a reduction in sample to 30 (+/-10%) so if the numbers were high exclusion criterion would be applied. Panellists would be chosen for R2 and R3 if they met two or more of the inclusion criterion (Fig34).

Fig34 inclusion and exclusion criterion

Inclusion criterion	Exclusion criterion
Practising CAT therapist or trainee Scholarly work on subject Experience of working with metaphors in clinical practice Experienced with working with art/pictures' in clinical practice	No experience of working with metaphors in clinical practice No experience with working with 'art/pictures' in clinical practice No Scholarly work on the subject

A qualification or working towards a qualification in CAT was considered necessary as was experience of metaphor and if possible PM. Membership of ACAT become a default sample because members are deemed to be knowledgeable, because of their CAT and previous training, achieving an accepted level of expertise. Practising therapists from a range of levels in CAT and a range of therapeutic backgrounds were sought including trainees, practitioners and Psychotherapists as the researcher wanted a depth and spread of experience in both CAT and in Therapy. Being a member of ACAT was congruent with the literature describing a range of definitions of expert (Baker et al. 2004).

However, experience and psychotherapy effectiveness is complex and does not rest on years alone. Bennett et al. (2004 and 2006) have researched this area and it seems as if the quality of the alliance, rather than age of therapist, is the most consistent predictor of outcome in psychotherapy. Experience has not been predicated on number of years in the field because responders may have significant experience in psychotherapy but limited experience in CAT. Metaphor working and art working may be part of their pre CAT

training but not included in their CAT training or supervision. Based on these criterion responders should have credible knowledge and expertise around psychotherapy, metaphor and art in combination (Williams and Haverkamp 2010). Demographic data captured experience, working with metaphor and PM, and years in practice as a therapist and/or a CAT Therapist for examination.

Service users have not been included in the research at the Delphi stage as the researcher was seeking expert knowledge from therapists but were included in the preliminary study. Service user or stakeholder voices are heard through clinical examples, information gained from the training materials as reflective comments, goodbye letters and dialogue, from both patients and therapists. Service users are the therefore the therapists and the patients involved in the study and have been consulted at regular intervals.

As the initial Delphi panel self-selected, all elements of the population had a chance to be selected (Polgar and Thomas 1995), they could also deselect by non-response. A number of prompts were initiated by email. If responders were excluded or fell away due to attrition they could maintain knowledge of the research through articles published in the ACAT journal '*Reformulation*' and with the researcher directly. Delbecq et al. (1975) note 'it may be sufficient to feedback to respondents the results of the second Delphi questionnaire' (p106). Dissemination has occurred at each study cycle of this research with briefing papers attached to the questionnaires or included within the survey.

Results and analysis

Demographic data (all rounds)

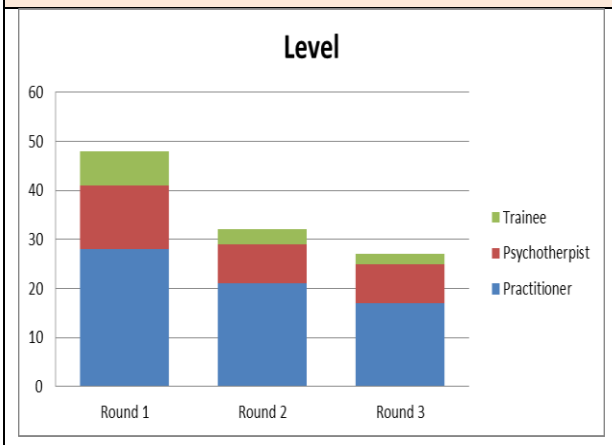
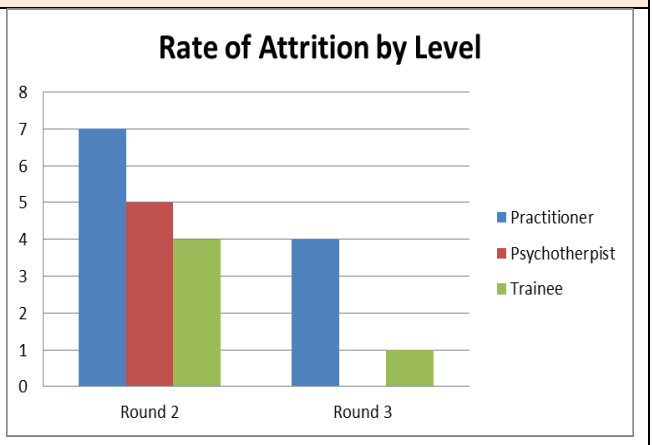
A sample of informed experts was gained for all three rounds (Fig35 and 36) using criteria outlined earlier. Initial responders (n=101) to the Email survey were sent the R1 questionnaire achieving a 48% return. Additional demographic data is presented in Appendix XIV). The sample included all three levels of CAT. Trainees are not fully competent with the CAT model, Practitioners have completed a 2 year training and Psychotherapists a further 2 years (and are registered as CAT psychotherapists with the UKCP).

This sample is congruent with critical reviews in the literature that there are a range of definitions of expert (Baker et al. 2004).

Fig35: Sample by round

N= 101 expressed an interest in R1 with n=48 responses
N= 38 for R2 after conditions applied with n=32 responses
N= 32 for R3 with n=27 responses

Fig36: CAT level

CAT Level	Attrition by round
	

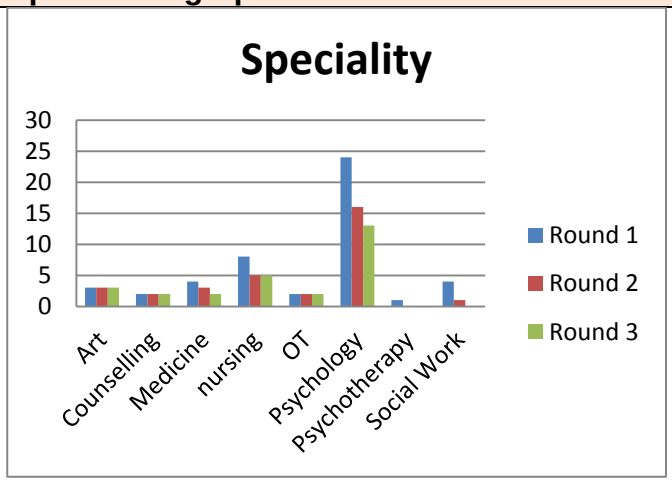
Eight professional groups which are representative of CAT practice and trainings were found (Fig37). A high percentage of psychologists is noted which matches CAT demographics

Fig37: Specialism

Specialism data

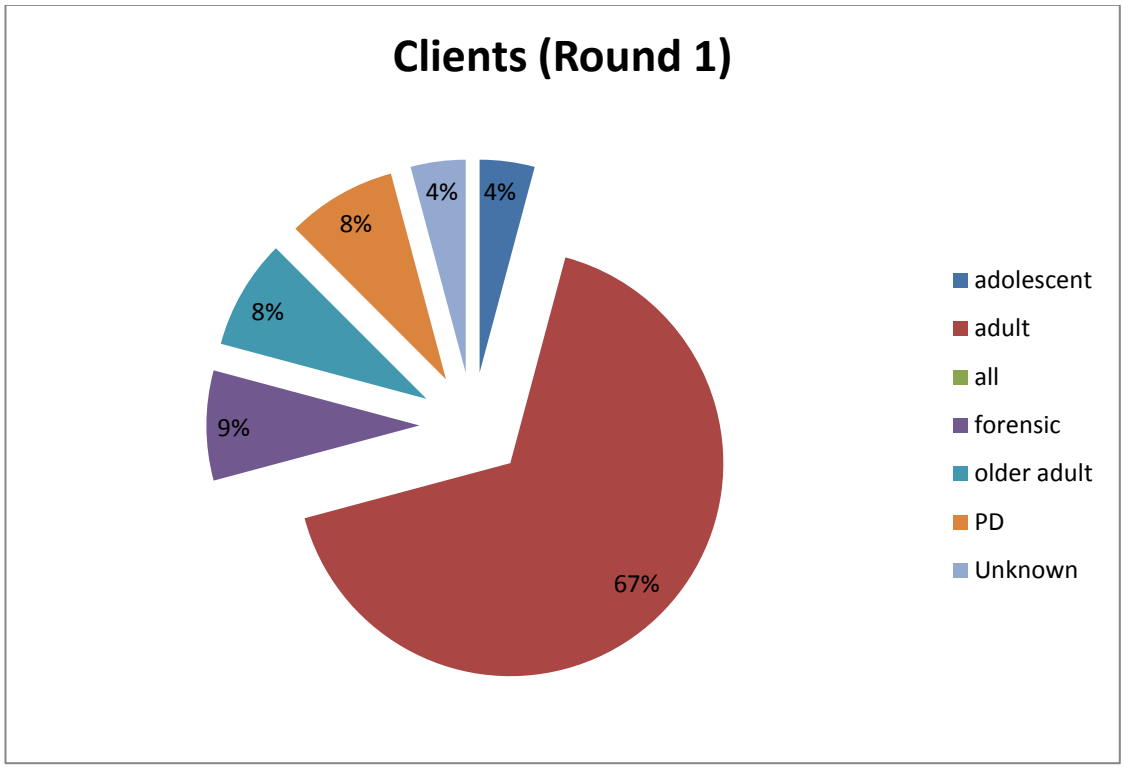
	R1	R2	R3
Art	3	3	3
Counselling	2	2	2
Medicine	4	3	2
nursing	8	5	5
OT	2	2	2
Psychology	24	16	13
Psychotherapy	1	0	0
Social Work	4	1	0

Specialism graph



The patient base of responders (Fig38) was primarily adult with a range and spread of other areas including older adults, child, learning disability, forensic, adolescent care and personality disorder. This reflects the structure of services and the nature of CAT practice.

Fig38: Patient Base



A broad spread of UK and some international responses were gained in keeping with the principles of recruiting knowledgeable and skilful practitioners (Soanes and Stevenson 2003).

Fig39: Nationality

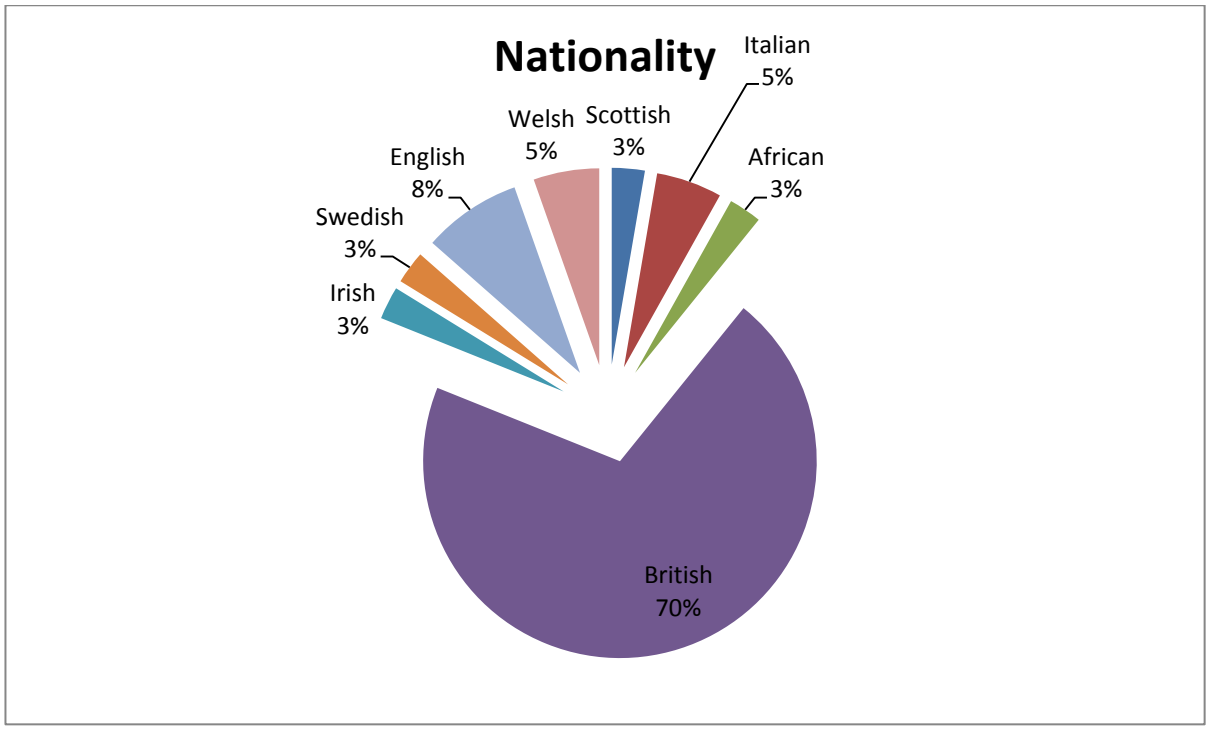


Fig39 indicates a primarily UK nationality of responders with Fig40 their region for R1 and R2. The Scottish and Welsh demographic is by self-report and increase the British nationality percentage to 86%.

Fig40: Location R1 and R2

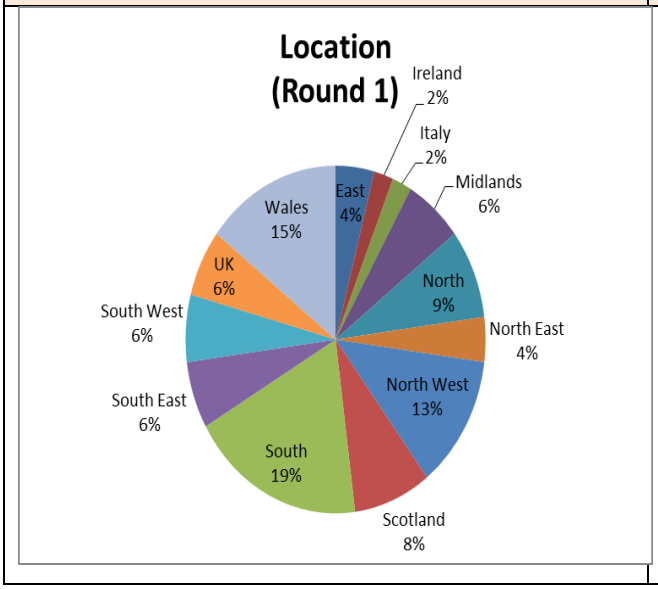
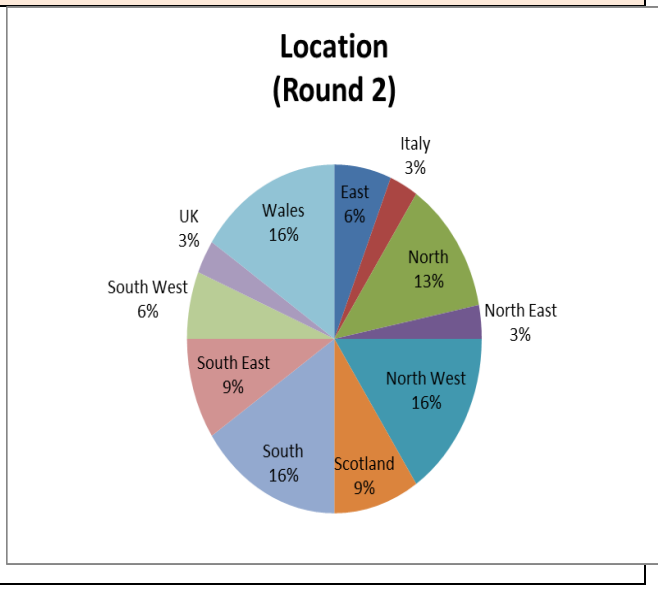
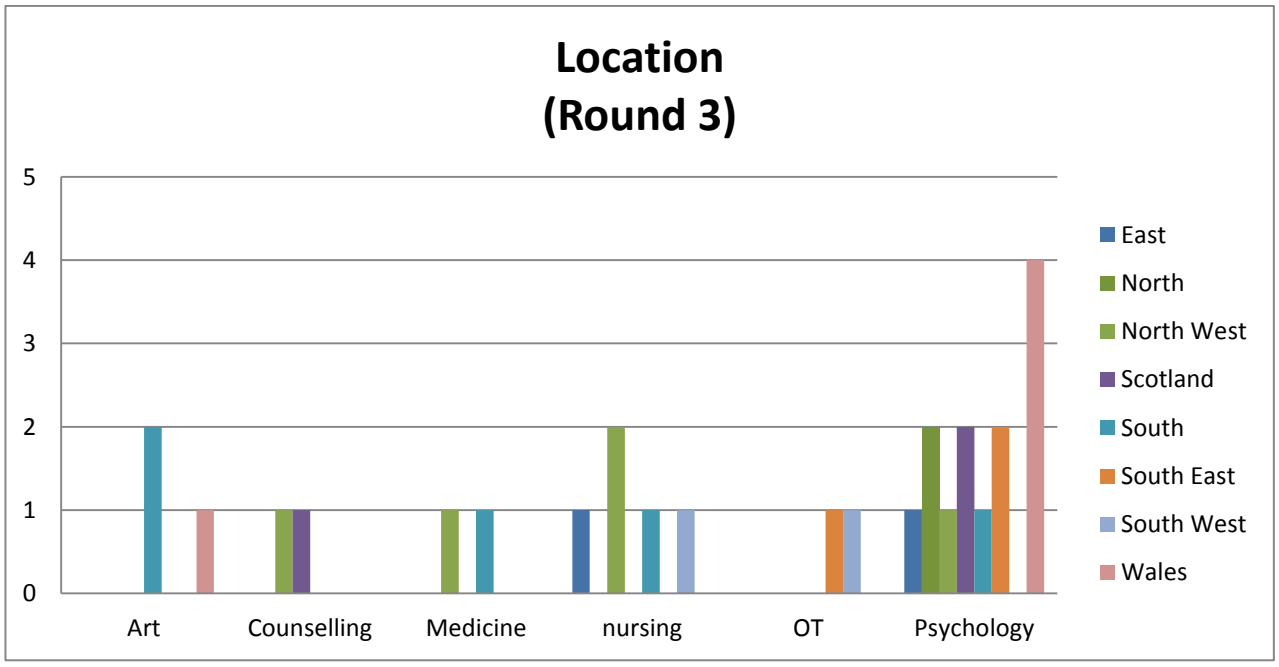
Location R1	Location R2
	

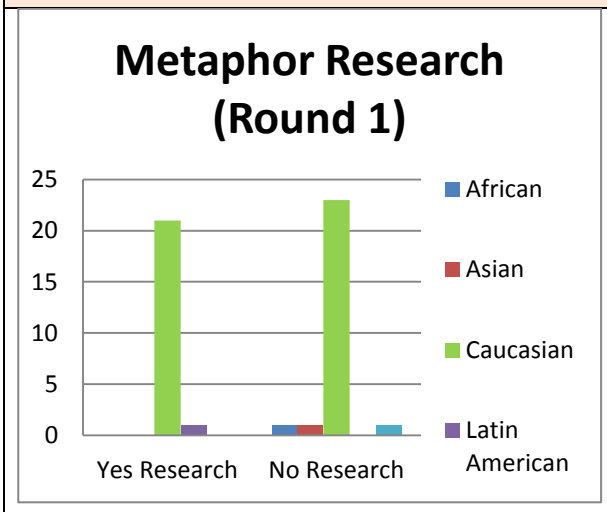
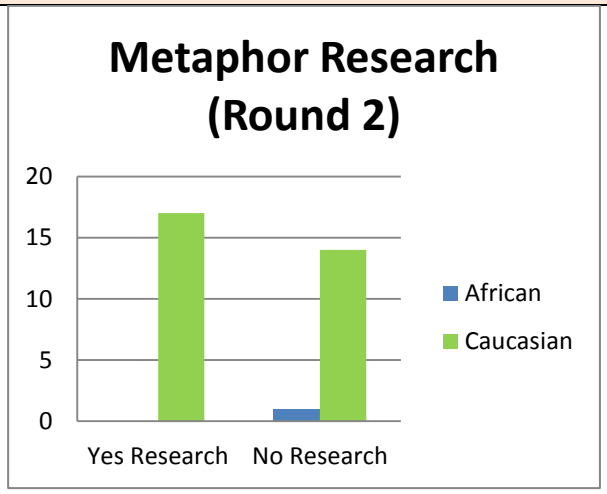
Fig41 indicates the sample for R3 from core groups and location. Psychology is the largest grouping. This was not always the case when CAT first developed but the model has become increasingly popular within psychology. This may be due to access to funding, ease of access to training time, and their developing professionalisation.

Fig41: Location R3+Specialism



A limited ethnic diversity (Fig42) was noticed in the data with the sample primarily Caucasian. What the sample did express was considerable experience.

Fig42: Ethnicity R1 and R2

Experience of working with metaphors	Experience of working with metaphors
	

Four sets of demographics can be articulated in support of defining knowledge. First age and years in practice, second their experience within mental health and third their gender.

Fig43 describes the age and years in CAT of responders. Staudinger (1999) does not necessarily find that age=wisdom due to the fact that with age comes general degenerative changes, he concludes that there is some evidence that under certain supportive conditions age may equal wisdom. Sternberg (2005) notes there is no one trajectory of wisdom with age. It is as if wisdom is linked with experience as well as one's own self-reflective capacity.

Fig43: Age and years in CAT practice

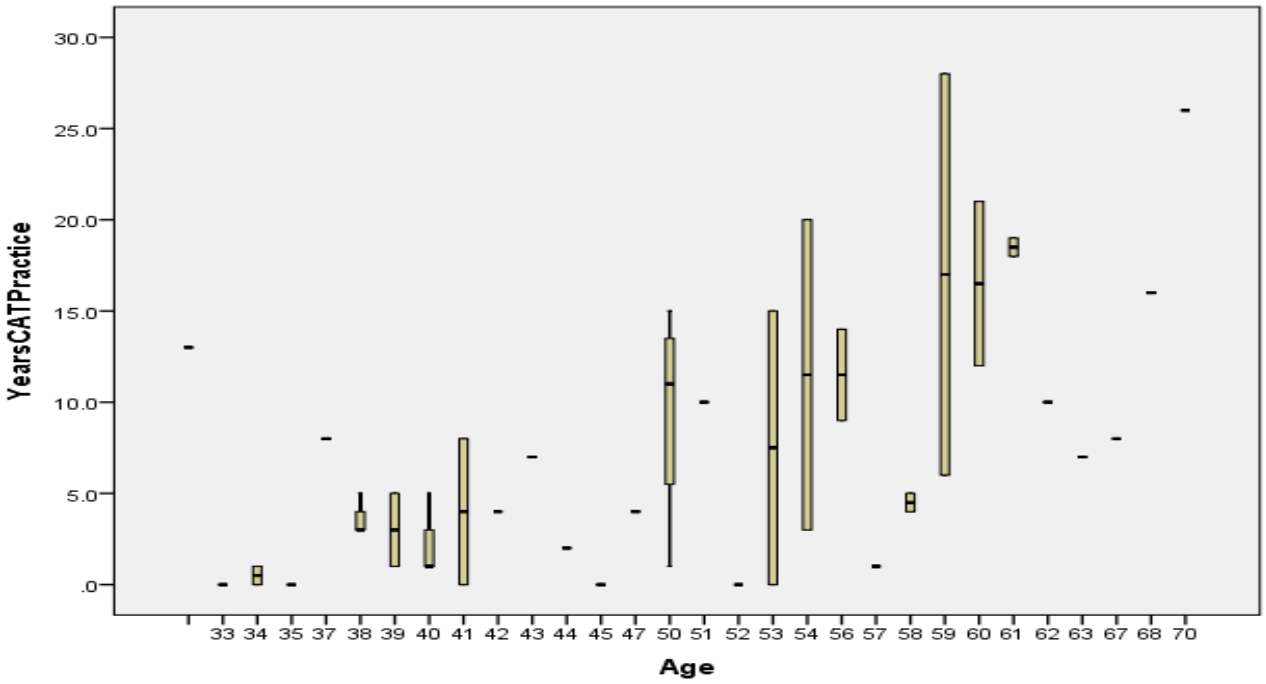


Fig44 and 45 indicate a considerable breadth and depth of knowledge with the average years in mental health being 19.5 years and the average years in CAT being 7.5. This would support a level of expertness in both fields.

Fig44: Years n MH +specialism

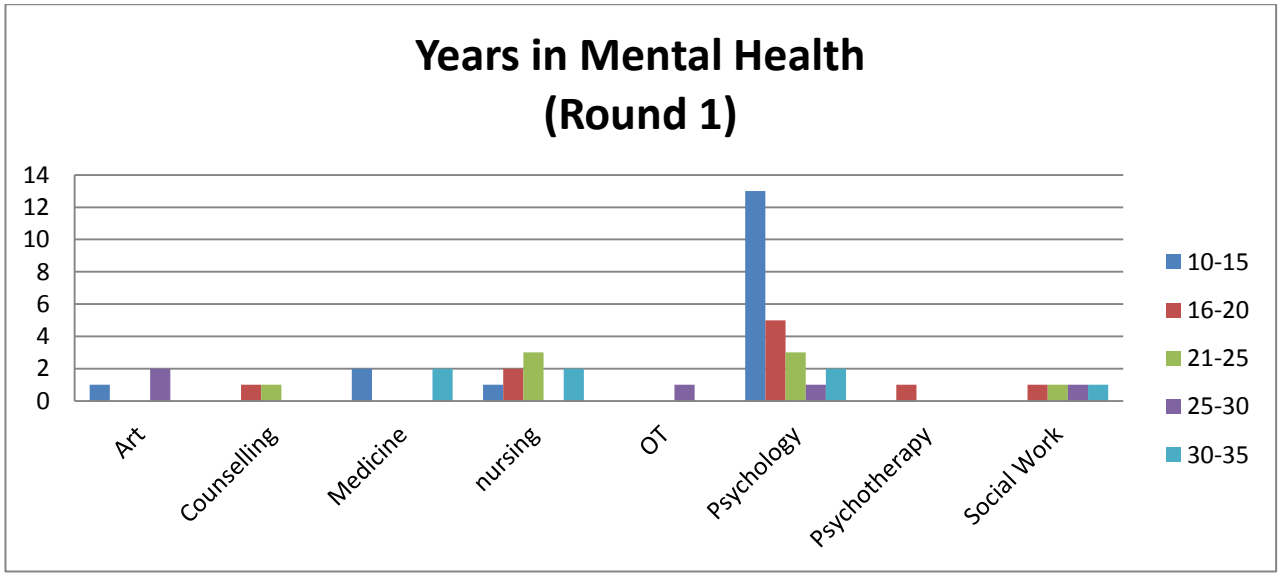
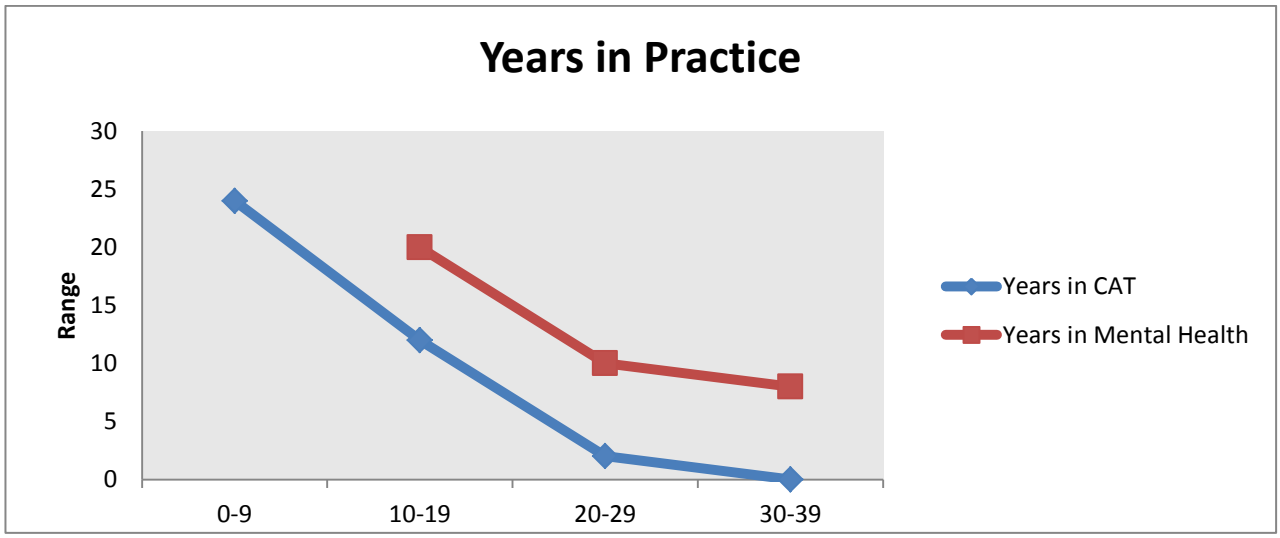


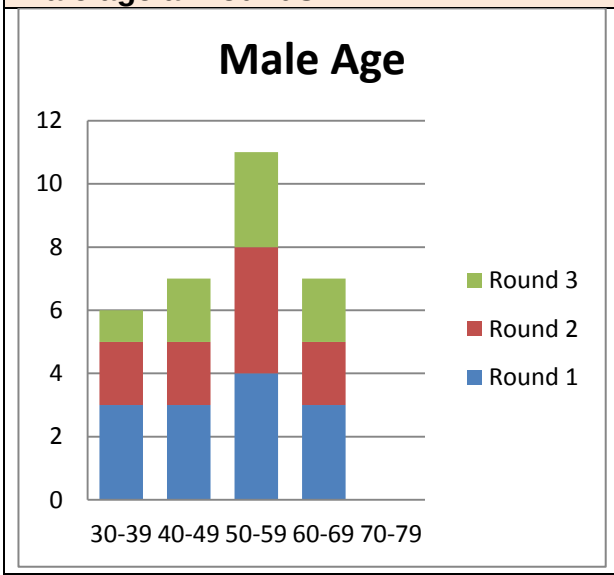
Fig45: Years in practice (b)



There are assumptions within the literature about gender in therapy and so it seemed reasonable to check whether the CAT sample is similar to a therapy sample (Fig45-48). Person (1983) notes that therapists requests based on gender are not predictive of outcome. Person's et al. (1974) found female patients rated women therapists as more helpful while men were more responsive to male therapists. More recently Zlotnick et al. (1998) found 'none of the therapist-patient by gender groupings (i.e., therapist gender, therapist–patient gender matching vs. mismatching, or patients' beliefs about whether a male or female therapist would be more helpful) were significantly related to measures of treatment process and outcome' (p657).

Fig46: Age (decades)+rounds

Male age all rounds	Female age all rounds



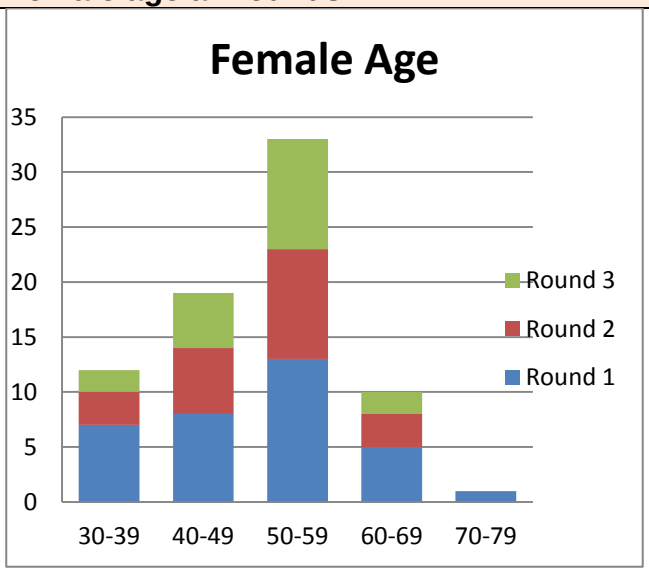
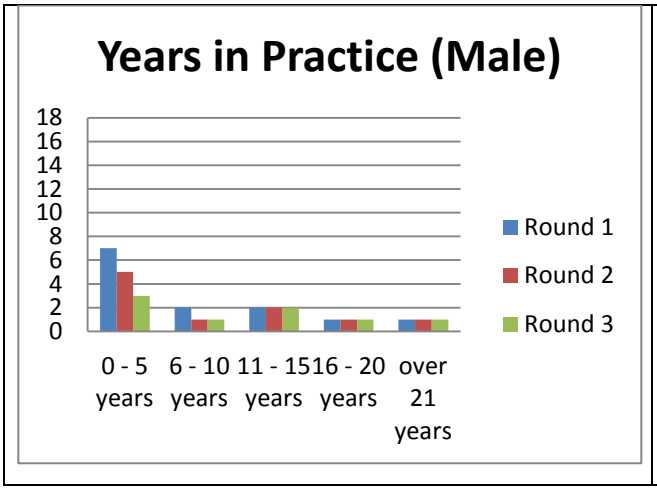


Fig47: Years in practice by gender+rounds



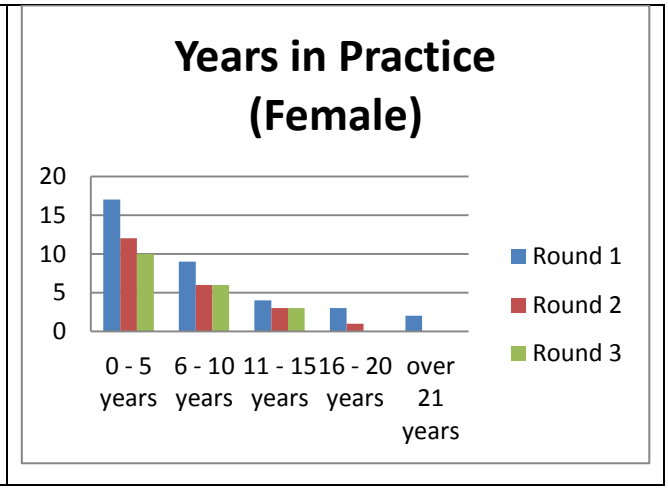


Fig48: Gender

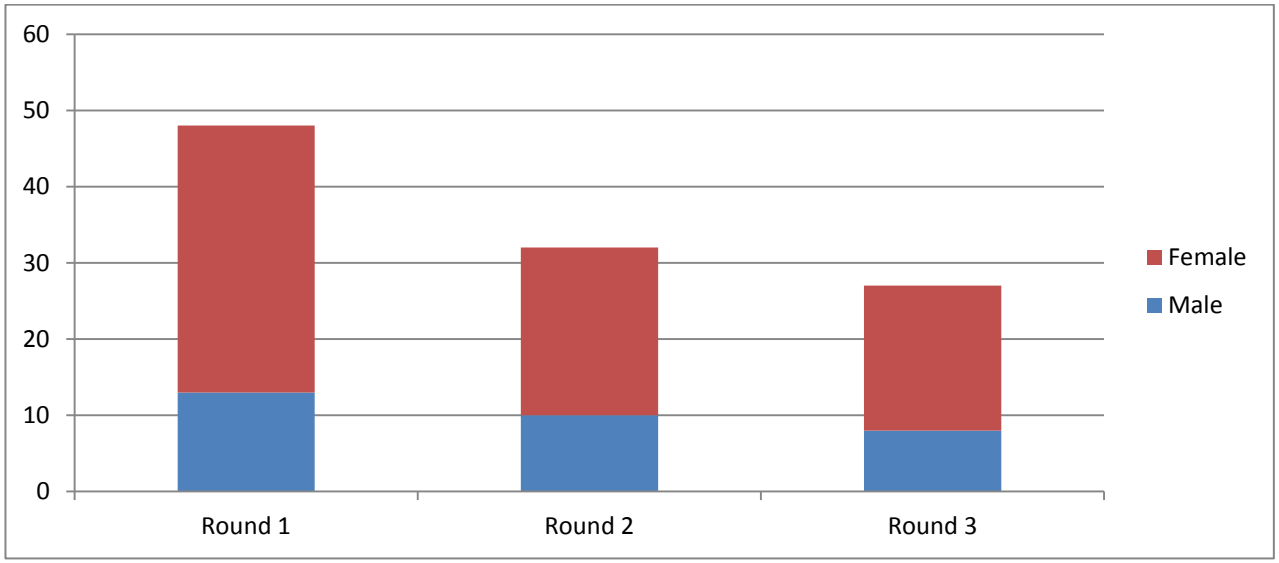


Fig49: Gender + experience

Male x experience/years (stats)

Male			
	Round 1	Round 2	Round 3
0 - 5 years	7	5	3
6 - 10 years	2	1	1
11 - 15 years	2	2	2
16 - 20 years	1	1	1
over 21 years	1	1	1
	13	**10**	**8**

Female x experience/years (stats)

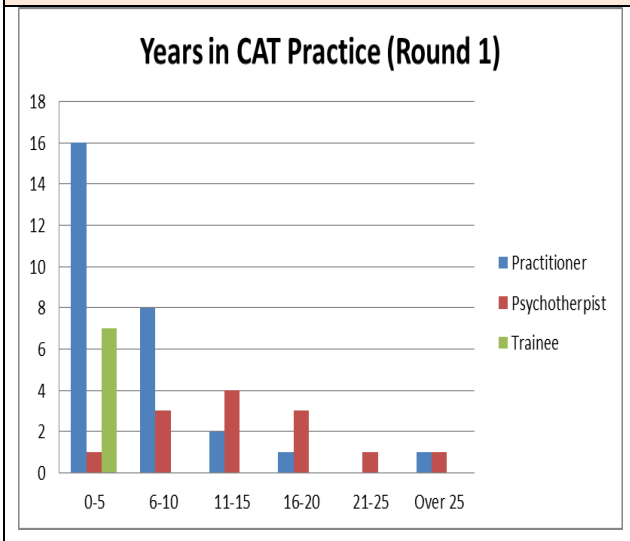
Female			
	Round 1	Round 2	Round 3
0 - 5 years	17	12	10
6 - 10 years	9	6	6
11 - 15 years	4	3	3
16 - 20 years	3	1	0
over 21 years	2	0	0
	35	**22**	**19**

In Easton's (2012) review of psychotherapy professional grouping by gender, female therapists accounted for around 80% of individuals static over ten years. This study has found a 70% female to 30% male response rate. It is important to note that in a review of research in this area results do not demonstrate support for a patient-therapist match on any of these variables (Flaskerund 1990).

Demographic data has informed and supported the expertness of the sample. However, within this research, a set of inclusion and exclusion criterion were set as per protocol. Figures 50 to 56 expand and critique the samples inclusion criterion demographics:

Fig50: Experience post qualification

Experience post qualification R1



Experience post qualification R2

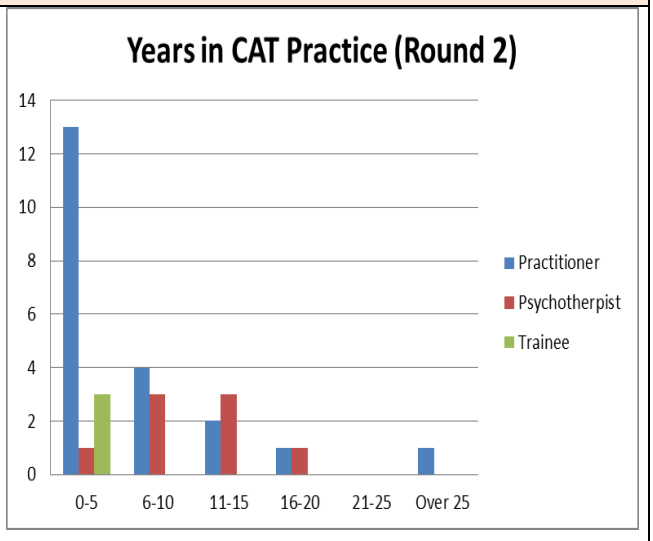
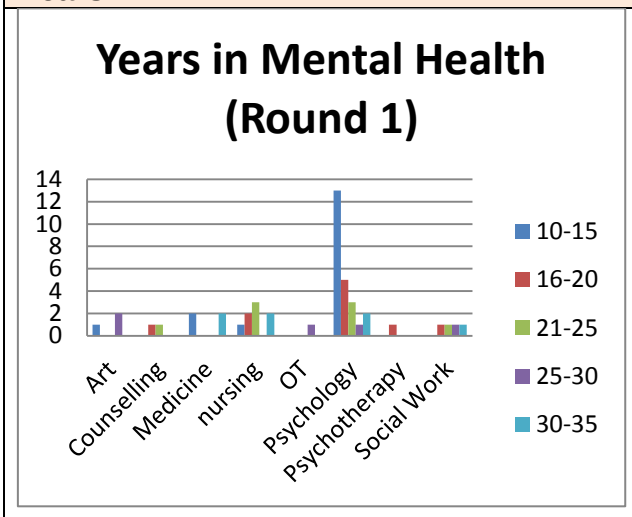
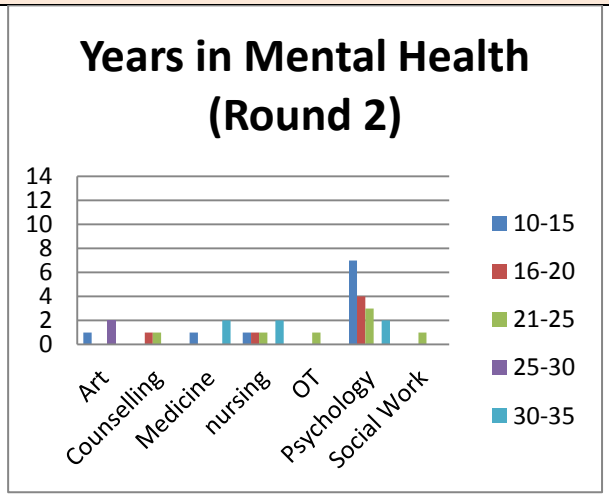


Fig51: Years in MH+ specialism

Years in MH R1	Years in MH R2
	

Data was collected on scholarly work in CAT/Art/Metaphor. On reflection the question was too broad as it does not separate out metaphor research. However, a level of research and scholarly activity the responders were engaged in is noted.

Fig52: Research experience

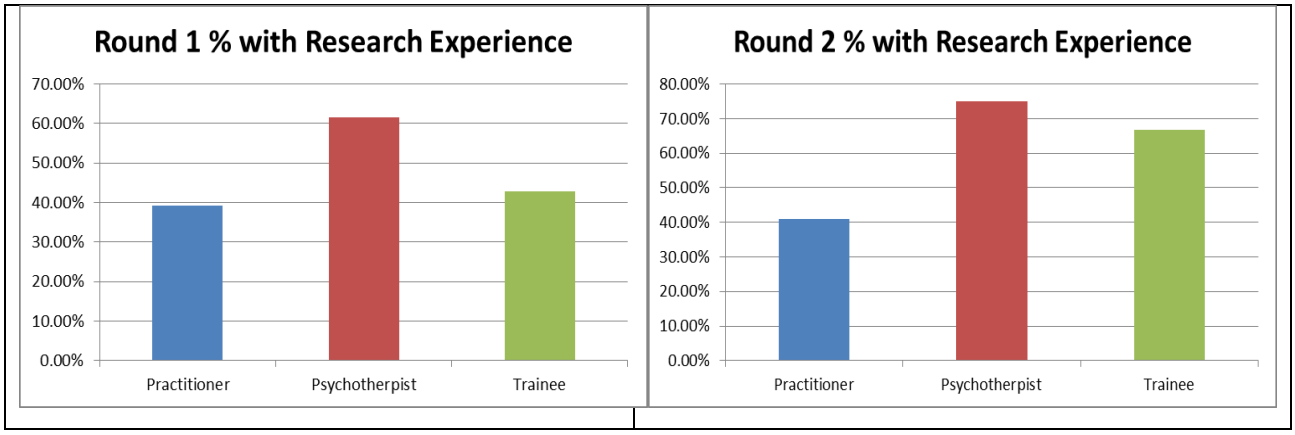
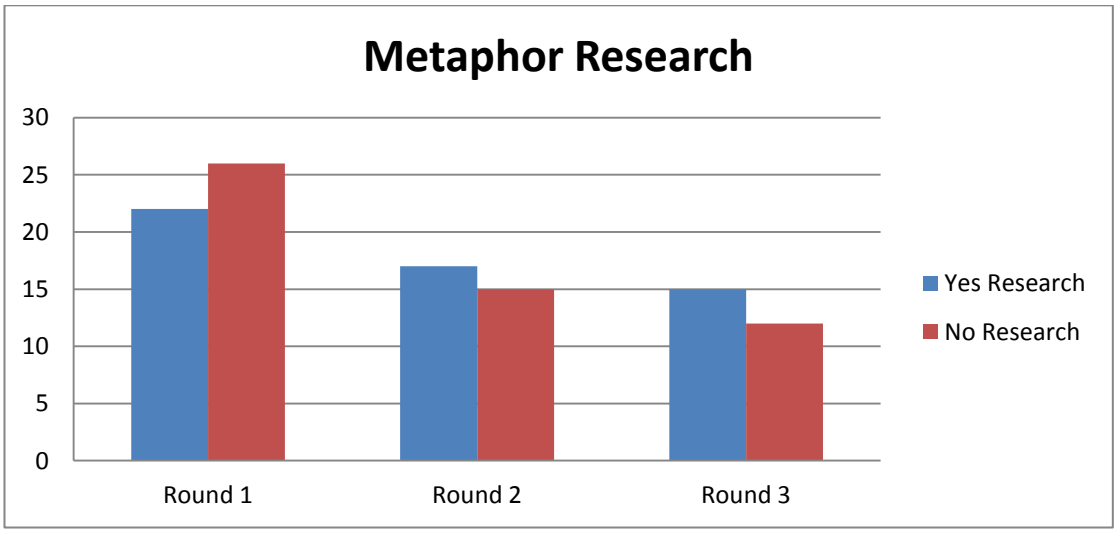
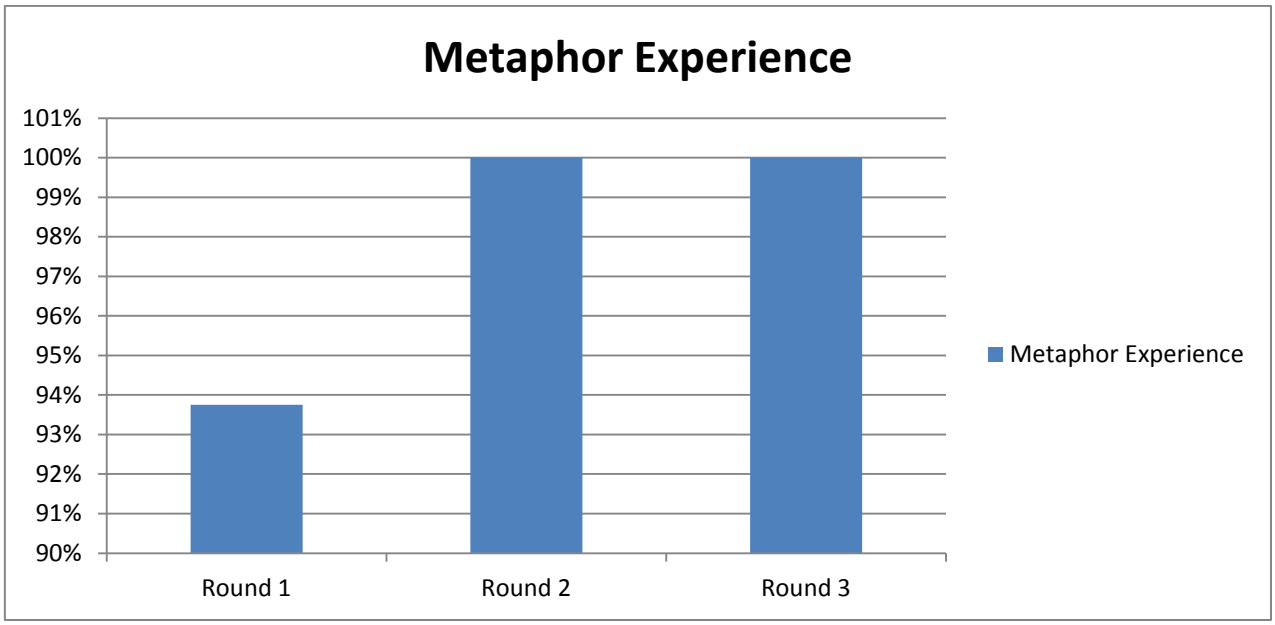


Fig53: Metaphor research



Distinctions and criteria in the selection and location of informants are appropriate as it allows the investigator to account for situational and temporal issues that in turn determine the content, quality and representative nature of the data (Denzin 1970). Tables indicate responders with metaphor and art experience were stable over three rounds for both metaphor and art.

Fig54: Metaphor experience



In R1 thirty eight (79%) had experience of using metaphor in their clinical work, thirty three (69%) had used some form of art, with five having no experience. Seventeen (35%) had generated some research, or been involved in research into the topic.

Fig55: Metaphor and Art

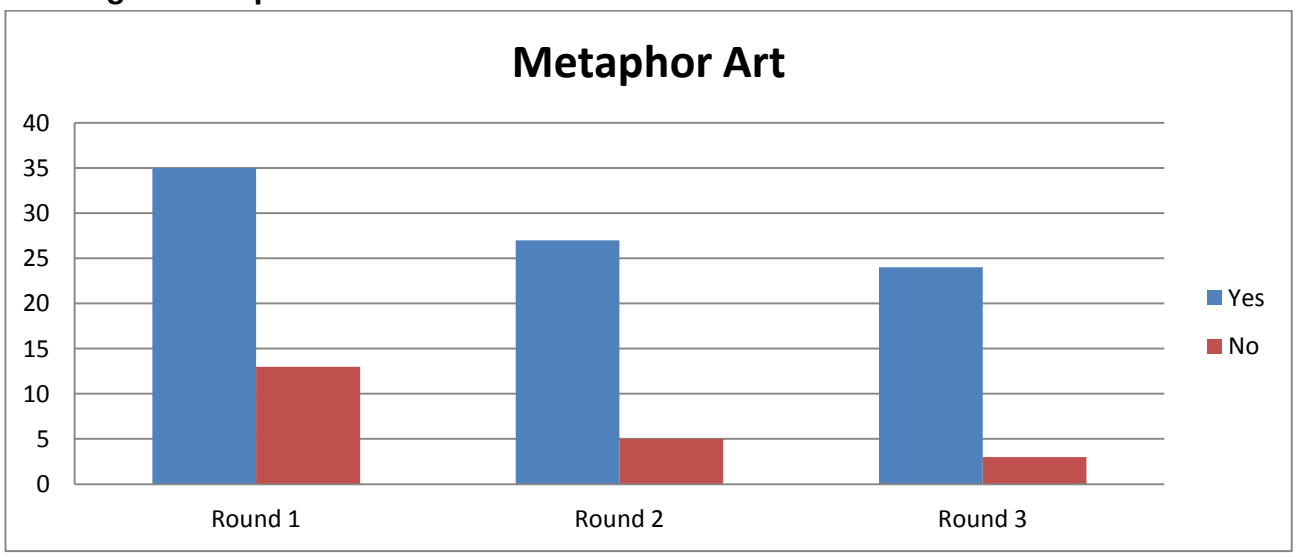
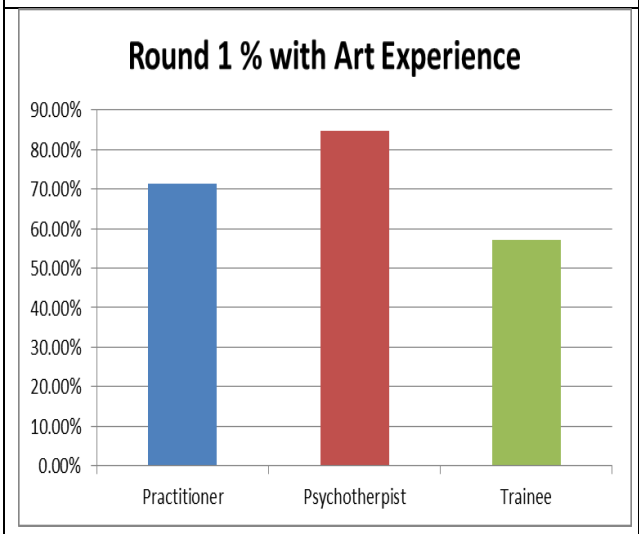
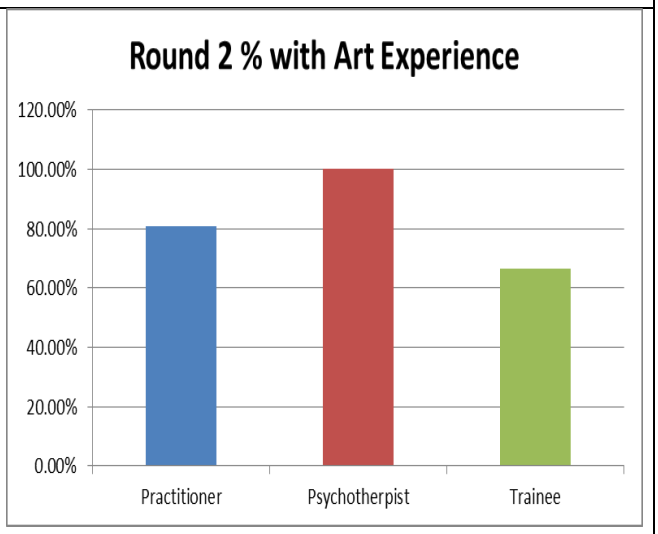
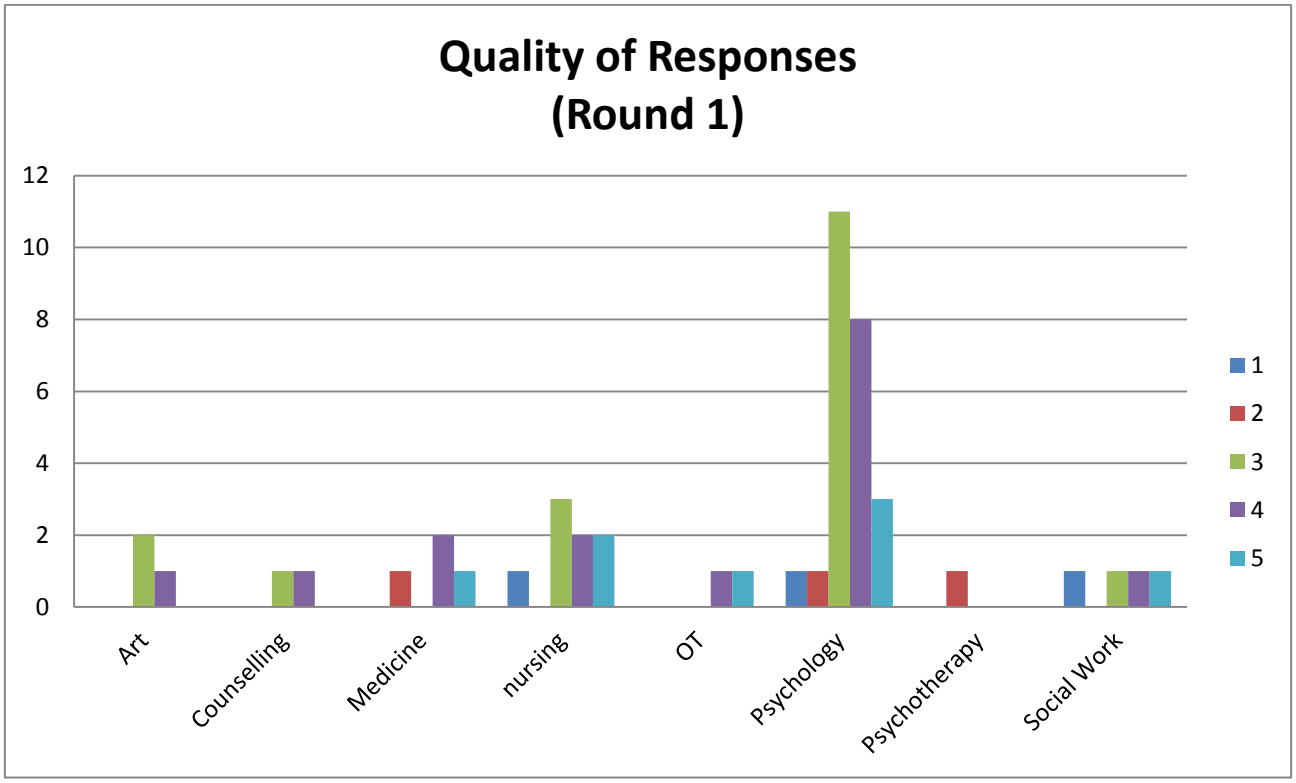


Fig56: Metaphor art + Rounds + Level

Art experience R1	Art experience R2
	

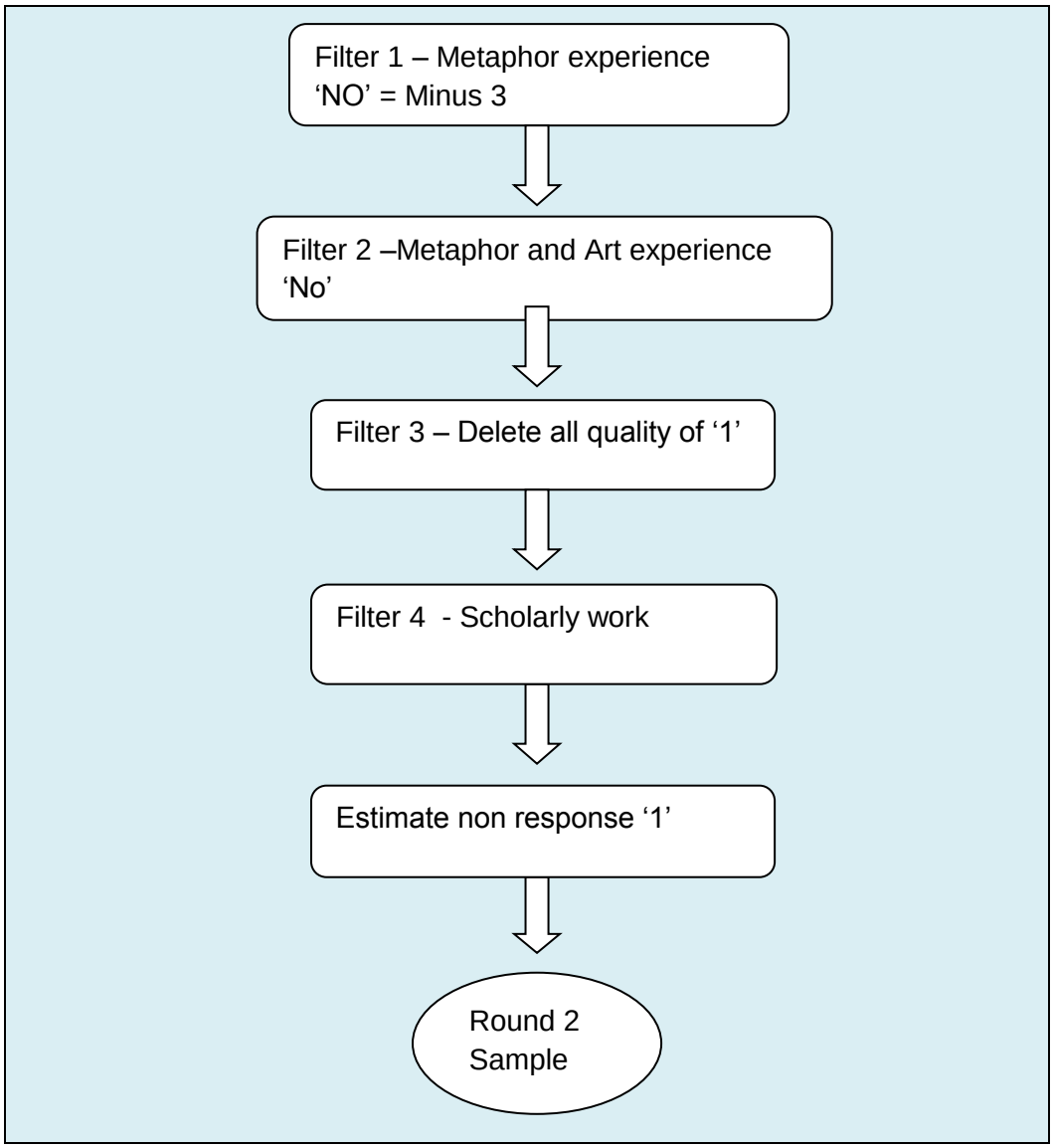
A fifth criterion, the quality of response (0-5, 0=very poor/5=very good) (Fig57), was discussed and agreed with the researcher's supervisors. An assumption was made of knowledge and experience as well as perceived future commitment and engagement based on quality of information given in the R1 questionaire.

Fig57: Objective evaluation of quality of response



The initial protocol for this study indicated a sample reduction for R2 and 3 to 30 (+/-10%). Panellists were chosen for R2 and 3 if they met 2 or more of the exclusion criterion. In hindsight as R2 and 3 data was primarily statistical we could have easily managed a full sample of n=48 going forwards into R2 and 3 (See Fig58).

Fig58: R1 to R2 'Filter' applied to reduce sample flowchart



Demographic data has been interrogated comprehensibly looking at core data as well as relationships between data. An expert panel of informed, specialist or knowledgeable and experienced) participants were managed throughout three iterations of the Delphi (Keeney et al. 2001, Scheele 1975, Pill 1970. Based on these demographics the researcher would support the view that the sample has the right level of expertness, knowledge, experience and representativeness to make generalisations based on the Delphi results

R1 Questionnaire Results and Data Analysis

A 48% response rate represents 16% of the available population. This is not considered low, as is often the case with studies using questionnaires as there are a number of considerations (Keeney et al. 2006) one being that recent years have seen a responses to online surveys decline (Bower et al. 2014). The researcher attempted to generate energy and awareness of the topic to encourage responses, though workshops, conference presentations and publications. Dialogue has been opened and maintained with a number of individuals who have contacted the researcher for further information, suggesting a level of interest in the CAT and therapy community for understanding metaphor and PM. Whilst this work encouraged a response there were a number of problems with the return that were not fully anticipated:

- One responder sent their replies in the post (so it needed transcribing).
- Others sent the replies to ACAT (so they had to be sent on) and it may be that some were lost in this process.
- Others may have been filtered out by the Universities 'SPAM' server (which I unfortunately did not check to know if this was the case). Although this is unlikely as the response was 'identified' with a user who had previously corresponded to the researcher and as such these are not normally filtered out, it remains a possibility.

R1 Step 1 data analysis

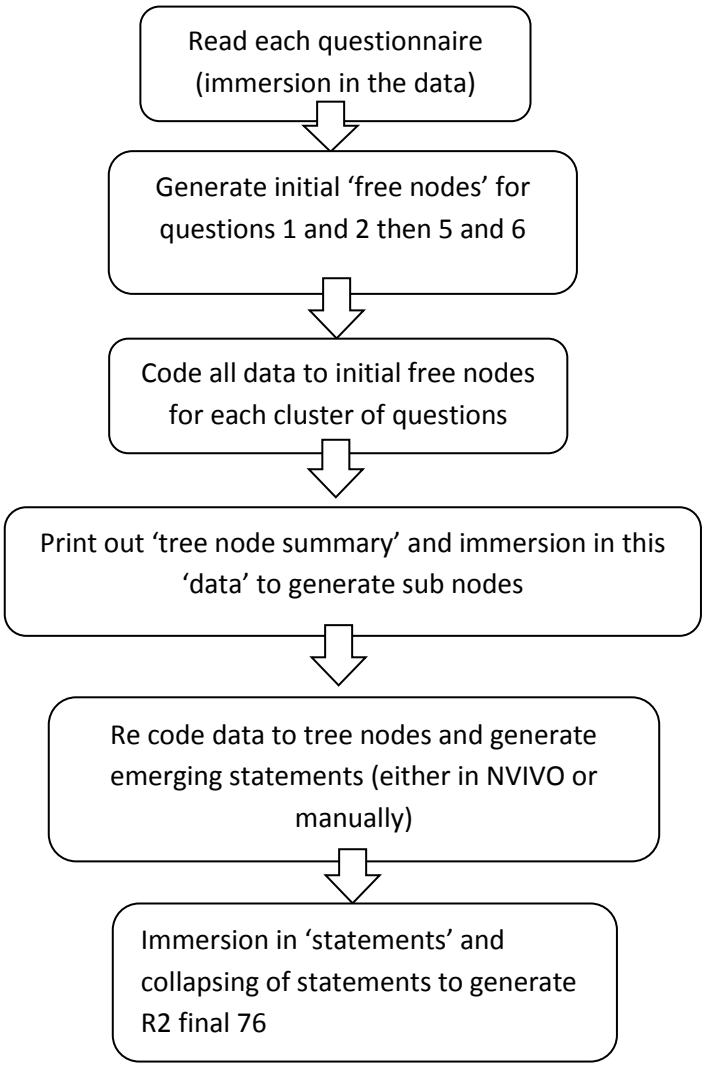
Analysis of R1 responses followed the content analysis design set out earlier. The administration process for managing data generally incorporates three steps. Initially brainstorming, then narrowing down, and finally consensus (Okoli and Pawlowski 2004). Initial steps involved organising the data into a manageable format by transposing files into NVIVO so that a number of methodological steps could be undertaken…

- Sorting and categorizing the data.
- Analysing the data for meanings.
- Identifying criterion and standards of judgements.
- Generating evidence.

(Whitehead and McNiff, 2006, p80)

The researcher maintained a journal throughout the research process and documented steps of analysis. An example can be seen in Fig59.

Fig59: Researchers process notes (2/10/11)



Seventy six statements were managed following this procedure into seven categories using three differing 7 point Likert scales; an agreement scale (34 statements); an importance scale (20 statements); and a likelihood scale (22 Statements) (Fig31).

R1 Sorting and categorising

Data was analysed in Step 1 for Questions 1, 2, 5, and 6. The researcher read through all the responses under consideration making process notes, considering the content, and looking for matches that addressed the overall study question for each of the subsections in the questionnaire. Sorting, categorizing and brainstorming began with the initial construction of emerging nodes of enquiry based on the responses. Whilst the nodes were primarily influenced by the process of coding and categorizing they were also informed by the questionnaire headings and the headings generated within the review of the literature. Within NVIVO, text is coded to emerging nodes which enabled cross referencing and statistical validation for analysis as it developed. An example of an anonymised completed questionnaire is presented in Appendix XII.

R1 Analysing for meanings (Questions 1, 2, 5, and 6)

On initial reading and immersion in the questionnaires a free node for example ‘Theme 1: Training’ emerged then ‘Theme 2: Associated Models Metaphor’ and so on. In reading through the response, the ability to code and click within NVIVO, generate nodes and code comments that related to this theme across into this free node was facilitated. Subsequently as the researcher read through the 48 questionnaires other (sub) nodes or tree nodes emerged and were coded. Nodes emerged intuitively from the responders data. Twelve nodes were identified as the researcher moved from one response to another, developing nodes or creating new ones (Fig60).

Fig60: R1 First step nodes coding frequency

Theme 1 – TP (48 sources 55 references)
Theme 2 - Associated models metaphor (18 sources 37 references)
Theme 3 - Barriers (48 sources 75 references)
Theme 4 - Case examples (31 sources 43 references)
Theme 5 - CAT and metaphor (40 sources 105 references)
Theme 6 - Helpfulness of Metaphor (30 sources 76 references)
Theme 7 - Left right brain comments (3 sources 4 references)
Theme 8 - Pictorial metaphor (48 sources 102 references)
Theme 9 - Principles relationship and metaphor (44 sources 117 references)
Theme 10- Process (48 sources 181 references)
Theme 11- Supervision (15 sources 22 references)
Theme 12- What is metaphor (14 sources 23 references)

R1 Identifying criterion and standards for judgement

For each developing node a further content analysis was undertaken and emerging free nodes and statements recorded that came to mind. These were either generated verbatim from a responder or an amalgam of multiple coded responses. Keeney et al. (2011) recommend that…

> 'Once statements that are the same or very similar are all grouped together, the researcher should make a decision on whether these statements should be collapsed into one statement, and if so what wording to use'
>
> (Keeney et al. 2011, p85)

Reaching the stage of statement generation and collapsing entailed a process of computer aided coding and collapsing alongside a process of traditional analysis using pen and paper. This is, in essence, was using a data base to utilise the cutting and coding as one would have done pre computer technologies enhanced support. What is useful in NVIVO is the ease within which comments can be coded, viewed and if relevant multiply coded to one or more nodes if the comment spoke of one or more topic.

Each node was scrutinised in its entirety for the second round of analysis, ordering the content into tighter sub nodes or tree nodes (to use NVIVO's language) as required and developing statements that reflected the differing points that arose from the data. Statements that spoke of seven overall themes emerged from the coding. 116 initial statements were identified and then distilled though further condensing and collapsing to 76 statements within 7 themes (see Appendix XXV). Data was verified at stages in the process by the supervisory team for congruence in order to manage researcher bias.

Theme 1 Training programme (Case example of node analysis 'a')

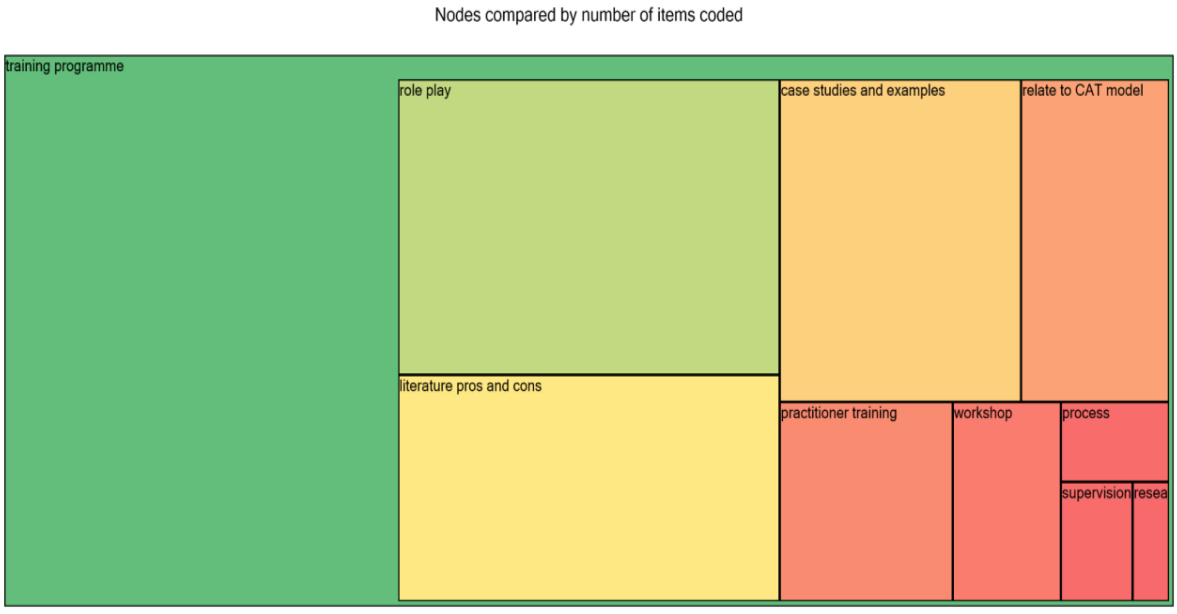
Theme 1 relates directly to Q6 '*What should be included in a TP for metaphor and pictorial metaphor in CAT'*. Data regarding 'expectations' of what to include in a TP, and data for coding and categorising to inform the overall 'metaphor and PM' question were coded. Managing comments on both these aspects made the most of the experience and guidance available from the responders thus ensuring that multiple voices are forming the training, delivery and content.

Rich and informative data emerged from the analysis, not only on the case examples and content of the workshops, but also regarding models and practices that the therapists had been trained in or were aware of. As the TP is one end product of the Delphi, the analysis was slightly different to the approach taken within other themes. No 'statements' for rating emerged, rather a guideline as to the nature, content and style of the workshops, was extrapolated for exploration. If data spoke of emerging statements in the remaining 11 nodes then they were coded accordingly in that node. Coding of the 'TP' data followed a naturalistic route:

- Data coded info to main node 'Training'
- Immersion in the data and sub nodes created
- Data coded to sub nodes
- Data collapsed and analysed into narrative.

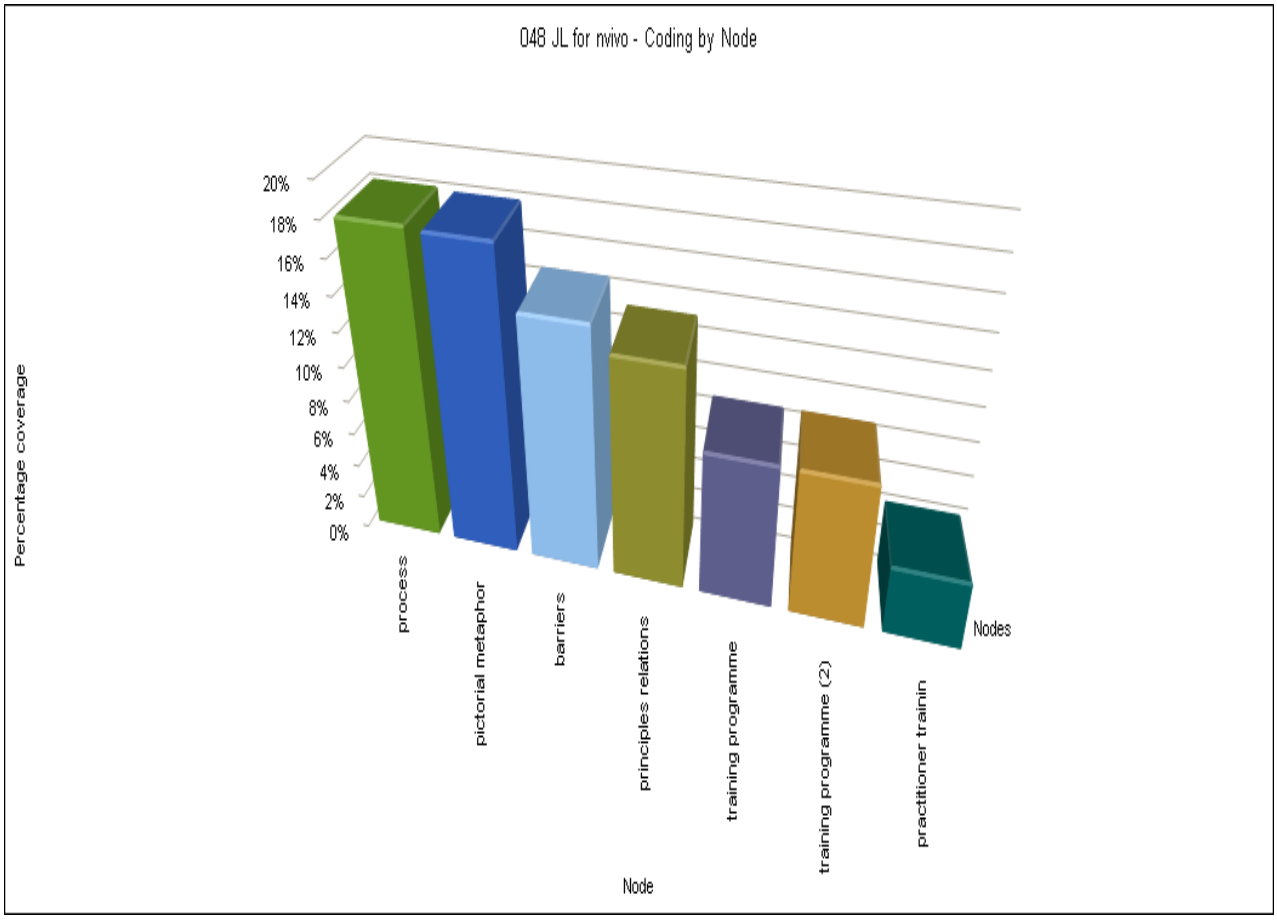
Ten sub nodes emerged and can be seen visually in Fig61, which indicates by colour and volume the coverage of coding for each sub node: TP expectations, role play, literature, case examples, relate to CAT, practitioner training, workshop, process, supervision, and research.

Fig61: Nodes compared to number of items coded



Data source illustrations can be extrapolated from NVIVO as to the numbers, range and scope of response to this theme. These provide a visual representation of the data. For example, a total of 48 responders made 55 comments regarding training. Coding for one responder (048) can be visually depicted as in Fig62.You can see that the responses were coded on 7 of the initial 12 overall themes.

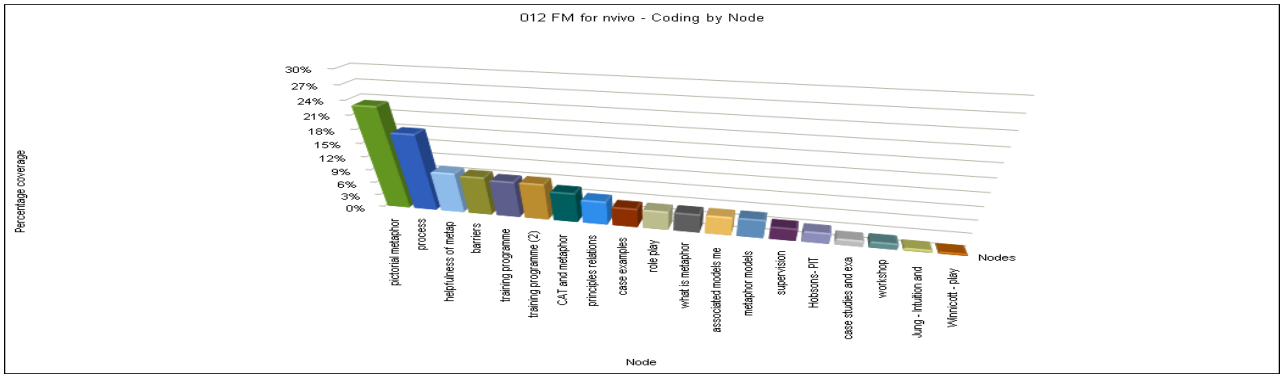
Fig62: NVIVO Responses responder '048' in TP Theme1



The responders' comments were coded to a range of nodes and as a percentage of their overall coded responses to each node including process 18%, PM 18%, barriers 14%, principles relationships 12%, TP 8%, and practitioner training 4%. When reviewing this the usefulness is in noting the depth and spread of the data provided by the responder.

By means of contrast, responder 012's responses (Fig63) were coded to 19 nodes (both theme and free nodes included). This responder had 18% of their comments coded to TP but also a range and spread of comments on all other areas of interest to the researcher. For example metaphor models as four sets of coding refer to models of working (Winnicott, Jung, Hobson and Model) making 18% of coded comments.

Fig63: NVIVO Responses responder '012' in TP Theme1

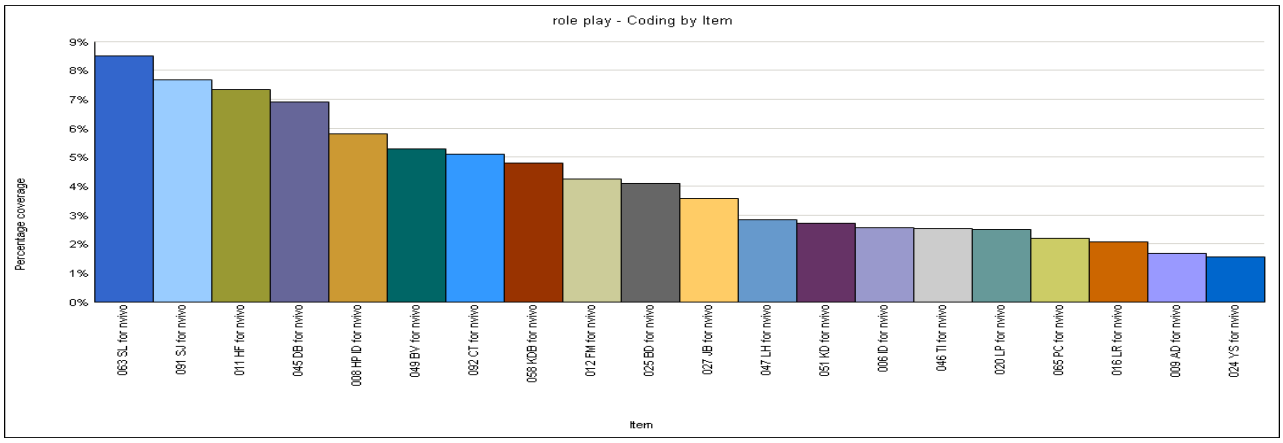


What this examination doesn't show is the overall 'volume' of comments for this responder vs another responder, as the percentages are coded for 'individual coding/individual response'. Responder 012 wrote 1398 words and 048 wrote 403 words which provides the researcher with an indication and opportunity to make considered decisions on inclusion and exclusion for subsequent rounds based on content.

Role play

NVIVO can further enable the researcher to cross reference which responders made which comments on themes. Fig 64 indicates 20 responders made 38 references gained from 26 sources to inform the TP supporting 'role play' as a means to facilitate learning.

Fig64: NVIVO role play coding by item



Literature pros and cons

Two aspects emerged in this node, the first relating to models that incorporate metaphor the second literature pros and cons. The models were noted and recoded within Theme 2. The literature was coded and developed into a statement within theme 'literature' for rating in R2, the statement is '*Working with metaphor is enhanced by an understanding of the relevant research literature'*

Case studies and examples

Case examples were coded to a node and turned into cue cards for use in the workshops. Data in the case studies was also coded to emerging themes if congruent, as the case studies. 31 responders provided 43 case examples.

Relate to CAT model

Eleven sources made thirteen references to metaphor working and the CAT model. '*CAT lies in the joint creation of clear, higher order understandings which help the person stand back and think….working with metaphors needs to fit into and be part of the overall aim and purpose'* (005) and be collaborative (005,045). Metaphor seen to be important, as an '*additional tool'* (009). Working within the patients ZPD (011). On PM…*'CAT therapists are less likely to be comfortable using pictures than words'* (011). That metaphor should be linked to the SDR/Reformulation (087, 030, 011, 027, 058, 092). A reservation was that people incline towards imagery/analogy/metaphor *'and it would be hard to train someone without this inclination to do it successfully*' (067).

Practitioner training

Eight References from eight sources were coded. 50% noted that a workshop on metaphors could be part of the creative approach aspect of CAT practitioner training. There were some reservations; that this is not a 'should' (048) but an opportunity so the '*capacity to use metaphors and even pictorial metaphors…can be taught*' (088).

Workshop

Five comments noted the style and content of workshops on Metaphor/PM suggesting a half day to two full day's workshop. These might occur either in CAT training or as CPD events. The importance of linking metaphors to the reformulation through case studies and developing skill by role play was noted.

Training process

Two references were coded to this node seeking some '*concrete advice on specific techniques to develop visual metaphors'* (008) and '*creative solutions'* (082) leaning on some of the models proposed in another section of the questionnaire notably the 6PSM (Dent-Brown 2011).

Supervision

Two comments were coded to this node, one that spoke of the use of metaphor within supervision improving creativity (013) the second suggesting that if there were training in Metaphor working it would be useful to follow it up within supervision…*'Because the approach is a novel one for most CAT practitioners it would be helpful for training not just to be a one-off, but for periodic supervision (even if only peer supervision) to concentrate on and reinforce the metaphorical work' (058).*

Research

One reference (1.36% coverage) was made in this node that in the TP '*the effectiveness of metaphor in therapy (if any exists) should be included*' (092).

Theme 2 Associated models metaphor

Responders were aware of or trained in a number of models that incorporated metaphor. Fig65 highlights the 29 occurrences incorporating 12 models (one of which is 'none') were coded. One responder commented on set models as they felt that their practice was 'I tend to be organic in approach rather than working from a model or set models, I go with what the patient gives and we develop the metaphor together' (064). As models can inform the literature these models were reviewed within the literature section.

Fig65: Theme 2 Associated models

Fig 68 :Theme 2 associated models	occurrences
Bruner (Narrative Therapy)	2
Transpersonal Psychotherapy	1
None	4
Winnicott (Play)	3
Hobson (PIT Conversational model)	5
Jung (Intuition and symbol)	3
Gendlin (Focussing)	1
Heron and Reason (Action Learning)	1
Bateson (reasoning by analogy)	1
NLP	1
Dent Brown (6 Part story method)	6
Freud (Free association)	1

Theme 3 Barriers (B)

Barriers (48 sources, 75 references) are mostly coded from:

- Q5 What obstacles might get in the way of working effectively and developing metaphor and PM in CAT and how can they be addressed?

Some 19 pages of comments were coded leading to 30 statements and a number of insights with regard to cautions and barriers that have implications for practice that had not emerged from the literature review (Fig70). Statements generated were verbatim from a responders comments or were a strand of emerging data that coalesced into a statement or a number of statements. A cross referencing of each coded comment was undertaken to provide an overview of the occurrences of comments relating to each emerging statement. These statements were managed into five broad categories: art, confidence, awareness, CAT model and metaphor usage.

Art Experience

Seven statements on art and the use of art in the therapeutic sessions were developed. For example, making materials available (003, 082, 088 (B6)) and using a shared room (033). Helpfully responders provided solutions to this dilemma; a response that was often noticed where responders were offered solutions to practice problems they suggested within the questionnaires. Responder 005 suggested that using art '*changed roles within the therapy relationship'*, and pushed the ZPD. During analysis it was noted this initial statement combined two issues, the 'ZPD' and 'art experience'. ZPD comments were also coded and analysed within 'CAT Model', as the ZPD is an integral aspect of CAT practice.

Two Comments referred back to childhood, the age of patients (006) who left school early and it appears they were not '*comfortable with writing and drawing'* and '*feeling that they are not much of an artist'* (011(B9)). This relates to statement B28 and B30 whereby the '*inadequacies*' and possible anxiety developed in both drawing and using metaphors may be felt (027, 065, 078, 058) leading to '*judgement*' (051, 049) and '*perceived mockery'* (056) or indeed self-criticism (064). B30, in particular, emerged from the data to recognise these 'negative associations' (084) rather than 'age' issues. For example 051 noted '*both the patient's and therapists embarrassment'* regarding art competency. This *'discomfort in using art'* (008, 084), '*self-consciousness'* (063) and/or '*reluctance or inability'* to use metaphor (046, 047) may lead to the therapist not using this approach

(B11).

One responder supplied a counter with '*these would be addressed by such means as therapist's sensitive awareness and attunement, open exploration and discussions'* (063). A further solution was to emphasis the 'enjoyment' that others have gained from using metaphor and art and using the therapeutic relationship to manage the feelings (058, (B26)).

Other issues noted that the therapist was not using art or metaphor because they '*don't tend to think pictorially very readily'* (006 (B8)). This could lead to '*reluctance or inability to use metaphors'* (046). The other issues is reciprocal where the therapists might hinder the working with metaphor and PM if the therapist came across as '*trying too hard'* (051, 066, 077) or *'too arty'* in *'imposing the therapists creative and ingenious ideas'* (065, 077) thus creating a narcissistic transference (047 (B25)). A solution offered was to '*develop metaphors jointly'* (044) and discuss in supervision (077, 082, 045).

Confidence

Four statements emerged regarding confidence issues (although the issues in art also included issues of confidence based on previous perceived experiences). Initial thoughts were about therapists having to be 'arty' (009) or not being artistic at all (011, 032, 082, 101) and the associated anxiety that might come from this lack of perceived ability (057, 065 (B12)). The solution would be to '*have a go'* (057) and/or invite the patient to draw or bring their own drawings in (032) as this would '*embrace the collaborative nature of CAT'* (009). A further notion that using art was some kind of 'special' skill (012) because '*some people don't feel comfortable with drawing and would rather use words'* (020) leading them to be '*out of their depth'* (066, 101 (B16)) was noted.

Two final statements emerged regarding first the practicalities of '*working fluidly with other modalities (such as metaphor) to working in CAT where there are timescales and specific processes I am trying to keep to'* (012) adding a perceived 'extra' into an already busy therapy (B15). Secondly, a lack of any perceived theoretical framework/guidance as to how to use metaphors (033 (B23)).

Metaphor Awareness

Five general awareness comments that led to five statements arose that in using metaphors one needed to be open to metaphors (B3). Responders noted resistance due to the therapists '*closedness of mind'* (005, 084, 088, 101), '*limitations*' (006, 063), '*lack of attunement'* (09) and '*lack of confidence'* (009, 044, 058, 078) limiting the approach. A solution offered was that this would be helped by '*inclusion of such tools and techniques in training courses and as CPD workshops'* (063, 088).

In the context of CAT '*noticing relational/social/cultural context of the metaphor'* was seen as important (001, 047) because differing cultural backgrounds '*may mean that a metaphor that is in common usage in one background may be unknown in another'* (020, 074) one '*must carefully explore the metaphor'* (036, 067(B1)). When you do work with metaphor they need to be used in a timely manner (016), not dismiss the patients experience (034) and are not one dimensional but through integration in CAT model are grounded in the intersubjective (everyday) life of the patient (026, 088 (B18)).

Two statements B2 and B13 emerged regarding a '*lack of training might limit using metaphors'* (002, 101) and that training is useful as it *'is helpful for opening ourselves up to other ways of working/thinking'* other possibilities (006, 009, 013, 026). There was a sense that working with metaphor might '*require specialist skills to be able to respond to pictures/sculptures'* (012). Because of this they might have missed opportunities in their consulting rooms. The usefulness of supervision as a solution to these 'obstacles' was cited (026, 066) and access to resources and training for prompting this work in CAT (033, 051, 066,067).

Therapeutic considerations 'CAT Model'

One initial statement (B4) noted a barrier as the '*centrality of verbal expressions in CAT'* (005, 057) as it seems as if '*CAT is primarily a verbal (or diagrammatic) mode'* (012), working with words (026). A solution was where '*Some people just don't connect with the pictorial representation of their TPP's..then be creative'* (020). The second comment related to time pressures of their work in the NHS and the busyness of CAT (046) that because of this pressure there might be less time to work creatively and tended to '*emphasise working on symptoms rather than taking a holistic approach to psychological recovery'* (B19).

It was important to maintain the framework of CAT when working with metaphors (068, 087, 088). Working within the therapists and patients ZPD is well documented. A number of comments related to statement B7 '*moving out of the ZPD'* (036, 047, 049, 091, 101). Working pictorially *'changed roles within the therapy relationship'* (005) and had to be actively managed, '*not imposing something that is not been accepted by the patient'* (047). There is something here about this obstacle also having a relationship to a '*problematic or insufficiently developed therapy relationship*' (091).

Therapeutic considerations 'Using metaphor'

Two statements were coded regarding a need for a sound rationale for using metaphor (026, 058) and where it may not be useful, for example with borderline personality disordered patients (084 (B29)). The second statement is about a perceived lack of empirical evidence (058 (B27)). Using metaphors involved a shared understanding (B17 and B22) was noted on 11 occasions '*creating a dialogue which is open to different ways of using metaphor'* (013) and allowing space to explore the metaphor (013, 032, 047, 065) and noticing that metaphor can condense many meanings 084) so not mixing too many metaphors (036). If the therapist generates a metaphor and it is not understood it is equally important to seek shared understanding (020).

Not making prior assumptions (B10) was coded seventeen times the highest recurrence within the selected material. This involved a failure to check out the shared understanding of a metaphor and its meaning, coming to assumptions or making interpretations (008, 036, 044, 046, 047, 065, 067, 091, 092). If this is not done then '*there is a risk of alienating the patient'* (032). This was the case for patient and therapist derived metaphors and if therapist initiated, it is tentatively offered that ensuring it was agreed rather than imposed is vital (047, 067, 070, 075). This shared understanding was particular important when working with patients with learning difficulties, literacy problems or particularly concrete way of thinking (025, 030, 091) so keeping them simple, *'nothing too fantastical'* is one strategy (047, 056, (B20)).

It was noted that some metaphors (because they embody so much) may contain *'pejorative implications or symbolism'* (011, 056). The therapist needs to be sure that they use the metaphor with the patients 'permission' (036) and take them seriously (047, (B14)).

Concern was expressed regarding over using metaphor to '*un-name difficult things*' by '*allowing the patient to feel more distanced from their emotions and clearly this may or may not be desirable'* (047, 005, 092). There is a 'risk' (036) because of the inherent emotion carrying potential (047) and power of metaphors, or even the therapist being entranced by the metaphor and colluding with emotional distancing (047) (B5). Comments further noted the importance of being prepared to seek alternative metaphors or indeed approaches if metaphors weren't working or '*resonating with the patient'* (032). In effect one size did not fit all as metaphor is not for every patient so be prepared use an alternative, don't persists or change to another medium (032, 045, 057, 074(B21). B24 alludes to this as judging who to use metaphor with (044).

The process of managing the data was to 'generate intuitive statements'. In hindsight generating 30 initial statements during the initial coding led to complexities as some were similar (see Appendix XV). The later stages of analysis were designed to condense and collapse statements so this caution was managed.

Fig66: Theme 3 example of 4 'Barriers' statements

Theme 3 Barriers	Occurrence
B1 It is important to notice the relational/social/cultural context of the metaphor	8
B2 Lack of training opportunities would limit the use of this metaphor method in practice	10
B3 Therapists 'closeness of mind' or self-conscious anxiety would limit the approach	13
B4 The centrality of the CAT model and focus on verbal expressions	8

Theme 4 Case examples

Theme 4 - Case examples (31 sources, 43 references). Case examples were coded with NVIVO then extracted into Microsoft Word to produce 'cue cards' to be used within the TP. Fig67 are two such examples of working with 'metaphor And fig68 examples of PM working…

Fig67: Metaphor Case examples for TP

In recent work one patient used metaphors extensively for much of her therapy, as her familiar and preferred way of expressing and describing things. We actively engaged with them during the sessions, until she got to the point of recognising her over-reliance on them and how she might be hiding behind them to avoid getting on with breaking unhelpful patterns. This signalled us moving on to the Revision stage of the work.

With another patient a very powerful image emerged for me within a session, which I named with the person, and which became a shared symbol for the stance he needed to adopt in relation to himself, both during and after the therapy, and which we both referred to in the good-bye letter.

Fig68: PM case examples for TP

I have used very simple pictures – at the level of black holes and dark clouds – to help on maps with people who are less comfortable with words or struggle with reading. I guess I would think the same principles again apply – I wouldn't see a differential between metaphor, pictorial metaphor or other ways of communicating including more general dialogue, letters, maps or other creative / dramatic techniques.

A pictorial SDR once for a client who found it really difficult to work with a SDR with writing on it. The sketches I used were the images that came to my mind for various parts of her diagram, for example, her abandoning RRP was a sketch of a bed – because she used to go to bed and hide from the world when she felt low. Another area on her map was a sketch of a vat with her just managing to keep her head above the water level to represent her sense of drowning in her emotions.

Theme 5 CAT and metaphor (M)

CAT and metaphor (40 sources 105 references) references noted the importance of maintaining the fidelity of the CAT model whilst using metaphors to link the reformulation, SDR and RRP's (M1) or vice versa (001, 003, 009, 012, 013, 020, 030, 033, 046, 067). Responders noted metaphor as being '*a way of symbolising a procedure can be particularly powerful'* (003) and '*helpful to link the metaphor to the patient's RRP's and the dialogical voices associated with RR's and/or TPP's'* (001). Explaining the patient's metaphors in the reformulation occurred (M9) '*I will use the metaphors they have used in their reformulation letter'* (020) and the '*reformulation letter can be viewed as a metaphor of the patient's experience'* (013). Relating back to the metaphor in the goodbye letter whilst revisiting the reformulation was noted (087).

The patients language was stressed where '*using the language of the patients reflects back that they have been heard and understood and that the therapists language has not been imposed on them'* (009), is '*more collaborative*' (008) and '*it is important to use the patients own metaphor material'* (046) (M4). The patient's metaphoric language (M12) is indicative as a '*means of developing effective signs with patients'* (074).

Metaphors as facilitative in the TE were coded. For example, having located the metaphor to the reformulation, they were resonant with a scaffolding of support (M13). How metaphor helps manage the encounter, perhaps as a central theme was noted (M5) and *'can form the basis for the whole therapy or be a transitory illustration during the session'* (046), '*capturing my journey'* (009) and a '*short cut, a brief way of expressing a range/complex interaction of different emotions or actions'* (082) that '*allows therapy to be integrated into everyday experience*' (012). Metaphor can also provide illumination to possible transference and counter-transference (M3) where '*metaphor is synonymous with transference'* (027) as metaphor allows '*space for this to emerge*' (008).

In relation to art *'it is led by the patient or jointly put together'* (070) and the use of PM *'captured my journey through therapy*' (009). Drawing a metaphor picture on the SDR (M11) was noted on 10 occasions with responders noting '*we have made use of metaphor to represent a particular state on her SDR'* (008) and *'if a person is finding it hard to name one end of a reciprocal role, or if they are able to name it but are unable to describe how it might feel, then I would ask them to draw/paint/collage an image of how it feels'* (020). A central theme (M2) linked to diagrams *'Metaphors contribute to the development of more accessible diagrams, diagrams that the patient can revisit and constantly alter while keeping a consistent language*' (091). Finally, an indication of the *'I don't use pictures in CAT except when I want to draw an observing eye on a map/SDR'* (034) speaks of the inadvertent use of an image to create a position.

In keeping with the CAT model statements related to working within the patients ZPD (M6) included, for example, *'if the therapist is careful to stay within the patient's ZPD and is attuned to their response to the use of imagery and metaphors, I think they could be very helpful'* (011). Supporting change within sessions, helping patients to 'unstick' (M8) where exits can develop from the use of metaphors (088) and where '*the patient can choose how he or she might alter the perspective of what meaning of the events might be*' (046) by using metaphor.

An example of using metaphor from films came from Star Trek *'Mr Spock felt like an alien on planet Earth, vulnerable and different while Capt. Kirk's character was in charge of himself and able to make decisions…..this formed an exit for him'* (046). These are in effect using the metaphor as being 'one step removed' or as an 'as if' (M10) means of containing powerful emotions (M10). *'Working with metaphor 'means working directly with the 'as if in therapy'* (046) where *'it allows an exploration of the space where the '* it is not me' *relates to '* it is me' *might help to develop…exit strategies'* (088).

Responders commented that metaphors are facilitative in the encounter, creating new possibilities and suggesting they can be 'playful' whilst providing a scaffolding and a *'sense of safety and containment'* (088). Playfulness (M7) arose on three occasions noting metaphor can '*bring life'* (012) into therapy, *'therapy is partly a process of helping someone become less concrete and more able to 'play' with images, Metaphors, etc.*' (011) in a fairly '*free and spontaneous way'* (088). Thirteen emerging statements were developed the data. Fig69 shows some of the statements and occurrences within the text coded in support of each statement (Appendix XVI).

Fig69: Theme 5 Example of four 'CAT Model and Metaphor' statements

Theme 5 CAT Model and Metaphor	Number of occurrences
M1 Metaphors can provide a **link to a patient's reciprocal roles**	16
M2 The use, understanding and development of metaphor **establishes the patterns of communicating** in the relationship	2
M3 Metaphors allow space for the **transference and counter transference** to emerge	3
M4 Using **patients language** shows they are being heard and understood and that the therapist language has not been imposed	7

Theme 6 helpfulness/Potential of Metaphor (H)

Helpfulness of metaphor (30 sources, 76 references). Sixteen nodes emerged from the data that reflect similar nodes in other themes. The most coded data (H4) spoke of the ability of metaphor to '*combine and express complex and often contradictory issues'* (005), '*capturing complexity and enrich description'* (065) whilst '*providing a bridge between 'thought and feeling* (011). One responder commented on how '*allowing difficult pictures and images to come to exist is also important if they allow the patient to express pain or people in the past who have hurt them'* (051).

They suggest that metaphor has a way of '*changing perspective from a locked pattern of thought'* (012) by '*translating actual experiences into a pattern that can be generalised and applied to both past, present and future'* (026, 056). This again resonates with a central theme (H1). This 'central theme' has metaphor *'summing up'* (001) and *'a quick way to access their assumptions'* (067) using '*consistent language'* (088) with patient's who may be '*struggling to grasp what a reciprocal role procedure is or means'* (049). In particular one responder 056 commented *'I often reflect with patients on the processes at work: they usually express pleasure and surprise at how quickly significant material came to the fore'* (when using metaphor).

Metaphors were noted as helpful in noticing enactments (H3) of damaging or self-limiting procedures (001) by providing an observing position (H14) or to explore the patients '*idealisation*' (087) of the therapist. Metaphors can be useful when a patient '*tends to be defended against more explicit psychodynamic exploration'* (065). A number of comments noted the ability of metaphors to extend and develop the relationship (H9) whilst supporting collaboration (H10). Building on a '*shared language'* (011) whilst '*aiding the patients understanding of the therapeutic process'* by using metaphor to help set achievable goals and *'get to previously untouchable or unmentionable'* emotions (026). Collaboration, through active listening and focussing on the patient's experiences (026), recognising metaphors are part of a patient's identity, are a '*powerful means by which the therapist can communicate with him/her'* (051) and in doing so and allowing creative exploration *'of the patients sense of self and may reconnect the patient to a new sense of self and self-expression*' (087).

The utility of a patient derived metaphor (H12) to be one step removed (H5) and in being so provide a link between thought and feeling (H11) was noted whilst demonstrating and validating (H7) that their experiences are worthy of note (H6). The notion of being 'one step removed' creates a sense that metaphors can *'bypass the censor and allow people to acknowledge things that might have otherwise feel prohibited from expressing*' (005) and *'bypass the usual defences'* (058) as noted by Falck (2010). Examples of using metaphor (006) as a *'first step'* and/or in discussing *'parallels to the therapeutic process, in effect being reflective of interactions between patient and therapists and allowed discussion to be had about what may be happening'* (009). A metaphor '*stemming from the therapist only can also be powerful in illustrating a particular point or theme'* (016)

What seems important is the ability of metaphors (016) to link '*the creative exploration of the patients sense of self and may re-connect the patient to a new sense of self*' (087) and '*so engaging with them the therapist is getting close to a patient's emotional self*' (051) (H11). There were a number of statements coded in 'validation' of the patients metaphor/story…'*I am entering the patients world'…'when I use metaphor and imagery that leaves the patient feeling particularly understood, valued and validated'* (008) (H9). Creativity, or 'playfulness' in the encounter (H8) like Winnicott's capacity for 'play and playfulness' (005) is important as '*we rely a lot on verbal expression and descriptions'* (005).

Letting the patient take the lead (087) and co-constructing metaphor has therapeutic potential (065). This all speaks of the importance of demonstrating that the patient's experiences are worthy of note. Five comments were coded in H6 that '*when working with metaphor you get a better grasp of the challenges at work'* (005), '*I think I use metaphor often when I am stuck….perhaps finding it difficult to find a way to get to a place of shared understanding'* (006), *'it demonstrates their experiences are worthy of note….that we have time to look at these in detail together'* (008), '*developing a shared frame of reference'* (012) and '*by engaging with them (metaphors) the therapists is getting close to the emotional self*' (051).

The CAT model linked to metaphor was noted as '*contributing to more accessible diagrams'* (088-H15) and enabling working within the patients ZPD (H13) and helping '*unstick a patient'* (H16) and support 'ending' (H2). Linking the metaphor to the diagram based on case presentations *'benefited the case greatly'* (032) whilst having an awareness of the patients ZPD and nudging the ZPD when '*someone is struggling to describe or connect with a feeling'* (092). Data was coded to '*I see metaphor as a way of extending someone's ZPD'* (092) and *'aim to create difference without too much difference within the ZPD'* (065). Managing an ending had one reference noting that '*a metaphor may acknowledge and contain affect associated with ending'* (001).

Sixteen statements were extrapolated from the data which are presented below (Fig70) with the number of occurrences within the text coded in support of each statement. It seemed important at this stage of the data and analysis to provide and maintain some 'evidence' of the support for each statement as this provides rigour to the interpretation (for the full list see Appendix XVII).

Fig70: example four Theme 6 helpfulness statements

Theme 6 helpfulness	occurrences
H1 A metaphor may be helpful to succinctly **sum up an overall theme** in the reformulation.	**4**
H2 A metaphor may acknowledge and contain **affect associated with ending**	**1**
H3 Therapist and patient being caught in **enacting damaging/self-limiting RRPs** that - use of SDR, metacommunication around the dynamics in the therapeutic relationship	**2**
H4 Their power lies in their ability to combine and express complex and often contradictory issues within an easily **accessible image**, where using words you could get bogged down in detailed descriptions	**8**

Theme 7 Left/right brain comments (N)

Left/right brain comments (3 sources, 4 references). Responders suggested that *'the identification of procedures and language of CAT may be a 'left brain' activity and the introduction of metaphor could evoke the 'right brain' allowing increased access to feeling'* (013) and *'cognition was seen to be….the right or non-verbal hemisphere'* (027) and '*metaphors tap into the right brain and therefore get beneath the intellectual barriers'* (064)(N2). One statement was condensed from these coded references.

Fig71: Theme 7 Left right brain comments

Theme 7 Left right brain comments	occurrence
N2 Utilising metaphors in CAT enables different emotion connectedness to the patient's problems (left to right brain thinking**)**	4

Theme 8 Pictorial metaphor (PM)

PM (48 sources 102 references). The most frequent nodes related to 'Co-constructing' a metaphor n=27 references (PM7) and pictures 'opening a dialogue' n=13 (PM4). Working with and co-constructing pictures as the patients preferred medium was seen to be important (009) and they need to be '*palatable'* to the patient and not include information that goes beyond their ZPD (016) (PM8). Patients could either bring work to sessions (030) or it could be generated in sessions collaboratively (066, 078). What is developed is only of use if the patient (and therapist) understands it (045) and is comfortable with it (047).

There is a need to explore what patients associate with the metaphor, getting them to do the work (058) and facilitate exploration of the meaning of the metaphor, understand the part the metaphor plays in therapy and what different parts mean to him/her (048, 074, 088, 092). Metaphors usually 'emerge' from the narrative material (065, 082), '*it should make the therapy clearer, rather than more complicated'* (101).

Utilising PM to open dialogue may be energising (065, 009) as it allows patients to consider aspects of themselves outside their current gaze, accessing more unconscious, emotional issues (065, 033, 006), and actively connecting the patient to the emotions (047). Using '*pictures/metaphor or image are ways of expressing feelings that some people find easier/safer'*. Images help people to express how they feel (027, 026, 013) (PM2). It is important to be aware that as powerful emotions can be 'released' by using drawing/art they need to be 'contained' (049). For example *'with a recent patient I was able to use art work to explore feelings and states in a safe manner….we identified the areas and feelings that he struggled with and encouraged to see if he could draw/paint these out'* (092). As part of the dialogue, *'keeping the picture (or art work) between us (literally) even when not directly addressed as part of a conversation*' was important (012). However, it is not a 'simple' tool working with metaphor as patients who are unable and/or unwilling to work in this way '*may have negative associations with their image making capacity and anxiety needs to be avoided'* (084).

Frequent comments were '*with some patients PM may be a more acceptable medium'* (001, PM1), pay attention to the ZPD (PM 8), integration with SDR (PM9) where they can be like a shorthand (PM14). Pictures are primarily seen as being '*patient led'* (012, 045) and developed from '*a sensitive position of mutual respect*' (013). There is an acceptance that *'images can be created by the patient or therapist or both or pictures can be obtained from other sources'* (036, 070).

Working within the ZPD generated many references. *'It is important to use pictures if this is the patient's preferred way of working….this is a way of working within a patient's ZPD'* (009). Both 009 and 003 suggest that as a medium, pictures are helpful when there are sensory deficits with a patient. In fact checking that working with pictures is ok is both a patient and therapist 'check for fit' within the ZPD (030, 032, 057).

Integrating pictures within the CAT model and tools came across as important. Therapists '*often use simple visual metaphors on the SDR'* (09, 074, 067, 048, 057) as the SDR is the *'most important place to see where metaphor may add, enrich and support the patient in the process of therapy'* (087). For example *'idealised or aspired places I often put into 'dream cloud bubbles' and use small circles instead of arrows to highlight the different nature of these RR's'* (082) or *'use collages from magazines to map a procedure from the SDR'* (087), problem procedure are represented in an image to help 'understand'.

One respondent noted *'I think in pictures myself so I probably use metaphor in most sessions. It helps me understand'* (049). Like therapists, patient's, may prefer an SDR rather than prose and this might be an indication they will '*do better with pictorial metaphor'* (045) (PM9). It was interesting to note that some responders saw the SDR as a 'visual' tool others saw it as essentially verbal…*'as the classic form does not incorporate pictorial representations'* and because of this *'particular attention would have to be paid to pictorial metaphor'* (011) (PM8).

As a shorthand to procedures and experiences one *'can use simple and not well drawn drawings to help with transference and counter–transference of the therapists being seen as the expert'* (013) making procedure easier to *'recognise when it is repeated in daily life*' (027). A caution here is not being able to explore the image fully as one responder noted *'the position of her cat changed her pictorial metaphor and she was reluctant to talk about these changes, constantly assuming the image was self- explanatory'* (088).

PM2 and PM5 both speak of using metaphors to manage complexity. *'Encouraging patients to 'doodle''* was one starting point for responder 074 and can be used where language and sensory deficits may be an issue (001, 009, 044, 074). Images are used '*to enhance comprehension, to add to memory, to help attention and concentration, to work side by side together'* (044). Complexity seems to indicate a 'fear' of emotions or inability to describe their feelings. Metaphors can be used to get to 'warded off' experiences*, 'I suppose I have only been prompted to use pictures when I feel someone is restricted*' (033). With complex patients art work is a way of expressing their inner thoughts (009) and feelings *'communicate how she felt in relation to others and to the world'* (013)

PM3 and PM6 speak of the development of the metaphor, '*using images from the patient'* and '*how it comes to mind'* which in terms of process includes having a non-judgemental approach (PM10). Metaphors '*do conjure up an image'* (047) which arises from the encounter and can be drawn but also created in 'imagination' like a box with feelings and thoughts inside (006) or sketches that *'came to mind for various parts of her SDR*' (026). One responder suggested that we are *'alert to metaphors' from the outset and 'get drawing' with the patient*' (046) using a 'picture' when the patient uses a metaphor that *'is easily translated into a picture'* (101). Asking patients *'how they would symbolise/picture the concept under discussion which they then draw'* (064) seems a straightforward approach, then subsequently exploring how they feel in relation to this.

The context of the metaphor is also important, how it comes to mind '*the colours used'* (009) and '*the wider image as elaborated on in the discussion'* (058). A '*meaningless scrawl on paper may be highly significant and represent a richly detailed and complicated concept'* (058) (PM6). The therapist needs to be vigilant as to the 'power' of '*seeing something about yourself'* (016) whilst at the same time noticing that 'pictures' may offer a 'less painful way for the patient' (009) (PM5).

PM 16-19 include practice considerations that '*that metaphors can distance patients from their emotions'* (PM16), the way the work is undertaken needs to be '*playful*' (PM17), the therapist must avoid *'interpretation'* (PM18) and the picture must '*resonate*' with the patients experience (PM19). PM16 has only one comment but one which seems important '*the therapist can perhaps become overly entranced with the metaphor and collude with the process of distancing'* (047). This speaks of the 'one step removed' nature of emotional working with metaphor that it is necessary to ensure that they resonate with the patient's experiences and not collude with emotional distance. However, in the process of developing a metaphoric position it is important to be '*playful and interesting'* (063) as 058 notes *'metaphor work can be done quickly and can be lightened by describing it as fun experimental, light hearted process'*. '*Working with pictures is a bit like playing with a child, where they decide which picture to use even if it does not make sense to you'* (067) (PM17).

Avoiding interpretation is a core aspect of CAT, because in CAT collaboration and co-construction is practised rather than interpretation, as this can be '*unarguable with'* (087) (PM18). Not imposing therapist's ideas on '*these artistic creation from patient's'* (087) was

noted. It may be that the therapist can offer *'responses and thoughts evoked by the metaphor but not impose meaning'* (048). By avoiding interpretation the therapist joins in with the patient and their work can resonate with the patients experiences *'encouraging an in depth exploration of the potential of the metaphor'* (088), *'what do you think it means?*' (087)

Practical considerations arose from the data, '*having materials to hand'* (PM11) being an obvious option. Also managing not too complex pictures…*'simple not perfect drawings being important'* (PM12) where it would be important to reassure the patient that the '*quality of the picture is irrelevant, only they need to understand what the squiggle represents'* (058). Anxiety regarding artistic ability (PM15) gained a number of references to '*not being arty'* (044), '*being inhibited by their lack of confidence and limitation of art skills'* (013). Reluctance to using PMs was mentioned *'I suppose what I am suggesting rather than drawing out, though sometimes people have talked about 'Pandora's box*'' (006), *'I have not used pictures much'* (078), 'I *have no experience of this other than SDR's'* (016) and *'I'm not sure why not…possibly me feeling it is not allowed'* (011). What seems important was '*checking for fit'* whenever non-verbal tools were used (030).

Two comments on supervision (PM13) suggested that this way of working should be discussed in supervision. *'Supervisors should encourage the use of metaphor*' (024) and '*metaphor can be used in supervision to explore the counter-transference'* (024). Case examples were noted and coded which have been extracted and put into 'case example' cue cards (see Fig72 for examples).

Fig72: Case examples for TP

'Pictorial metaphor, drawing a refuse bag I which the patient can put all the stuff from the past that she wanted to get rid of, it worked for her as this had particular relevance' (003)
An example was where we were drawing a patient's social network in 'rings' representing levels of intimacy. It started to look like a flower and so we used that idea a lot in seeing the picture as representing her social world but also her own potential to flower (043)

Nineteen statements were extrapolated from the data (Fig73), with the member of occurrences within the text coded in support of each statement (Appendix XVIII).

Fig73: example four 'Theme 8 Pictorial metaphor statements'

Theme 8 Pictorial metaphor	occurrence
PM1 Some patients may find pictorial ways of working a more acceptable medium but important that generated from the patients dialogue	10
PM2 Using pictures and images could be particularly useful when working with children and with patients who have difficulties expressing their thoughts	5
PM3 In developing a pictorial metaphor it is useful work with 'images ' that come from the verbal metaphor in the mind's eye then sketch this out on paper with the patient	6
PM4 Using a picture may open a dialogue and extend awareness, particularly with patient who struggle to verbalise inner thoughts.	13

Theme 9 Principles Relationship (PR) and metaphor

Principles relationship and metaphor (44 sources, 117 references) 20 'statement headings' arose. Themes within the statements covered; CAT model, shared understanding, central theme, managing emotions, pragmatic practice steps, choice and listening for metaphor. Most frequent nodes were, shared understanding, CAT model, central theme, emotions, practice, choice, and listening.

Shared understanding was frequently noticed (003, 008, 030, 032, 044, 047, 056, (PR2)). Between the therapist and patient metaphors can, and have to have, a shared understanding. Shared language '*deepen(ed) joint understanding'* (063, (PR3), but metaphor should be checked for understanding (032, 045, 047, 067) to make sense (078) and be '*mutually agreed'* (008). As well as *understanding* of metaphor the therapist's '*empathy and understanding'* for each patient was noted (030). The metaphor had to '*flow freely rather than being imposed'* (064, 049), use the patient's own metaphor and language (065, 091, 046) and be 'jointly constructed' (057, (PR6)). This speaks of the 'alliance' how working with metaphors '*develop and maintain'* (001, 063, 032) and '*can strengthen the therapeutic bond*' (056, (PR3)).

The **CAT model** was mentioned on a number of occasion and in a number of contexts, whereby their use should not compromise the CAT model (101, (PR20)). The ZPD, SDR and RRP's generated a number of others. Working within the patients ZPD was stated as a matter of 'fact' (044, 049, 057, 063, (PR11)), Responder 044 commented '*it is not about having free rein, the art to it is about observing and refining my awareness of the ZPD.'*

Metaphors were used to *'describe feeling states, reciprocal roles…and exits'* (046, 057, 063, 091, (PR13)) and when this occurs to '*consider whether there might be links to the 'SDR or RR's'* (048, 056, 075) and enable recognition of possible collusion with these (056, 049, (PR16)). For example '*on the SDR I have a borderline patient. She will draw her anger as red cat waiting and prowling over the SDR waiting to pounce anytime'* (056). Using metaphors to help with 'exits' have been noted above and an example of 'playing chess' as a way of describing a path towards exits was given, where the metaphor becomes a 'shortcut' to the reformulation (091).

Metaphors as a shorthand or shortcut (008, 091) to a patient's problems and as a **central theme** arose. For example, a metaphor or image, once understood, can act as a '*shorthand,*' an *'encapsulation of that rich and important detail'* (008), and *'form the basis of the whole therapy or a transitory illustration during a session*' (046, (PR4)). Alaos they can capture **emotions** or have the ability to '***engender powerful emotions'*** (036, (PR9)) *'as humans think abstractly metaphor can be used to help give our feelings form or meaning'* (056, (PR19)). Metaphors might be a way of '*distancing oneself from their emotions'* (047). This was seen as '*may or may not be desirable'* (047, PR15)).

Practically attuning to metaphor was described as a way of working, where the first step would be to recognise that *'metaphor is everywhere'* (036 (PR5)) and regularly used in the 'room' (056, 075). In this respect attunement is listening out for metaphor and supporting a patient's curiosity to use metaphor (063, 065, (PR5)). Using metaphor when 'stuck' (056, (PR17)) to recognise manoeuvres in the relationship when seeking exits for example (091) was commented. Being non-judgemental (048, (PR14)), not 'judging' the work or indeed the capacity of the patient to use metaphor (058, (PR14) was also noted.

Comments related to the '*one size does not fit all*', therapists should be selective with patients '*as it is not for everyone'* (036, (PR10)) and has to be relevant (078, 101, (PR18)). The therapist would know this from **listening out** for metaphor and capturing the context of the metaphor (001, (PR1)), and by exploring what they 'associate' and explore the 'meaning' and images created by the metaphor (048m, (PR12)). This can to help the patients to further their '*capacity to think about their difficulties'* (030, 056, (PR7)). On 'pictures', they provide '*an insight into the patients world'* (049), as the emotions can't be expressed in words (051) as if the image can 'sublimate' feelings that '*we may be embarrassed about but are happy to see represented in something pictorial*' (056, (PR12)).

Four examples of the 20 initial statements are provided in text (Fig 74 and Appendix XIX).

Fig74: Theme 9 Principles Relationship and Metaphor

Theme 9 Principles Relationship and Metaphor	occurrences
PR1 Capture something of the **context** in which the metaphor arises	4
PR2 **Shared understanding**	16
PR3 Metaphors can deepen the therapeutic alliance	3
PR4 Can become a shorthand to access problems and understandings	3

Theme 10 Process (PP)

Theme 10 Process (48 sources, 181 references), twenty two statements were extracted from the comments (See Fig 79). Understandably by this stage in the analysis many nodes shared a relationship with nodes in previous themes. Nodes were, therapist and patient derived, shared understanding, therapeutic alliance, CAT model, emotional content and cautions, practice, and playfulness.

Patient Derived - Whether metaphors and PMs are patient derived or offered by the therapist has been commented upon in previous themes. It seems that there is an acceptance for a therapist derived 'giving' of a metaphor (001, 016, 068, 091), using examples '*of what I am thinking about*' (049) but with a caution that it should be 'checked out' with the patient for fit (058, (PP1)). Data suggests that patient derived metaphors are more often worked with (046, 020, 024, 066, 067, 068, 091, 101, (PP10)). Therapists may '*share one of these (metaphors) that comes to mind and see if it resonates with the patient'* (027) offering metaphor as a 'sign' where '*new meanings are formed'* (001, (PP1)).

Shared Understanding - A collaborative and shared understanding generated numerous activity (005, 006, 013, 016, 020, 065, 068, 074, (PP4)), checking out' the metaphor (091), allowing time and space (016) to 'explore' (048, (PP6)) their development. This can lead to '*ah ha or yes that's it'* moments (09, PP15)) where the metaphor is viewed as a 'summary' or shorthand for experiences (032). 032 notes that metaphors *'help to summarise the patients experience in a way that can feel more accessible' (PP20).*

Therapeutic Alliance – Developing metaphor collaboratively, where they make sense, leads to shared understanding (074, 084, 025, 027) had 18 references, being 10% of overall comments (PP9). Alliance factors included allowing space for the metaphor, by being 'open' to the work (005) and the therapist picking up and reflecting back the metaphor (016). The story needs '*telling and retelling'* (058), through a '*shared exploration'* (091) before '*mapping to real life'* (058). Practice would lead to a strong alliance which is *'In the range of experience of both participants when possible'* (012) it is useful to '*emphasise the meaning of utterances'* (026) whilst working together to '*further their own understanding'* (032) but it must be '*meaningful…and resonate'* (101).

Fidelity to the **CAT model** (101) was noted with 26 references being coded to this. In particular noting the relationship of metaphors to RR's and '*drawing images either on or that relate to the SDR'* whilst working within the ZPD (005, 013, 065, PP5). For example, 001 notes '*if the pictorial metaphor becomes meaningful in any way'* it '*may be helpful to link the metaphor to the patients RRP's' (001,027, 066). As* 046 comments *'Metaphors can be used throughout CAT to describe feeling states, reciprocal roles' (PP2).* Other comments note '*good metaphors have a quality, simple without being oversimplified, they might represent quite complex formulatory ideas'* (091). These reciprocal roles form part of a patient's SDR and a number of comments supported linking the SDR with the metaphor (066) where *'I often encourage patients to doodle with me…some patients have been willing to draw their experience…for use on the SDR'* (PP17). The overall sense from this section was that metaphors can be used and are used extensively within CAT but that they needed to be utilised as part of the overall CAT approach and maintain the 'fidelity' of CAT processes (101, PP22).

Emotional Content – Metaphor as an 'emotional' aid enabled communication and can '*get behind defences'* (012) through capturing complexity, '*gaining a deeper understanding'* (092, 072) and enrich descriptions enabling '*access to painful emotions'* (065, PP8). It was suggested that metaphors '*often provide a safer platform to explore feelings'* but that the verbal processing of the 'content' can occur following the session (092, PP11). Cautions were expressed regarding managing emotions that whilst doing this the therapist had to be mindful of utilising *'sophisticated language for therapist ego'* (012) and also that some metaphors can be '*graphic and contain sexual/violent connotations'* (012) or can be 'derogatory' (074, PP12).

These observations are tempered by the recognition that working with metaphor enables emotions to be one step removed, *'it is as if we (patient and therapist) can both 'pretend' that the story is just a story with no personal relevance while it is being developed. But as soon as we start to unpack the story and relate it to actual biographical material, it is no longer possible to keep up that pretence' (058, PP19)*.

Practice comments were numerous initially recognising the importance of recognising metaphors as '*naturally occurring'* (001, 011, 036, 075) or '*arising/flowing freely'* (009,064), '*being alive'* (091) in the encounter (PP7), '*particularly in the early stages of therapy'* (032, 067). Patients are actively encouraged to use their imagination and curiosity (001, 092), with the therapist *'facilitating the exploration of the meaning of the metaphor'* (048, 067). Subsequently metaphor is noticed, attended to more '*as I am looking out for them'* (046). One comment was coded as 'stuck' where exploration *'sometimes helps to stimulate/give permission and encouragement for the patient'* (049). Some practical suggestions as to wording of questions were given…

- *Can you tell me more about the main characters?*
- *Is the main character feeling scared?* (058).

Cautions arose from the data such as trying to use metaphor with every patient as it is '*not reliably possible to know in advance who will work successfully and who will not'* (058). Also using 'cliché' or 'dead' metaphors (012) are '*sapped of meaning'* for the patient (091, PP13). Entwined with this comment is the recognition of letting go of a metaphor when it loses connection (024, PP14). Even though metaphors were seen as naturally occurring it was noted that one needs to '*check for fit'*, using '*do you think*' questions (032, 058), and not assuming what is meant (066, PP16). These cautions reinforce the 'non-judgemental' and 'non-assumptive' approach to working with metaphors (048, PP18) whilst recognising the nature of the 'proximal world' of the patient (091). For example if they live and work in a steel works then their proximal metaphors will most likely relate to this world (PP21).

Playfulness – Being 'creative and playful' was coded three times (001, 003). Comments related to creating an atmosphere where exploration could emerge as well as using this as an opportunity to 'play' with the metaphor itself to gain understanding, '*to wonder but not know'* (048, (PP3)). Twenty two statements were extrapolated from the data (Fig75), and the number of occurrences coded in support of each statement (Appendix XX).

Fig75: Theme 10 Process practice

Theme 10 Process practice	Occurrences
PP1 The **therapist may offer their own metaphor** as a means of creating a 'sign' **i**n which old meanings may become decontextualized and new meanings found	9
PP2 It is helpful to link the metaphor to the **patients RRP's** as they can allow you to represent complex formulatory ideas	13
PP3 It is important to be **creative and playful** when co constructing the pictorial metaphor and reassure that they only have to be 'good enough' drawings	3
PP4 Important to have a **shared understanding** of the metaphor	18

Theme 11 Super vision (S)

Supervision (15 sources, 22 references (Appendix XXI), coding and condensing developed three supervisory questions to be taken forward for rating in R2 (Fig 80). As the approach was novel it would need to be reinforced in supervision (058) and those metaphors could enhance creativity in supervision (013, (S1)). This kind of 'creative work' could be included within CAT training and actively encouraged within supervision (012). Creative work like metaphor working should be discussed in supervision as it can help explore counter transference (024, 056, (S1)), metaphors help bring a patient to mind (005, (S2)), help reflection (009) and *'understanding concepts better and widening my metaphor repertoire'* (016, (S3)). There is evidence that metaphor working is already part of one individual's supervisory practice…

> *'There is a much bigger context here where it seems to me that most of us enter into the use of metaphors and similes all the time in our common speech and communication without considering the degree to which metaphor and simile is being used. To test this out a little I listened to a couple of supervision tapes I was doing with this thought in mind and was not surprised to find that the therapists and patients were both using a great deal of metaphor and simile. "You had just come off a roller coaster when .....", "I'm a sheep when it comes to them" etc.* (036)

Fig76: Theme 11 Supervision

Theme 11 Supervision	occurrence
S1 Bringing patient's metaphors to supervision and enabling a supervisor to see what is happening in the room can often give you a chance to see that you may be **colluding with a patient's RRP**.	6
S2 In supervision an image or metaphor can often help bring a supervisee's **patient to mind in an instance**	3
S3 Asking supervisees to draw how they perceive their patients can help them reflect on where they are in therapy, particularly if they are feeling **stuck**.	3

Theme 12 What is metaphor (W)

Twenty three references from 14 sources spoke about the 'what is' metaphor, the *'it is not me but it relates to me'* (088). Metaphor as a 'sign' (001), offered by and to the therapist to form new meanings and provide a '*rich opportunity to gain a deeper understanding'* of the patients emotions (092); '*I couldn't work the way I do without access to metaphors, using the patients own words'* (067, (W1)). Metaphor was viewed as a means of communication, sharing meanings and holding a dialogue but importantly needed to be generated from the patient's utterances (006, 051, 088, 092), 's*o picking up on this is a quick way to access their assumptions (067).*

Metaphor was a 'bridge' or link between thought and feeling and a way of connecting disparate experiences (012, 027). Metaphor was a less threatening way of discussing difficult things (033, (W2)), enabling greater reflection by the patient because the metaphor allows some emotional distance on the content whilst getting close to the patients emotional self (051, 033, (W3)). Therapists pick up '*metaphors, analogies from the first assessment…will bring to (later) sessions*)' (067). Therapists used *'images/sounds, etc that came to mind to flesh out reciprocal role procedures'* (067, 088) and the patients '*words, colours, pictures… to inform their Traps, Snags and Dilemmas'* (087). Metaphors also appear to '*contribute to the development of more accessible diagrams'* (088, (W4)).

Four main statements emerged from this analysis with a number of supporting references. These are mainly verbatim from the responders and capture the analysis above (Fig77 and Appendix XXII).

Fig77: Theme 12 What is metaphor

Theme 12 What is metaphor	Occurrence
W1 I would say that metaphors used would best be drawn from the **patient's own expressions and utterances**	7
W2 Metaphor or picture can be seen as **a bridge** between what is known subconsciously and what can then be made explicit verbally	6
W3 Utilising metaphors re-enforces the patients **feeling of being understood**, and therapists sense that s/he has a handle on what's going on.	4
W4 Metaphors contribute to the development of **more accessible diagrams**, diagrams that the patient can revisit and constantly alter while keeping a consistent language	6

R1 Step 2 Sorting and categorising

Following on from Step 1 coding of Questions 1, 2, 5, and 6, Questions 3 and 4 were coded as if they were new data.

Q3 What do you think are the 10 most important factors when working effectively with metaphor in CAT – generated 23 themes from 335 items

Q4 What do you think are the 10 most important factors when working effectively with PM in CAT - generated 24 themes from 304 items

The justification for this separate coding was to try to develop a hierarchy of factors whilst enabling triangulation of the data within the data. No statements were generated from this list rather headings. At this stage the Step 1 data analysis was also checked for congruence by the researchers lead supervisor for reliability. A list of words rather than statements were provided for the ten asked for (if they could get to ten). Some answers were the same for both questions where the responder had cut and pasted from one to the other either verbatim or with some additions or deletions. Emerging themes were developed using the same content analysis in Step 1, immersion in data, step by step coding, node generation, and coding to nodes.

A level of validation with the coding in Step 1 was noted as the nodes were similar. This is expected as the researcher was already familiar with coding the data and so contamination of the observer position occurred. This is not considered an error as the data was still coded organically and generated the title of the node for comparison. Appendix XXIII shows the nodes and coding for both questions in two columns. Interestingly the top 10 for each match closely and account for over 63% of coded comments (Fig78). It is not surprising that these frequencies describe the practice of metaphor but also that they speak of the practice of CAT and/or any collaborative therapy.

Fig78: Ten most frequent coding

Shared Understanding	91
Patient Derived	62
Locate to CAT model	60
Therapeutic Alliance	41
Collaborative	36
Willingness to work with metaphor	33
Simplicity	31
Work within ZPD	29
Ongoing	28
Non judgemental	29

There was no attempt to stop or reduce the generation of statements at this step of analysis as it felt important to work with, and understand emerging statement within each theme and for each question.

R1 Step 3 Collapsing and condensing

The next stage of analysis was to combine and collapse these important factors within the statements generated. Statements were aligned against these headlines in order to generate both a list of statements and a sense of the frequency of the statements as measured with the headlines. The statements were subsequently collapsed to 76 statements to take forward to R2.

Fig79: Step 3 analysis process

Step 3: Step 1 and Step 2 statements and themes correlated with each other for similarity and repetition and then condensed to form a new set of statements and themes (116 statements from 37 themes). Statements were distilled and/or if required reworded, then organised into themes and statements for the R2 questionnaire (76 statements).

Once all statements had been managed 76 statements from the initial 127 were highlighted and managed into 7 themes (A-G) correlated with the seven themes of the literature review (Fig80).

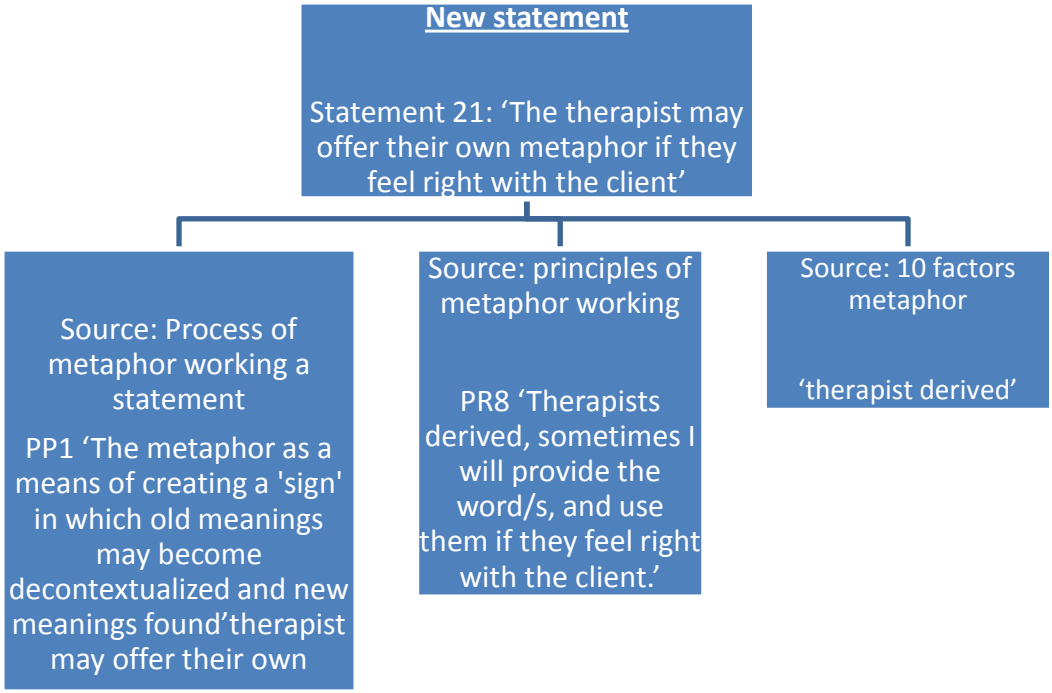
Fig80: Theme frequency vs collapsed frequency

Theme	Frequency (all)	Frequency (collapsed)
Barriers	30	13 (Theme g)
CAT and metaphor	13	5 (Theme a)
Helpfulness	15	18 (Theme e)
Neuroscience	1	-
Pictorial metaphor	19	18 (Theme f)
Principles relationship	20	5 (Theme c)
Process practice	22	14 (Theme d)
Supervision	3	3 (Theme b)
What is metaphor	4	-
Total	127	76

Fig 81 is an example of how one statement emerged form a number of similar statements. Statements were condensed and collapsed if they spoke of the same meaning. These can be seen in full in Appendix XXV.

This was a highly intuitive process and meaning emerged from the significant immersion within the data that the analyses led to. Statements were validated by the supervisory team in order to be triangulated to the data.

Fig81: Collapsing statements example



R2 Questionnaire results and data analysis

Sample

A sample of responders (n=38) were sent a link to an online questionnaire (see Appendix XIII for an example of one statement in the questionnaire) consisting of 76 statements generated from R1 (Appendix XXVII). Demographic data of the sample is on p176-192 of this submission. Responders were selected based on inclusion criterion applied to R1.

Inclusion criterion

- Practising CAT therapist or trainee
- Level of experience post qualification
- Research/scholarly work on subject
- Experience of working with metaphors in clinical practice
- Experienced with working with 'art/pictures' in clinical practice
- Quality of response: Objective evaluation of quality of response (0-5, 0=poor/5=very good)

The researcher wanted to stay as close to the initial protocol as possible but could not reduce numbers using the initial criterion set. A subjective judgement as to the quality of response was made. Responses that appeared to be limited in their data and seemed to suggest a minimal attention to the research topic were managed out. The assumption being that the responder may not have had the relevant expertness or possibly motivation to progress further in the study based on the level of motivation and expertness applied to the R1 questionnaire. This was tricky, as the researcher was grateful for the responses, they provided data, and because the responder had put time aside to complete and return their response. The researcher is mindful of hindsight and with hindsight he could have included all the responders n=48 sample from R1 and allowed for reduction in response based on natural attrition.

Setting consensus bar

Consensus is viewed as setting a percentage level of agreement that ranges from 55 to 100% (Powell 2003). Consensus level is a complex figure to decide upon. Keeney (2011) set a bar at 70% whilst Mir et al. (2012) set consensus as ‘defined as >80% of respondents ranking the statement as ‘4’or ‘5’, on a 1-5 Likert scale in effect taking agreement as passing the bar of neutral.

The researcher experimented with a sliding scale to ascertain levels of consensus starting at 70, then 80 then 90%. 90% seemed overly ambitious and there were no studies in the literature that had set the bar that high, with most being between the 70-80% agreement where agreement is registered above the neutral. Agreement was initially set on the cumulative percentage +/= to 80% on all statements scoring 1, 2 or 3, 80% and above seems to be a generally acceptable level of consensus (Mir et al. 2012). Statistics were run with a power calculation/interval initially of 70% confidence, then 80% confidence (95% p value 5%) then 90% confidence in order to assess the data for rerating in R3. The reliability of non-categorical ratings of two judges is estimated with Pearson’s Correlation coefficient (Cramer 1998, p388). At 80% Cronbach alpha was calculated at 0.93 suggesting confidence in the results. 22 statements fell below the bar and were extrapolated for re-rating.

Powell (2003) notes the importance of indicating the central tendency and dispersion of scores for rounds within a Delphi. Showing the dispersion appears to be important as a ‘bi-modal distribution’ could indicate a disparity in consensus that would otherwise elude the

researcher (Powell 2003). Greatorex and Dexter's (2000) analytical approach to Delphi offers one framework for the management of data generated in this study. The approach uses three graphs the fountain graph (items mean and standards deviation (SD) is plotted), Item graph (the graph plots the mean and SD across appearances) and trajectory graph (a group of items from an identified category and their mean and SD are plotted for each).

Kilner (2011) notes the acceptability of the Cronbach alpha coefficient to assess internal consistency where a score of greater than 0.7 is desirable. Kilner (2011) suggests that to determine the level of agreement between members the data should be analysed using the Kendall coefficient of concordance. This produces a correlation coefficient (W) between 0 and 1 where 1 represents positive correlation and 0 no correlation. The score also indicates the statistical significance (p) of the correlation coefficient. George and Mallery (2003) suggest that anything above Cronbach 'a' of .9 be considered excellent.

Delphi R2 – Frequency Tables

Theme A - Qualities of the therapist

1. **Willingness to work with metaphor is an important factor**

Q1 Willingness R2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	10	31.3	31.3	31.3
	Strongly agree	14	43.8	43.8	75.0
	Agree	8	25.0	25.0	100.0
	Total	32	100.0	100.0	

2. Working with metaphor is enhanced by an understanding of the relevant research literature

Q2 Literature R2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	1	3.1	3.2	3.2
	Strongly agree	6	18.8	19.4	22.6
	Agree	12	37.5	38.7	61.3
	Undecided	6	18.8	19.4	80.6
	Disagree	6	18.8	19.4	100.0
	Total	31	96.9	100.0	
Missing	0	1	3.1		
Total		32	100.0		

(NB: Statements highlighted in RED are those that have not achieved consensus)

3. CAT therapists need to consider whether developing a pictorial metaphor is out with their and/or patient's ZPD

Q3 ZPD R2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	5	15.6	16.1	16.1
	Strongly agree	17	53.1	54.8	71.0
	Agree	6	18.8	19.4	90.3
	Undecided	3	9.4	9.7	100.0
	Total	31	96.9	100.0	
Missing	0	1	3.1		
Total		32	100.0		

4. It is important to be attuned to metaphor in therapy sessions

Q4 Attuned R2

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	10	31.3	31.3	31.3
	Very important	12	37.5	37.5	68.8
	Important	8	25.0	25.0	93.8
	Moderately important	2	6.3	6.3	100.0
	Total	32	100.0	100.0	

5. Allow time and space for patient to describe and develop image/metaphor before moving to analysis and process work

Time and Space

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Almost always true	8	25.0	25.0	25.0
	Usually true	11	34.4	34.4	59.4
	Often true	9	28.1	28.1	87.5
	occasionally true	3	9.4	9.4	96.9
	Sometimes but infrequently true	1	3.1	3.1	100.0
	Total	32	100.0	100.0	

Theme B - Training and Supervision

6. Lack of training in metaphor working limits the use of metaphor in practice

Lack of Training

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	1	3.1	3.1	3.1
	Strongly agree	2	6.3	6.3	9.4
	Agree	15	46.9	46.9	56.3
	Undecided	9	28.1	28.1	84.4
	Disagree	5	15.6	15.6	100.0
	Total	32	100.0	100.0	

7. Metaphors and working with pictorial metaphors need to be discussed in supervision

Discussed Supervision

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	2	6.3	6.3	6.3
	Strongly agree	13	40.6	40.6	46.9
	Agree	16	50.0	50.0	96.9
	Undecided	1	3.1	3.1	100.0
	Total	32	100.0	100.0	

8. In supervision an image or metaphor can often help bring the supervisee's patient to mind in an instance

Supervision

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	3	9.4	9.4	9.4
	Strongly agree	22	68.8	68.8	78.1
	Agree	6	18.8	18.8	96.9
	Undecided	1	3.1	3.1	100.0
	Total	32	100.0	100.0	

Theme C - about the therapeutic relationship

9. The use, understanding and development of metaphor establishes the patterns of communicating in a relationship

Patterns

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Almost always true	4	12.5	12.5	12.5
	Usually true	6	18.8	18.8	31.3
	Often true	16	50.0	50.0	81.3
	occasionally true	4	12.5	12.5	93.8
	Sometimes but infrequently true	2	6.3	6.3	100.0
	Total	32	100.0	100.0	

10. Metaphors can support 'playfulness' in therapy and lead to insights into a patient's problems

Playfulness

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Almost always true	5	15.6	15.6	15.6
	Usually true	12	37.5	37.5	53.1
	Often true	14	43.8	43.8	96.9
	occasionally true	1	3.1	3.1	100.0
	Total	32	100.0	100.0	

11. Using a patient's language shows they are being heard and understood

Patients language

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	6	18.8	18.8	18.8
	Strongly agree	23	71.9	71.9	90.6
	Agree	3	9.4	9.4	100.0
	Total	32	100.0	100.0	

12. It is important to recognise the impact of the verbal processing of metaphors after therapy session

Verbal Processing

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	5	15.6	16.1	16.1
	Very important	9	28.1	29.0	45.2
	Important	13	40.6	41.9	87.1
	Moderately important	4	12.5	12.9	100.0
	Total	31	96.9	100.0	
Missing	0	1	3.1		
Total		32	100.0		

13. It is important to be creative and playful when co-constructing the pictorial metaphor

Playful

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very important	11	34.4	35.5	35.5
	Important	13	40.6	41.9	77.4
	Moderately important	7	21.9	22.6	100.0
	Total	31	96.9	100.0	
Missing	0	1	3.1		
Total		32	100.0		

Theme D - 'In session' process of using metaphor

14. It is important to acknowledge metaphors as naturally occurring and be open to their expression and exploration

Naturally occuring

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	6	18.8	18.8	18.8
	Very important	16	50.0	50.0	68.8
	Important	7	21.9	21.9	90.6
	Moderately important	3	9.4	9.4	100.0
	Total	32	100.0	100.0	

15. It is important to check out with the particular patient if the metaphor is making sense to them

Making sense

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	18	56.3	56.3	56.3
	Very important	13	40.6	40.6	96.9
	Important	1	3.1	3.1	100.0
	Total	32	100.0	100.0	

16. It is important that metaphors are relevant to the patient

Relevance

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	19	59.4	59.4	59.4
	Very important	9	28.1	28.1	87.5
	Important	4	12.5	12.5	100.0
	Total	32	100.0	100.0	

17. It is important to ensure materials are kept confidential

Confidential

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	21	65.6	65.6	65.6
	Very important	6	18.8	18.8	84.4
	Important	5	15.6	15.6	100.0
	Total	32	100.0	100.0	

18. It is important to notice the relational context of the metaphor

Relational context

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	15	46.9	46.9	46.9
	Very important	9	28.1	28.1	75.0
	Important	6	18.8	18.8	93.8
	Moderately important	2	6.3	6.3	100.0
	Total	32	100.0	100.0	

19. It is important to notice the social context of the metaphor

Social context

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	10	31.3	31.3	31.3
	Very important	12	37.5	37.5	68.8
	Important	8	25.0	25.0	93.8
	Moderately important	2	6.3	6.3	100.0
	Total	32	100.0	100.0	

20. It is important to notice the cultural context of the metaphor

Cultural context

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	10	31.3	31.3	31.3
	Very important	12	37.5	37.5	68.8
	Important	6	18.8	18.8	87.5
	Moderately important	4	12.5	12.5	100.0
	Total	32	100.0	100.0	

21. The therapist may offer their own metaphor if they feel it is right with the patient

Therapist metaphor

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	1	3.1	3.1	3.1
	Strongly agree	13	40.6	40.6	43.8
	Agree	16	50.0	50.0	93.8
	Undecided	2	6.3	6.3	100.0
	Total	32	100.0	100.0	

22. The patient could create a metaphor which is not understood by the therapist so important to allow space to explore this

Allow space

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	5	15.6	15.6	15.6
	Strongly agree	19	59.4	59.4	75.0
	Agree	8	25.0	25.0	100.0
	Total	32	100.0	100.0	

23. Metaphors must be grounded in the actual experience of the patient

Grounded

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	4	12.5	12.5	12.5
	Strongly agree	4	12.5	12.5	25.0
	Agree	6	18.8	18.8	43.8
	Undecided	9	28.1	28.1	71.9
	Disagree	8	25.0	25.0	96.9
	Strongly Disagree	1	3.1	3.1	100.0
	Total	32	100.0	100.0	

24. The pictorial metaphor must be meaningful and accessible to the patient and must resonate with the patients experience

Resonate

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	11	34.4	34.4	34.4
	Strongly agree	13	40.6	40.6	75.0
	Agree	7	21.9	21.9	96.9
	Undecided	1	3.1	3.1	100.0
	Total	32	100.0	100.0	

25. Use of metaphor should not compromise fidelity of the CAT model e.g. Used as a way to explore/link patterns to SDR

Fidelity of CAT

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	4	12.5	12.5	12.5
	Strongly agree	6	18.8	18.8	31.3
	Agree	12	37.5	37.5	68.8
	Undecided	7	21.9	21.9	90.6
	Disagree	3	9.4	9.4	100.0
	Total	32	100.0	100.0	

26. It is helpful to link the metaphor to the patient's reciprocal role procedures

Reciprocal role

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	5	15.6	15.6	15.6
	Strongly agree	10	31.3	31.3	46.9
	Agree	16	50.0	50.0	96.9
	Undecided	1	3.1	3.1	100.0
	Total	32	100.0	100.0	

27. Drawing metaphors on the Sequential Diagrammatic Reformulation can be a way to get to unattainable places

SDR

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Almost always true	2	6.3	6.5	6.5
	Usually true	9	28.1	29.0	35.5
	Often true	15	46.9	48.4	83.9
	occasionally true	4	12.5	12.9	96.8
	Sometimes but infrequently true	1	3.1	3.2	100.0
	Total	31	96.9	100.0	
Missing	0	1	3.1		
Total		32	100.0		

Theme E - The potential of using metaphors

28. Metaphors can become a shorthand to access problems and understandings

Shorthand

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Almost always true	6	18.8	18.8	18.8
	Usually true	14	43.8	43.8	62.5
	Often true	12	37.5	37.5	100.0
	Total	32	100.0	100.0	

29. Metaphors are memorable and available for recognition helping to summarise the patient's experience in an accessible way

Memorable

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Almost always true	6	18.8	18.8	18.8
	Usually true	16	50.0	50.0	68.8
	Often true	10	31.3	31.3	100.0
	Total	32	100.0	100.0	

30. A metaphor may acknowledge and contain affect associated with ending

Ending

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Almost always true	1	3.1	3.1	3.1
	Usually true	8	25.0	25.0	28.1
	Often true	16	50.0	50.0	78.1
	occasionally true	7	21.9	21.9	100.0
	Total	32	100.0	100.0	

31. Metaphors can allow you to represent complex formulatory ideas

Formulatory ideas

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Almost always true	6	18.8	18.8	18.8
	Usually true	11	34.4	34.4	53.1
	Often true	14	43.8	43.8	96.9
	occasionally true	1	3.1	3.1	100.0
	Total	32	100.0	100.0	

32. Metaphors can be facilitative because they are one step removed from the actual experiences of the patient

One step removed

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Almost always true	3	9.4	9.4	9.4
	Usually true	8	25.0	25.0	34.4
	Often true	13	40.6	40.6	75.0
	occasionally true	6	18.8	18.8	93.8
	Sometimes but infrequently true	2	6.3	6.3	100.0
	Total	32	100.0	100.0	

33. Metaphors can be powerful and get behind defences

Behind defences

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Almost always true	4	12.5	12.5	12.5
	Usually true	11	34.4	34.4	46.9
	Often true	15	46.9	46.9	93.8
	occasionally true	1	3.1	3.1	96.9
	Sometimes but infrequently true	1	3.1	3.1	100.0
	Total	32	100.0	100.0	

34. Metaphors can be a bridge between thoughts and feelings

Bridge

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Almost always true	6	18.8	20.7	20.7
	Usually true	10	31.3	34.5	55.2
	Often true	12	37.5	41.4	96.6
	occasionally true	1	3.1	3.4	100.0
	Total	29	90.6	100.0	
Missing	0	3	9.4		
Total		32	100.0		

35. A metaphor may be helpful to succinctly sum up an overall theme in the reformulation

Succinctly sum up

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Almost always true	3	9.4	9.4	9.4
	Usually true	18	56.3	56.3	65.6
	Often true	10	31.3	31.3	96.9
	occasionally true	1	3.1	3.1	100.0
	Total	32	100.0	100.0	

36. It is as if we (patient and therapist) can both pretend that the story (metaphor) is just a story

Just a story

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Almost always true	1	3.1	3.1	3.1
	Usually true	3	9.4	9.4	12.5
	Often true	7	21.9	21.9	34.4
	occasionally true	8	25.0	25.0	59.4
	Sometimes but infrequently true	5	15.6	15.6	75.0
	Usually not true	8	25.0	25.0	100.0
	Total	32	100.0	100.0	

37. Metaphors can help when we are 'stuck' and create new possibilities

Stuck

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Almost always true	2	6.3	6.3	6.3
	Usually true	12	37.5	37.5	43.8
	Often true	16	50.0	50.0	93.8
	occasionally true	1	3.1	3.1	96.9
	Usually not true	1	3.1	3.1	100.0
	Total	32	100.0	100.0	

38. Metaphors can be a means of containing powerful emotions in response to reciprocal role procedures

Containing

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Almost always true	4	12.5	12.5	12.5
	Usually true	13	40.6	40.6	53.1
	Often true	12	37.5	37.5	90.6
	occasionally true	3	9.4	9.4	100.0
	Total	32	100.0	100.0	

39. Focussing on metaphors demonstrates to the patient that the details of their experience are important and worthy of note

Experience important

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Almost always true	2	6.3	6.3	6.3
	Usually true	10	31.3	31.3	37.5
	Often true	14	43.8	43.8	81.3
	occasionally true	4	12.5	12.5	93.8
	Usually not true	2	6.3	6.3	100.0
	Total	32	100.0	100.0	

40. Metaphors allow space for transference and counter transference to emerge

Transference

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	8	25.0	25.0	25.0
	Agree	14	43.8	43.8	68.8
	Undecided	10	31.3	31.3	100.0
	Total	32	100.0	100.0	

41. Metaphors can enable recognition of collusion with patients' reciprocal role procedures

Collusion

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	5	15.6	15.6	15.6
	Agree	12	37.5	37.5	53.1
	Undecided	15	46.9	46.9	100.0
	Total	32	100.0	100.0	

42. Working with metaphors has the potential to enhance the therapeutic alliance

Enhance alliance

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	3	9.4	9.4	9.4
	Strongly agree	20	62.5	62.5	71.9
	Agree	7	21.9	21.9	93.8
	Undecided	2	6.3	6.3	100.0
	Total	32	100.0	100.0	

43. Metaphors can help in establishing a collaborative working relationship with the patient

Working relationship

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	3	9.4	9.4	9.4
	Strongly agree	19	59.4	59.4	68.8
	Agree	10	31.3	31.3	100.0
	Total	32	100.0	100.0	

44. Metaphors can develop and extend our therapeutic understanding

Develop and extend

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	3	9.4	9.4	9.4
	Strongly agree	15	46.9	46.9	56.3
	Agree	14	43.8	43.8	100.0
	Total	32	100.0	100.0	

45. Metaphors can capture a central theme in the patient's dialogue

Central theme

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	4	12.5	12.5	12.5
	Strongly agree	22	68.8	68.8	81.3
	Agree	6	18.8	18.8	100.0
	Total	32	100.0	100.0	

Theme F - On Pictorial metaphors

46. It is important that the process of developing the pictorial metaphor is not judgemental

Non judgemental

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	18	56.3	56.3	56.3
	Very important	10	31.3	31.3	87.5
	Important	3	9.4	9.4	96.9
	Moderately important	1	3.1	3.1	100.0
	Total	32	100.0	100.0	

47. It's important to pay attention to the representative aspect of a pictorial metaphor as well as the colours used

Representative aspect colour

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	9	28.1	30.0	30.0
	Very important	7	21.9	23.3	53.3
	Important	12	37.5	40.0	93.3
	Moderately important	2	6.3	6.7	100.0
	Total	30	93.8	100.0	
Missing	0	2	6.3		
Total		32	100.0		

48. It's important to pay attention to the representative aspect of a pictorial metaphor as well as the way it comes to mind

Representative aspect mind

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	9	28.1	31.0	31.0
	Very important	7	21.9	24.1	55.2
	Important	11	34.4	37.9	93.1
	Moderately important	2	6.3	6.9	100.0
	Total	29	90.6	100.0	
Missing	0	3	9.4		
Total		32	100.0		

49. It's important to pay attention to the representative aspect of a pictorial metaphor as well as the way it was made

Representative aspect made

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	10	31.3	34.5	34.5
	Very important	6	18.8	20.7	55.2
	Important	9	28.1	31.0	86.2
	Moderately important	3	9.4	10.3	96.6
	Of little importance	1	3.1	3.4	100.0
	Total	29	90.6	100.0	
Missing	0	3	9.4		
Total		32	100.0		

50. It's important to pay attention to the representative aspect of a pictorial metaphor as well as the context it arose

Representative aspect arose

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	10	31.3	34.5	34.5
	Very important	7	21.9	24.1	58.6
	Important	11	34.4	37.9	96.6
	Moderately important	1	3.1	3.4	100.0
	Total	29	90.6	100.0	
Missing	0	3	9.4		
Total		32	100.0		

51. It is important to use words and images that the patient has brought to the session

Words and images

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	7	21.9	21.9	21.9
	Very important	18	56.3	56.3	78.1
	Important	4	12.5	12.5	90.6
	Moderately important	3	9.4	9.4	100.0
	Total	32	100.0	100.0	

52. It is important to reassure the patient that they only have to be 'good enough' drawings

Good enough

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	11	34.4	35.5	35.5
	Very important	11	34.4	35.5	71.0
	Important	7	21.9	22.6	93.5
	Moderately important	1	3.1	3.2	96.8
	Of little importance	1	3.1	3.2	100.0
	Total	31	96.9	100.0	
Missing	0	1	3.1		
Total		32	100.0		

53. It is important to link the 'picture' to the SDR and reformulation to ensure integration

Link to SDR

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	7	21.9	22.6	22.6
	Very important	12	37.5	38.7	61.3
	Important	11	34.4	35.5	96.8
	Moderately important	1	3.1	3.2	100.0
	Total	31	96.9	100.0	
Missing	0	1	3.1		
Total		32	100.0		

54. Providing simple not 'perfect' drawings can help to reduce transference of the therapist being seen as the expert

Therapist as expert

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Almost always true	5	15.6	16.7	16.7
	Usually true	8	25.0	26.7	43.3
	Often true	12	37.5	40.0	83.3
	occasionally true	4	12.5	13.3	96.7
	Sometimes but infrequently true	1	3.1	3.3	100.0
	Total	30	93.8	100.0	
Missing	0	2	6.3		
Total		32	100.0		

55. One reason CAT therapists don't work with pictorial metaphor is a lack of confidence in their artistic ability

Confidence

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Usually true	3	9.4	9.7	9.7
	Often true	8	25.0	25.8	35.5
	occasionally true	12	37.5	38.7	74.2
	Sometimes but infrequently true	4	12.5	12.9	87.1
	Usually not true	3	9.4	9.7	96.8
	Almost never true	1	3.1	3.2	100.0
	Total	31	96.9	100.0	
Missing	0	1	3.1		
Total		32	100.0		

56. A pictorial metaphor can act like a shorthand to Target Problem procedures when the pattern is repeated

Shorthand

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Almost always true	2	6.3	6.9	6.9
	Usually true	10	31.3	34.5	41.4
	Often true	13	40.6	44.8	86.2
	occasionally true	4	12.5	13.8	100.0
	Total	29	90.6	100.0	
Missing	0	3	9.4		
Total		32	100.0		

57. Pictures may open a dialogue and extend awareness, particularly with patient's struggling to verbalise inner thoughts

Extend awareness

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Almost always true	7	21.9	22.6	22.6
	Usually true	13	40.6	41.9	64.5
	Often true	9	28.1	29.0	93.5
	occasionally true	2	6.3	6.5	100.0
	Total	31	96.9	100.0	
Missing	0	1	3.1		
Total		32	100.0		

58. Some patient's may find pictorial ways of working a more acceptable medium

More acceptable medium

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Almost always true	1	3.1	3.1	3.1
	Usually true	9	28.1	28.1	31.3
	Often true	11	34.4	34.4	65.6
	occasionally true	10	31.3	31.3	96.9
	Sometimes but infrequently true	1	3.1	3.1	100.0
	Total	32	100.0	100.0	

59. In developing a pictorial metaphor it is useful to work with 'images' that come from the verbal metaphor and sketch out

Sketch verbal metaphor

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	8	25.0	25.8	25.8
	Agree	11	34.4	35.5	61.3
	Undecided	9	28.1	29.0	90.3
	Disagree	2	6.3	6.5	96.8
	Strongly Disagree	1	3.1	3.2	100.0
	Total	31	96.9	100.0	
Missing	0	1	3.1		
Total		32	100.0		

60. It is useful to have drawing/art materials available

Art materials

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	2	6.3	6.5	6.5
	Strongly agree	7	21.9	22.6	29.0
	Agree	16	50.0	51.6	80.6
	Undecided	4	12.5	12.9	93.5
	Disagree	2	6.3	6.5	100.0
	Total	31	96.9	100.0	
Missing	0	1	3.1		
Total		32	100.0		

61. Pictorial metaphors are most effective when developed collaboratively

Developed collaboratively

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	6	18.8	19.4	19.4
	Strongly agree	10	31.3	32.3	51.6
	Agree	7	21.9	22.6	74.2
	Undecided	6	18.8	19.4	93.5
	Disagree	2	6.3	6.5	100.0
	Total	31	96.9	100.0	
Missing	0	1	3.1		
Total		32	100.0		

62. Not all therapists will be comfortable with non verbal metaphors so it is important to check for fit when they are used

Comfortable

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	1	3.1	3.2	3.2
	Strongly agree	8	25.0	25.8	29.0
	Agree	18	56.3	58.1	87.1
	Undecided	2	6.3	6.5	93.5
	Disagree	2	6.3	6.5	100.0
	Total	31	96.9	100.0	
Missing	0	1	3.1		
Total		32	100.0		

63. Using pictures/images can be useful when working with children and patient's having difficulty expressing their thoughts

Expressing thoughts

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	4	12.5	12.5	12.5
	Strongly agree	15	46.9	46.9	59.4
	Agree	10	31.3	31.3	90.6
	Undecided	3	9.4	9.4	100.0
	Total	32	100.0	100.0	

Theme G - The potential downside of using metaphors and necessary cautions

64. Metaphor working might be hindered if there is no clear rationale for using this approach

Rationale

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	2	6.3	6.3	6.3
	Agree	17	53.1	53.1	**59.4**
	Undecided	10	31.3	31.3	90.6
	Disagree	3	9.4	9.4	100.0
	Total	32	100.0	100.0	

65. Working with too many metaphors can hinder understanding

Too many

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	1	3.1	3.1	3.1
	Strongly agree	11	34.4	34.4	37.5
	Agree	16	50.0	50.0	87.5
	Undecided	4	12.5	12.5	100.0
	Total	32	100.0	100.0	

66. Metaphors can often engender powerful emotions and once acquired they may be hard to contain

Powerful emotions

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	4	12.5	12.5	12.5
	Agree	5	15.6	15.6	28.1
	Undecided	10	31.3	31.3	59.4
	Disagree	12	37.5	37.5	96.9
	Strongly Disagree	1	3.1	3.1	100.0
	Total	32	100.0	100.0	

67. There is a potential risk of using a metaphor to avoid or un-name difficult things

Unname

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	3	9.4	9.4	9.4
	Agree	11	34.4	34.4	43.8
	Undecided	11	34.4	34.4	78.1
	Disagree	7	21.9	21.9	100.0
	Total	32	100.0	100.0	

68. It is necessary to caution against narcissistic admiration of how 'arty and clever' the therapist is

Narcissistic

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	5	15.6	15.6	15.6
	Strongly agree	8	25.0	25.0	40.6
	Agree	13	40.6	40.6	81.3
	Undecided	4	12.5	12.5	93.8
	Disagree	2	6.3	6.3	100.0
	Total	32	100.0	100.0	

69. CAT therapists must avoid offering interpretation of a patient's metaphors but seek to deepen the patient's description

Interpretation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In all cases	4	12.5	12.5	12.5
	Strongly agree	6	18.8	18.8	31.3
	Agree	9	28.1	28.1	59.4
	Undecided	8	25.0	25.0	84.4
	Disagree	5	15.6	15.6	100.0
	Total	32	100.0	100.0	

70. Consideration of the patient's previous experience with 'art' should be made as their previous experience may be a block

Art experience

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	1	3.1	3.2	3.2
	Agree	18	56.3	58.1	61.3
	Undecided	10	31.3	32.3	93.5
	Disagree	2	6.3	6.5	100.0
	Total	31	96.9	100.0	
Missing	0	1	3.1		
Total		32	100.0		

71. It is important to be aware that metaphors may have pejorative implications or symbolism and avoid collusion with that

Pejorative

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	3	9.4	9.4	9.4
	Very important	8	25.0	25.0	34.4
	Important	12	37.5	37.5	71.9
	Moderately important	7	21.9	21.9	93.8
	Of little importance	2	6.3	6.3	100.0
	Total	32	100.0	100.0	

72. It is important not to make prior assumptions and jump to conclusions when working with a patient's metaphor

Prior assumptions

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	13	40.6	40.6	40.6
	Very important	13	40.6	40.6	81.3
	Important	6	18.8	18.8	100.0
	Total	32	100.0	100.0	

73. It is important to let go of the metaphor when it loses connection for the patient

Let go

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	7	21.9	21.9	21.9
	Very important	13	40.6	40.6	62.5
	Important	9	28.1	28.1	90.6
	Moderately important	3	9.4	9.4	100.0
	Total	32	100.0	100.0	

74. It is important to be selective with the patients' you use metaphor with as one size does not fit all

Selective

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always important	8	25.0	25.0	25.0
	Very important	5	15.6	15.6	40.6
	Important	15	46.9	46.9	87.5
	Moderately important	3	9.4	9.4	96.9
	Unimportant	1	3.1	3.1	100.0
	Total	32	100.0	100.0	

75. It may be that metaphors are nothing but a diverting side line

Diverting side-line

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	occasionally true	9	28.1	28.1	28.1
	Sometimes but infrequently true	6	18.8	18.8	46.9
	Usually not true	14	43.8	43.8	90.6
	Almost never true	3	9.4	9.4	100.0
	Total	32	100.0	100.0	

76. The centrality of the CAT model and its focus on verbal expressions might hinder working with pictorial metaphor

Q76 Focus on verbal CAT

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Often true	2	6.3	6.3	6.3
	occasionally true	9	28.1	28.1	34.4
	Sometimes but infrequently true	5	15.6	15.6	50.0
	Usually not true	14	43.8	43.8	93.8
	Almost never true	2	6.3	6.3	100.0
	Total	32	100.0	100.0	

Inter-rater reliability (agreement) for all 76 statements, for the 54 that were 80% and one for the 22 that were below the bar. This is interesting to note the responders agreement for the initial survey and for rerating the survey, in order to validate the decision to sort a bar at 80%. Of note is the internal consistency for the statements. For example, for the whole sample the Cronbach for 76 (R2) is 0.91 and the statements over 80% achieved 0.93 yet for the excluded statements in R2 the Cronbach was 0.53 and R3 0.62.

R2 Qualitative comments

A number of helpful considerations for developing this metaphor work within CAT have arisen from the qualitative comments to the questionnaire relating to the process and use of metaphor; some related to specific questions; some with respect to the language used to construct the sentences; others were more about the way metaphors were used; and others spoke about the responders ability to answer questions. One overall comment was '*Completing the survey has made me think more about issues with metaphor I hadn't considered before'* (11620) which is good to hear AR in 'action' so to speak.

Process and use of metaphor - Having read and re-read these comments a number of times they speak of the process of managing and working in the TE with metaphor. There is also a degree of congruence with specific questions formulated from R1 analysis which may serve to support the analysis made from this round. Because of these factors it seems an appropriate way to present the statement and then the clarifying comment.

I am mindful of the analysis involved in the development of each statement but they did seem to clarify what the responders were initially stating in their R1 response. As this study is designed to add to the body of literature on CAT and metaphors it is pleasing to see both clarification and an individual's validation of their own practice within these comments. However, there is also a note of professional boundaries regarding art therapy and other therapies incorporating art (comment re S55). I am mindful of this and have had a response to a paper published about this research regarding the role of art therapy and CAT that I have responded to. It was never my intention to develop CAT therapists as art therapists as I am not qualified to do so. It was merely to help expand the model to understand and undertake a deliberate step, in the recognition of the importance that metaphor and PM can have when worked with in the TE, either as a strategic or tactical approach.

Responders comments on specific questions – I have dealt with the specific responses to questions in the previous paragraphs but there were some particular observations of note. Although two responders felt the questions were good (11640) and interesting (11606). There were some responders who avoided questions or found it hard to rate questions because of the *language* used or the type of patient they were thinking of. For example (11625) thought some questions (not specified) 'confusing'.

Responder 11636 noted, '*I wanted to remove an answer and leave unanswered, but that wasn't possible. I felt there was not enough clarity about what a metaphor was and if all images are seen as metaphors? It was unclear if the metaphors were only drawn by the therapist in one set of questions or if it was an assumption most of the time in the questions asked'.* Whilst I appreciate the comment I can't fully accept its salience as the study was about metaphors and images and the supporting information made it clear what was what. However, as 11610 notes '*here is no final word and there is no final metaphor*' which I agree, and the work the responders have provided have left me with a significant body of knowledge to add to the 'dialogue' rather than having a final word. I think both these comments speak about the value of the study in clarifying what is metaphor and PM and opening a specific dialogue within CAT about the topic. Responder 11613 stated '*Hope the research will lead to more dialogue in training, CPD and Reformulation about working with metaphor and pictorial metaphor in CAT.'*

Decisions in managing data

A number of decisions when managing the data were made. The first problem was that Survey 2 showed a curious number of responses. There were 42 unique identifiers in the range shown up on survey2 '11600-11642' yet there were only 38 potential responders. It may be that the individual logged on to the survey then logged out due to interruptions (an occurrence that has happened to the researcher) thus creating an 'identifier' but no data. These accounted for identifiers 11609, 11617, 11618, 11619, 11626, 11641 (n=6).

The second problem was some responses showing up in the survey had no data next to them or no name/contact details to return R3 to them. These were responses 11614, 11616, 11623, 11629 (n=4), a decision had to be made as to whether to include these, in order to maintain as much data as possible, or to exclude them. The decision was made to remove from the data set because it was deemed that the data would be unusable going forward.

The third problem that applied to the usable n=32 data set was that because there was an option within the software to miss answering a question there were blanks (coded as 0). Again a decision had to be made regarding this 'data'. In order to maintain as much integrity as possible these statements were coded as '0' within SPSS. The remaining statements rated by the individual were kept in the database and the 'missing' data was managed by SPSS as a blank. This is an acceptable approach in managing data as it maintains as much of the data as possible.

In order to understand some of the reasons why there were blanks there were some helpful comments made by the responders. I recognise that despite having support to manage the online statements my skill level in ensuring all were completed was left wanting. Responders 11615, 11640, 11620, 11628 and 11630 who left some statements stated reasons for this as…

- *'it feels too 'cognitive' to separate out thoughts from feelings*. (11615)
- *'I couldn't understand the statements'* (11620)
- *'as there was no option to enter 'undecided' or 'don't know'*(11628)
- *'I've left some questions blank because I have little experience of working with the 'pictorial' aspect of metaphors'* (11630)
- *'some of the questions seem to assume a shared/common/coherent practice of*

'working with (pictorial) metaphor in CAT' that I'm not sure exists - my own practice with is much more ad-hoc and opportunistic, and so makes some of these questions difficult to answer' (11630)

In order to check the statistical variability this caused for the overall data an analyses using blanks coded as '0' was undertaken which appeared to show little variance on the overall Cronbach alpha scores.

Round 3

Decisions had to be made about the content of R3, whether to repeat all 76 statements or to exclude responses 80% in agreement. Accepting the 80% agreement bar would leave 22 statements for rerating. The literature suggests no clear approach to repeat Delphi rounds. Keeney et al. (2011) note that re-rating all the questions enables each statement to get an equal chance to be re rated to gain consensus at the highest level. The disadvantage is that the questionnaire will not get shorter and so subsequently the researcher might lose participant interest. The decision was to resend the 22 statements falling below the 'consensus' bar creating an opportunity to rerate previous scores in the light of the overall picture which is considered an important element in the move towards consensus (Powell 2003).

Summary of Procedure for R3

Statistical guidance suggests that statements for repeat rounds that have reached consensus 'should have their mean calculated and the mean should then be used to rank statements in order of importance' (Keeney et al. 2011, p90). One consideration was to rank each statement in relation to the percentage of strongly agree, agree etc. In doing this it made statistical analysis overly complicated as what I was looking for was agreement over the mid-point. Results are not discriminated between distances away from the mid-point so maintaining fidelity with the weighting measured.

Statements that received less than 80% agreement were constructed into an online survey. Each responder received a unique set of results for the statement for rerating indicating the mean median and mode for the statement and their individual score. The results were presented in this way so that any changes in rating can be identified and commented upon. Transparency of the data can then be managed and any comments that relate directly to the statement can be captured.

Delphi R3 frequency tables

Theme A - Qualities of the therapist

2. Working with metaphor is enhanced by an understanding of the relevant research literature

Q2 Literature R3

		Frequency	Percent	Valid Percent	Cumulative Percent	R2 rating
Valid	Strongly agree	6	22.2	22.2	22.2	22.6
	Agree	13	48.1	48.1	70.4	61.3
	Undecided	6	22.2	22.2	92.6	80.6
	Disagree	2	7.4	7.4	100.0	100.0
	Total	27	100.0	100.0		

Theme B - Training and Supervision

6. Lack of training in metaphor working limits the use of metaphor in practice

Q6 Lack of Training R3

		Frequency	Percent	Valid Percent	Cumulative Percent	R2 rating
Valid	Strongly agree	5	18.5	18.5	18.5	9.4
	Agree	12	44.4	44.4	63.0	56.3
	Undecided	5	18.5	18.5	81.5	84.4
	Disagree	4	14.8	14.8	96.3	100.0
	Strongly Disagree	1	3.7	3.7	100.0	
	Total	27	100.0	100.0		

Theme C - about the therapeutic relationship

13. It is important to be creative and playful when co-constructing the pictorial metaphor

Q13 Creative and Playful R3

		Frequency	Percent	Valid Percent	Cumulative Percent	R2
Valid	Very important	7	25.9	25.9	25.9	35.5
	Important	15	55.6	55.6	81.5	77.4
	Moderately important	4	14.8	14.8	96.3	100.0
	Never important	1	3.7	3.7	100.0	
	Total	27	100.0	100.0		

Theme D 'In session' process of using metaphor

23. Metaphors must be grounded in the actual experience of the client

Q23 Metaphors must be grounded in the actual experience of the patient

		Frequency	Percent	Valid Percent	Cumulative Percent	R2
Valid	In all cases	3	11.1	11.1	11.1	12.5
	Strongly agree	10	37.0	37.0	48.1	25.0
	Agree	7	25.9	25.9	**74.1**	**43.8**
	Undecided	3	11.1	11.1	85.2	71.9
	Disagree	4	14.8	14.8	100.0	96.9
	Total	27	100.0	100.0		

25. Use of metaphor should not compromise fidelity of the CAT model e.g. Used as a way to explore/link patterns to SDR

Q25 Fidelity of CAT R3

		Frequency	Percent	Valid Percent	Cumulative Percent	R2
Valid	In all cases	1	3.7	3.7	3.7	12.5
	Strongly agree	8	29.6	29.6	33.3	31.3
	Agree	11	40.7	40.7	**74.1**	**68.8**
	Undecided	5	18.5	18.5	92.6	90.6
	Disagree	1	3.7	3.7	96.3	100.0
	Strongly Disagree	1	3.7	3.7	100.0	
	Total	27	100.0	100.0		

Theme E - The potential of using metaphors

30. A metaphor may acknowledge and contain affect associated with ending

Q30 Contain affect associated with Ending R3

		Frequency	Percent	Valid Percent	Cumulative Percent	R2
	Almost always true	1	3.1	3.1		3.1
Valid	Usually true	3	11.1	11.1	11.1	28.1
	Often true	16	59.3	59.3	**70.4**	**78.1**
	occasionally true	8	29.6	29.6	100.0	100.0
	Total	27	100.0	100.0		

32. Metaphors can be facilitative because they are one ›ved from the actual experiences of the client

Q32 One step removed R3

		Frequency	Percent	Valid Percent	Cumulative Percent	R2
Valid	Almost always true	3	11.1	11.1	11.1	9.4
	Usually true	10	37.0	37.0	48.1	34.4
	Often true	11	40.7	40.7	88.9	**75.0**
	occasionally true	3	11.1	11.1	100.0	93.8
	Sometimes but infrequently true					100.0
	Total	27	100.0	100.0		

36. It is as if we (client and therapist) can both pretend that the ‹ aphor) is just a story

Q36 Just a story R3

		Frequency	Percent	Valid Percent	Cumulative percent	R2
	Almost always true					3.1
Valid	Usually true	2	7.4	7.4	7.4	12.5
	Often true	2	7.4	7.4	14.8	34.4
	occasionally true	8	29.6	29.6	44.4	59.4
	Sometimes but infrequently true	7	25.9	25.9	70.4	75.0
	Usually not true	8	29.6	29.6	100	100.0
	Total	27	100.0	100.0		

40. Metaphors allow space for transference and counter transference to emerge

Q40 Transference R3

		Frequency	Percent	Valid Percent	Cumulative Percent	R2
Valid	Strongly agree	8	29.6	29.6	29.6	25.0
	Agree	17	63.0	63.0	**92.6**	**68.8**
	Undecided	2	7.4	7.4	100.0	100.0
	Total	27	100.0	100.0		

41. Metaphors can enable recognition of collusion with Client's reciprocal role procedures **Q41 Collusion R3**

		Frequency	Percent	Valid Percent	Cumulative Percent	R2
Valid	Strongly agree	4	14.8	14.8	14.8	15.6
	Agree	16	59.3	59.3	**74.1**	**53.1**
	Undecided	7	25.9	25.9	100.0	100.0
	Total	27	100.0	100.0		

Theme F - On Pictorial metaphors

55. One reason CAT therapists don't work with pictorial metaphor is a lack of confidence in their artistic ability

Q55 Confidence R3

		Frequency	Percent	Valid Percent	Cumulative Percent	R2
Valid	Usually true	2	7.4	7.4	7.4	9.7
	Often true	7	25.9	25.9	**33.3**	**35.5**
	occasionally true	13	48.1	48.1	**81.5**	**74.2**
	Sometimes but infrequently true	5	18.5	18.5	100.0	87.1
	Total	27	100.0	100.0		

58. Some client's may find pictorial ways of working a more acceptable medium

Q58 More acceptable medium R3

		Frequency	Percent	Valid Percent	Cumulative Percent	R2
Valid	Almost always true	1	3.7	3.7	3.7	3.1
	Usually true	1	3.7	3.7	7.4	31.3
	Often true	14	51.9	51.9	**59.3**	**65.6**
	occasionally true	9	33.3	33.3	92.6	96.9
	Sometimes but infrequently true	2	7.4	7.4	100.0	100.0
	Total	27	100.0	100.0		

Responder 11982 noted that the statement was *'written in a vague way ie 'some patients find...' and to then rate this as 'usually' can be a little confusing as it is almost like a double-negative, only a double-vagueness. If the question were firmer eg 'patients find ...' then it is easier to say yes, no, usually or sometimes with greater confidence'* (11982).

59. In developing a pictorial metaphor it is useful to work with 'images' that come from the verbal metaphor and sketch out

Q59 Sketch verbal metaphor R3

		Frequency	Percent	Valid Percent	Cumulative Percent	R2
Valid	In all cases	1	3.7	3.7	3.7	
	Strongly agree	5	18.5	18.5	22.2	25.8
	Agree	11	40.7	40.7	**63.0**	**61.3**
	Undecided	8	29.6	29.6	92.6	90.3
	Disagree	1	3.7	3.7	96.3	96.8
	Strongly Disagree	1	3.7	3.7	100.0	100.0
	Total	27	100.0	100.0		

61. Pictorial metaphors are most effective when developed collaboratively

		Frequency	Percent	Valid Percent	Cumulative Percent	R2
Valid	In all cases	4	14.8	14.8	14.8	19.4
	Strongly agree	13	48.1	48.1	63.0	51.6
	Agree	7	25.9	25.9	88.9	**74.2**
	Undecided	2	7.4	7.4	96.3	93.5
	Literally under no circumstances	1	3.7	3.7	100.0	100.0
	Total	27	100.0	100.0		

Theme G - The potential downside of using metaphors and necessary cautions

64. Metaphor working might be hindered if there is no clear ratic sing this approach

		Frequency	Percent	Valid Percent	Cumulative Percent	R2
Valid	Strongly agree	3	11.1	11.1	11.1	6.3
	Agree	14	51.9	51.9	**63.0**	**59.4**
	Undecided	8	29.6	29.6	92.6	90.6
	Disagree	2	7.4	7.4	100.0	100.0
	Total	27	100.0	100.0		

66. Metaphors can often engender powerful emotions and once acquired they may be hard to contain

		Frequency	Percent	Valid Percent	Cumulative Percent	R2
Valid	Strongly agree	1	3.7	3.7	3.7	12.5
	Agree	10	37.0	37.0	**40.7**	**28.1**
	Undecided	6	22.2	22.2	63.0	59.4
	Disagree	9	33.3	33.3	96.3	96.9
	Strongly Disagree	1	3.7	3.7	100.0	100.0
	Total	27	100.0	100.0		

67. There is a potential risk of using a metaphor to avoid or un-name difficult things

		Frequency	Percent	Valid Percent	Cumulative Percent	R2
Valid	Strongly agree	1	3.7	3.7	3.7	9.4
	Agree	14	51.9	51.9	55.6	43.8
	Undecided	5	18.5	18.5	74.1	78.1
	Disagree	7	25.9	25.9	100.0	100.0
	Total	27	100.0	100.0		

69. CAT therapists must avoid offering interpretation of a client's metaphors but seek to deepen the client's description

Q69 Avoid Interpretation R3

		Frequency	Percent	Valid Percent	Cumulative Percent	R2
	In all cases	3	11.1	11.1	11.1	12.5
	Strongly agree	1	3.7	3.7	14.8	31.3
	Agree	11	40.7	40.7	**55.6**	**59.4**
Valid	Undecided	10	37.0	37.0	92.6	84.4
	Disagree	1	3.7	3.7	96.3	100.0
	Strongly Disagree	1	3.7	3.7	100.0	
	Total	27	100.0	100.0		

70. Consideration of the client's previous experience with 'art' should be made as their previous experience may be a block

Q70 Art experience R3

		Frequency	Percent	Valid Percent	Cumulative Percent	R2
	Strongly agree	2	7.4	7.4	7.4	3.2
	Agree	18	66.7	66.7	**74.1**	**61.3**
Valid	Undecided	5	18.5	18.5	92.6	93.5
	Disagree	2	7.4	7.4	100.0	100.0
	Total	27	100.0	100.0		

71. It is important to be aware that metaphors may have pejorative implications or symbolism and avoid collusion with that

Q71 Pejorative implications R3

		Frequency	Percent	Valid Percent	Cumulative Percent	R2
	Always important	3	11.1	11.5	11.5	9.4
	Very important	4	14.8	15.4	26.9	34.4
	Important	12	44.4	46.2	**73.1**	**71.9**
Valid	Moderately important	5	18.5	19.2	92.3	93.8
	Of little importance	2	7.4	7.7	100.0	100.0
	Total	26	96.3	100.0		
Missing	0	1	3.7			
Total		27	100.0			

75. It may be that metaphors are nothing but a diverting side line

Q75 Diverting side line R3

		Frequency	Percent	Valid Percent	Cumulative Percent	R2
Valid	occasionally true	4	14.8	14.8	**14.8**	**28.1**
	Sometimes but infrequently true	6	22.2	22.2	37.0	46.9
	Usually not true	14	51.9	51.9	88.9	90.6
	Almost never true	3	11.1	11.1	100.0	100.0
	Total	27	100.0	100.0		

NB: double negative statement - R2= 72%, R3=85.2%

76. The centrality of the CAT model and its focus on v expressions might hinder working with pictorial metaphor

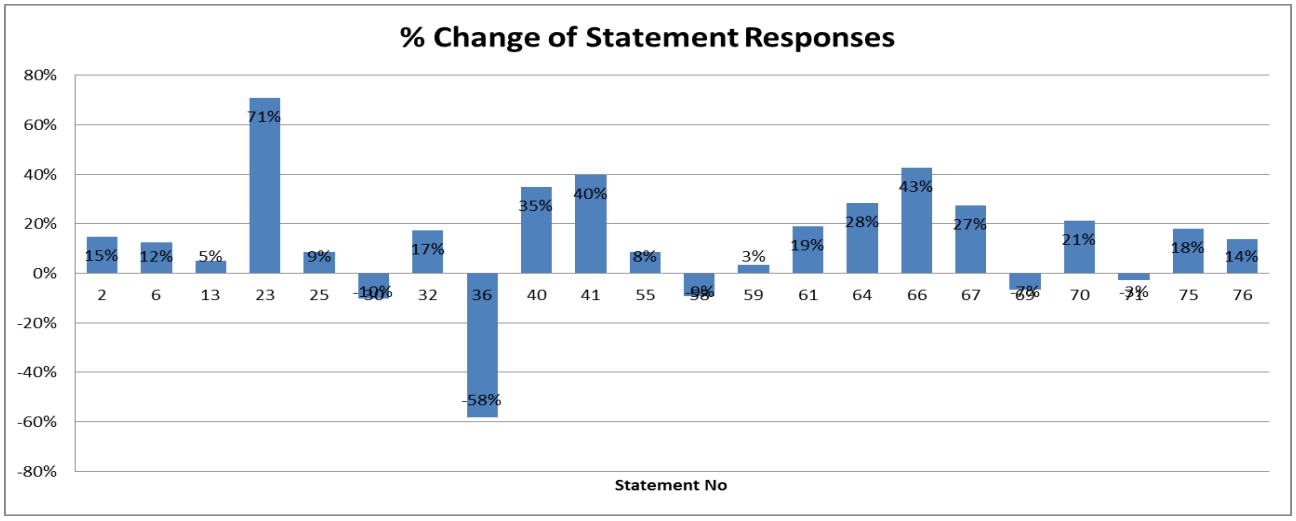
Q76 Focus on verbal CAT R3

		Frequency	Percent	Valid Percent	Cumulative Percent	R2
Valid	Usually true	1	3.7	3.7	3.7	6.3
	occasionally true	6	22.2	22.2	25.9	34.4
	Sometimes but infrequently true	9	33.3	33.3	59.3	50.0
	Usually not true	9	33.3	33.3	92.6	93.8
	Almost never true	2	7.4	7.4	100.0	100.0
	Total	27	100.0	100.0		

NB: double negative statement - R2= 65.7%, R3=74%

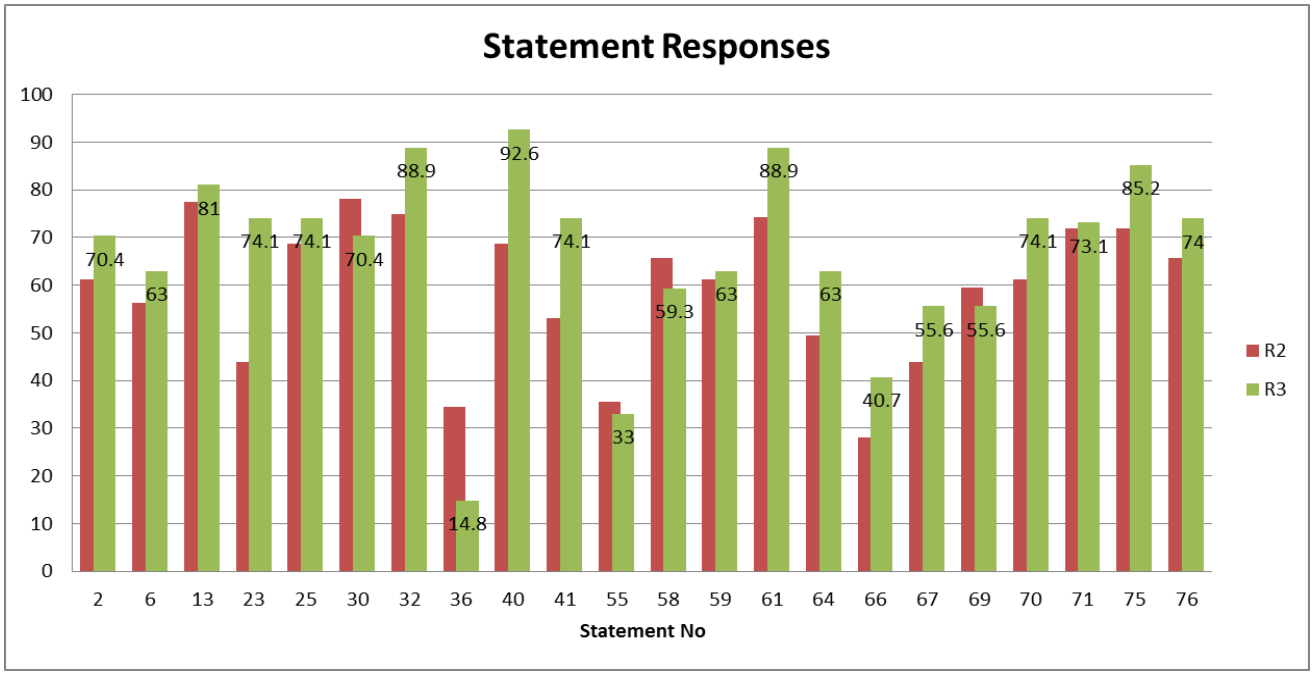
Of the 22 statements five achieved over 80%, a further 8 over 70% and the remaining 9 remained below the bar. Fig82 indicates change in diagrammatical form. See Appendix XXVI for a full table of percentage change R2-R3.

Fig82: percentage change of statement responses



R3 has shown some interesting maintenance of R2 scores and some change (Fig83). Five were scored lower than R2 (30, 36, 58, 69) with the remainder increasing. Of the increasing scores four achieved consensus above 80%, (13, 32, 40, 61) five were rated above 70% (statement 30 reduced but remained above 70%) and the rest (n=8) were below 70%.

Fig83: Statement response percentages



Round 3 qualitative comments

A number of considerations and reflections for developing this metaphor work within CAT have arisen relating to the process and use of metaphor; with respect of the language used to construct the sentences; about the way metaphors were used; and the responders' ability to answer questions.

Process and use of metaphor: Responder 11650 noted how metaphors reinforce the importance of the therapeutic relationship whilst another responder noticed that because of their engagement in the survey they had engaged with *'deliberately developing my use of verbal and pictorial metaphors with patients*' so their views were developing during the process (11651). Another responder reflected on their work and found some pictorial metaphors that s/he had used '*one using photos patient collected and bought to sessions, other using stick-people drawings...parenting photos were of men with babies, which she was unaware of...her father had bought her up'* (11649).

Responder 11651 noted a general support for the approach as '*There may be something here about the willingness of the therapist to work in this way as the main driver for its success as patients from all ages, backgrounds and ability levels naturally bring imagery and metaphor into the therapy room*' (11651). The key is *'jointly arrived at metaphors; the therapist's artistic and poetic skills may be way outside the patient's ZPD and therefore be another example of how the patient experiences being disempowered'* (11646).

Questions with respect of the language used: '*In attempting to answer honestly and thoughtfully I have felt conscious of the difficulty of 'pinning down' responses when they are taken out of the context of dialogue - so maybe some of my answers would have been different if questions could have been explored in conversation'* (11657). *'Maybe if you could have supplied some clinical examples to contextualise some of the questions it would have helped'* (11957).

Ability to answer questions: Two responders noted the temptation to be 'invited' to consider my responses in relation to the 'right' (median) answers when completing this stage of the survey (11651) or '*to answer with the same score as previously'* (12219). This is a complexity with repeat questionnaires but also the nature of seeking stability over time and stability with the responders original opinion as discussed by Delphi theorists. Responders felt that the questions were 'sophisticated' (11957) and therefore difficult to answer generically at times because they were thinking about the multiple voices of patients in that way it was difficult to get to any 'set answer' (11849). Equally, as some responders felt they did not have a depth of knowledge in metaphor and PM, their answers were calculated guesses (11957 and 12220). This is what the researcher was looking for, a response based on experience and clinical knowledge to inform the discussion.

Some responders commented on the constraints of Likert scales. The use of 'potential' for example, made rating vaguer because '*most things have some potential, a stronger statement I think could lead to a more confident rating, which may be more likely to lead to consensus'* (11982). A second comment *'I felt limited in the response options eg sometimes I wanted to answer in some instances, rather than how much I agreed with the statement'* (11957) is in a similar vein. The difficulty here was, as the statements arose

from the richness of the R1 qualitative statements, I wanted to represent these faithfully. For example statement 67 is verbatim from R1, was corroborated in a number of responses, so there was much support for inclusion.

On reflection I needed to consider the wording of some of the statements more closely and how Likert scales might restrict response. However, as the purpose of the survey was to a) gather qualitative views on metaphor working and b) extrapolate some core aspects of metaphor and PM these limitations whilst important are not derailing. The Delphi has enabled the researcher to reach a reasonable sample and gain many insights into the working of a number of individuals into metaphor and PM to inform this study and in particular inform the next two cycles the TP and the case studies. Hindsight, leads the researcher to consider the nature of each statement more closely to seek out ambiguity but perhaps this would have arisen, no matter how carefully the sentences have been constructed, due to the nature of the multiple voices engaged in the discussion?

Discussion

The Aims of the Delphi were to generate a range of principles, approaches, practices, theoretical models and factors when working with and developing PM in CAT and to test these through a consensus exercise in order to extrapolate the most important approaches, practices, theoretical models and factors. Three rounds were undertaken at the end of which seven major themes were identified, congruent with areas explored within the literature and are qualities of the therapist, training and Supervision, about the relationship, in session focus of using metaphor, the potential of using metaphor, on PM's, and the potential downside of using metaphors. In this summary discussion, statement scores, the literature and R1 analysis will be interwoven as a prose to inform the research.

Qualities of the Therapist (Theme A)

The therapist and their approach is such an important aspect of any therapy. Hubble et al. (2000) suggest 30% of the effectiveness is the relationship. R1 analysed a number of aspects of the therapist's approach that emerged and coalesced into 5 Statements.

Statement 1, **Willingness** of the therapist to work with metaphor held a 100% agreement with 'in all cases' rated as 31.3%. This extreme measure provides clear consensus for the statement. Statement 2, asked whether understanding the **literature** could support the use of metaphor and subsequently enhance the TR. R1 analysis undecided with about

61.3% of responder's rating 'disagree' or 'undecided'. On repeat in R3 this was increased to 70.4% agreement (+9.1%).

Statement 3, 4 and 5 the **ZPD**, **attunement** and **allow time and space** for exploration of metaphor' were all rated +80%. Unsurprisingly as CAT therapists trained to notice and work with the ZPD this acheved 90.3% agreement with 9.7% undecided. As to being attuned to listening out for metaphors and allowing time and space for them to develop and be understood 93.8% and 87.5% rated these two as over the 80% threshold for consensus. Both attunement and time and space were offered in R1 as potential solution to barriers when working with metaphor.

Training and supervision (Theme B)

Statement 6 asked whether a **lack of training** would limit the use of metaphor in practice. In R1 a 56.3% agreement was noted and re-rated I R3 with a 10% increase to 63% agreement. These results are complex and worthy of further analysis which will be undertaken within Study3 as part of the analysis of the TP. Because the literature and this research so far has noted the 'training' therapists to be attentive to and utilise metaphor in practice (Martin et al. 1992). This study has found a number of comments that suggest some form of training in metaphor and PM either as a separate CPD event or as part of the core curriculum of CAT Practitioner training, not a 'should' but an opportunity.

Three initial statements on supervision emerged (S1-S3) and were collapsed into statements 7 and 8. Statement 7 was practical, to **discuss metaphor in supervision,** with statement 8 being more detailed around using metaphor to '*an image or metaphor can bring a patient to mind in an instance*'. Both statements achieved a 96.6% agreement the feeling being that metaphor working '*improves creativity*.'

The literature noted that the use of metaphor in supervision could be enhancing or enabling as was playfully utilising metaphors in supervision (Edwards 2010). For example Guiffrida et al. (2007) conclude that addressing metaphor in supervision might assist students in understanding the process of becoming a counsellor and facilitate students' case conceptualisation skills. There were cautions noted relating to the limited research within this area. Borders (2009) also supports the use of supervision in her commentary and literature review on using metaphors for the patient, counsellor, or counselling relationship drawing on 1 and Borders' (1998 and1999) work.

About the therapeutic relationship (Theme C)

Fuchs (2004) notes the increasing importance of the role of the therapeutic relationship, of being aware of how pre-reflective processes may enhance therapeutic effectiveness. Mann (1973) considers the selection of a central issue is important in therapy and essential for progress. Wilkinson (2010) and (Abbateilo) 2003 consider metaphors to be an embodiment of this central issue and have been shown to be indicated in successful therapies. Metaphors arise in the novel context of the therapeutic relationship, whereby a strong therapeutic alliance is considered the most reliable predictor of change in psychotherapy (Cappas et al. 2005). Furthermore, psychotherapy leads to a better modulation of potentially indeletable neuronal response patterns at the level of the limbic system by higher cortical centres (LeDoux 2000 and 2002, Beutal et al. 2003). Kandel (1998) comments that learning is measurable on the brain so psychotherapy is also measurable as it is a process of learning.

With these thoughts in mind this research set out to explore the nature of metaphors within the therapeutic relationship, whether they were helpful or a hindrance. Statements 9-13 were developed that suggested that metaphor could establish 'patterns' of dialogue, can be creative and playful leading to insights, can validate the patients utterances, (letting them feel properly heard), and can be reflected on post session.

Statement 9 emerged from a number of comments regarding **patterns** that also relate to statement 45 a **central theme** described by James Mann's (1973). In Study1 a responder noted how '*metaphors can give us new ways to describe things/patterns'* and their '*Creative use can lead to expansion of understanding*.' R2 responders scored statement 9 81.3% whilst statement 45 scored 100% above the mid pint (in all cases 12.5%, strongly agree 68.8%, agree 18.8%). This provides strong evidence for using metaphor and returning to metaphor in each session for further clarification and/or modification.

Statement 10 and 13 concern Winnicott's (1971) **creative** and **playful** management of the encounter, 'In playing, and perhaps only playing, the child or adult is free to be creative' (ibid, p53). Responders echoed this suggesting that working with pictures can introduce elements of playfulness. Wilkinson (2010) noted that metaphors allow the patients creative processes to be drawn upon as well as their cognitions and Loock et al. (2003) observe images and art as insightful, their creative expression can be a non-threatening way of problem identification.

Triangulation of ‘playful’ comments note 18 references to playfulness in ’10 factors’ with 32 overall references within the R1 text that led to 4 initial statements. R2 rating achieved 96.9% for statement 10 and 77.4% for statement 13. However, as 77.4% fell below the ‘bar’ this was re-rated in R3 achieving 81.5% an increase in 4.1%. In hindsight this statement should have been better placed within the theme ‘pictorial metaphor’.

Statement 11, using a **patient’s language** shows they are **being heard** achieved 100% with 71.9% ‘strongly agreeing’ and 18.8% ‘in all cases’. This is strong support for the statement and reflects a significant body of literature and responders comments within the research. Shared understanding and using patient’s language had 297 separate items of dialogue coded within the Delphi.

Statement 12 concerned the impact of **post session** verbal processing and reflections by the patient (and indeed the therapist). As noted Glucksberg and Keysar (1990) see metaphor as not ‘instantiations of temporary ad hoc categories’ but reflect schema and structured memories so it seems reasonable that patients will continue to process these between sessions. An 87.1% agreement was noted with the statement as ‘important’ 41.9%, very important 29% and always 16.1%. This statement is resonant with Statement 56 which notes the PM as a ‘shorthand’ to be discussed later.

Process factors (Theme D)

Statements 14 – 27 cover a range of process factors that include aspects of working with metaphor from a patient and therapists point of view and aspects of the CAT model. Statement 14 acknowledges metaphors as **naturally occurring** and being open to their expression and exploration and achieved 90.6%. This mirrors the literature (Stott et al. 2010) and can be seen as confirmation that practitioners ought to pay attention to the metaphoric utterances of their patients. It seems difficult to ignore over .5 million CINAHL and other search engines reference to metaphor in psychotherapy. Statement 15 and 16 relate to whether the metaphor is **making sense** and is **relevant** to the patient. Both scored 100%. Statement 22 (also scores 100%) indicates support for the therapist to allow for time and space to explore a metaphor if it is not understood by the therapist.

Statement 17 is about maintaining **confidentiality** and at this stage in the analysis seems to be a statement that could have been noted and worked out as confidentiality is embodied in all appropriate codes of professional conduct and unsurprisingly scored 100%.

Statement 18, 19 and 20, notice the **relational**, **social** and **cultural** context of the metaphor. These score 93.8%, 93.8% and 87.5 % respectively. As CAT recognises the relational, social and context of a patient (as do many other therapies) again this rating is not surprising and is congruent with therapy practice.

Statement 21 concerns the use of a **therapist derived metaphor**. This seemed quite contentions and certainly created debate within the workshops and preliminary work. For example the literature raised concerns that therapist delivered metaphors could be 'silencing' by being more prominent that the patients (Milioni 2007). Despite these cautions there was general support in the literature for a therapist derived metaphor. Barker (1996), Kok et al. (2011) and Martin et al. (1992) note the strategic use of therapist metaphor and that patients rated therapy sessions positively especially when these metaphors were developed collaboratively and repetitively. Patients recalled therapists' intentional use of metaphors as more helpful than sessions in which they recalled therapeutic events other than therapists' intentional metaphors.

Responders gave this statement an agreement of 93.8%, higher than I had anticipated given some of the qualitative comments. Whilst data suggests that patient derived metaphor is often worked with a sensitive, collaborative delivery of a therapist metaphor in order to elicit a response and confirmation, is proposed. In Fig 85 the therapists derived metaphor statements as an example of condensing and collapsing can be viewed. It seems as if the key part of the developed statement is 'if it feels right with the patient'.

Statements 23 and 24 suggested metaphors to be grounded in the **experience of the patient** and must be **meaningful and accessible,** resonant with the patient's experience. One hundred and sixteen moments of coded data in R1 related to a patient derived and patient experience being the foundation for metaphor. Statement 23 was rated 43.8% in R2 and 74.1% in R3, whilst this is a big change it did not meet the required 80% threshold. The qualitative comment sheds light here as a responder noted metaphor is not the '*whole sum of their experience,'* if it was it might reductionist. The comment suggest importance for the patient's experience being grounded and resonating so it is likely it is the wording of the statement which is at fault.

Statement 24 speaks of a similar process with a 96.9% agreement (although this is specifically about PM as opposed to verbal metaphor) although at least one responder felt they were used as an ancillary tool rather than being integrated within the process. Perhaps Steele's (2013) caution, that if the therapists focus on a metaphor without checking it out, s/he may be unwittingly giving more weight to one rather than another has salience here.

Statement 25 not compromising the **models fidelity** raised one initial statement but was based on 138 overall coded moments of data across 9 themes of coding and 26 NVIVO references so it was important to test out in practice being rated 68.8% in R2 and 74.1% in R3. On analysis in R3 this statement seemed complex to rate as it had two meanings. Despite a pilot of the statements responders were 'unsure' how to rate it. One responder helpfully noted more helpfulness of metaphor as part of CAT rather than compromising the model. Whilst there is no 80% consensus it does appear that the fidelity of the model is important to responders, although the duality of the statement has caused some confusion. The clarification '*e.g. Used as a way to explore/link patterns to SDR '* in a way detracts from the initial statement and could have been stated separately as about the fidelity and linking the SDR. However, statement 53 does not support the use of metaphor with the SDR as it comes up with a 96% consensus but does not relate to the fidelity of the CAT model. Results confirm that fidelity is important but it is the articulation of the metaphor to the reciprocal roles and SDR that has salience.

Three statements related to Reciprocal role procedures (RRP's) (26, 38 and 41), linking to a metaphor in Statement 26 linking to the **reciprocal role** achieved a 96.9% agreement with 15.6% rating 'in all case' and 31.3% 'strongly agree'. Statement 27 **drawing on the SDR** to 'get to unattainable places' was rated as 83.9% in R2. Drawing on the SDR to produce more accessible diagrams was mentioned, as was the benefit ensuing from linking the metaphor to the diagram based on case presentations. Whilst this is not immediately PM technique, support can be gained here for utilising PM that relates to the SDR. The importance is the one step removed aspect of metaphor to coalesce complex strands of thought emotions as noted by Holmes and Bateman (2002). What these process factors offer are an approach to working with PM, there is no rule as such but if these principles are followed then the data suggests the conditions for effective use will occur.

Potential of using metaphors to understand emotions (Theme E)

It has been argued that cognitive and behavioural approaches rely almost exclusively on the propositional/syllogistic form of cognition (Fabregat et al. 2004) when formulating a patient's problems (e.g. self-talk, automatic thoughts and irrational beliefs) and cognitive schemas. Cognitive interventions are integral, indeed integrated, within CAT whereby an important aspect of therapy is to understand the automatic, repetitive patterns of problem thinking and behaviours. These can be described as automatic thoughts related to past events or situations. One example of this comes from Wilde McCormick (2012) who noted from the patient's metaphor that she was 'either a battering ram or modelling clay. One week she spontaneously reached a middle position which married the positive value of each pole of her dilemma…like springy steel' (Wilde McCormick 2012, p87). This metaphor creates a rich insight into the patient's current state and experience.

In the new edition of '*Metaphors We Live By'* Lakoff and Johnson (2008), the authors provide an afterword regarding research into metaphor noting 'how we think metaphorically matters on many levels' (p243). It seems from the literature on metaphor that a number of steps are important. First to notice the metaphors in dialogue, second to extend the metaphors and relate to experience, and third to attempt to alter the metaphor to a 'preferred position' creating linkages between the two to help the patient change. There is support for either the patient or therapist generating metaphor. Aspects of the process involve listening and being available for working with metaphor and art in session. The way the image comes to mind and the colours used have been important to capture as this leads the picture to be more representative and culturally specific.

Statements 28-45 concerned the perceived usefulness of metaphor. The results suggest that they can be a **shorthand** and can **summarise** a patient's experience. Statements 28 and 29 both scored 100% agreement as did statement 44, and notice that metaphor can develop and extend our therapeutic understanding. Responders agreed that metaphors can represent complex formulatory ideas with a score for statement 31 of 96.9% with the same score for being able to succinctly **sum up** an overall theme in a reformulation (statement 35). In effect enabling the capture a **central theme** (statement 45, 100%) as noted by Martin et al. (1992) and Mann (1973).

Whether metaphor could be used as part of managing the **ending** (Statement 30) was initially rated as 78.1% then in reduced to 70.4% in R3. As Ryle (1995) suggests endings are an important focus in CAT. Responders suggested that the 'metaphor' could be incorporated in the reformulation letter as well as the goodbye letter if they had become a useful part of therapy. It seems that there is some support for recognising the usefulness of a metaphor to contain affect regarding ending but not above the consensus bar.

Statement 36 clearly rejected the notion that a metaphor can be considered **just a story** with an initial rating of 34.4% reduced to 14.8% on rerating. This is worthy of note and provides complimentary evidence in support of statement 32, **One step removed** scoring 75% and then 88.9% metaphor allows a distance from the felt sense to be achieved and emotions worked within in this space. Statement 37 can help when we are stuck scored 93.8%, a number of responders noted metaphor as enabling moving on. In the experience of many therapists the metaphor '*I am stuck in a rut'* is a common orientation (or predictive) metaphor that gives the idea of movement (Kovecses 2000).

From an analytical perspective statements 33 and 34 supported the notion that metaphors can **get behind defences** (93.8%) and provide a **bridge** between thought and feeling (96.6%) as Fabregat et al. (2004) found in their research. Responders supported and struggled with these statements, concurring that metaphor can work in this way but finding the statements very 'cognitive' in separating out thoughts and feelings.

Analytical thinking can encompass the sense that metaphor can be **containing** of powerful emotions (Statement 38) which also scored high with a 90.6% agreement. One responder noted the nature of the implicit felt experience within a metaphor whilst another felt that this was too cognitive to separate out thoughts and feelings. Whilst this latter comment is useful as a means to understand the responder's answers (or lack of one) this is not the anticipated understanding of MH where primarily practitioners work with and understanding of thoughts engendering emotion and visa-versa. Statement 40, **transference** achieved no agreement in R2 scoring 68.8% but rose to 92.6% in R3. Statement 41 **collusion** achieved only 53.1% rising to 74.1%. Transference and counter transference are complex as Hepple (2011) and where stray thoughts can be as metaphor to provide meaning (Eynon 2002). Whilst this statement has a rating above 70% the agreement is not as clear cut agreement as other factors.

Statement 39 demonstrates and validates the **patients experience** (81.3%) which relates to the value of the therapeutic relationship (TR) whereby Statement 42 indicated 93.8% agreement with this. *S*tatement 43 relates in that metaphors help in **establishing collaborative relationship** (100%). The TR has need of a secure base (Gobfert and Barnes 1995) and according to Hubble et al. (2000) accounts for 30% of the TR.

Pictorial metaphor (Theme F)

CAT has its own history and as a therapy has moved from a position of integration to differentiation and is now, as one would expect of an emerging therapy, in the process of elaboration. Across the CAT community innovative ways of exploring CAT with different groups is being developed and evaluated. On reviewing the CAT literature and having been present at a number of CAT conferences and events, the use of metaphor, either as metaphorical stories or images, has been observed. In both the CAT and wider psychotherapy literature there is often references to the use of PM's (Wilde McCormick 1990, Dunn 1997, Billings 1991).

Blackburn and Davidson (1995), suggest that it may be useful to use mental imagery to recreate the situation. This mental imagery might be in the form of metaphors or pictures or representations of events and experiences. As Vygotsky noted art, alongside language, numbering and signs are the means by which a culture can be conceptualised and understanding these tools can create, organise and transmit thinking (Child 2004, Rogoff 1999).

Statements 46 to 63 concern the 'pictorial metaphor.' Statement 46 'non-judgemental' scored 96.9% and statement 52 **good enough** 90.6%. These appear to link to Statement 54 that using **simple drawings** reduces transference of the therapist as 'expert' 83.3%. Importantly for the pictorial focus of this study support was achieved, with the importance of using pictures if patients preferred it being emphasised and where they can be **linked to SDR** (statement 53, 96.8%).

Developing more accessible diagrams and linking the drawings to the CAT model and process had 138 coded references in the NVIVO analysis, the second highest score (see Appendix XXIV) a part of which is reproduced in Fig84.

Fig84: CAT Model NVIVO coding references

10 factors metaphor	10 factors pictorial metaphor	Barriers	CAT Model	Helpfulness	Pictorial metaphor Principles	Principles relationship	Practice	What is metaphor	
Locate to CAT model 34 references	Locate to CAT model 26 references	CAT model and verbalisation 8 references	Reciprocal roles 16 references Link to SDR 10 references Reformulation letter 2 references	Accessible diagrams 3 references	Link to reformulation and SDR 12 references	Link to sdr/rrp 8 references	Link to SDR/RRP's 13 references	More accessible diagrams 6 references	138

Statements 47 to 51 relate to a picture being **representative** and therapists needing to pay attention to the colours, (statement 47, 93.3%), how it comes to mind (statement 48, 93.1%), how it was made (statement 49, 86.2%) and context (statement 50, 86.2%) as well, as practically having art materials available 80.6% (statement 60). I recently added colour with a patient to a simple line diagram picture and the vibrancy that the colour created was dramatic. Noticing colour has been supported by Guillemin (2004) in her research on visual methodologies.

Statement 51's results validate the use of **patients words and images** when forming the PM (90.6%) with a supporting statement, 62 'check for fit,' achieving agreement of 87.1%. These results appear indicative of the collaborative and co-constructing nature of CAT. The literature suggests 'It is as if bringing the image to conscious awareness can alleviate the conflict through the therapeutic relationship' (Lacroix et al. 2011). Statement 56 where PM can be used as a **shorthand,** achieved 86.2%. Statement 57 **struggling to verbalise** achieved 93.5% and statement 63 d**ifficulty expressing thoughts** 90.6%.

Statements rerated were 55, 58, 59 and 6. Statement 55 lack of **confidence in art** initially scored 35.5% then on repeat 33.3%. Interestingly the midpoint scored 74.2 and 81.5 respectively as an indicator of undecided. This research has been informed by Art therapy, some responders came from this field, and the researcher has consulted with Art therapists as well as being supervised by an art therapist. It was never the researcher's intention to train people to be art therapists (as this is without his field) but to understand and explore whether this technique was supported in therapy, could be disseminated through training an could benefit the TE. Results indicate support for training and the PM.

Statement 58 concerns whether pictures may be a **more acceptable medium** (65.6%) and was re-rated as 59.3%. The qualitative comment suggests that the statement was a bad statement which in hindsight, despite the rigorous way the statements were developed appears the case. Results are inconclusive but do suggest that pictures are useful but not essential, for example in R1 being **prepared to abandon** the approach was coded 11 times in the triangulation analysis with 28 references coded altogether which suggest the therapists as being flexible and selective in their use as the results of statement 74 support.

Statement 5, work from **images** that come from the verbal metaphor, achieved 61.3% then 63%. There is no significant change and results remained below the consensus bar. I am left puzzled by these responses as other statements that relate to using the patients words and images suggest that this is the case. In practice and in the literature using images that come to mind is exactly what the natural and suggested process is, as metaphors emerge they are noted, and if noted can be enhancing to the therapy (Angus 1996, McMullen 1985, Levit et al. 2000 and Kopp 1995). In fact Kopp's (1995) step 4 to explore and define feeling in relation to the metaphoric image where the process when drawing the image is to agree not to intrude but to create and explore forms a foundation for the researchers practice.

Statement 60, PMs are developed **collaboratively**, achieved 74.2% then 88.9%, a 14.7% increase. The statement was based upon 36 references within the triangulation of '10 factors' NVIVO coding in Appendix XXIII and 45 when combined. This is the 5th highest coding occurrence and is understandably resonant with CAT as a collaborative therapy (so in one way the results are understandable) but also suggestive of the importance of working collaboratively. Not producing **perfect** drawings but developing them together refers back to Winnicott's (1971) playful and creative approach. This percentage change is quite a shift and may be explained by the responders increase understanding of the research question that can come about with a repeat questionnaire but also a desire on behalf of the responder to please the researcher. I am not sure if this was the case as there are variations in percentage agreement change and percentage disagreement change and if responders were wanting to, or felt obliged to support the researcher's statements then there might have been more variation to the positive. However, this is worthy of further exploration and may also apply to other statements rerated in R3.

Cautions and barriers (Theme G)

Twelve statements were developed that suggested cautions and barriers when working with metaphors (statements 64-76). Statement 64, **rationale** was initially rated 59.4% and rerated as 63%. There is no clear consensus for this statement. Statement 65 asked for opinion on **too many** metaphor's and achieved 87.5%, keep it simple is the message which has already been noticed in previous sections.

Statement 66 relates to metaphor engendering powerful emotions that may be hard to contain, whilst statement 38 scored 90% agreement that metaphor can be **containing of emotion** in session participants rated statement 66 28% and then 40.7%. This would indicate a lack of support for the idea that emotions incorporated in metaphor could be hard to manage. Some responders spoke of the holding nature of therapy in that it is important aspect of therapy to manage.

Statement 67 risk to **avoid or unname** difficult things scored 43.8% and then 55.6%. It seems from these the risk is not the use of metaphor too unnamed but not working with them at all. Statement 68 supported the therapists being aware of not being **narcissistic and clever (**81.3%). A wise caution for all therapists, that was noted within the literature by Kirkland (2010), in relation to power imbalances in the therapeutic relationship. I am mindful of Milioni's (2007) mistakes of an overly clever therapist who might use metaphor as a silencing device, or might hijack a patient's dialogue. It seems as if the therapist might interpret the patients metaphor but I would draw the reader back to the collaboration and shared understanding repeatedly been rated as important that the use of metaphors requires attention to this rather than delivering a finished and perfect example.

Statement 70 **art experience** achieved 61.3% then 74.1%. This suggests that, whilst this is a useful consideration, it is not key in working with PM. Statement 73 **let go** was rated as 90.6% indicating agreement. The researcher recalls working with a patient who specifically stated she did not want to work pictorially because of her feelings about art making so I honoured this. In her final session she brought in a picture she felt reflected her struggles in life. Of course this can be interpreted in a range of ways but it was powerful whichever way one looks at it. Statement 71 **pejorative implications** rated 71.9% then 73.1%, suggesting this was worthy of note but not significant. This statement relates to Statement 74 **selective** which achieved 87.5%.

Statement 75 **diverting side-line** rated 28.1%. This statement is a double negative for coding, and was resent to clarify the role of metaphor as the comment stood out in analyses

of R1 as a potential challenge to the use of metaphor in clinical practice. On analysis it appears that there is agreement that the statement is not true. For example in R2 the cumulative percentage response was 72% and in R3 the percentage agreement over the bar had increased to 85.2%. It would seem that metaphor is not a diverting side-line but has importance for CAT practice.

Statement 76 rated whether the **CAT model** might hinder working pictorially. Scores were 34.4% 'occasionally true' but the mirror score of 'not true' indicated 65.7%. From these results there appears to be disagreement with the statement. Agreement using this scale would be 65.7% for R2 and rising to 74% in R3, based on calculating percentages +3 items below the bar of neutral to 'occasionally true'. Interpretation of results indicate that working with metaphor is complimentary to CAT, the model is not a hindrance to working, even though the consensus bar of 80% has not been met. In Theme G a number of comments to specific questions (64-76) noted cautions and downsides.

Limitations and reflections on data analysis

Limitations to Delphi studies are noted and the study design is not without complications or concerns. An early caution to keep in mind when asking experts as one might be misled. For example, in the Greek myth of Oedipus, whose question to the oracle at Delphi led him to marry his mother and kill his father (Mead and Moseley 2001). A large number of experts can be consulted without face to face meetings which reduces the opportunity for cross examination (Okoli and Pawlowski 2004, Irvine 2004), but there is no clear consensus as to how many experts should participate in a Delphi (Keeney et al. 2011). The researcher articulated a number of expert considerations managing a sample that produced evidence that had robust findings based on an appropriate level of expertness.

Ensuring a robust mechanism for the aggregation and managing of scores and examining the importance of the meaning of consensus is often seen as a failing of Delphi (Powell 2003). Whilst there are no apparent firm rules for when consensus is reached the final round will usually show convergence of opinion. A further concern in this approach is the expertness of the expert, Baker et al. (2006), Sumsion (1998), Hardy et al. (2004), Jeffery et al. (2000) and Keeney et al. (2001) all note the vagaries of experience and expertness and the dilemmas involved. For example, Keeney et al. (2011), notes 'the existence of consensus from a Delphi process does not mean the correct answer has been found' (p82).

Keeney et al. (2001) express a concern that a Delphi may be seen as a replacement for scientific research, and because of its increasing popularity the method is being adjusted limiting its validity. Delphi is perhaps more art than science (Baretta 1996). Kennedy (2004) shares these concerns whilst recognising a paucity of research involving follow on studies to investigate data developed from a Delphi. Baretta (1996) found in some follow on studies, where follow up questionnaires were sent out, that findings were similar but not the same as the original study.

Rigour can be increased through incorporating qualitative data, recognising the limitations of the Delphi approach, and managing results accordingly. As Delphi is based on the assumption there is safety in numbers (Hasson et al. 2000) decisions are strengthened using rigorous management of the data using approved techniques. This research is addressing these concerns by testing the theory out in practice. In some ways this should allay the fears presented by Sackman (1975) and Goldschmidt 1975) who believe that the oracle should make way to science. This research was guarded against these potential mishaps by keeping in mind Tinstone and Turoff's (1975, p6), five cautions towards 'failure' of Delphi:

- 'Imposing monitor views on the Delphi by over specifying the structure of the Delphi and not allowing for other perspectives'.
- Assuming Delphi can be surrogate for all other forms of communications.
- Poor techniques of summarising and presenting the group response.
- Ignoring and not exploring disagreements.
- Underestimating demanding nature of Delphi and recognition of time given by experts'.

Whilst the Delphi method was articulated well managing the data provided a second complication. Decisions having to be made to manage the sample as per protocol led to a number of participants not being followed up who might have contributed. The researcher considers this a lost opportunity as managing the data returns in SPSS could have easily accommodated a larger sample. Due to the nature of work there may have been cases of staff moving on and changing email addresses to the ones held at ACAT. Wright (2005) points out thousands of organisations are now on line where the advantage of the internet provides access to individuals and groups of individuals (Wright 2005). Other advantages include, time as response rates can be speedy and cost as no postage or paper is required. Wright also notes a disadvantages regarding sampling and access, as little may be known

about responders. In this study something is known as they are CAT therapists/trainees and some demographic data is also being collected and ACAT managed access via ACAT webserver.

During the three steps of data analysis in R1, my skills in managing the data developed and improved. Initially I was generating statements from the comments, coding them into NVIVO, generating statements and identifying them to particular responders e.g. (009). As my understanding of the data developed I realised that I needed to also do this for the all statements e.g. 'M23'. So I went back over the qualitative analysis noting where the statement emerged and who the responders were. Because of this a level of reliability and validity can be achieved as a second reviewer can transparently see my working steps.

The next level of rigour was to go back through all the coded responder comments and note the number of occurrences these were coded to within the initial questionnaires. I then triangulated these with the statements and with Step 1 and Step 2 sorting and categorising. This achieved a further immersion in the data enabling intuitive understanding of the emerging statements and nodes and any repetition that may be viewed as a quantitative indicator of their importance. This counting enabled understanding of the nature and frequency of 'statements' and a 'numerical' value for each. Having ascertained a 'value' this in an intuitive way provided comparison with the 'mean' that was generated for responses to statements in rounds 2 and 3 of the Delphi.

The other development of note is the nature of the first few rounds of coding and statement generation emerging from the data compared to the later stages. Nodes developed within the first few sections then 'affected' the emerging development of other nodes. Because of this 'previous knowledge' there were shared nodes to other sections for example 'shared understanding' arose within all of the sections. The researcher is mindful in this respect of concerns regarding bias in managing data such as the 'prediction urge' (Mulgrave and Ducanis 1975, Parente and Parente 1987) whereby most human beings have a desire for certainty and so the authors (ibid) recommend a cautious interpretation of data generated by Delphi. I think this is why I wanted to run a parallel quantitative and statistical representation of the qualitative data in order to safeguard against bias and the prediction urge. Data is more transparent to the researcher and to others looking in at the data. As well as this safeguard a second 'review' was undertaken by the researchers' supervisors as well as a statistics expert. The researcher would suggest that triangulation of the data was gained through objective reviewers.

The use of statistical packages such as NVIVO can provide triangulation as they manage the data one step removed from the researcher's interpretation and provide valuable statistical and numerical validation for the emerging themes. Demographic data was transposed and uploaded into a major file in SPSS enabling a top down and side to side matrix analysis (or scaffolding) of variables from all rounds of the Delphi to emerge.

I round 2 decisions had to be made in managing data. The researcher has learned many lessons from this study not the least being the complexities of managing electronic responses as well as the nature of software to manage and coordinate responses. Some of the R1 data may have been lost due to spam filters in computer software as well as the researchers developing knowledge and skill in setting up an electronic database. It transpired that the way the Suvey2 system was set up and the nature of the survey having sections some statements were not able to be set up as mandatory so responders were able to skip a question. Helpfully many made qualitative comments as to why this was which added to the researchers understanding of the statement. This led to difficult decisions being made regarding initial management of responses, management of incomplete responses, where to set the 'bar' for consensus and how many statements to repeat.

The initial step in managing data was by translating the Excel spreadsheet generated by Survey2 into SPSS. Demographic data was mainly managed in Excel and some aspects in SPSS as they both provided tablature and statistical analysis in understanding the expertness of the panel. SPSS is a logical, intuitive structured flat file database so it can understand data better than EXCEL. Computation in SPSS was used to provide correlations between responses to questions (nonparametric) to be examined.

A large number of statements arose from the data and because of this it was complex to manage these. A lot of time was set aside to explore each statement and test and retest whilst. At the same time triangulating the statements with the qualitative comments and the review of the literature. In hindsight it might have been beneficial to further reduce the statements and scrutinise the wording of the statements with a pilot group prior to sending out to the Round2 raters as some of the statements seemed to lack congruity. For example statement 23 which was rerated in round 3. It speaks well of the importance of the metaphor arising from the patients experience but it seemed as if the wording could be misinterpreted and would have benefited form more clarity.

However, technical steps on the Delphi were robust and followed protocol but despite this some of the statements sent for rating in R2 appeared to be too complex to reply to. The researcher has learned from this and from the way one populates an online survey to ensure that language is as clean as possible and that responders have to compete all rating opportunities. This would have increased completion and the overall data set. Other complexities were follow-up of non-responders and potential lost data due to my lack of technological adeptness. Despite these limitations a valuable expert panel was recruited and a strong data set was gleaned and analysed.

Summary

The researcher set out to achieve two aims, to develop and evaluate consensus with regard to best use of PM in CAT and to refine existing ideas of PM's to inform a TP and materials. Results indicate a general consensus to utilise metaphor and PM. Understanding the picture is close to a pictorial representation of the SDR and can be incorporated onto the SDR or be a separate drawing working collaboratively alongside.

The images are suggestive of a patient's core pain and metaphoric language and can then be the stimulus for the development of coping strategies, unsticking the patient from the problem procedures represented in the SDR and reformulation. In developing the PM there is an enmeshment of early life experiences, patient derived metaphors described in sessions and the SDR. What is important is the drawing capturing, in a non-judgemental way, the patients experience and words but can also incorporate a therapist derived metaphor or image if this is checked out and co-constructed with a patient.

Potter (2010) in his informative and creative article describes the mapping and telling of a reformulation using sketches and diagrams to represent words and feelings…'it is here, in this meaning making where the sketching of maps helps the therapist and patient to hover above the detail and to see the bigger picture' (p1). Although Potter was not describing co-creating a metaphoric image the principle is the same, creating meaning from dialogue using symbols and images.

Engagement with the patient in describing how their picture represents their life and psychic conflict are supportive of the therapeutic relationship, clearly showing that the patient is being heard. Utilising metaphor and PM as a central theme, in a similar way to the SDR by

checking for changes and revisions, is supported by the data. One way this can be managed in the creative way is by being playful, not seeing the drawings as perfect but part of the jointly understood journey, working in the patients and therapists ZPD. In fact support for patients with language and emotional distancing was noted where metaphors can help get to unattainable places, by being one step removed. A list of Socratic questions for therapists to follow in therapy sessions, meshing findings of this study with findings from the literature, when utilising the PM, has been extracted from the data (see Appendix XXXVI).

Some cautions and barriers were noted in the expertness of the therapist and being prepared to abandon the technique if it did not resonate within the therapy. It was suggested that training would be helpful incorporating role play and some literature, but in particular case examples which this study has generated a number of as useful resources to take forward. Results are robust and meaningful and can progress this research forward to further understand and implement the PM technique in clinical practice.

The findings of Study1 and Study2 have progressed the researchers understanding of metaphor and Pm in clinical practice. Insights into process and practical application of the technique have been understood and analyses. A number of useful cautions and limitations have emerged which were not immediately apparent from initial understandings prior to Study1 and have been clearly articulated in Study2. In particular noticing the co-constructed and collaborative nature of working in the patients ZPD has been highlighted, not making assumptions and interpreting but working alongside the patient as if on a journey of discovery. Winnicott's playfulness arose in both working with metaphor and Pm as an important consideration and the researcher had not fully appreciated the importance of tis as part of the approach.

Whilst the Study2 had some limitations and some lost data, overall a robust method of data collection, analysis and interpretation has led to a much clearer understanding of the research topic and aspects to take forward into the developing training programme. Study1 training programme has been influenced significantly and now much better represents the multiple voices captured as part of Study2. Study3 aims to further progress this research investigation by developing a programme of education that can provide a skills training for therapists in order to utilise this technique in their clinical practice whilst working within their accepted model of intervention.

Chapter Six: Study3 – Training Programme Evaluation

Introduction

Study1 and Study2 collected and explored data, developed theory and context, and provided support and guidance on the use of metaphor and PM in CAT. Evidence based trainings are a central tenet of health care delivery (McHugh and Barlow 2010). Contextual examples of clinical metaphors, PM, and models were coded, categorised and articulated into training materials. Emerging data directly informed the TP particularly with regards to resources and structure of the workshops. Questions posed by participants included practical aspects such as incorporating research evidence and whether the method could be taught. Seven learning outcomes emerged from the data for Study3…

- **Part of core training in CAT**: As a 'creative therapy' can it be taught and in particular could this be part of the practitioner training or as a follow on workshop?
- **Supervision:** Would participants utilise the PM in supervision to describe their patients?
- **Incorporate literature**: How much emphasis should be placed on the literature in the TP?
- **Link to reformulation**: Does this technique maintain fidelity with the CAT model or the model participants were trained in
- **Case examples:** Do these enable the participants to develop the technique?
- **Role play, playfulness and fun:** How much balance to put on the delivery of available literature, the practical aspect of the technique in a non-judgemental and 'playful' way to enable learning of the clinical technique
- **A range of timings**: what is the 'best fit timing for the workshop (short/half/day?)

Aims

For Study3, the Training Programme (TP), the research aims to:

- Develop a TP based on research results
- Undertake an evaluation of the TP and resources used
- Deliver training materials in a series of iterative workshops
- Evaluate therapists experience of PM in practice

Method

AR should be collaborative, context related, change practice and generate theory (Lyon 1996). AR is increasingly workplace based, fitting well with evaluative studies, with practitioner research aiming to improve practice through improving learning (McNiff and Whitehead 2011). Relating personal accounts and living theories with those of others, and ensuring that these are put in the public domain, enables researchers to contribute to new discourses (ibid). Evaluation studies use a scientific method and the rigorous and systematic collection of research data, to assess the effectiveness of programmes (Bowling 2009, p10).

Qualitative methods are also appropriate in programme evaluations because they tell the programmes story (Patton 2005). Study3 incorporates analysis of previous cycles, the workshops inform knowledge transfer based on sound research evidence. Precedents are found in research to develop training programmes from Delphi studies. For example Sharkey and Sharples (2001) research; whose training resource was based on a Delphi consensus method.

Data collection

Two main evaluative tools will be utilised in the Study3 a primarily quantitative evaluation questionnaire of the training events and a qualitative self-reflection post workshop. Consent and confidentiality were obtained and maintained (Appendix XXVIII).

Questionnaires with open ‘reflective comments’ enable data to be collected for thematic analysis (Burns and Grove 2001) and Likert scales to gain a statistical impression of the application of method, as favoured by Wilkinson (2000), were adopted. Two questionnaires were developed, the first to evaluate the workshops (Appendix XXIX): and a follow up reflective questionnaire (Appendix XXX). The workshop questionnaire was based on a ‘standard’ and routinely used set of evaluative statements the researcher had previously utilised as part of a series of workshops delivered in a local NHS Trust.

The questionnaire have both a numerical rating of statements and areas for qualitative comments. Previous results had found the data was intelligible and lent itself to analysis in order to reflect on the programme. The questionnaire was piloted and modified based on feedback, utilising a previously developed and evaluated questionnaire applied the researcher to evaluate a TP for Cancer Care Specialists. As a reflection *on action* the questionnaire provided valuable material for analysis. Boud et al. (1985) state reflection is…

> 'An important human activity in which people recapture their experience, think about it, mull it over and evaluate, and involves those intellectual affective activities in which individuals engage and explore their experiences in order to lead to new understandings and appreciation' (ibid, p19).

Reflection is an experience from which we learn, and involves self and must lead to a change in perspective, this is crucial in distinguishing reflection from analysis or deep thinking (Atkins and Murphy 1994). Riley-Doucet and Wilson (1997) suggests that there are a number of personality traits required for reflection, self-awareness, discipline, Security, Development, personal needs, influence and the environment. Reflection, both 'in' and 'on' action can provide rich data (Conway 1994, Schön 1983).

Reflection *in action* enables the individual to recognise a new problem or situation and reflect whilst still in the activity. In-action reflection occurs in the practice setting and requires the practitioner to think on her feet. It is a form of AR and is often intuitive and seen in practitioners who demonstrate 'professional artistry' (Conway 1994). Reflection *on action* requires a retrospective, looking back, analysis and interpretation of practice in order to uncover knowledge used and the accompanying emotive content within a particular situation (Richardson and Maltby 1995). 'On-action' reflective questionnaires and two prompts were sent to all participants who completed a research 'opt in' consent form. As in Study1 and 2 reflexivity based on the researchers own reflections of utilising the PM in practice was drawn upon as well as the results of the research (Murphy et al. 1998, Hutchings et al. 2006).

Three opportunities for 'measurement' of workshop content were managed, a full day (6hrs, Fig85), a half day (3-3.5hrs, Fig86) and a short programme (1.5-2.5 hrs, Fig87) with broadly the same learning outcomes (Fig88).

Fig85: Full Day workshop plan

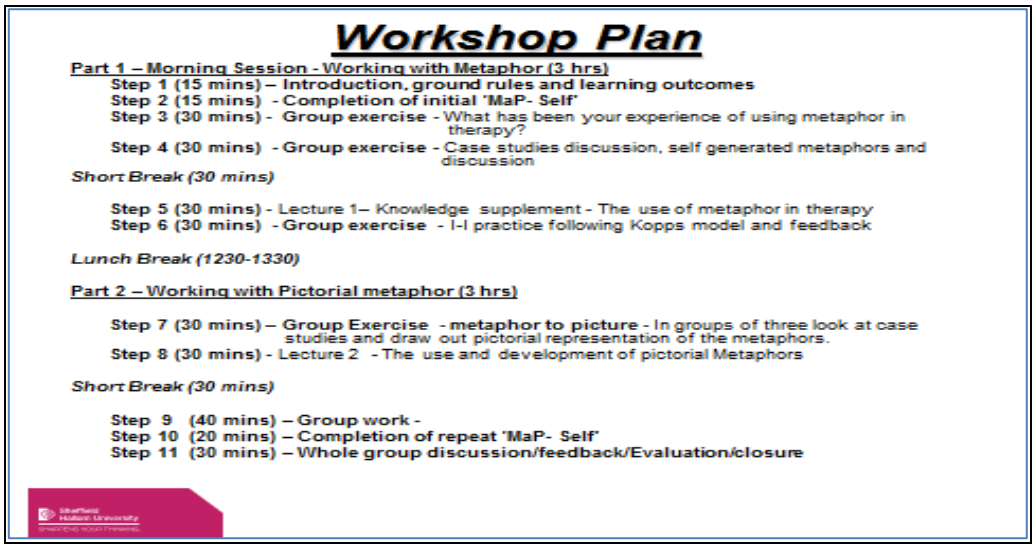


Fig86: Half day workshop plan

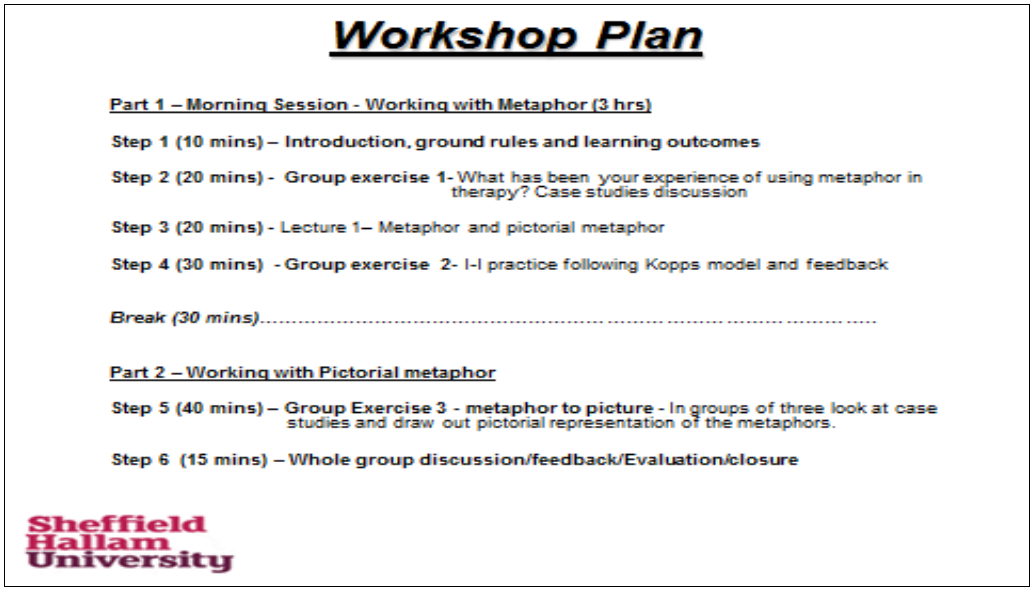


Fig87: Short programme

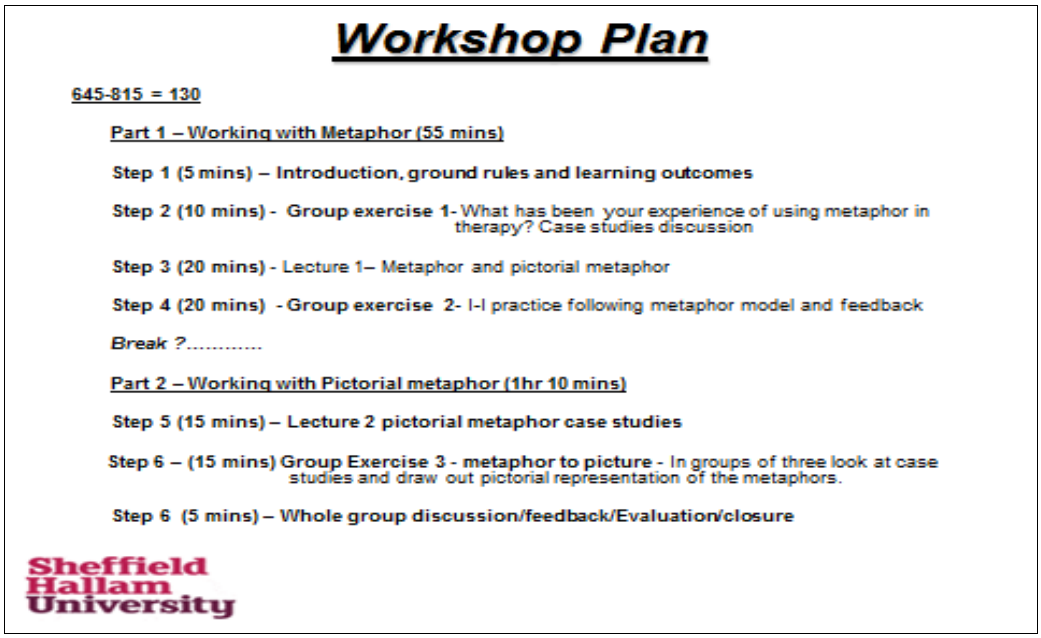
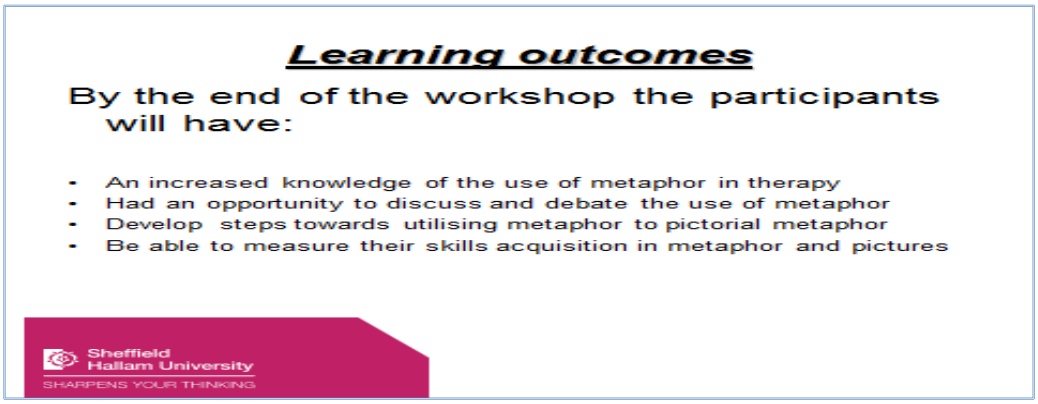


Fig88: Learning outcome of workshops



Ethical Approval

Ethical practice was fully maintained at all stages. Consent was gained in the workshops to utilise data generated from the workshops. In practice, as the technique is one that is considered a technique within a therapists' usual model, it was supported as service development with appropriate consent and governance approvals obtained.

Ethical approval was gained for the study from ACAT, CRUSE, the NHS Trust and SHU and full information and consent gained from all participants (See Appendixes V-VIII). Consent was sought to utilise responders data as well as any drawings that the participants gave to the researcher. The initial protocol intended to record a focus group at the end of each workshop indicating '*Participation will involve you giving the benefit of your expertise by taking part in the workshop and feeding back through questionnaires, use of materials and a follow up focus group after a suitable time period after the training'*. On reflection, a focus group did not seem an appropriate way to evaluate and due to contact complexities, a follow up questionnaire was utilised only. With the follow up questionnaire a set of amended consent, confidentiality and information letters were included.

Sample

Sampling is a key issue in researching psychological therapy (Dallos and Vetere 2005). Denzin (1970) suggests that one should attempt to locate as many data sources as possible, thus increasing the probability that theories will be fully tested. Sampling methods mirrored those of Study1 and Study2 as a representative judgement sample (Hek et al. 2002, Honigman 1994). A limited sample was available as CAT has only a limited

number of registered practitioners and trainees. As the study developed, an opportunity, as Denzin (1970) reinforces, was made available to include a more infinite number of individuals (Bowling 2009), sometimes described as snowballing. The technique has been exploited in a number of large population studies described as origin based snowballing (González Ferrer and Beauchemin 2011).

Snowballing grew from conference encounters where this research was presented and subsequently enabled opportunities for data collection to locate and access heterogeneous data from a group of counsellors who had some CAT experience. This snowballing increased with an invitation to present the research at a CRUSE international conference and subsequent regional workshops based on a request by them to be included in the research and evaluation of the TP.

The action research living theory philosophy of this study would support data being collected from a range of samples as the individuals have a depth and breadth of experience and so represent a heterogeneous and homogenous group (Parahoo 1997). The method is similar to Biernacki and Waldorf's (1981) assumption that the method yields a study sample through referrals who possess some characteristics that are of research interest. Seven Pilot and experimental workshops were facilitated with a further four planned:

- Mental Health NHS Trust counsellors (2012)
- CAT Berkshire (2013)
- CAT Scotland (2014)
- CRUSE counsellors (2015)
- CAT Berkshire (2015)
- SPACES counselling (2015)
- CRUSE counsellors (2016)

Results and Data analysis

Data was analysed in two parts; **Part 1** workshop questionnaire data and comments; **Part 2** responses to the reflective commentary questionnaire were collated and analysed. In Part 1 participants were taught the pictorial metaphor technique in the workshop and were supported to develop a pictorial metaphor of a group generated metaphor example. The part 2 follow up reflective commentaries were returned if a participant had used the technique as part of their clinical practice with a patient.

Demographics

A range of demographic questions were asked in order to ascertain the level of experience and knowledge of the subjects. These are congruent with the demographics of Study2, the expertness examined in the Delphi methodology, and should enable the researcher, as he progresses with this theme, to manage data accordingly. All responders in the sample met the criteria of expertness as the data in the charts (fig89 and 90) below attest.

Fig89: Patient group

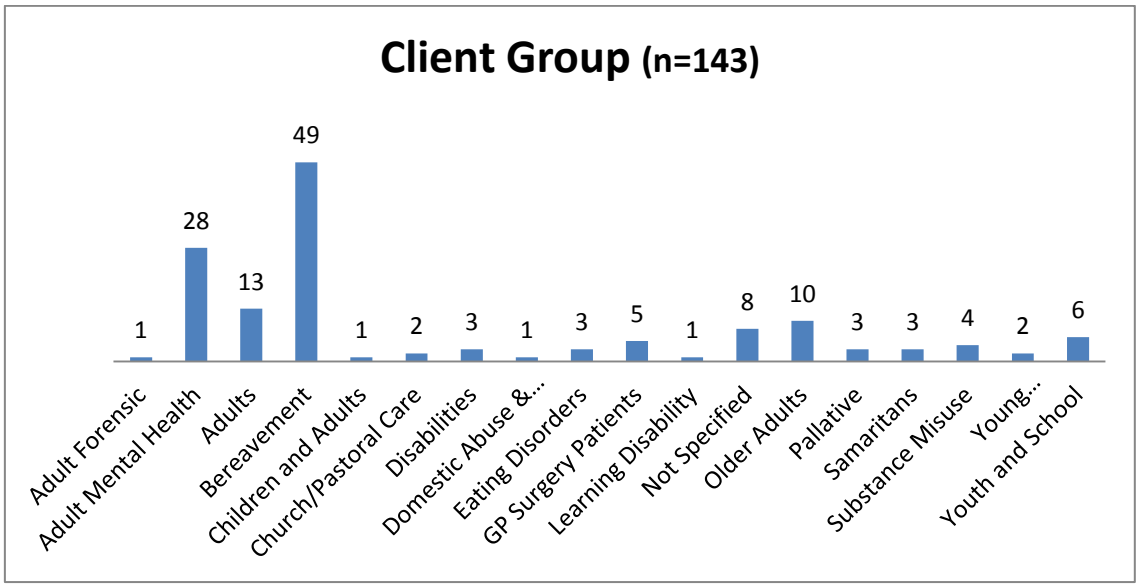
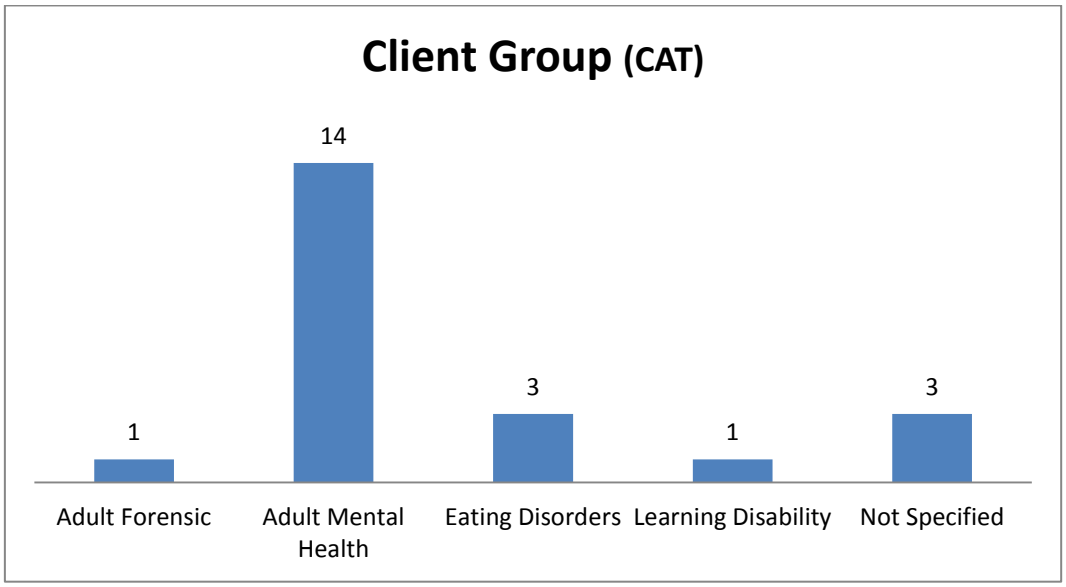


Fig90: Patient Group CAT



In order to represent this knowledge and expertness of the sample decisions had to be made in interpreting the data. For example, there were initially 65 differing patient groups from the sample of 143 so a level of interpretation was placed upon the data in order to manage these into 18 recognisable areas.

Level of training

Level of training had breadth and depth with 68 unique values standardised to 15. The CRUSE, counselling and CAT groups have a strong professional foundation in a therapeutic modality with the remainder having a range and spread of trainings. Of the CAT sample 91% were trainees (Fig91). Those with less experience would be the trainee counsellors and some CRUSE counsellors who were either embarking on their career or were trained in the CRUSE bereavement model. The CRUSE sample are often also qualified in other therapeutic models which is why account for 50% of the overall sample but only 9% as CRUSE counsellors as their previous training was considered the master (Fig92).

The 2016 CRUSE workshop provided some complexity as the audience was made up of a range of helping professions and some non-clinical staff. The non-clinical staff were managed out of the sample so as not to contaminate the results as their comments were mostly about being non-clinical and therefore struggled with the clinical focus of the workshop. At the time of delivery I was not aware of the range and spread of the sample until I met the groups. As a significant percentage was counsellors I maintained fidelity with the teaching materials and content in order to provide comparison with other groups' experiences.

Fig91: Level of training CAT

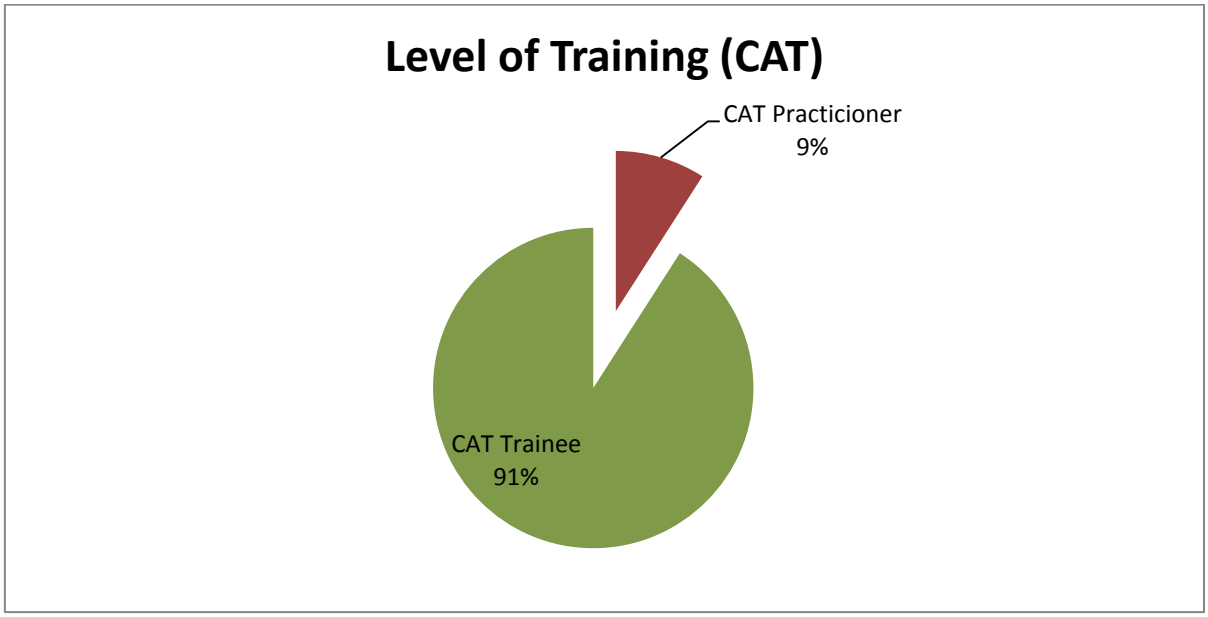
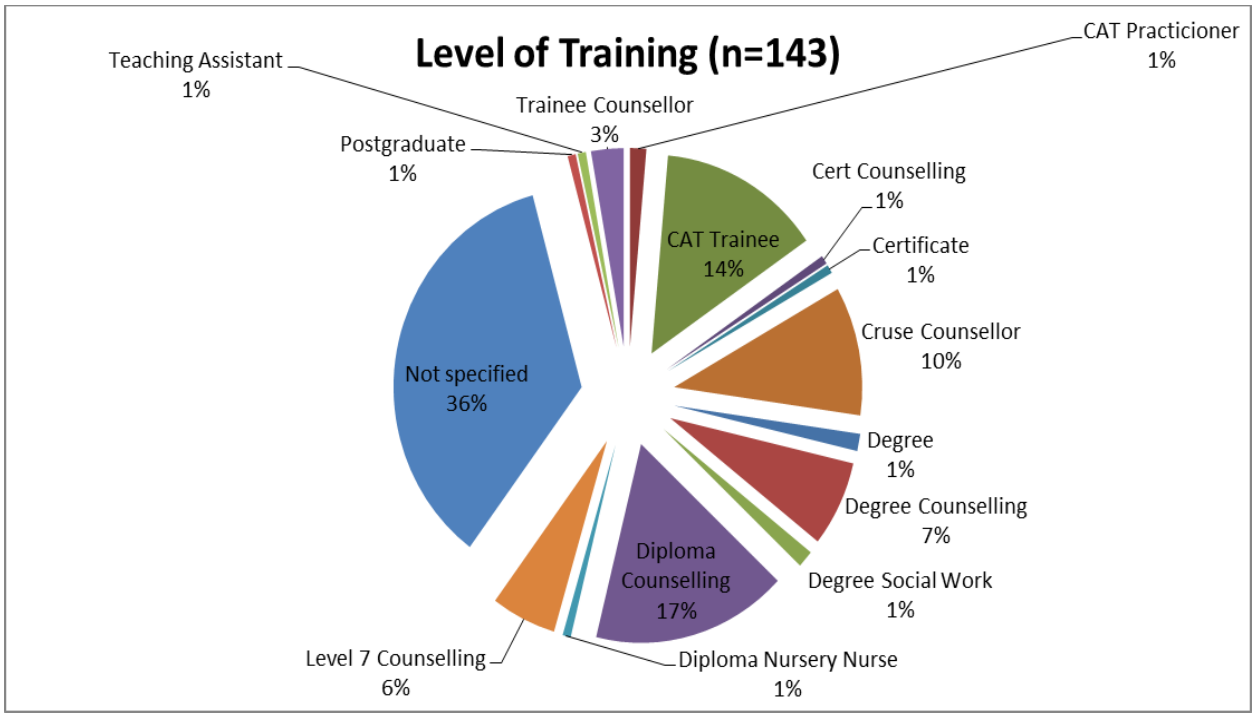


Fig92: Level of Training whole



There was a complexity with CRUSE Isle of Man 2016 sample as the author thought initially all the participants were working in bereavement care but it transpired that there were 8 groups of therapists in the workshops. Furthermore, one workshop had 40 people in which was twice the anticipated size. This made the workshop harder to deliver as there was less time for feedback and group support and the data more complex to manage.

Because of these complexities decisions had to be made to rationalise the patient group and professional background. A large part of the sample fell naturally into either CRUSE or Counselling category and the remainder were considered a discrete group. More insight as to the transferability of the technique emerged as the results for the 'remainder' (pastoral counselling, education, etc.) provided an insight into the use of metaphor and PM with these patient groups. The data was analysed in accordance with the protocol and laced into the 'master' groups previously identified of 'CRUSE', 'Counsellor' and 'other.'

Experience

The whole sample represents 1181 years in MH work an average of 10 years per participant. This figure is probably higher but there were 28 (18%) who did not specify their experience in years. The CAT sample had 284 years of MH experience an average of 13 years per person.

Fig93: Time working in MH/CAT

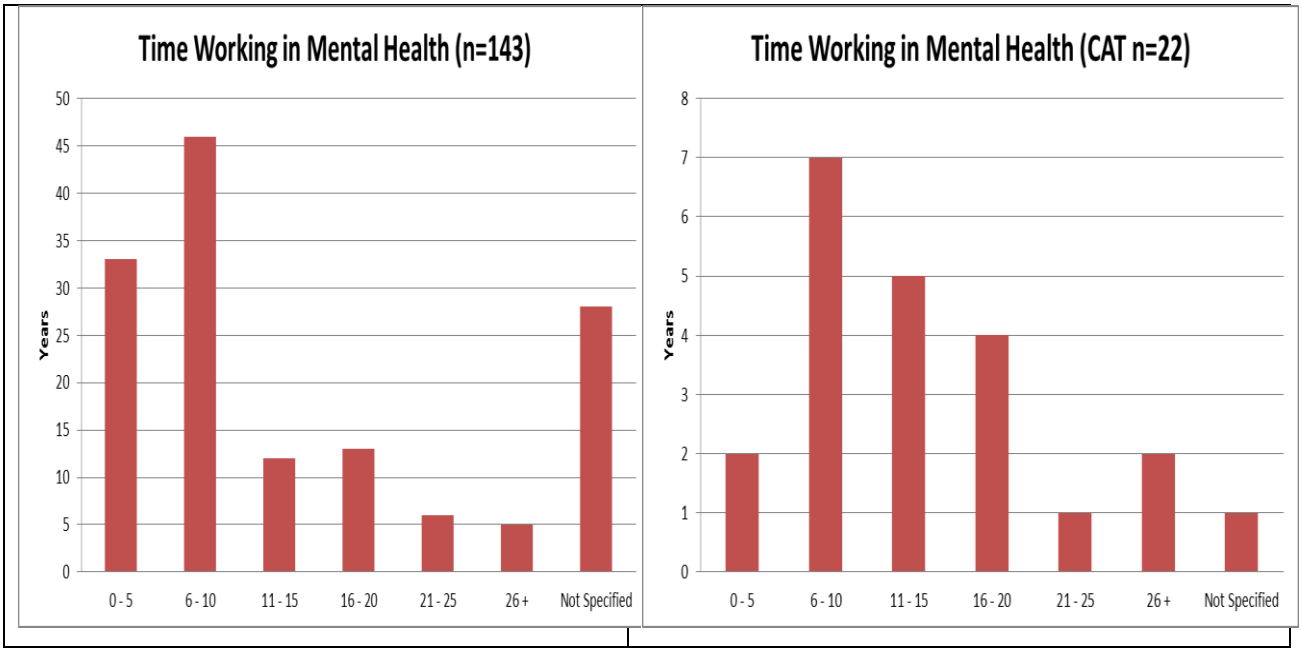
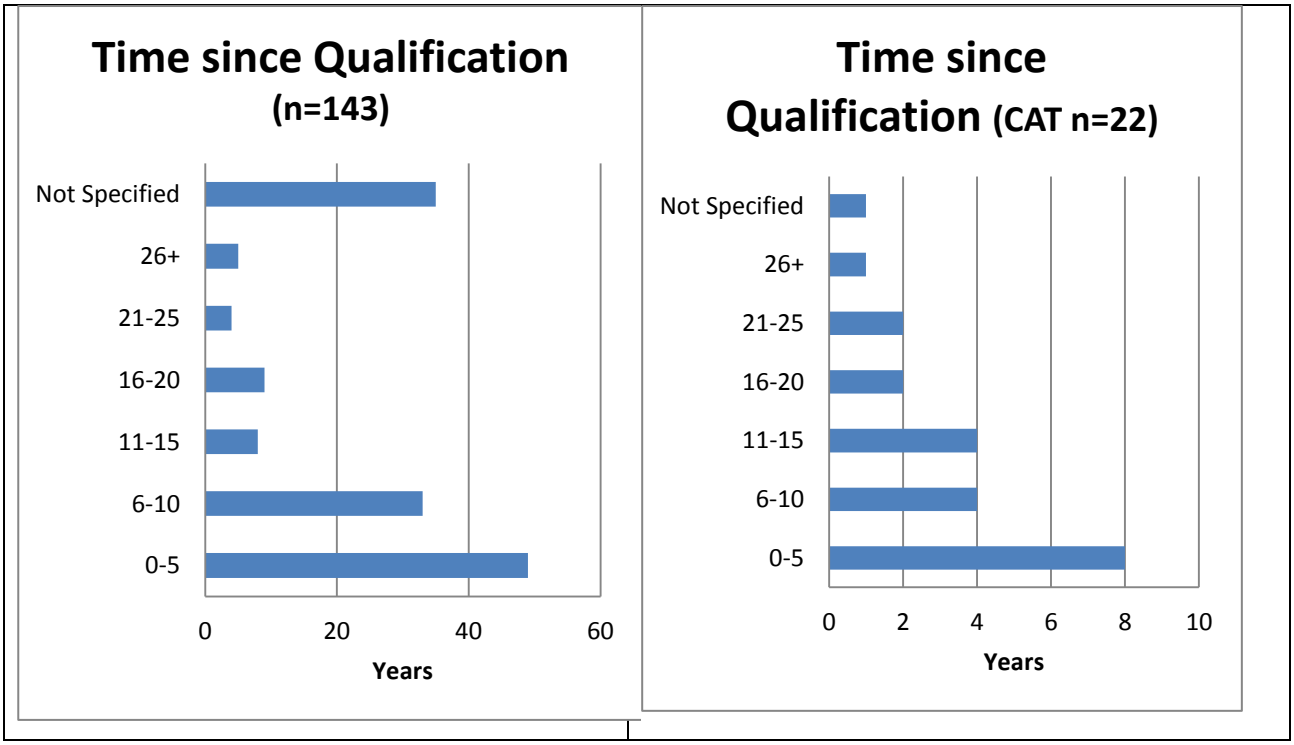
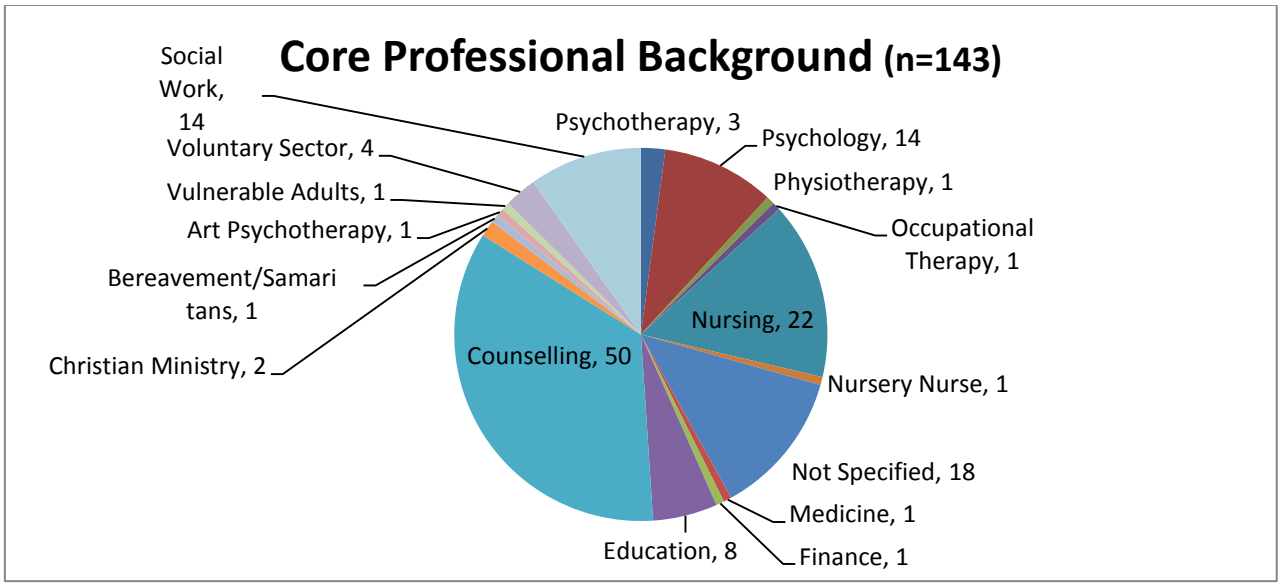


Fig94: Time since qualification



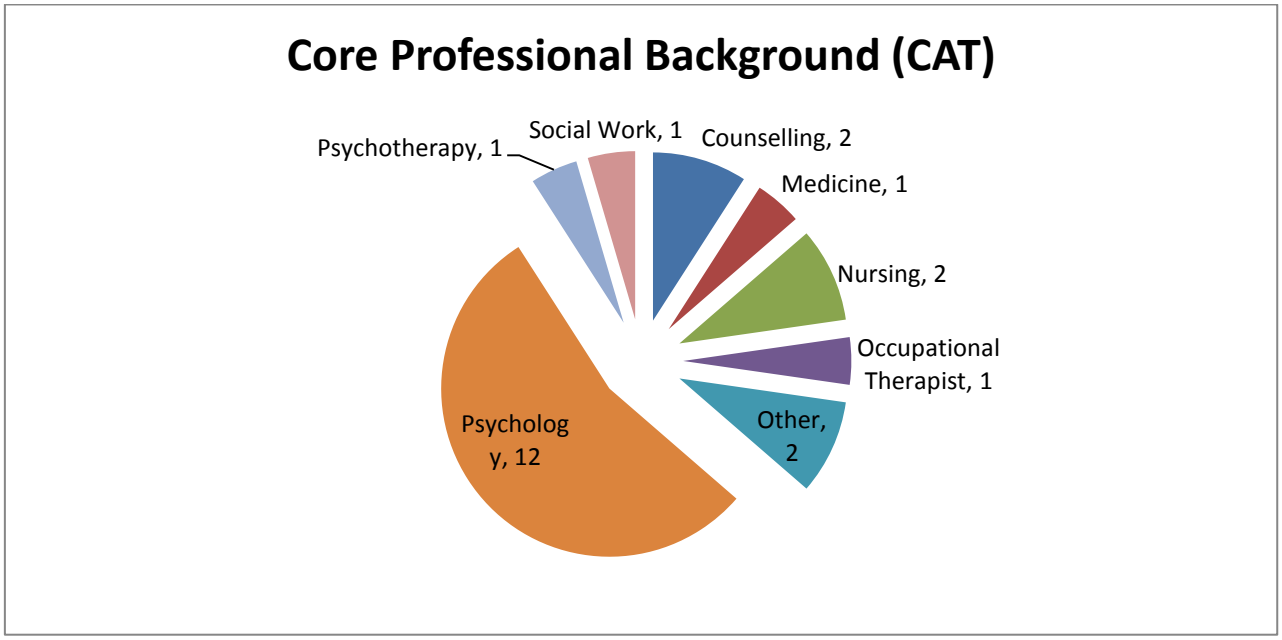
Half the sample was relatively new to therapy, which recognises the complexity of the CAT sample who would score themselves as trainees despite them having significant experience in mental health. The Counselling sample was less experienced with a mean of 6.3 years. The mean time since qualification is 8.7 years suggesting quite an experienced sample overall (34 responders did not specify).

Fig95: Core professional background (Whole)



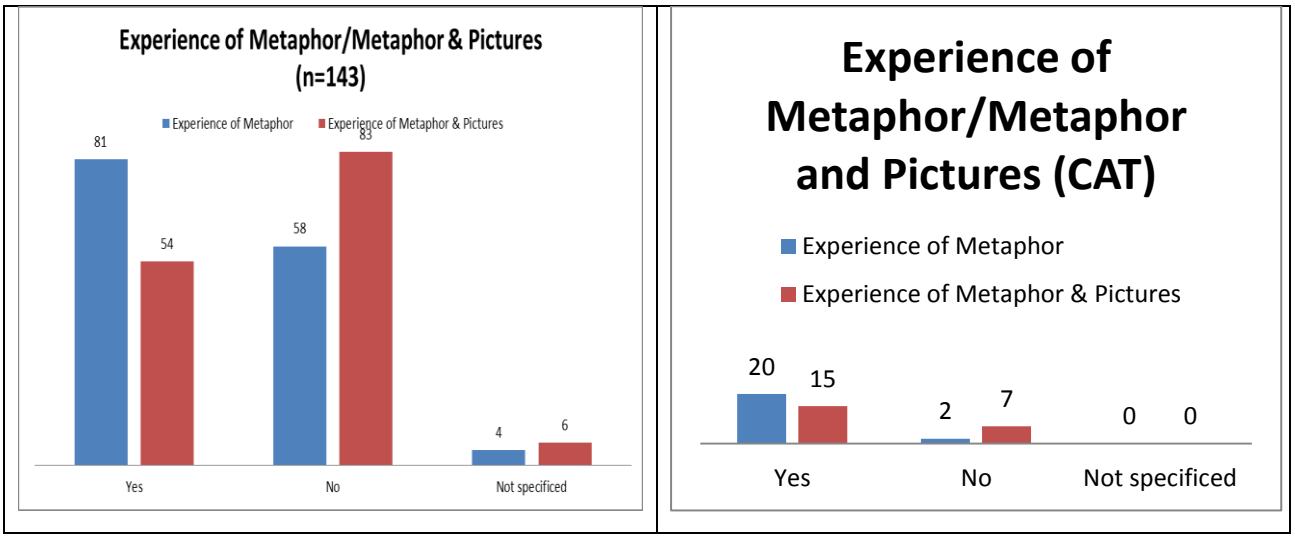
This category had 41 nodes with 77 duplicate values standardised to 17. The category 'Not specified' included professions like police, IT, dietician, and human resources.

Fig96: Core professional Background (CAT)



This core background represents the expected range and spread of professional grouping as part of an integrated therapy and mirrors Study1 and Study3 demographics. Fig97 indicates a leaning percentage towards metaphor overall as opposed to PM with 57% of the whole having experience of metaphor and 91% of the CAT sample. PM is by contrast 38% full and 68% CAT.

Fig97: Experience of metaphor and/or PM



Study3 Part 1 - Workshop evaluation

Demographic and evaluative data was managed within EXCEL. Using software enables relationships between scores and between groups to be looked at and analysed. Fidelity to the protocol 'Development of PM in CAT' was maintained as well as recognising the level of interest and opportunities for evaluation from a wider therapeutic field sample. The study is embedded 'in' and 'mutual' with CAT (Whitehead and McNiff 2006). N=143 completed questionnaires were received (Fig 89). Questionnaires were coded to each responder to ensure confidentiality.

Quantitative analysis utilised EXCEL, qualitative comments were managed though NVIVO and traditional content analysis. Results were analysed by 'sample' and 'sub set of sample' to ensure an analysis of the emerging groups was articulated. This enabled the CAT group data to be measured against the emerging 'multiple' sources of data as Denzin (1970) suggests.

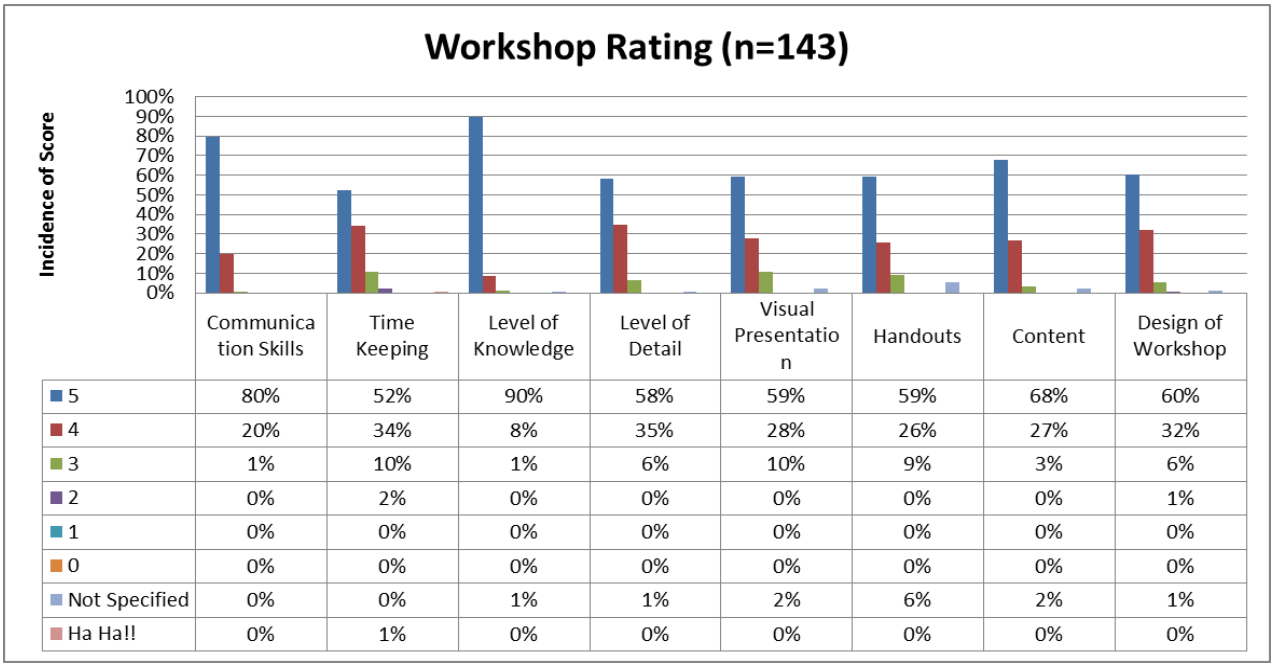
Fig98: Study3 Returns

Workshop returns		**Groupings**
Mental Health NHS Trust (2012)	n=13	CAT n= 22
CAT Berkshire (2013):	n=9	Cruse n=52
CAT Scotland (2014) (n=8 lost)	n=2	Counsellor n=32
CRUSE (2015)	n=41	Other n=37
CAT Berkshire (2015)	n=11	
SPACES (2015)	n=12	Totals: n= 143
CRUSE (2016)	n=55	

Quantitative data

Figs 99-101 present the levels of satisfaction with the 8 items for the whole and CAT groups. Overall 7 of the 8 areas for the whole sample rated achieved 90%+ satisfaction rating of agree to strongly agree with the timekeeping being 86%. There was complexity here as the short programmes were either a lecture in a workshop or a lecture attached to the workshop as a plenary. The content was maintained 'in' and 'out' of the workshop format but as with all delivery to a large audience timekeeping can vary. The CAT sample was more circumspect about visual presentation and handouts although no participant scored any area below acceptable.

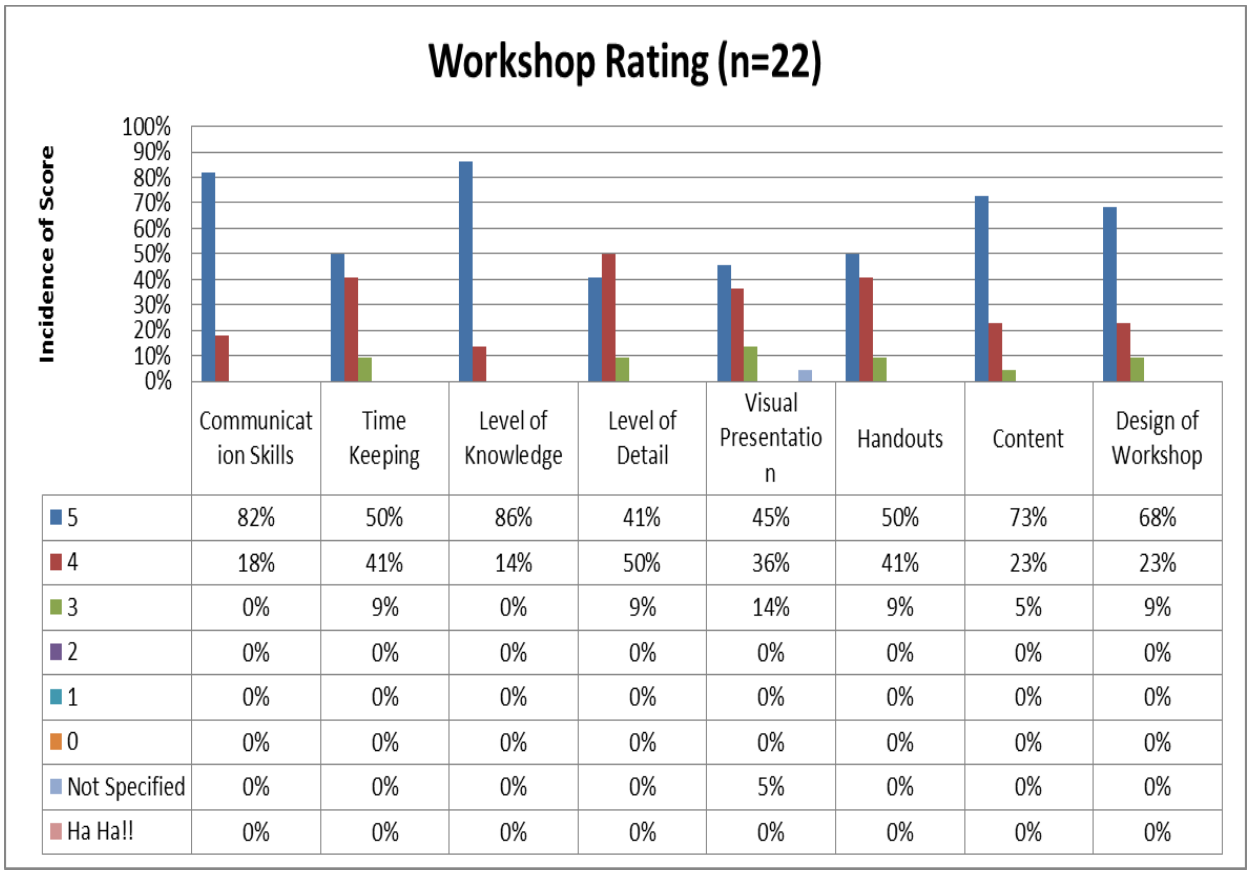
Fig99: workshop rating whole



	Communication Skills	Time Keeping	Level of Knowledge	Level of Detail	Visual Presentation	Handouts	Content	Design of Workshop
5	80%	52%	90%	58%	59%	59%	68%	60%
4	20%	34%	8%	35%	28%	26%	27%	32%
3	1%	10%	1%	6%	10%	9%	3%	6%
2	0%	2%	0%	0%	0%	0%	0%	1%
1	0%	0%	0%	0%	0%	0%	0%	0%
0	0%	0%	0%	0%	0%	0%	0%	0%
Not Specified	0%	0%	1%	1%	2%	6%	2%	1%
Ha Ha!!	0%	1%	0%	0%	0%	0%	0%	0%

The responder who scored timekeeping low created their own rating of 'ha ha' and also made many positive comments and ratings in other areas and their comment is considered a humorous reflection of rating as in one plenary my timings were well off; but it does reflect the 'playfulness' of the teaching method and level of detail suggesting that the responders wanted tighter timekeeping (which is complex when trying to manage a range of group expectations). The visual presentation was also let down in some venues by the sophistication of the PowerPoint technology (or lack of it) which was a small screen and projector as opposed to the quality of technology available in say a university teaching venue.

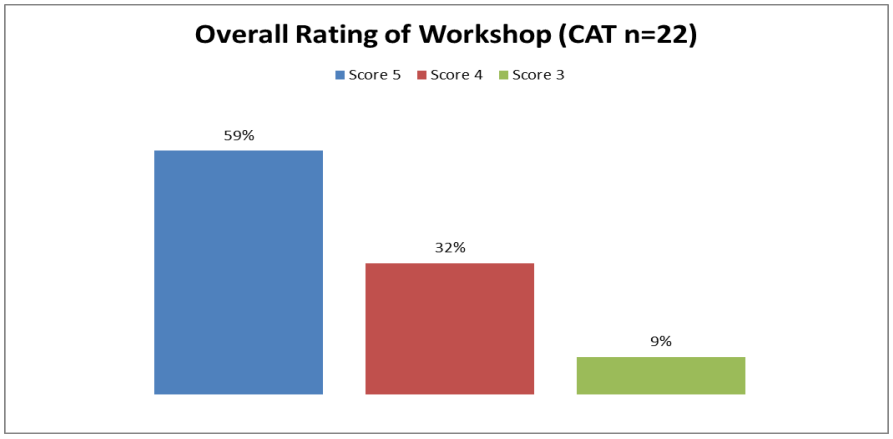
Fig100: Workshop rating CAT



	Communication Skills	Time Keeping	Level of Knowledge	Level of Detail	Visual Presentation	Handouts	Content	Design of Workshop
5	82%	50%	86%	41%	45%	50%	73%	68%
4	18%	41%	14%	50%	36%	41%	23%	23%
3	0%	9%	0%	9%	14%	9%	5%	9%
2	0%	0%	0%	0%	0%	0%	0%	0%
1	0%	0%	0%	0%	0%	0%	0%	0%
0	0%	0%	0%	0%	0%	0%	0%	0%
Not Specified	0%	0%	0%	0%	5%	0%	0%	0%
Ha Ha!!	0%	0%	0%	0%	0%	0%	0%	0%

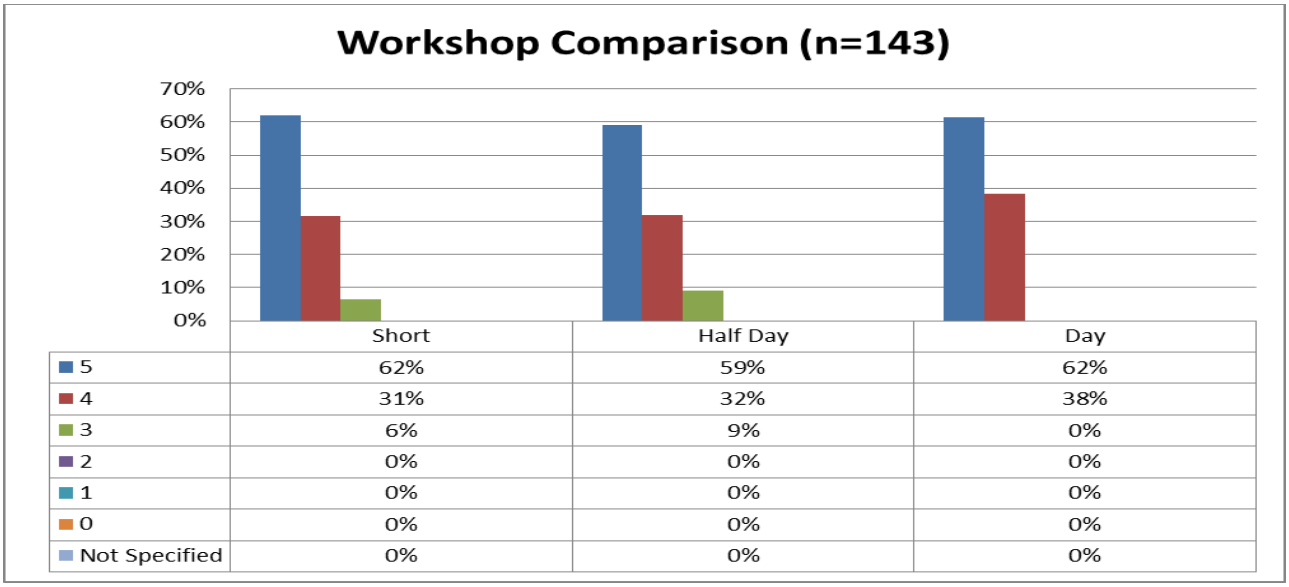
The CAT responders (Fig100) scored the workshop as acceptable 9%, good 32% (cumulative 41%) and 59% excellent (cumulative 100%).

Fig101: Overall rating (CAT)



Comparison between the duration of the workshop (Fig101) shows no significance between the timings with a score of 5 (excellent) achieving 59-62%, and a slightly higher support on score 4 for the day's workshop. No participant rated the programmes below acceptable (Score 3).

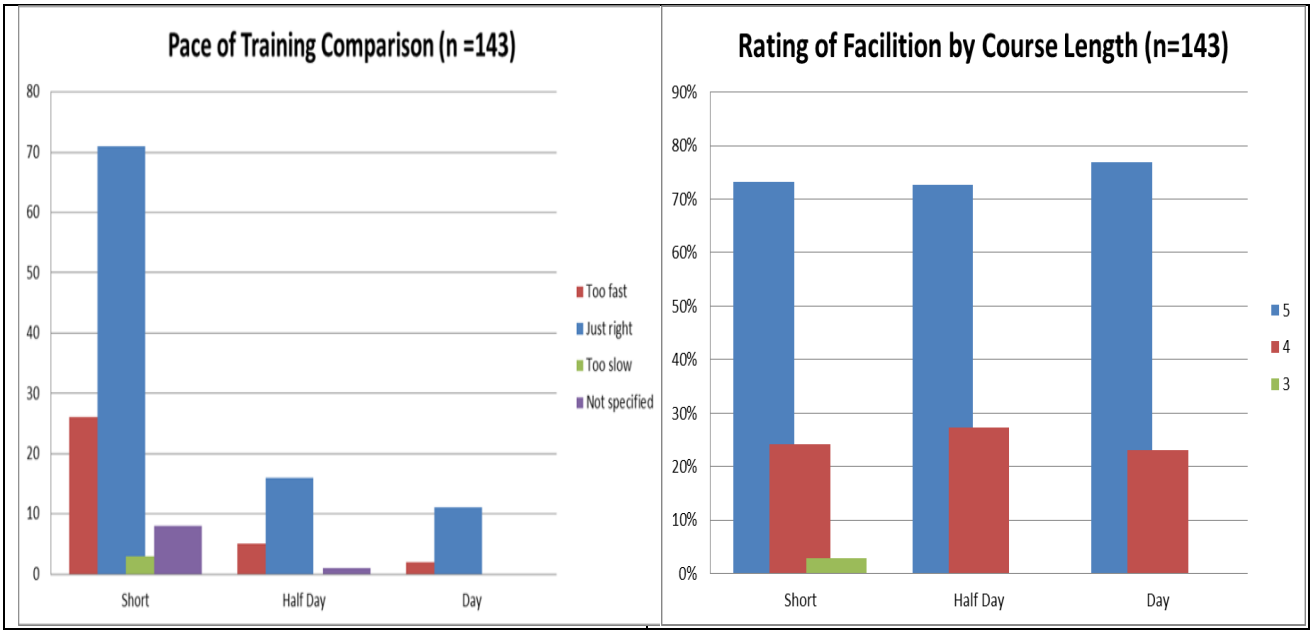
Fig102: Comparison between timings



	Short	Half Day	Day
5	62%	59%	62%
4	31%	32%	38%
3	6%	9%	0%
2	0%	0%	0%
1	0%	0%	0%
0	0%	0%	0%
Not Specified	0%	0%	0%

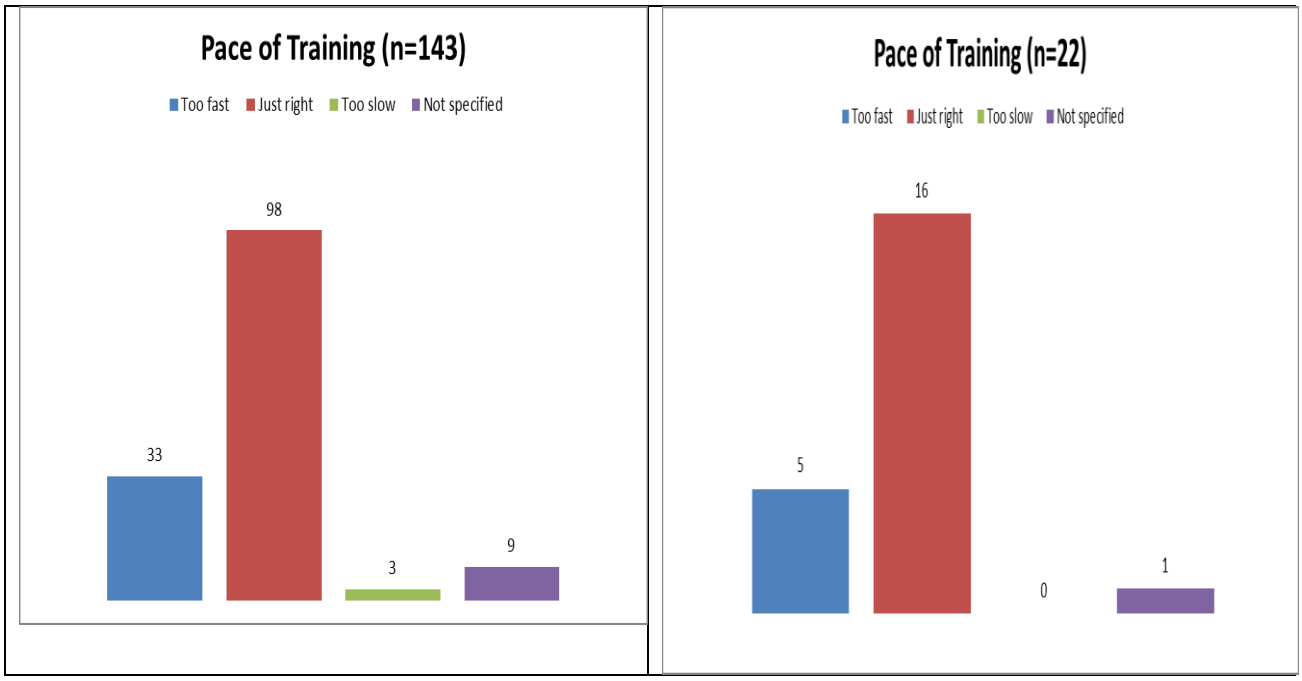
Figs 103-104 indicate percentage satisfaction. One responder scored the pace as too slow and this was in the complex group in 2016 where there were 40 participants in one workshop. No responder reported that their objectives had not been met. The short and day's programme achieved over 70% satisfaction with objectives met over 90% for both programmes. Clearly the 'brief' session is less effective in introducing the technique.

Fig103: Pace and facilitation of training



The pace of training in the 1 day workshop scored significantly higher than scores from workshops that were half day or shorter programmes 51% rated the short programme as 'just right' whilst 73% of the Half day and 85% of the day rated 'just right'. The scores for facilitation for the full day were slightly higher than the shorter programmes.

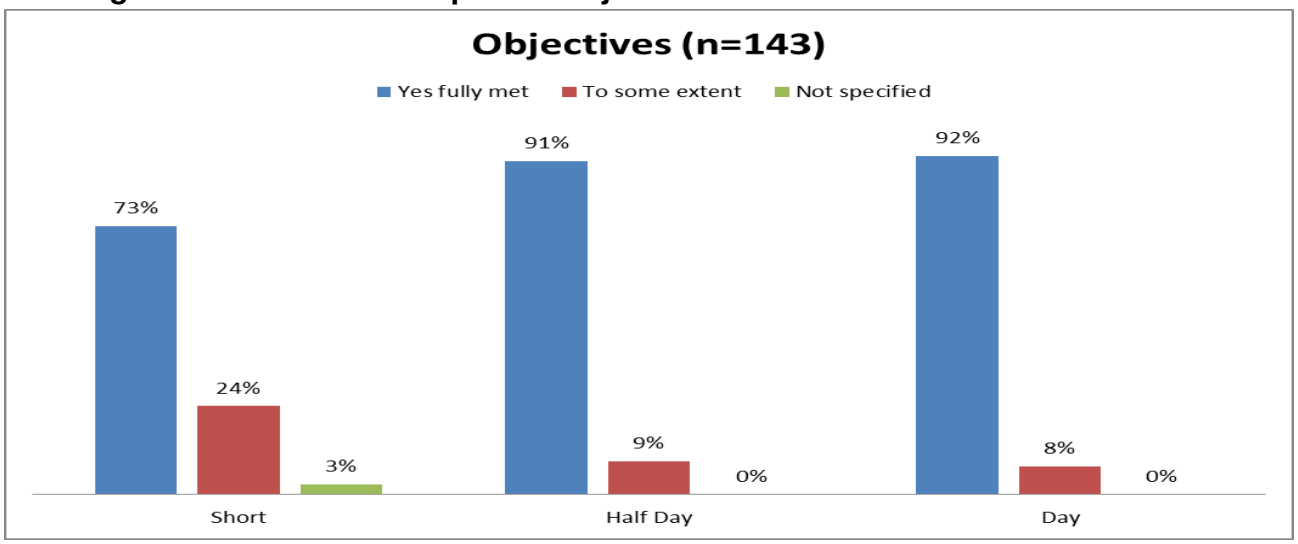
Fig104: Pace of training



Objectives met, rated 79% of the short day, and 91% the half day. 92% the day workshop were rated as 'fully met' (Fig105--106). In terms of resource management, this would suggest that a half day is sufficient to meet learner's objectives.

The whole group achieved 78% satisfaction and the CAT group 91% of objectives met. This is a reasonable difference of 13%. Facilitation overall was rated as cumulative 100% for all three programme lengths.

Fig105: Did the workshop meet objectives?



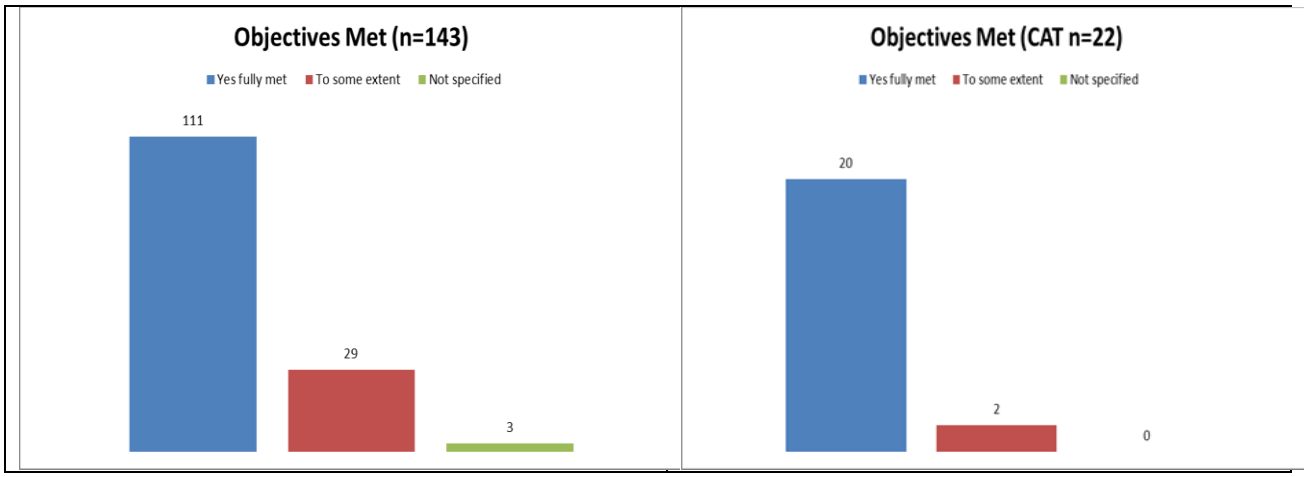
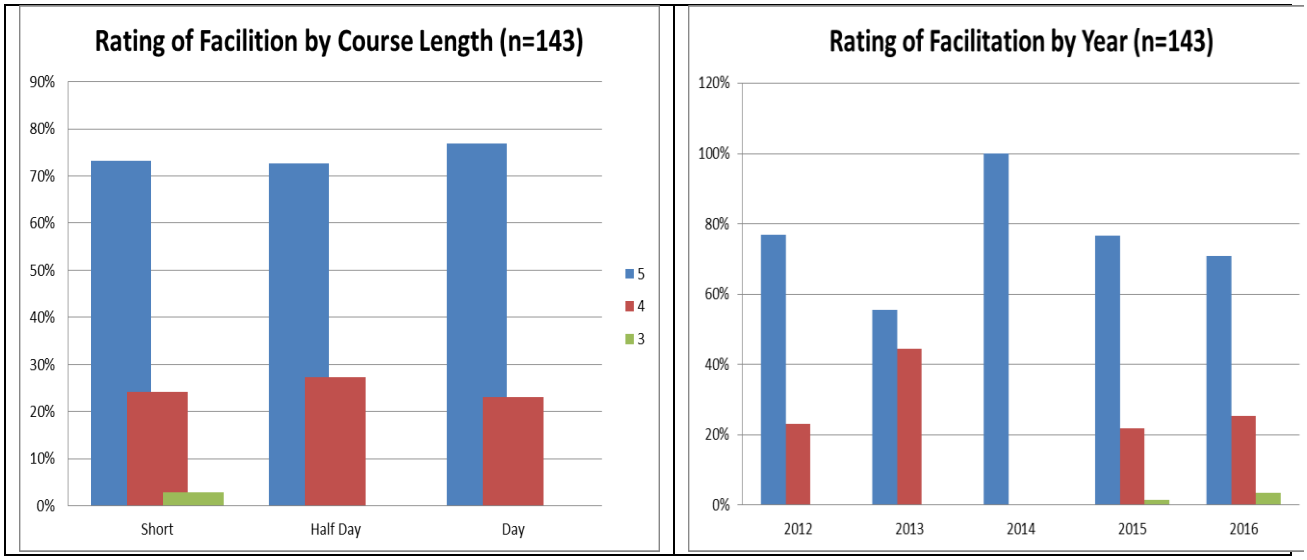


Fig106: Rating of facilitation by length and year



NB: For information the graphs for counselling, CRUSE and OTHER are presented in Appendix XXXI for further examination of the differing professional groups and fields. I have included these for reference but it is important to note that their overall scores are presented here as 'whole' alongside the CAT sample to maintain a focus on the CAT group. I have provided these for critique and analysis of the potential transferability of the PM across other fields of care as responders contributed their knowledge and experience to this study. However, their qualitative comments are included within the following text as they added to the overall understanding of the topic and it seemed important to represent these alongside the CAT responses in order to explore the wider applicability of the PM and recognise the contribution of multiple responders generosity for providing data.

Study3 Part 1 - Qualitative comments

Metaphor Experience

CAT

90% of responders were 'attuned' to metaphor having scored their metaphor experience as 'Yes'. Responder 82 sums up a number of comments *'I almost can't help using them! I think that they can be a very powerful tool to encourage the patient to understand something/see from a different perspective' (82).* One responder had an art background (87), another had training in mindfulness based cognitive therapies, and although mentioned in the manuals, did not use patients' own metaphors (60). Responder 57 had noticed metaphor since their early training with 67 using them to '*illustrate points, enhance understanding*' and responder 56 'strongly connected' to metaphor as '*joint sign mediation'* so it '*forms a large part of my practice both in verbal and non-verbal form*.' What came across was a willingness to work with and '*Suggest/discuss metaphors'* (84)

The 'no' or 'limited use' responders clarified their position as lacking confidence (65), **'***only just started to experiment with them'* (83) or '*only with some patients'* (86). There was a sense of not paying enough attention, not being focussed (62) to metaphor as if *'in passing' rather than an integrative part of therapy'* (90). Also there was a reflection on metaphors usefulness '*as I have missed so many opportunities'* (58)

Practice comments were elicited with 85 noting **'p***icking up on words used by patients that are not literal, observing non-verbal body language and offering metaphors'* (85). Responder 63 routinely using metaphors with patients, co-constructing them to *'illustrate points/issues particularly when patient is stuck'.* Case examples of patient-derived metaphors were provided including:

- '*Use narrative, images, meaning during clinical work'* (66).
- '*Within SDR's: A smashed up TV, a top dog, a rickety ladder, opening and closing doors, trauma being locked in a box with chains around it. The number of chains goes up and down as therapy progresses'* (59).
- '*To describe problems and dilemmas e.g. swan in water, palm tree blinds, a shepherd's pie to represent longing for being satisfied/nurtured, cages* etc'. (64).
- '*Dark place described as being in the sea with sharks'* (68).

Going forwards two responders felt the workshop had helped them noting, as non-native English speaking, '*this would be a great alternative tool'* (88) and '*enabled them to notice metaphors in a formalised way*' (89).

CRUSE

63% of responders had worked with metaphor and 15 (37%) had not. One responder noted that it was 'o*nly by default not design'* (2), whereas others included them as part of normal patient work (4, 5, 7), in their own therapy (7, 20) and '*Often work with pictures/images with patients'* (33). One used them as part of hypnotherapy (31). Responders 6, 21, 38, 39 and 41 used them a little whilst 22, following the workshop, noted s/he '*used them all the time in Cruse but did not know'*.

Training and supervision were mentioned a few times. Responder 9 noticed their use in training and 12 used them as part of their teaching. In supervision responders 11 and 26 recognised that they use them when '*speaking about patient work - aware of patients using them and tend to pick up verbal metaphors'* (26)'. Roth and Pilling (2008) note 'good' supervisors tended to allow the supervisee's story to develop, track the most immediate concerns/queries of the supervisee, and make comments that were specific to the material being presented' (p7).

In relation to practice **'***art/pictures tell a thousand words'* (5) and imagery work emerges from patients' story (40, 10, 24) and is used them when words are not enough *'Helps me to see deeper meanings and work through situation'* (28). There was a sense of using metaphor to '*establish where they were/are on the journey'* (13). The focus was on verbal descriptions from both the patient and therapists (16, 27). Examples of practice were offered:

- '*Use a lot of visual/audio imagery in hypnotherapy script to describe likes/dislikes, favourite places, feelings, colours/shapes'* (18).
- '*A women whose adult daughter died by suicide…She has described a juggernaut heading towards her at top speed from the brow of a hill. She also described being behind a pain of frosted glass*' (25).
- '*Russian dolls, stones, shells, drawing, creative writing'* (29).
- '*Pictures, words, stones, buttons etc*' (32).

Counselling

Of the sample n=25, 8 (32%) had not worked with metaphor (knowingly). There was reference to using metaphor in '*written form'* (70), *'to explore loss/bereavement…to unlock emotional meaning'* (44) and to *'explain feelings'* (51). One noted they use their own *'to explain processes…feelings/situation'* (45). One responder had had a half-day metaphor training on supervision course (81) and another on a training course *'to focus on bodily sensations and feelings and expand their images'* (46). Peoples practice was to work with patient's metaphors in session '*when they arise or introducing metaphors in order to empathise'* (52), to '*make an effort to pick up on it and explore further if patient brings up metaphors'* (55) and '*I try to get them to describe further*' (48).

- One example was a patient's story '*through stories of wanting to be a dog very powerful and want to use more - not yet linked this to pictures'* (53).

OTHER

Nine responders were from an 'adult' patient grouping. Comments included 'interesting' (117, 123) and wanting to follow this through with patients (117, 124) one responder with over 30 years of MH experience noted they used metaphor but '*didn't know it before this'* (110). A responder from a substance misuse service (137) thought we used metaphor more than they realised.

- An example '*Light at the end of the tunnel. Often patients say there is no light. Suggest to them there is it's just that they are in a bend in the tunnel. Keep moving forward and the light will appear eventually'* commenting '*maybe we use metaphor more than we realise*' (137).

Ten responders were from older adults who made limited comments, although one such described respite care as a 'holiday' and overall they were interested in progressing this work in their field.

Pictorial Metaphor experience

CAT

68% of the sample had used pictures and metaphor in some way or other in their practice. The importance of working within the ZPD was highlighted…'*I would try to work with pictures and images drawn either individually or jointly in the session*' (56). Responder 60

used pictures from 'Acceptance and Commitment Therapy' and less so from patient's own pictures whereas 63 noted '*I have experience of patients bringing artwork/visual representations of how they are feeling to sessions for us to explore together.'*

Six responders had not used pictures and a some noted they either didn't use pictures or only a little. Responder 62 had '*tried a few times to draw things but I lack confidence'* (62). *'With metaphor more than pictures, tried 6 part story a few times'* (67) whilst responder 57 noted '*I enjoy increased use of pictures and metaphors'* (57). Two responders noted locating the picture to the SDR '*when asking patient to discuss something*' (88) and *'I often draw these or ask patients to draw them or selecting picture cards to represent metaphors on the SDR'* (59)

CRUSE

Half of the CRUSE sample had used PM in some way. It was interesting to note the 'naturalistic' way responders used picture '*with positive ways of connecting*' (32) as 5 notes '*easier for me to work this way…did not realise so much academic stuff behind it.'* Therapists utilised pictures with young people (21, 41) but only '*Depending on patient I have sitting in front of me*' (29). Examples of practice include:

- *'photos and pictures'* (8)
- '*Sand trays, playing cards, blob tree'* (17).
- '*Not on paper - but using the mind when relaxed'* (18).
- Therapists had also used them in their own therapy (7 and 10).

Teaching and supervision was mentioned on a number of occasions, responder 12 used them in teaching as had 25 who 'worked with collage and pictures as metaphors for the learning journey'. Responder 26 noted they had not used picture 'b*ut will now'* and responder 32 plans to '*promote such resources when training others.*'

Counselling

Of the counselling sample, twelve had not used pictures, four were unspecified and nine (36%), had used pictures in some way. Those who utilised them were in '*anger management, in one to one, couple therapy*' (81) and '*a patient has done some drawing of subpersonalities'* (46). Two responders had used art in session or from outside session to produce them (45) but were not always 'drawn' rather 'described' (44). 51 felt s/he '*never*

managed to get as much out of metaphors as I have felt is there' whereas 53 noted '*not together but separately'*. Responder 44 had not used pictures but was '*excited to take this forward and use with patients*.'

Other

Seven responders were from education who made some interesting comments '*I used to work with a young boy with S.E.B.D - used metaphors e.g. volcano to help him understand'* (130), '*descriptive work/art therapy'* with young people (133) and '*very positive with young people as not perceived to be directly about them'* (134,) the one step removed function of metaphor. This has a shared finding with both previous studies as well as the literature as Barker (1996) notes the way pictures, when drawn, can represent core pain; the 'all better' position through drawing (akin to the miracle question in solution focussed therapy). Barker (1996) notes…

> 'This process is designed, first, to help the child disassociate from the pain. By drawing it, the child may be enabled, at least to some extent, to dissociate from it. It is now on the piece of paper on which it is drawn, rather than in the child. Some distance from the pain is thus created' (p112).

Additional comments

CAT

The CAT workshops were a half day in duration. 16 (72%) of the responders felt that the timing was just right and 20 (90%) indicated that the learning objectives were fully met. A few responders commented that they would have liked a longer workshop. Comments were provided which fall into a number of headings: confidence, role play, playfulness, and literature.

Responders 83, 56 and 58 noted increased **confidence** and willingness to draw with their patients. The workshop has '*ignited my interest…for using pictures'* (68) and noticing they already worked somewhat '*by using clip art on the SDR'* (57). Responders 84 and 66 were '*inspired to have a go at using pictures to explore metaphors in therapy*.' 58 noted how the seminar gave them confidence *'in finding the right type of questions to ask to understand the meanings of the metaphors. I will now try and elicit more metaphors that patient's use.'* This view was shared by responder 62 noting 'm*akes me want to try to draw more in therapy'* and responder 88 who noted '*will definitely give it a go as I think it's a beautiful way to engage the patient'* (88). It seems that overall the content, structure and delivery of

the workshop enabled individuals to take this technique forward in their practice. One useful comment about process was noted in relation to any reticence and reluctance therapists might experience regarding drawing as responder 59 commented...

> '*holding back…may reflect our own RRs and TPPs yet we expect patients to bring themselves into the room…The importance of us recognising this and being brave and the richness this can bring if we do.'*

Role play and examples elicited three comments related to the role play '*appreciated the chance to practice'* (84) and case examples '*were very helpful'* (59) whereby the '*format/structure of the workshop gave me lots of opportunities to think about my practice'* (86). **Playfulness** related to numerous comments about the informative, inspiring and light-hearted delivery of the workshop whilst the session maintained rigour, one responder noting '*enjoyable and made me think about working creatively'* (61).

The initial workshops were at first 'dense' in literature, I think because I had been trying to 'justify' the approach by securing it within the available literature. Later workshops had a more balanced incorporation of **literature vs role play/practice** with a maximum of a third of the time being 'didactic.' It may be that too much is offered and more practice time is needed, but the usefulness of the literature can be seen in responder 60's comments, '*we covered a lot in the short time we had, but it was all very welcome material…it has been really helpful just to think of ways to explain in greater depth and make more use of patient's metaphors'* (60). Responder 65 noted that the material was '*well informed both clinically and theoretically*' but another responder wanted to '*spend more time to discuss theory and explore metaphors, do drawings'* (67).

CRUSE

The CRUSE workshop was 2.5 hours as it combined a 'lecture' then a 'workshop'. The responders were generous in their support of the style and delivery with numerous comments relating to 'interesting' (2, 23, 31, 105) 'engaging and inspirational' (11, 9, 7, 14, 15, 34, 36, 101) and 'energy' (5, 6). Responders commented on the *'extra tools to work with both patients and nurses'* (27) and the validation on current practice '*put a name to techniques already using'* (33). A number of responders desired a more extensive workshop (13, 20, 24, 29, 41). It seems as if the workshop has enabled responders **confidence**, through its style and delivery, to use this in '*1:1 sessions, felt it fits with how I am with people'* (9) enabled '*thinking beyond the box'* (22). Sharing 'artistry' helped one

responder '*feel more comfortable about my own ability'* (7) and for another '*confirmed the direction I feel my work is going…give me the confidence to continue'* (14) and '*trying it out with patients'* (19). Making sure that all groups can provide feedback was noted by 102 in the context of a group that was oversubscribed, normally all groups would have an opportunity to open their dialogues to the group.

Playfulness was not noted within clinical work but as part of the delivery of the workshop where 'playfulness adds to learning' (3) and the blend of information, theories and humour was enlightening (7,28). Responders liked the practical nature of the workshop exercises (3) with one noting the PM was an '*extension of a tool used in hypnotherapy…good tool to have'* (18). One reflected on an example they worked on to *'think through a patient's current use of metaphor - image of chrysalis and the visual representations of that and how I myself related to that image. How it touched upon both physical/psychological. Exercises were useful in unpicking this'* (4). One point about 'materials' was to ensure a range of prints are available…'*thank you for large print - I am visually impaired*' (26).

Counsellors (1 day workshop)

100% of participants rated learning objectives as met with responders having gained more expansive knowledge when working with metaphor (71). Responders also '*gaining **confidence** in the use of metaphors'* (81) with intentions to use this technique (75, 78, 80), '*get started introducing metaphor and PM in practice…opened up a whole new toolbox for me, lots of rich learning'* (76). The style of the workshop was commented on where ***'fun** and good humour …maintained interest and motivation throughout'* (69, 81) and they were able to question and explore. A good blend of **theory and role play** was welcomed (73, 76, 77, 80) with one responder wanting a '*book of metaphors'* to take away (74). Responder 72 wanted the introduction to include 10 minutes for group work to share metaphors; this has been included in subsequent workshops. Role plays were supported '*Having the opportunity to relate everyday issues of my own in terms of metaphor'* (70). The presentation seemed too quick for some as they wanted more time to digest the visual presentation.

Counsellors (short programme)

The SPACES counselling group workshop was approximately 90 minutes. Twelve of the thirteen attendees felt the timing was 'too fast' and a number of qualitative comments corroborated this. Responders noted they '*have got so much out of this...I feel really*

motivated to take this forward into my patient work and feel like this will be so helpful to add to my toolkit' (44). Another noted, despite the timing, that valuable insight was gained '*I found it particularly surprising drawing my own metaphor. This allowed me to explore much further in the picture than from my own words'* (48). The general sense was that the workshop was interesting and stimulating but they wanted longer with a suggestion of a 1 day workshop…'*I think the content was fantastic but I think it would work beautifully over the course of 1 day'* (42).

Counsellors (Isle of Man)

Eight responders coded to 'counselling'' made a number of useful comments…'*fantastic and led to us as a group having fantastic conversation discussing delicate issues positively'* (131). Responder 135 commented *'it was a useful workshop, very informative and interesting…have never considered this type of therapy ever before'* and '*valuable to reassure current clinical practice'* (138).

Other

This was a complex section as 37 responders reported 8 different patient groups from 9 professional backgrounds and clinical areas such as social work, ministry, nursing, education and the voluntary sector. Nineteen qualitative comments were received. Many were '*thank you'* the remainder commented on personal development and processes. Responders '*learned a lot about myself'* (140), were interested to follow through with their patients (113, 124, 117, 127), but recognised that '*might be difficult when turnover was fast'* (125). This last comment mirrors some of the technical observations from the CAT group that the model was 'busy enough'.

Study3 Part 2: Reflective commentary evaluations

N=7 reflective questionnaires and two emails were received. There responses were from CRUSE (301, 306 and 307) and four from CAT (302, 303, 304 and 305). It seems appropriate at this stage of analysis to include these as a whole group rather than two separate groups. This enables a sense of the response from all responders to the reflective comments but also an ability to notice which background the responder was from by the unique identifier following each qualitative comment.

The analytical approach was content analysis in NVIVO and statistical analysis in EXCEL. The researcher immersed himself in the data by reading and re-reading the responses in order to manage the content and generate themes based on this immersion which were then triangulated with emerging themes coded within NVIVO. Questionnaires were coded 301-307 to differentiate them from Study3 part 1 responses. Twenty seven nodes emerged from the initial coding of the data (Fig106). A nodal summary produced from NVIVO and the ability to 'find' in the navigation pane enabled cross referencing and checking as the analysis progressed.

As each comment was incorporated into the prose it was colour coded as 'used' (see Fig 107). During analysis, because the nodes generally revealed 'topic' responses it was easier to immerse and interpret the data and collapse into a meaningful prose. The more the researcher read and understood, the more understanding emerged.

Fig107: Study3 Reflections Node table

Agency/Boundaries	attuned	busy
Central theme	Client voice	creative
Difficulties drawing	examples metaphor	Experience of metaphor
Feelings stuck	Final comments	Helpfulness of metaphor
history	Language barrier/communication	Less threatening
Link to sdr	Non judgemental	novel
Pictorial metaphor	problems	Shared language
supervision	technique	Training confidence
Training helpful	Way that works	willingness

Therapeutic relationship

Willingness was noted in the responders offering to sketch out a metaphor '*I was thinking if I could find a way pictorially to communicate what roles or self*' (304) but also respect the patient's decision to decline (305). 306 noticed a new **technique** or 'habit' of '*listening to speakers to see how many metaphors they use…It's surprising.'* Intuition had improved (307), as had drawing out the metaphor, in responder 301's case a circle where each layer was explored as representing different emotional states.

Other examples were using a card game to 'distract' away from resistance by using metaphor (the researcher doesn't fully understand the method) which helped a patient communicate, '*writing a letter together naming emotions and linked metaphors*' (307). Responder 307 noted the usefulness of facilitating the **patients voice**, '*speaking in his own way'* about metaphor.

A **shared language** can be gained from metaphor 'something *that as a soldier he could use in a very practical sense' (302).* It seems as if 'noticing' metaphor, and once finding out a way to work with them then progress can be rapid (307), the patient needs to '*connect with metaphor of the image'* (304) and the therapist gains a sense of *'knowing my patient at a much deeper level and what he/she is experiencing' (301),* and *'I think the fact that the patient could see anger as a material thing made the session positive' (306).*

As a '**central theme'** metaphor has been noticed to be helpful (Martin et al. 1992), in Study2 100% support in rating metaphor as a central theme, where they '*can form the basis for the whole therapy or be a transitory illustration during the session*' (responder 046), was noted. Four of the Study3 responders noted their use over a period of sessions (307) enabling '*permission to explore his themes without getting stuck*' and '*we often reflected on it as therapy progressed'* (304). How useful the PM's were on work achieved was noted (301 and 304) with an in session revision of the PM noted by responder 302, *'as he progressed we were able to look at how he would like the path to be and we added in exits.'* In fact the responder noted how the patient had also noted the usefulness of working in this way in their goodbye letter.

Concerns about the PM were also noted. For example, a responder who did not progress the picture because it is '*the patient's session'* (305) and they felt they were '*putting their thoughts in place of the patients'*. Another noted to begin with it was '*a bit school room using pictures'* (306). 303 noted concerns of '*not thrusting metaphor on them'* (patients). Also, the 'time limited' nature of CAT and going off track. This reinforces that therapists should be prepared to abandon metaphor if it does not resonate with the patient.

Training

Responder 303 notes metaphors as a powerful part of therapy and the training providing ***'confidence** and rationale'* to work with metaphor in a range of ways and not mentioned enough in other TP's. In fact they were pleased regarding the use of metaphor as it

provided 'permission' to incorporate it in their CAT work. Responder 306 noted '*I feel more confident having seen it work*', 301's improved confidence had enabled integration of metaphor in their practice, and 302 '*has used metaphor several times since being taught on the workshop'*. 303 noted '*I'm still not confident with building upon, or reflecting back on drawings as frequently as I would wish*.' Seven comments were coded to the **helpfulness** node with responders commenting that the training provided legitimate reasons and an informed place from which to work with metaphor (303). The training was *'fascinating'* (306) and *'invaluable'* (301) and improved '*confidence*' (301, 303).

Difficulties drawing emerged, for example *'cheating'* by using computer generated images '*but the visual worked'* (306). The responder felt introducing pictures was difficult but drawing would have been more so. Responders 303 and 304 needed more '*practice*' and the *'courage'* to draw whilst responder 305 was concerned about being '*pushy',* taking over the patient's session. Responder 304 sought images out from the internet as they '*were not a good drawer'*. Six of the responders had used PM either generated in session or used an image generated on a computer then brought to session.

Supervision was noted as one responder couldn't manage the PM in session due to a request from their patient not to. They noted '*I am going to try this in supervision with my 1-1 supervisees to see if this way of working felt more comfortable'* (305). Etherington (2001) and Gil-Rios and Blunden (2012) support supervision as a way of manage complex therapeutic dynamics. Four comments were coded to the **'novel'** aspect of PM, responders had not used pictures before (306) and another noted the patients response supporting novelty, the patient saying '*you're not like the others'* as if '*being different (*creative) *helped him'* (307). 303 noted '*The CAT training in metaphor, gave me a new awareness and perspective regarding nurturing work with patients own metaphors, rather than just using 'off the shelf' examples'* but needed attunement and practice.

Getting to unattainable places

Two responders commented on the metaphor having '*discovered a way through….from **being stuck'*** (307). In fact responder 307 noted this aspect five times. 307 noted by '*being different for him his expectation…was less threatening'* (the therapist was playing cards and exploring metaphor whilst doing so) whilst 303 noted the **creative** process is a '*legitimate and useful approach'*.

Complexities with language

Language barrier/communication had two emerging themes; patients with difficulty expressing emotions; and those with disability. Metaphor enabled emotional expression by the patient to '*reveal what a patient wanted to say to their family'* (307), where one '*could not verbalise…helped identification of* feelings' (301) and where '*word seemed to not land well with her' (304).* Disability was indicated as dyslexia (of the therapist), poor literacy skills (302) and patients not articulate/well educated so *'working with metaphor, and PM seem to be helpful ways of building bridges of understanding, images allowed us to connect'* (301).

On Metaphor

In psychotherapy metaphors can be utilised in understanding a patient's **history** whereby the metaphor is a beginning and understanding speeds out from this 'kernel' though exploration. It is suggested that we learn through metaphors, their nature is a heuristic and epistemic device having salience for here and now emotions but also understanding past events. Responders confirmed this suggestion noting metaphor can unearth history, getting to those '*little gems of the past'* (307) but also indicated the patient group they utilised metaphor with. A range of histories including bereavement (306), significant personal illness (cancer) (302), and self-harm (304) were noted. The **helpfulness** of metaphor as being able to express the inexpressible emotion easily, the memorability and vividness of imagery that metaphor brings to mind are suggestive of their conceptual usefulness. Edwards (2010) comments 'metaphors, as expressed through images, and the colloquial idiomatic nature of language enables us to convey that which might otherwise be inexpressible' (p4). Six of the responders' comments were coded here with 13 references.

Key messages are:

- Free us from expectation – exploring without boundaries (307).
- A sense of knowing my patient (301)/ Better understanding and insight (303).
- Provided illumination (301)/ acceptance and humour (303).
- Often use verbal metaphor (306).
- Power in paying attention to metaphor –it enriches work (303).
- Communicating complex ideas (304).
- Loosening rigid thinking…which seems to instil hope (303).
- Helps when struggling to form a useful alliance (302).

The **experience** of PM enabled one patient to 'see' themselves as present either within the inner or outer layer of their diagram (301), whereas 306 used the picture '*to find a way of showing anger with bereavement is often uncontrollable, however it can be channelled'* and would use it again using various types of picture. One responder noted as part of their CBT training that they had utilised metaphor (303). Patient and therapist '**attunement**' where the therapist is aware of the power of pictorial representations (304) as well as the patient where, *'Working with metaphor, especially those patients have brought to sessions… A more attuned understanding of the complexity of their perspectives, about the world, themselves and significant others'* (303).

On PM

Two comments were coded to **less threatening;** the patients sense that using pictures was 'less threatening' (307), and the *'the patient seemed to have heightened interest, relaxed a little, indicated that they could relate to the metaphor, as depicted in a picture'* (303). Being **Non-judgemental** '*not putting them on edge they are able to feel their way through' (307)* was noted. Seventeen comments were coded to **metaphor and drawings** from five responders. Responder 307 thought using images released him from being stuck and was '*enabling.*' Responder 303 noted it was a '*legitimate creative approach, found it to be helpful, relaxed the patient and heightened their interest'* but also *'A bit of relief, (I do initially wonder if they might find my drawing things, alien, or silly) but so far I have felt our ability to communicate and understand his helped through.'* Responder 304 felt metaphors were effective and that '*the patient was able to connect with metaphor of what the image communicated'…'where words were more elusive'. Responder* 301 formed a diagram with the patient, hoping the picture would provide clarity, and was '*extremely happy with the session*' this was the case, as if it '*opened a window'*, clarity and '*a voice to my patients circumstances*.' 306 noted the visual representation to 'see *anger as a material thing made the session positive'* and would use the technique again.

A number of responders generously provided **case examples** from their recent practice that have been incorporated into PowerPoint training materials (Fig 108-110). One responder (301) felt that their picture enabled the patient *'take responsibility for self and personal boundaries*' and 'h*elped identification of feelings. Enabled my patient to communicate i.e. voice his/her concerns.'*

Fig108: Case examples of PM

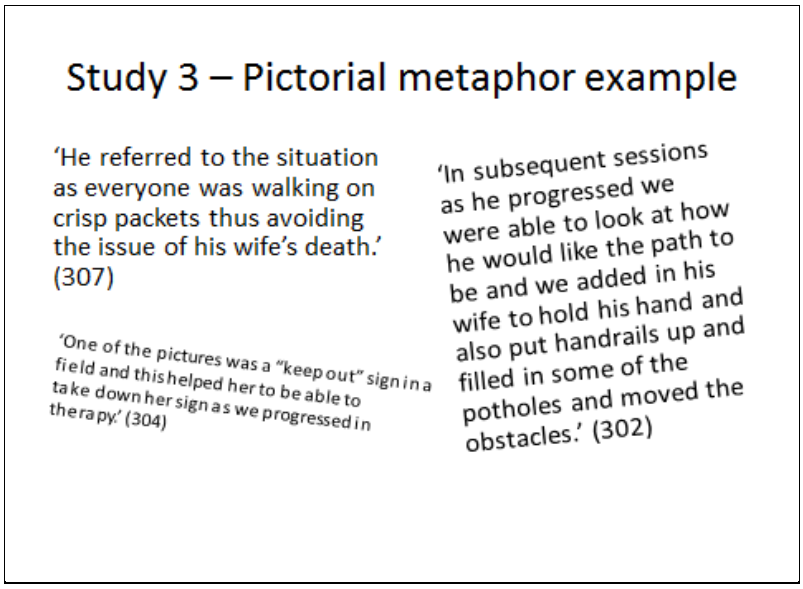


Fig109: PM example

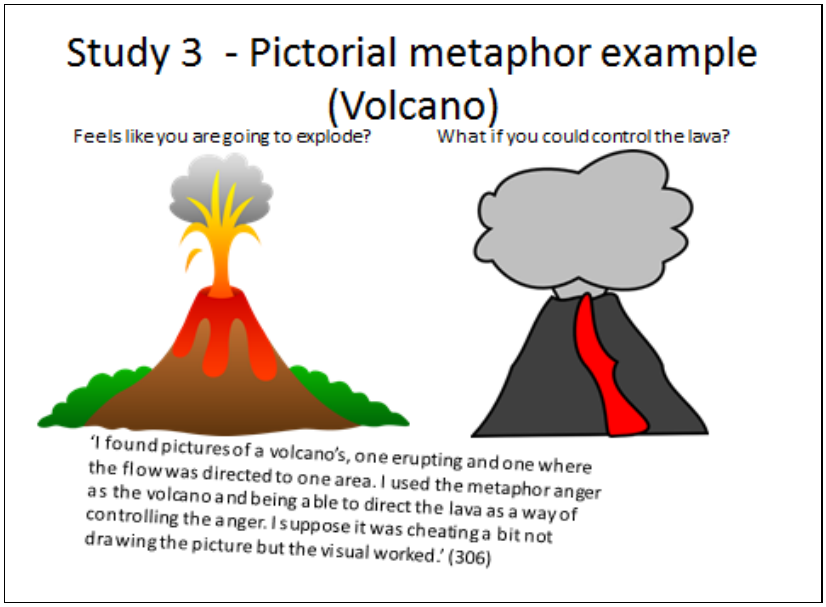
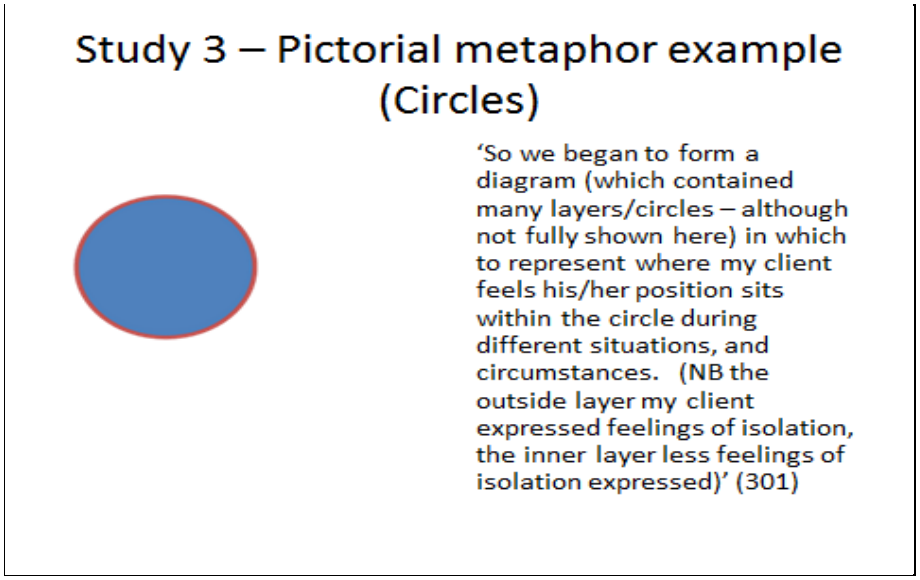


Fig110: PM example



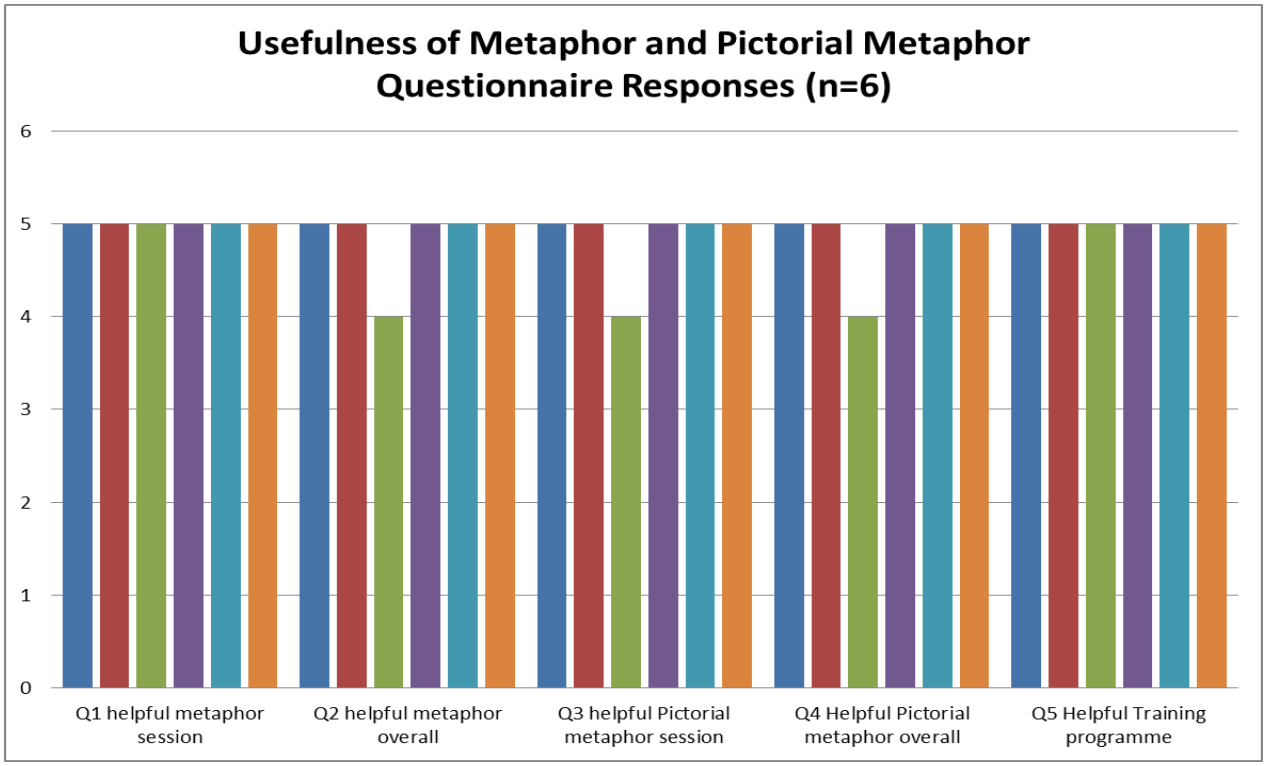
Model

Specific comments regarding how **busy** therapy can be and it is '*Hard to find time'* (303). Responder 303 noted '*working with metaphor, especially those patients have brought to sessions, has helped with developing better understanding and insight of how patients view themselves, the way in which earlier object relations experiences/RR's have, impacted on 'self to self' beliefs'*. The **Link to SDR** was reinforced where *'there were a couple of images which we put on the map* (SDR)' (304).

Likert scales

Five questions for rating were asked to supplement the qualitative comments to be rated on a Likert scale where 5= very helpful ranging to 1= very unhelpful. 100% rated the 'TP' and the use of metaphor 'very helpful'. Six out of seven responders rated this section. Questions included the helpfulness of metaphor and then pictorial metaphor 'in session', 'overall' and the helpfulness of the TP in facilitating working in this way (Fig 111).

Fig111: Helpfulness of metaphor and PM



Key

5= very helpful
4 = fairly helpful
3= neither
2= fairly unhelpful
1= very unhelpful

NB: The individual colours denote each individual responder

Final comments

Mostly offering a 'thank-you' for the inspirational delivery and content of the training but one in particular noted a patient's change '*The first time I saw him smile was a great reward for me. He became alive whereas his eyes were so dead when I first saw him'* (307).

Discussion

As a level of analysis and discussion has been incorporated within Study3 part 1 and 2, this section will address the research findings to date, and the study aims.

Develop a TP based on research results

Study3 explored whether a TP could be developed and delivered to enable therapists to utilise the PM technique. Participants evaluated the TP as well as completing a reflective commentary after they had utilised the technique in practice. There was comprehensive support for the nature and content of the programme. In Study2 responders commented that working with PM could be part of the CAT practitioner **training** and/or as CPD. The researcher has presented three workshops as part of CAT core training within the creative therapies content of the practitioner programme, and other workshops to a variety of therapists. Whilst this has been extremely useful for this research the researcher is mindful that this approach is one of many creative approaches CAT therapists could integrate into their practice, as Tony Ryle commented *'if it works use it'* (Ryle 2012). Analysis noted working with PM can be an addition but needs to fit the aims, be collaborative, and therapists needed to be trained. Cautions and solutions were provided that some therapists might be uncomfortable using pictures.

The researcher recalls the look of horror on the face of an experienced practitioner when in dialogue at a conference, she said there was no way the she could be taught to use pictures. Results suggest that these anxieties can be alleviated through training. Study3 clearly indicates therapists can be taught the PM technique with a number of comments supporting the 'going to give it a go' approach based on the practice they had completed in the workshop.

The Delphi consensus statement on **research literature** achieved 70%, indicating that an understanding of the literature was not essential. However, some responders' valued

having knowledge of the literature. The researcher would suggest that knowledge of the literature and training in the technique can enhance metaphor working. A thorough review of the literature to inform the research and training materials indicates metaphor and PM can, amongst other factors, generate an understanding of a patient's inner world. Working with metaphors in therapy can reach unconscious material (Adams 1997, McIntosh 2010, Levit et al. 2000). Their value as conceptual understanding, one thing likened to another, holds structure within language (McMullen 2008, Mills and Crowley 1986, Stott et al. 2010) and this dialogue constitutes a key conceptual pivot in human interactions (Bakhtin 1984). Study2 noted the way metaphors can embody emotion and provide a one step removed position in order to help individuals manage complex emotional issues. Their utterances can be emotional ontological, orientating and creative.

Metaphors have been 'categorised' into major stories, anecdotes, analogies, relationship metaphors, tasks and rituals, objects, and artistic presentation. Within the therapeutic approach metaphoric language in therapy has been noted extensively. In particular the common factors in therapy of purposeful activity, affective bond, empathic understanding and goal directed activity appear to rate highly when therapists notice and work with metaphor; new meanings are constructed and worked with in the encounter.

Study3 has found that practitioners practice can be validated through an introduction of the relevant literature as well as generating informative literature based on the results of the study. A number of participants were utilising metaphor but 'didn't know' and the workshop created a focus for them to utilise these

Undertake an evaluation of the TP and resources used

A number of points arose from the evaluation of the TP. Results were congruent with Study1 and 2 findings. There was a question in Study1 as to whether the technique could be taught and manualised. This seems to be answered by the responses as 90% of the responders were able to utilise the technique in practice. Interestingly, some drew from art in cyberspace developing pictures from ready-made samples as opposed to developing drawings in session. This is also the author's experience; generally pictures are drawn in session but also some pictures developed by the patients outside the session, based on the metaphor discussion in session. The congruence is that they are still memorable images that become a central theme and speak of the patients reciprocal role procedures as well as their developing exits.

It felt important at the outset to ascertain the best fit approach to the workshop and a major consideration was the duration of the training. There was no consensus in previous studies. It was noted that in a full day's workshop more 'theoretical' background can be supported whereas for the half day a more practical approach integrating theory into the practical session was supported. Data, particularly the triangulation of qualitative and quantitative comments, supports training as an enabler towards attunement to metaphor, engendering a willingness to work in this way. Robert and Kelly (2010) also found that metaphor can support change in counselling training.

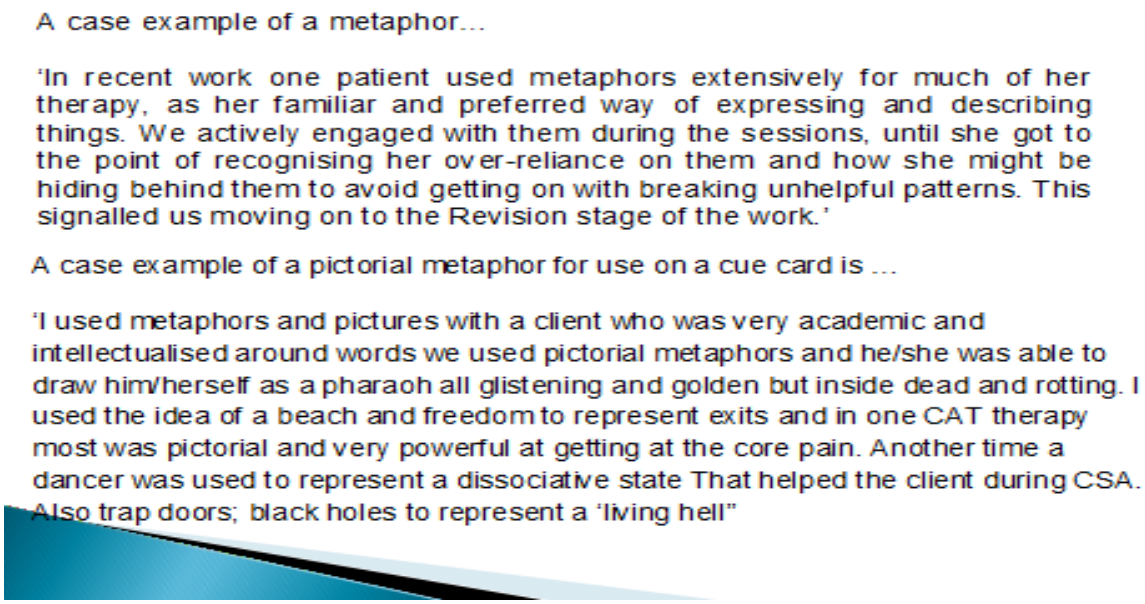
A range of timings were delivered in the groups from a programme of under 2 hours, a 2.5-3 hour half day, and a full day programme. The 90 minute session, although statistically unsupported, the qualitative comments deemed it too rushed and did not meet the responders expectations. The minimum workshop duration was of 2.5 hours/half a day and a day duration gained support as responders rated this as 100% 'objectives met'. In the shorter time period some of the depth of literature was disabled but role play and practice enabled. The half-day workshop increased confidence of participants to use the PM technique in their clinical work and I would suggest this is a minimum for best practice.

Deliver training materials in a series of iterative workshops

Martin et al. (1992) support training therapists to intentionally be attentive to and utilise metaphor in practice. Responders commented this is not be a *'should'* (048) but an option but agreed one could be taught to use PMs (088). There was universal support in previous studies for including **case examples** and metaphors therapists encountered within their practice. There are 16 'PM' examples and 26 uses of metaphor cue cards ensuring multiple voices are heard in the workshops as well as examples integrated within the PowerPoint presentations.

The style of the workshops integrated approach, with theory articulated through a PowerPoint. Providing a number of clinical examples (Fig 112), and role plays, was facilitated in three steps. Initially an exercise to discuss and develop a metaphor, next to integrate some of the research findings through exploring the metaphor further, and finally to develop a pictorial metaphor. Benner's (1982) novice to expert stages were anticipated in this managed environment with a skills accumulator occurring with participants learning from each other and developing the technique together.

Fig112: PowerPoint case examples



Utilising clinical case examples provide opportunity for discussion, vicarious learning and insight into the process of working with metaphor. Cautions regarding 'over reliance' on metaphoric descriptions are discussed as well as examples of PM. Case examples speak of the resonance of metaphors, how they are used in session, as well as how important it is to work actively with them as they may enable the patient to 'hide' behind them.

Role play was incorporated in all workshops; findings from Study2 noted 20 responders making 38 supporting references. The use of role plays and clinical examples enabled the responders to practice this technique and learn from others in the group., although in one workshop some of the participants felt that the exercises went on too long as not all participants engaged. Overall clear support for incorporating role play in workshops was achieved which is congruent with the co-constructed and collaborative nature of most CAT trainings where the student is developing 'skills.'

Incorporating 'playfulness and fun' as part of training mirrors the way in which this should be undertaken in practice. Roth and Pilling (2008) note the capacity to use and respond to humour as one of the meta-competences of cognitive based therapies. Results of all three studies support Winnicott's (1971) notion of **playfulness** in therapy when introducing and working with a PM. Responders supported the notion of play whilst at the same time providing a scaffolding, a sense of safety and containment.

Evaluate therapists experience of PM in practice

A number of the responders were already **noticing metaphor** but the TP appeared to formalise this work and offer guidance to work with metaphor and PM. Some responders were offering metaphors of their own in session as well as noticing the patient's. In particular there was support for metaphor as a central theme whilst working in the CAT model, locating metaphor to reciprocal role, procedures, drawing these either as a separate picture or locating the pictorial representations onto an SDR.

Supervision achieved support in the Delphi and Study3 data, noting that creative methods can bring patients to mind easily in supervision. Qualitative comments noted the use of metaphor within supervision improves creativity and if there were training in Metaphor working it would be useful to follow it up within supervision. The literature reports supportive findings on the use of metaphor in supervision (Guiffrida et al. 2007, Borders 2009).

The fidelity of the **model** was maintained**,** findings support PM in CAT but also in a range of therapeutic modalities. Study2 R1 noted the importance of linking the PM, noting that the verbal metaphor in reformulation should be linked to the SDR/reformulation. A general consensus of support for the technique being viewed as enhancing the therapeutic relationship and compatible with the model was noted in R2. Linking the picture to the model and SDR achieved a 97% agreement with the highest frequency of 'coding' in NVIVO analysis of 138. Of note is the representative and relational aspect of the 'PM' being akin to the 'reformulation' as a jointly arrived at, collaborative understanding. McIntosh (2010) supports the representative nature of metaphor as a consideration.

Lack of **confidence** was noted as one reason for the limited use and the TP seemed to help with this. Role play, case examples, and practice making 'PMs' were supported, as was the balance of literature to provide an academic foundation to the work. Not all comments were positive but over 98% of responders found the workshop helpful. Learning from comments include making sure that there is enough time for discussion but not too long as some responders might disengage, ensuring that all groups get an opportunity to feedback and ensuring that the facilitator works with each group for a reasonable period during the exercises.

Limitations

One of the limitations in longitudinal studies is maintaining contact with participants. Workshops spanned a four year period and in this time the researcher was also progressing the literature review as new material arose, and incorporating this as appropriate into subsequent workshops.

For Study3 a limited response to the follow up questionnaire was obtained. This was due to time delay on follow up and a delay obtaining retrospective ethics from the PCT. This is one of the realities of progressing AR (Hope 1998). In seeking to gather new knowledge of individuals practice, seeking a 'social-phenomenological position to examine the semiotic or textual structure of every day practical activity' (Packer 1985 p1086) because as the data moves on so can the participants.

Additionally workshops were 'organic' as they responded to feedback from participants. NHS changes impacted on the research as a cohort of counsellors was lost as the PCT disbanded and the staff were subsumed into a larger organisation. This led to problems with contact as well as problems gaining ethical/governance approval. One training session group came to an end and so it was complex to capture follow up data as the practitioners were dispersed. However, reflecting on these limitations 'on action' supports the process of reliability and validity.

Whilst the content and the evaluative methods for Study3 had internal consistency the PM workshop remains a researcher led delivery and it will be important over time to train and enable others to progress the workshop in order to test and retest validity. Data is still being gathered from the last run of the TP in the Isle of Man and these findings will further inform and progress the topic. Equally a TP for CAT therapist lasting a minimum of half day is anticipated, as is a 'train the trainers' workshop to further progress this creative approach within the psychotherapeutic modalities.

Summary

The learning outcomes arose from within the literature and the Delphi study and the TP evaluations have answered these and contributed knowledge. Many useful practice examples were given that enrich this AR and will further enrich the TP. It is interesting to note that CAT practice and comments mirrored the CRUSE and counselling themes and outcomes in relation to 'practice', 'limitations on practice' and 'training/supervision'.

Limitations to the study are primarily a small response to the follow up questionnaire and it being a 'researcher led' intervention. What will be important going forwards is 'training trainers.' Whilst the reflective response is disappointing there may be valid reasons such as the time between training and the sending of the questionnaire. As noted in the methodology one of the problems of longitudinal studies is a complexity in managing a research group. This may also be suggestive of a perceived lack of confidence following the programme. As there are a number of follow up workshops planned these results will inform the programme incorporating the 'positive' practice in the technique as well as concerns of the participants whereby focusing on 'solutions' based on the research results may increase the practitioners confidence in utilising the technique in their work.

Diverse samples can be a strength of this study as results would indicate a level of transferability across other therapeutic models and approaches. They may also be a potential weakness for testing the technique more stringently. The evaluation has been primarily a self-report with some comment from patients in therapies (Appendix III). It will be important as the research progresses to see if supervisors and patients find the PM as useful as therapists are finding it.

One aspect of self-development is the usefulness of a self-report measure. Many clinical trainings involve a supervisory checklist or some form of competency assessment. Arising from Study2 and Study3 data was a recognition of the importance of supervision and subsequently self-development in the technique. With this in mind a follow on study, Study4, was developed for evaluation of a self-report measure of self-assessment that took the statements from the Delphi that were most resonant. As the research had begun to develop a level of transferability the self-assessment was utilised in a counselling groups as opposed to a CAT group.

Chapter Seven: Study4 - '*MaP-SELF' Pilot*

Introduction

Ryle et al. (2014) suggest that therapies need a theory of the development of the structure and the process of change in the self, and as part of this theory development testing 'effectiveness' is important. Cox et al. (2012) reinforce the importance of continual improvement within the NHS to improve the quality of health care interventions and numerous initiatives have been supported to this aim. One aspect of improvement is developing skill and competence in new techniques as psychotherapy is a costly and complex intervention, contextualised to the work setting and involves multiple factors. The PM technique, as with any new or developing technique, requires evaluation.

The 'Metaphor and Pictures-Self Evaluation Learning Framework' (MaP-SELF) self-assessment questionnaire arose intuitively from the data analysis of the Delphi and results of the study thus far. The researcher wondered if it was possible to develop a self-assessment to support therapists in their use of the PM technique. This 'product is the result of the interplay between qualitative research and observations and the development and refinement of the hypothesis or question (Bowling 1997), akin to grounded theory (Glaser and Strauss 1967, Strauss and Corbin 1997). An inherent strength of QL research is that the investigator is free to shift ones gaze depending on the generation of data as long as the process does not become disorganised and reduce in rigour (Bowling 1997).

The questionnaire reflects the qualitative and statistical analysis to date to support therapists to reflect on their performance, function effectively in the therapeutic space whilst utilising the novel intervention, manage their performance, and increase agency and confidence. One hypothesis is that completing the scale could support their process of change because vicarious learning can occur as statements for rating are based on expert practice reinforcing those aspects of metaphor and PM practice that are weighted positively. Self-assessment is familiar to most therapists and in CAT a self-report measure and supervisors report measure are integral to practitioner training. The C-CAT measure (Bennett and Parry 2004a) is a well validated measure. The style and format of the C-CAT was followed in the MaP-SELF because it is familiar to CAT practitioners and as a validated measure the structure should stand up to scrutiny.

Bose et al. (2001, p4) consider self-assessment to be ‘an organisational factor that influences provider competence and motivation’ and notes six benefits: 1) low cost, 2) can influence behaviour, 3) aids professional development and self-awareness, 4) provides ownership over the evaluation, 5) can improve communication in supervision, 6) may help identify transferable skills.

Aims

The aims of this study are therefore:

- To develop and pilot a meaningful rating scale to measure therapists competence in the PM technique.

The objectives are to:

- Develop self-assessment rating scale based on best evidence.
- Test rating scale out in practice.
- Refine measure and make recommendations for further evaluation.

Method

Spall et al. (2001) have used similar self-reflective methods in a study on record keeping, where counsellors noted metaphors used immediately following sessions with patients. Self-assessment is similar as one is ‘noting’ one’s own practice. Competence can be managed, through questionnaire, exams, peer review, simulations, supervision, video analysis and observations amongst others (Cox et al. 2012). Bose et al. (2001) comment that supervision is an expensive resource but note also that it is the most traditional method of assessment. This research has noted the importance of supervision where a patient is brought to mind using metaphor and PM. However, self-assessment can also be a practical and cost effective way of evaluation (Cowan et al. 2008). Self-report measures are valuable tools for clinicians and researchers, as they are quick and cost-effective methods of self-assessment (McDonald et al. 2001). Others suggest that self-assessment is a prerequisite for maintaining professional competence (Das et al. 1998, Stuart et al. 1980), defined as:

> ‘The ability of a health (care) worker to reflect on his or her own performance strengths and weaknesses in order to identify learning needs, conduct a review of his or her performance, and reinforce new skills or behaviours in order to improve performance’ (Bose et al. 2001, p4).

They (ibid) go on to cite Marienau's (1999) work noticing that there are four benefits to self-assessment; learning from experience; functioning more effectively; strengthening commitment to competent performance; and fostering self-agency and authority.

Measuring competence is complicated and involves fidelity of treatment as therapist skill and competence to treatment outcome has dilemmas and as such has been neglected (Moncher and Prinz 1991). Moncher and Prinz (1991) undertook an analysis of 359 treatment outcomes across an eight year period examining treatment implementers, procedures to promote fidelity, aspect of treatment and assessment to test fidelity. They, like others, note that competence cannot be inferred from levels of training or experience but that there is some support for their benefits (Roth and Fonagy 1996). Margison et al. (2000) indicate measurement is the 'foundation of evidence based practice' and that advances in measurement should extend to support psychotherapy practice, concluding that professional self-efficacy is widely applicable in psychiatry.

Bose et al. (2001) notes Kim et al.'s (2000) study where a self-assessment and peer review in family planning counsellors in Indonesia found counselling performance was significantly higher in the groups using self-assessment and peer review than in the control group (ibid, p9). Whilst there is a strong support for self-assessment there are also concerns. Conflict between a desire for self-efficacy and defensive motives related to self-esteem is one (Trope and Pomerantz 1998) as responders may distort evaluative information to reflect more favourably on their performance (Bose et al. 2001). As the MaP-SELF is not a summative but rather formative measure of competence in a developing playful and creative technique (Coulter and Rushbrook 2011, Winnicott 1971, Van Eardon 2010), the author considers this caution valid but less of a conflict to successful self-rating. In fact the MaP-SELF is designed to reinforce cognitive abilities and skills after training which was noted as one of the core outcomes of self-assessment.

AR is seen as a means to close the theory practice gap (Hart and Bond 1995) involving change in some measure. Study4 sets out to explore a self-assessment of perceived competence as change over time by pre and post testing a training intervention and for self-supervision. Clinical governance and clinical effectiveness agendas in the NHS emphasise the need for evidence based practice and routine service audit and evaluation (Leach et al. 2004). Working with metaphor is a simple yet complex intervention, simple because we naturally use metaphor as part of our descriptive language, complex because the metaphors speak of more than the words used.

Campbell et al. (2000) suggest that studies in trials of complex interventions are more likely to be generalisable if they are performed in the setting in which they are most likely to be implemented. Greenwood (2011) favours case study approaches where art therapy with complex patients is evaluated using the write up of sessions and scores on the Core-SF (Leach et al. 2004). Rather than examine case studies and/or session notes this study based reflections on a self-report measure, generating a pool of items for study akin to Schutte et al.'s (1998) validation study of a measure, where their pool of items, similar to a Delphi, were rated using a meta-analysis.

A meta-analysis, as opposed to single case evaluation design, can lead to estimations of correlations (Spector and Jex 1998, p356). Meta-analysis is the statistical analysis of a collection of analytic results for the purpose of integrating the findings (DerSimonian and Laird 1986). Meta-analysis is favourable in psychotherapy research, as Lipsey and Wilson (2001) have indicated, this is where it originated. In a clear progression he notes…

- 1952: Hans J. Eysenck concluded that there were no favourable effects of psychotherapy, starting a raging debate
- 20 years of evaluation research and hundreds of studies failed to resolve the debate
- To prove Eysenck wrong, Gene V. Glass statistically aggregated the findings of 375 psychotherapy outcome studies
- 1977 Glass (and colleague Smith) concluded that psychotherapy did indeed work
- Glass called his method "meta-analysis

To suggest that Study4 is based on a meta-analysis is a bit grandiose as, despite a significant body of literature being reviewed a critical analysis was not applied, but a topic and narrative review. Likewise, as there are no other self-assessments for PM and only one pilot has been studied to date, and the cohort was in counselling not CAT (although the participants had had some CAT training so were not unfamiliar to the model), these are emerging findings.

However, the researcher's intention is to progress this measure within CAT, but also in other therapeutic/counselling groups to evaluate its transferability, so new data will be generated providing a wider and deeper foundations for future analysis. Thus the principles of measuring multiple subjects is the foundation in developing and evaluating a self-report measure for this research.

MaP-SELF development

The Study3 Delphi statements were re-written to reflect self-report statements. For example, Fig113 outlines theme 'A' therapist qualities. Statement D1 notices the 'willingness' of the therapist and is articulated into a self-report statement 'I felt' SR1. D2 was excluded as the Delphi results indicated this as having poor reliability. D3 is articulated from the third to the first person in SR3 and so on. Statements that scored high in the Delphi (+80%) were maintained and those that fell below the threshold were excluded. This was not a straight forward 'numbers' exercise as judgement was placed on each statement that scored low if the researcher, based on results of QT and QL data analysis previously felt that the content was important to remain.

Fig 113: Map-Self vs Delphi findings

Delphi Theme a - Qualities of the therapist (n=5)	MAP-SELF Theme a - Qualities of the therapist (n=4)
D1: Willingness to work with metaphor is an important factor	SR 1: I felt I created a space where the willingness to work with metaphor was present
D2. Working with metaphor is enhanced by an understanding of the relevant research literature (R2 61.3% R3 70.4%)	
D3. CAT therapists need to consider whether developing a pictorial metaphor is out with their and/or client's ZPD	SR2: I was able to consider and work within the clients and my own Zone of Proximal Development
D4. It is important to be attuned to metaphor in therapy sessions	SR£: I felt attuned to metaphor in therapy sessions
D5. Allow time and space for client to describe and develop image/metaphor before moving to analysis and process work	SR4: I allowed time and space for my client to describe and develop image/metaphor before moving to analysis and process work

Some of the +70% were included as they were supported by positive QL comments and/or rerated as above the threshold. For example:

- D13 *'It is important to be creative and playful when co-constructing the pictorial metaphor'* scored 77.4 and 81.5 was considered important to remain because of the strength of support within the literature, and having passed the threshold for R3 inclusion.
- D25 '*Use of metaphor should not compromise fidelity of the CAT model'* scored 68.8% and then 74.4% but a judgement was made to include this to ensure that therapists worked within their model as this is considered the 'holding' aspect of an intervention.

By following this approach for each statement they were reduced from 76 to 57. This was still a lot of statements so evaluating the time it took to complete the self-assessment was important to inform practitioners of the time involved. Appendix XXXII matches the MaP-SELF statements to the Delphi results. The statements are not in exact chronological order as judgement was applied to the order of statements to facilitate congruence and 'flow' of answers. Some statements share similar 'themes' and the researcher spent a lot of time considering whether to rationalise these. The conclusion was to maintain fidelity with the statements generated from the Delphi.

Ethical approval

Ethical practice was fully maintained at all stages. Consent was gained in the workshops to utilise data generated from the workshops. In practice, as the technique is one that is considered a technique within a therapists' usual model, it was supported as service development with appropriate consent and governance approvals obtained. Ethical approval was gained for the study from ACAT, the NHS Trust and SHU and full information and consent gained from all participants (See Appendixes V-VIII). Ethical approval proved complicated, but was eventually achieved, due to problems with the Trust's organisational arrangements. Initially support was gained through managerial support and a proposal sent to the governance department but the Trust then was reengineered with the changes to primary care trusts and staff were transferred to another Trust. This meant that retrospective ethical approval had to be resubmitted and eventually gained from the new clinical governance department.

Sample

The self-assessment was piloted in a workshop of heterogeneous counsellors who had previously undertaken an introductory training in CAT. The sampling strategy is an opportunistic sample of people concerned in the research (Polgar and Thomas 1995). Unfortunately due to significant changes in the NHS, where the PCT was absorbed in to wider NHS Trusts, contact with the cohort was lost. This had implications for follow up and clinical governance procedures as they had to be reapplied for. Governance structures were successfully navigated and approved but following numerous attempts to re-engage contact with the cohort there was no response to a follow up questionnaire.

Data collection

Data was collected at a one day workshop of counsellors. A pre and post administration of the MaP-SELF was administered. Participants scored their perceived competence before and after the training and also noted the time it took to complete the questionnaire. Completing questionnaires in situ can lead to a lower rejection rate, more detailed responses and can be interactive as the investigator is close to the topic of discussion (Polgar and Thomas 1995). Participants also completed the standard workshop evaluation questionnaire. The workshop evaluation methodology has been discussed previously.

Results and Analysis

Data analysis of demographic data and Likert scales is managed following expected methods previously utilised within Study1-3 by utilising EXCEL to manage statistical data and NVIVO or traditional content analysis to manage the comments. N=14 participants attended the workshop with N=13 completed workshop evaluations and N=14 completed Map-SELF (pre and post) on a 1 days TP (approx. 6 hrs).

One responder (S4-5) did not complete the second iteration of the MaP-SELF. The data analysis of mean/median/mode can manage missing responses as the mean and percentage change has been used for graphs as a measure of central tendency. Using the mean as central tendency is appropriate as the same range is available to all responders (0-5) so data cannot be skewed.

Analysis was undertaken within EXCEL with a mean pre and post testing for each statement and each section. This central tendency approach has validity even though it is relatively uncomplicated. The data stands up as the mean for the first iteration is given and then measured against the mean of the second iteration. Sensitivity to change using central tendency has been utilised by Toobert et al. (2000) in developing a self-rating scale for diabetes. Kristal et al. (1994) support responsiveness scores that are similar to effect size measures in that they compare change in an intervention condition with change in a control condition such as a pre and post questionnaire (Smith and Glass 1977).

Cronbach A was not managed for this study as was previously used in the Delphi, as the sample size is considered too small, however, as this research progressed the sample size will justify internal consistency examination, test- retest reliability, factorial and

concurrent validity as practiced by Davidson et al. (1997) who developed a comprehensive self-rating scale for PTSD

Demographic data

Fig114:Patient group+Level of Training

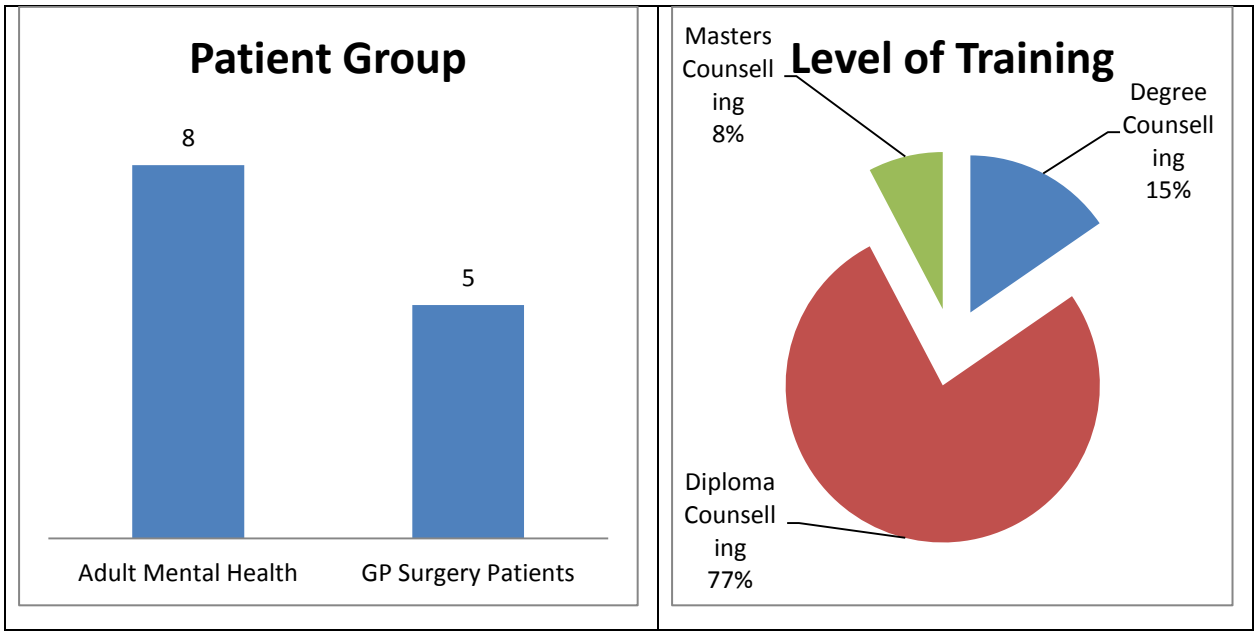


Fig115: Time in MH and Time since Trained

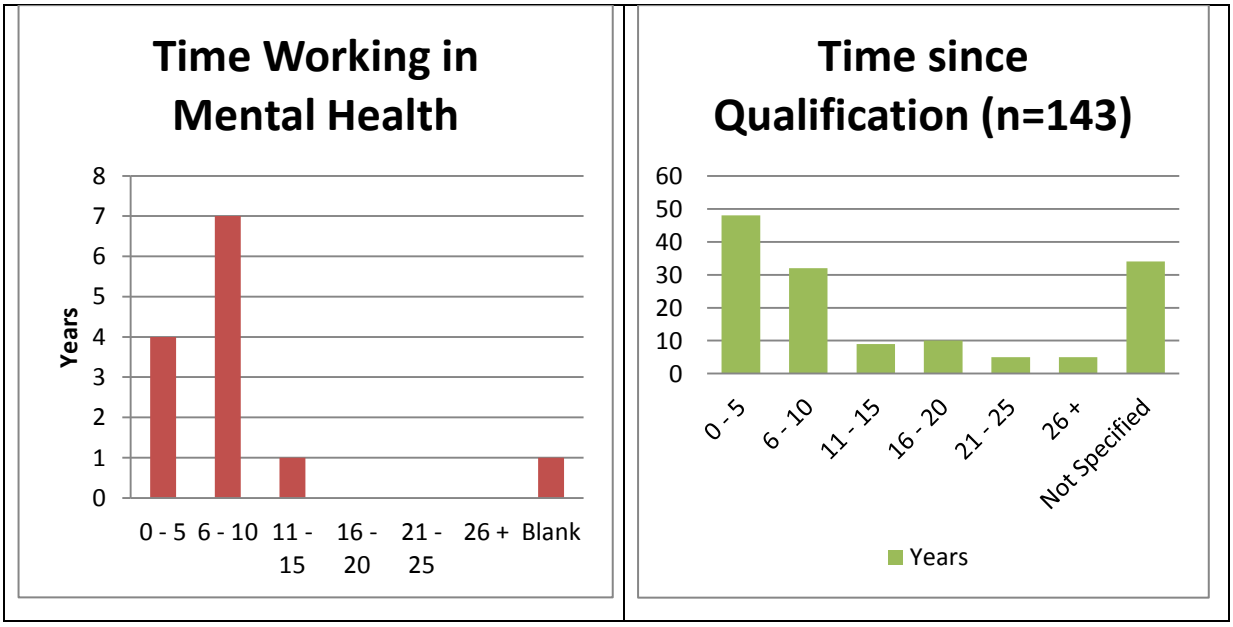
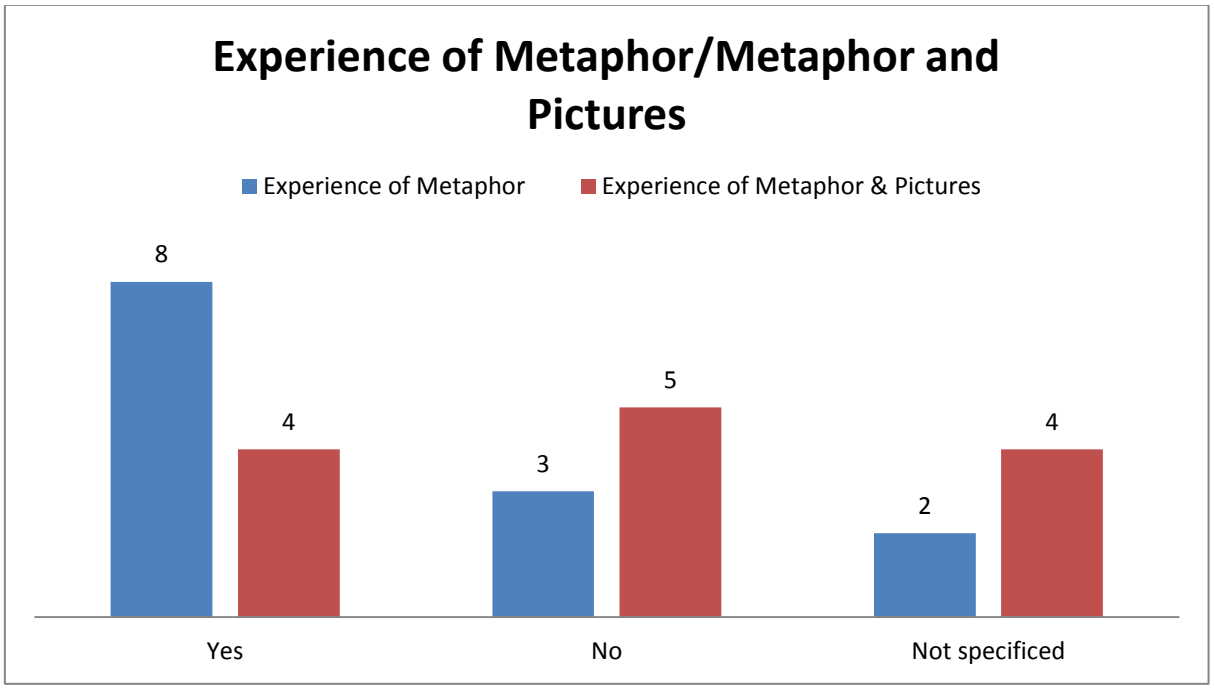


Fig114 and 115 indicate 61% of the sample was working in adult mental health and an average of 7 years in therapy. 39% are attached to GP surgeries. The average time since qualification is 6.5 years with an overall experience for the group as 84 years.

Fig116: Experience of metaphor/metaphor and pictures

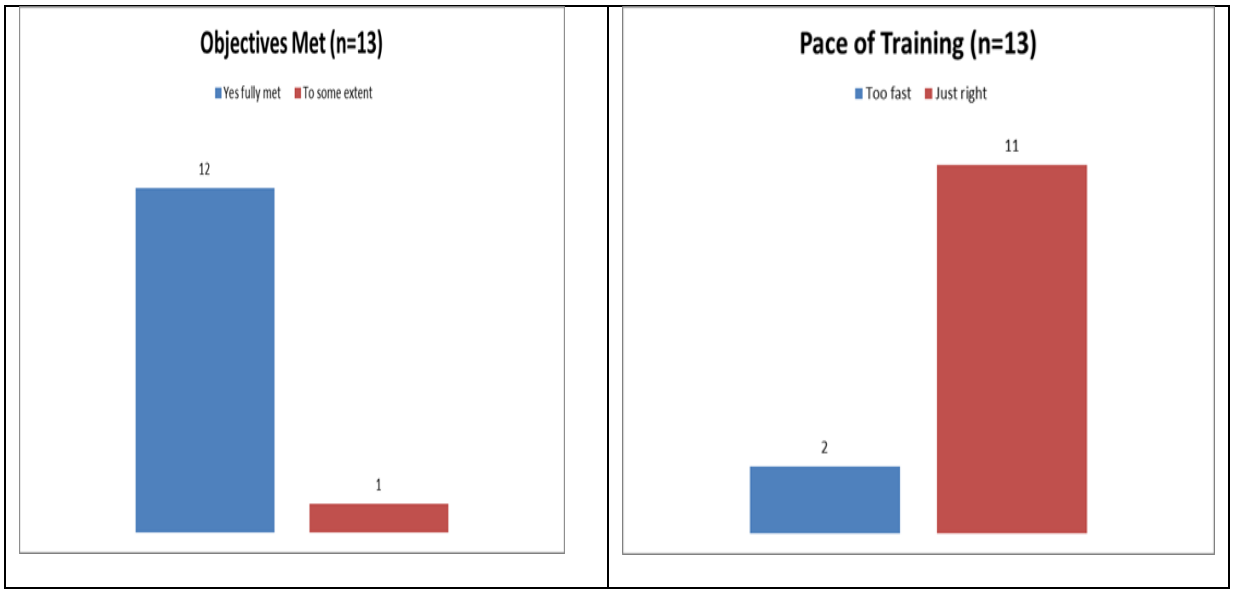


61% had experience of metaphor and 23% art in therapy (Fig116). This seems quite high but also reflective of the experience within the group. In the researchers experience therapists often become more comfortable incorporating integrative and 'creative' ideas and interventions as they develop.

Workshop evaluation

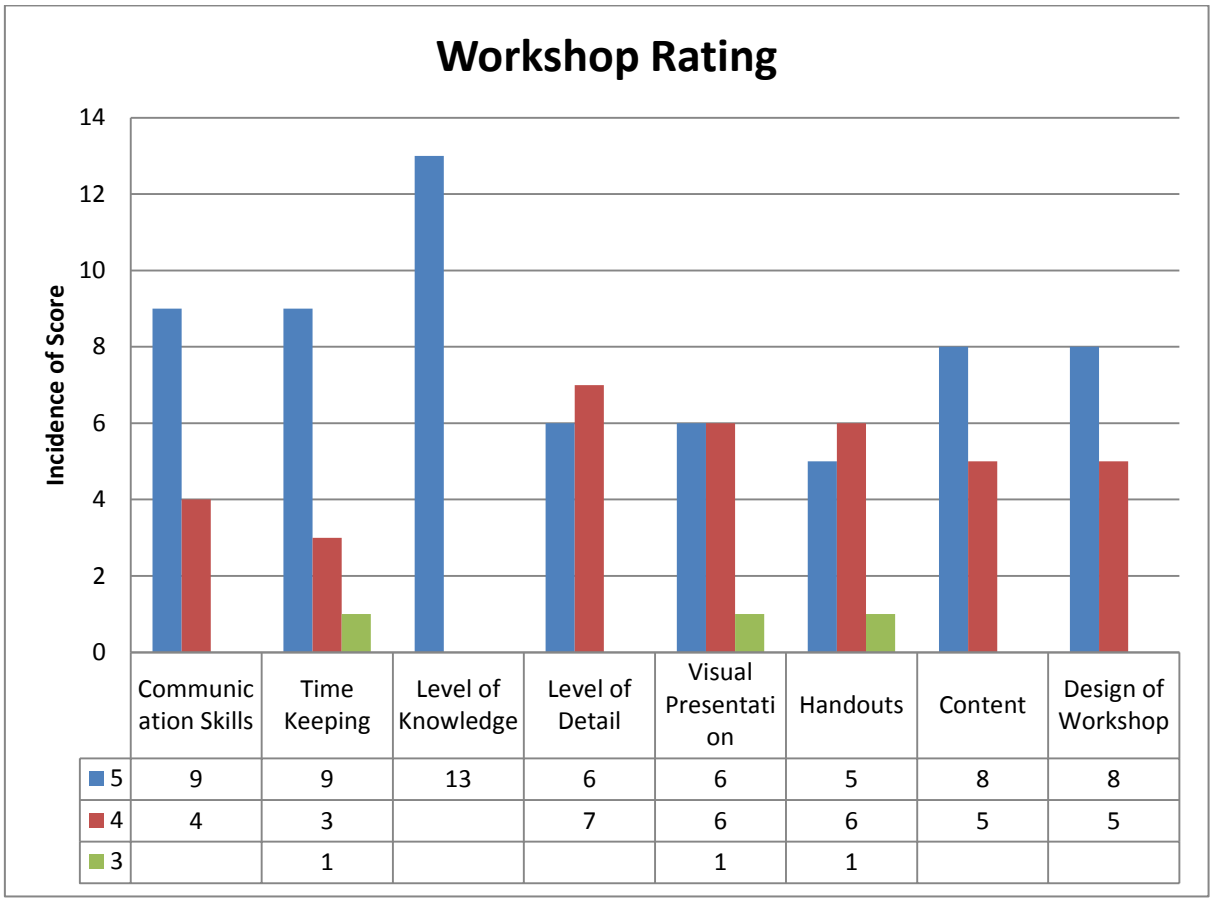
Most rated the workshop as 'excellent' (5), and 'good' (4). Two other areas of scoring were analysed, the overall 'objectives met' 92%, and 'pace' of training 85% (Fig117).

Fig117: Objectives met and pace of training



The workshop was rated favourably with 100% rating ‘acceptable’ to ‘excellent’. These scores are triangulated within Study3 analysis that noted participants rated the 1 day workshop as 93% achieving their expectations. Of the eight areas of rating all participants scored the workshop above the ‘average bar’ (Fig118).

Fig118: Overall workshop rating



MaP-SELF Analysis by section

Summary measures are often used to analyse repeated measures and are an accepted approach to manage statistical practice (Lars and Pocock 1992, Senn et al. 2000). Likert scales are presented as ‘mean median and mode’ for each section with the ‘mean’ as the graph descriptor. QL comments are presented with the QT analysis in questionnaire ‘theme’ sections. QL data was managed through a content analysis following the structure of the MaP-SELF. Normative data was collected on R1 (pre) and R2 (post) questionnaire using a ’contrast rating’ analysis. Not all statements were rated in R1 and/or R2 as one option was for ‘XI’ or ‘XM’ or XO’ to be rated (Fig119) if the responder could not rate.

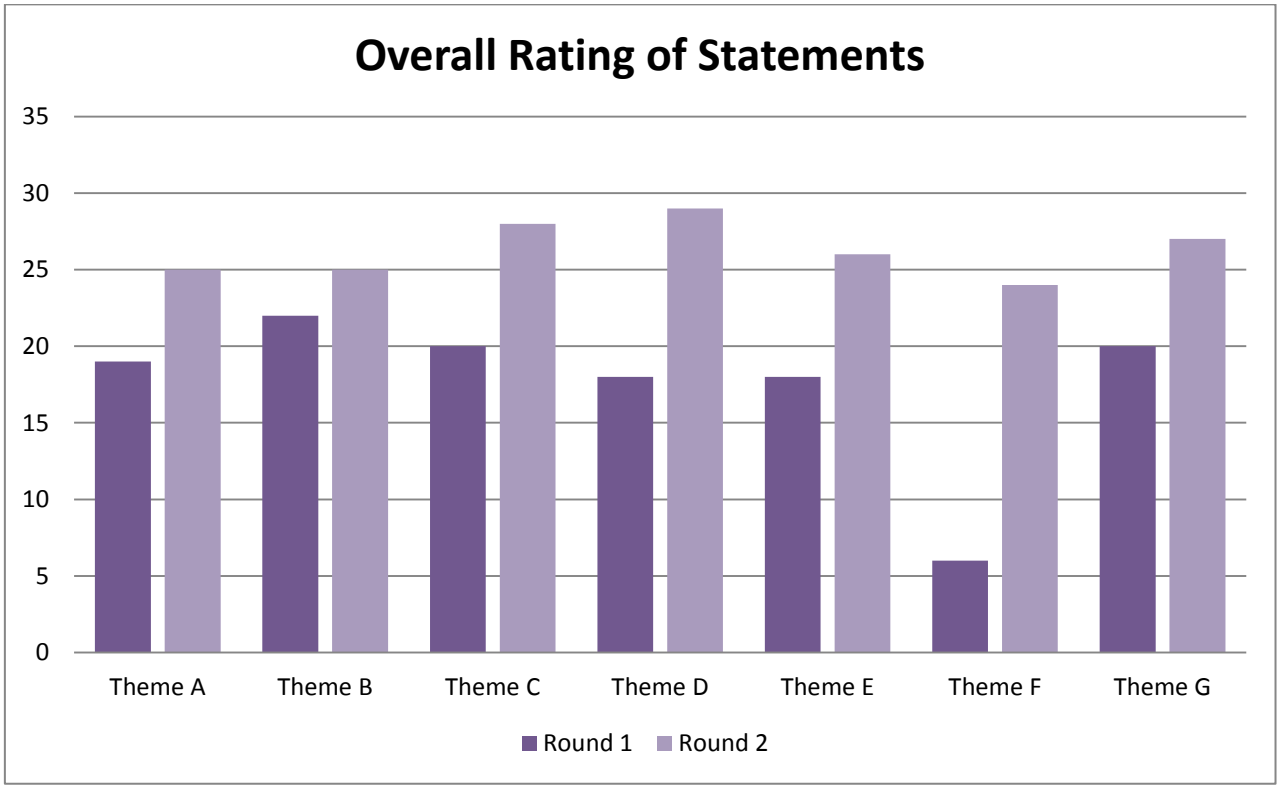
Fig119: Non rating from MaP-SELF key

If the competence was **absent,** consider the following points:

- Sometimes it is *inappropriate* for a particular competence to be demonstrated. Code this **XI next to the 'N'**
- The competence should have happened and didn't – the therapist failed to respond to a cue and there was a *missed opportunity*. Code this **XM next to the 'N'**
- If the competence was absent for some other reason, please specify XO **next to the 'N'**

Understandably in R1 responders noted a high incidence of being unable to rate the PM technique as they had not competed the workshop, role plays or produce elements.

Fig120: Overall rating all themes

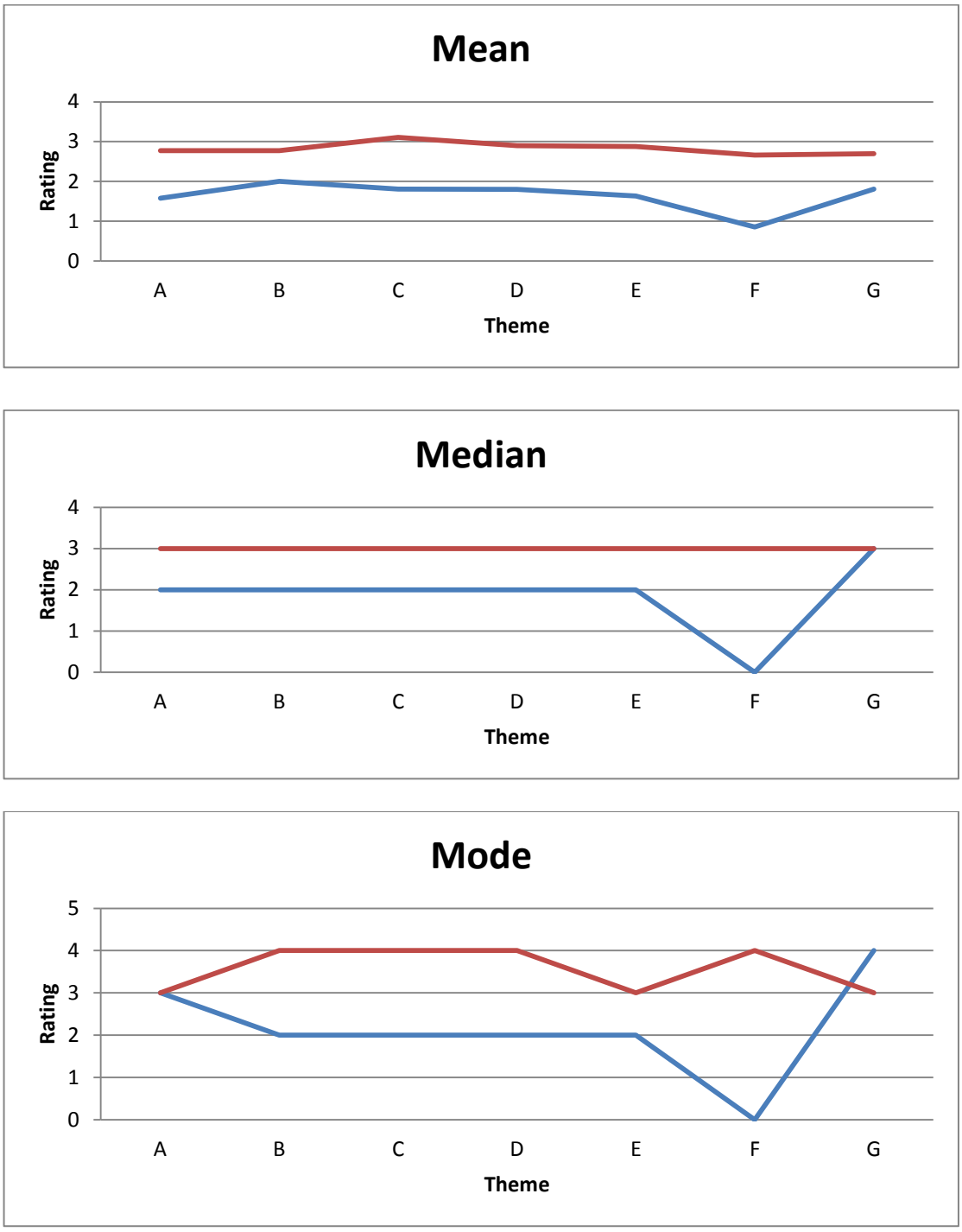


Key to Fig: 118	Theme D: Metaphor process
Theme A: Qualities of therapist	Theme E: Metaphor potential
Theme B: Training and supervision	Theme F: Pictorial metaphor
Theme C: Therapeutic relationship	Theme G: Limitations

In all sections an improvement on post rating scores was noted (Fig 120) suggesting participant's ability to utilise metaphor and PM improved based on the training received. Theme F PM scored substantially better as the participants had an opportunity to utilise the technique in the workshop.

The mean, median and mode (Fig 121) indicates a rise in rating for cluster F in particular (which is the practice or working with PM) and a general increase in perceived competency in all other areas.

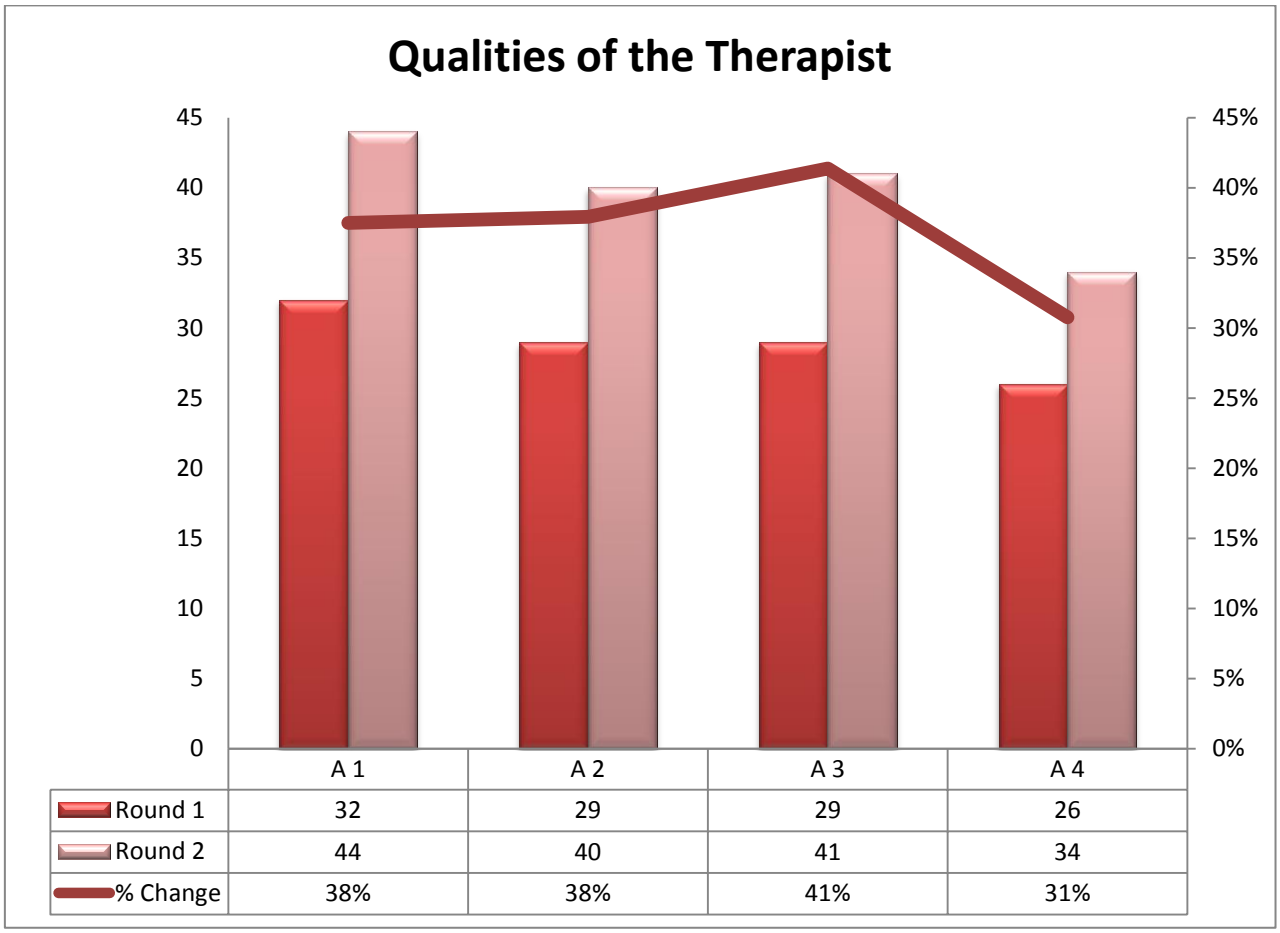
Fig121: Mode, Mean and Median all themes (NB: Blue line= R1 Red line= R2)



Overall these scores are promising of the ability of the MAP-SELF to be a pre and post workshop evaluation of self-assessment as well as having potential to support practice developments in PM working.

Section A: Metaphor

Fig122: Qualities of the therapist



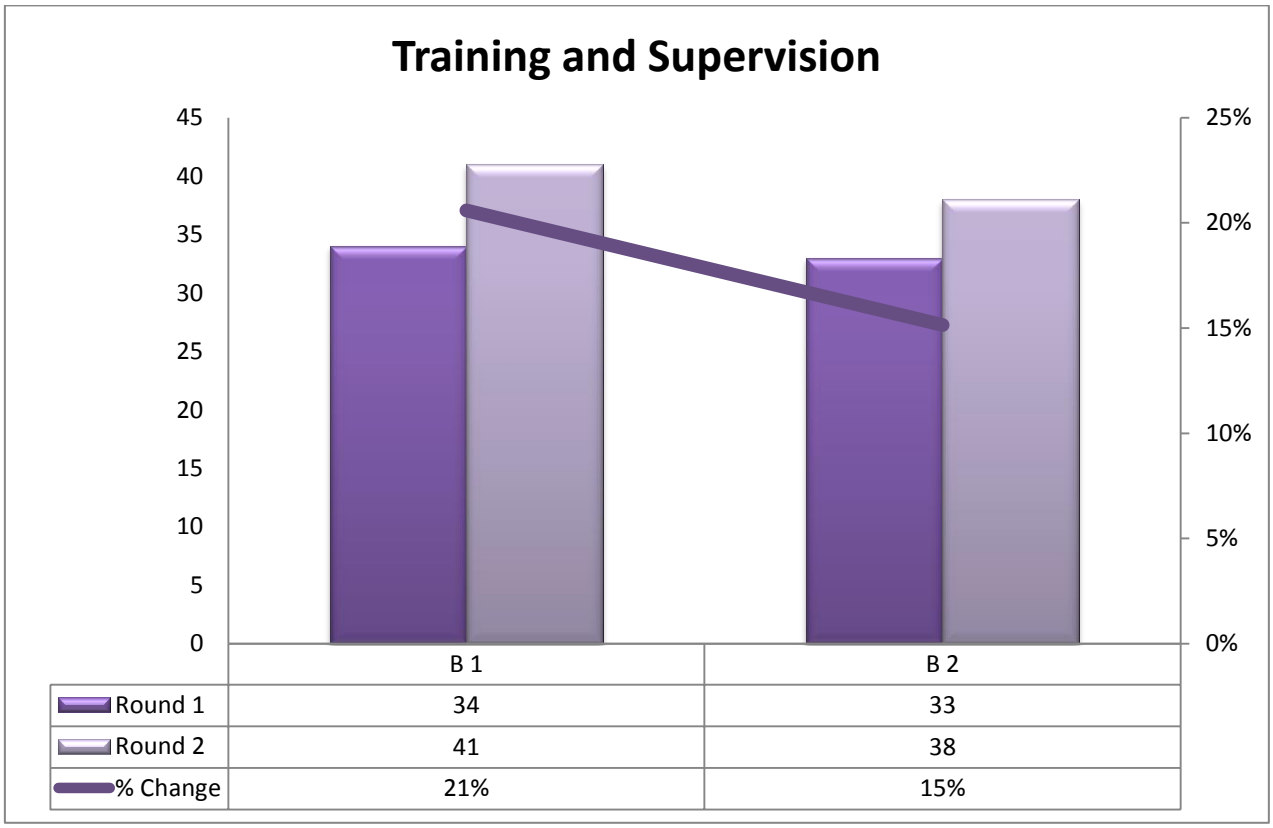
	A 1	A 2	A 3	A 4
Round 1	32	29	29	26
Round 2	44	40	41	34
% Change	38%	38%	41%	31%

An average 36% increase in effectiveness of rating the therapists' ability to be **attuned**, open and supportive of working with metaphor was found. Three responders in their first iteration said that they never used metaphor, a further three sometimes and two more that they would from now on. One responder commented they were '*not so aware of presently'* but noted missed opportunities as to metaphor observational and clarification. Of those who used metaphor '*I use their language and show them they've been heard…and when appropriate with a patient'* (S4-5), it '*benefits the TR'* (S4-8). S4-7 said that they '*cleared the fog'*.

An increased **confidence** and understanding in using metaphor was noted in the comments tempered by one responder wanting more practice as they still felt stuck and to rate their competence higher. It seems that one of the statements either needs removing for counsellors or more clarification in the TP as some of the responders note 'A4', regarding the ZPD, as not knowing what this means but one noted that they would explain the ZPD with their patients.

Section B: Training and Supervision

Fig123: Training and supervision



Data increased in support for **supervision** for statement B1 (21%) and B2 (15%), post testing indicating an increased support for discussing metaphor in supervision. 12 responders made comment regarding supervision. Most noted the encouragement to use metaphor and usefulness of describing a patient in session. The uptake was variable with responders.

> '*The use of metaphor was brought to group supervision in relation to anger and members of the group added their own use of metaphor in this area'.* (S4-9)

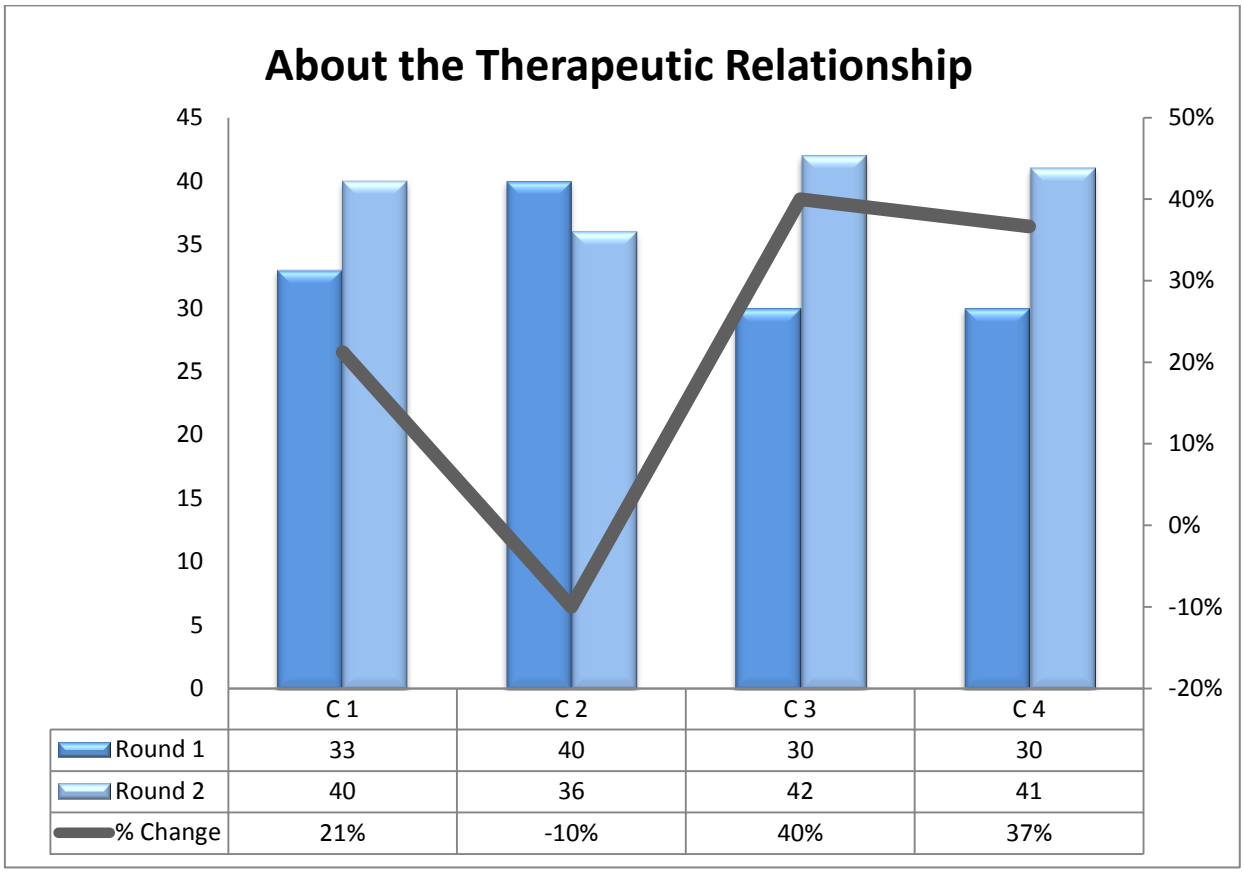
One thought their supervisor had used metaphor badly and was put off because of this (S4-11). Metaphors were used to describe patients and establish relationship…

> '*I've realised I used metaphors more frequently in supervision. This I am now very aware of. I am now aware how useful this would be in clinical work. Seems I'm missing valuable opportunities to practice this with patients. I do use imagery with patients but maybe not explore it enough with them'.* (S4-5)

Three responders noted the use of imaging as helpful and insightful and enhanced both patient work and supervision. One noted the attunement of the supervisor in letting go of the metaphor if not resonating.

Section C: Therapeutic relationship

Fig124: Therapeutic relationship



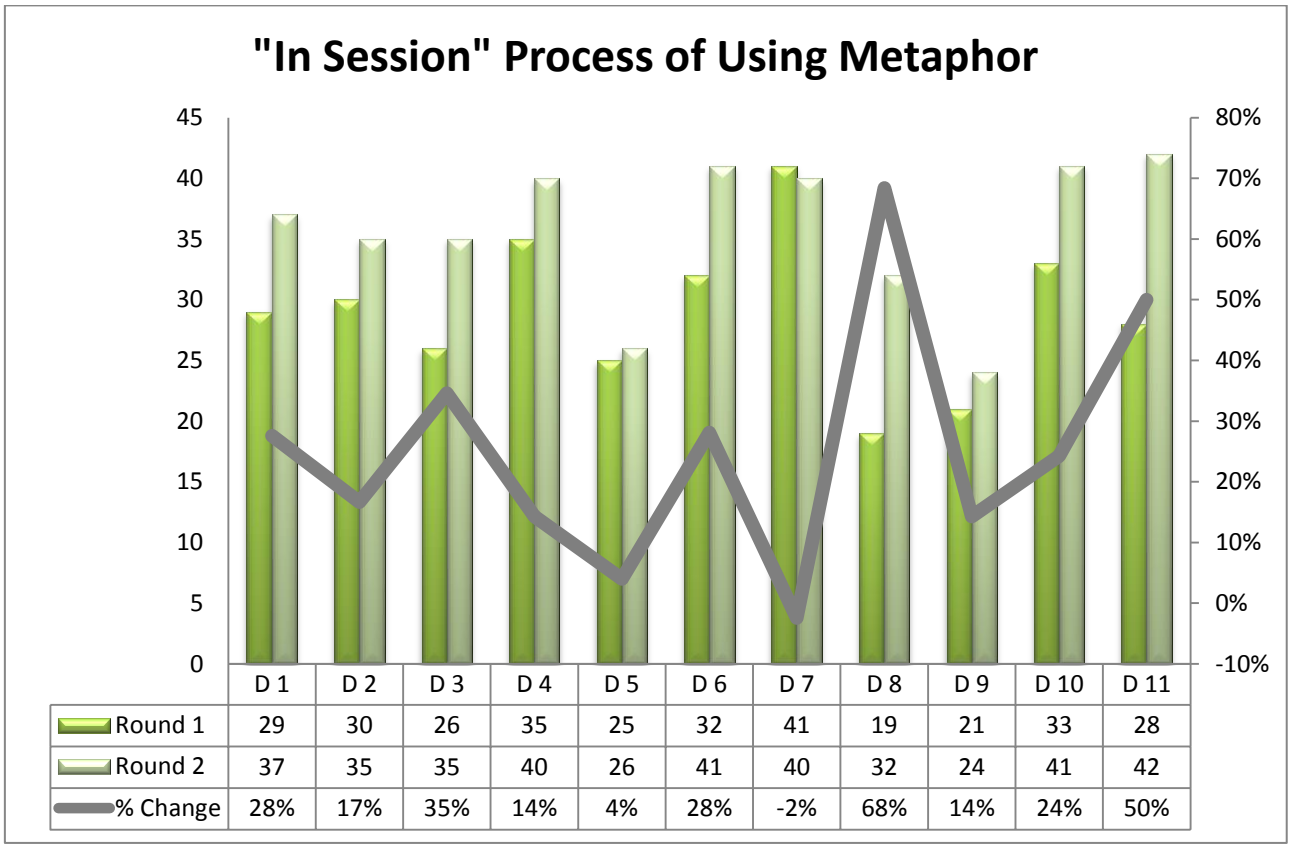
	C 1	C 2	C 3	C 4
Round 1	33	40	30	30
Round 2	40	36	42	41
% Change	21%	-10%	40%	37%

A 20-40% Increase in scores was noted for statements C1, 3 and 4 with a reduction for C2. C2 is about '*making a point of using patient's language'* which scored high on pre and post testing even though a 10% reduction was noted in R2. It was positive to note support for 'playfulness' in therapy (C3) and keeping post processing in mind (C4) (Close 1998, Combs and Freidman 1990) as metaphor can liberate us from preconceived notions (Pearce 1996). Three responders wanted further work to increase their understanding. Most felt visual tools were helpful, supported communication, showed sensitivity to patient's problems, made it easy to remember a patient's issues or main issue, and shows they have been heard.

Responders wanted to see an improvement in image making after the workshop. One noting using imagery with patients was not one of their strengths…'*maybe my inhibition with drawing gets in the way'* (S4-5). Playfulness and humour was noted by two responders where '*humour helps it along the way'* (S4-2) whilst another '*struggled somewhat with this, was not as playful and relaxed as I would wish to be'* (S4-8). These are important factors and have been noted in studies 1-3.

Section D: metaphor process

Fig125: Process of using metaphor



	D 1	D 2	D 3	D 4	D 5	D 6	D 7	D 8	D 9	D 10	D 11
Round 1	29	30	26	35	25	32	41	19	21	33	28
Round 2	37	35	35	40	26	41	40	32	24	41	42
% Change	28%	17%	35%	14%	4%	28%	-2%	68%	14%	24%	50%

Score on re-rating ranged from 4-68% improvement with D7 noting a 2% decline. D7 relates this to confidentiality and whilst this has changed the overall score for the statement is high. This brings into question the value of keeping this statement in the self-assessment, confidentiality is a cornerstone of therapy practice, so it may be unnecessary to reinforce it as part of the PM technique. D8 (relational aspects) scored the highest change next to D11 (link to formulation). These responses are encouraging as this suggests the metaphor is contextual and linked to the patient's problem procedures so has salience for the patient's recognition of their problems.

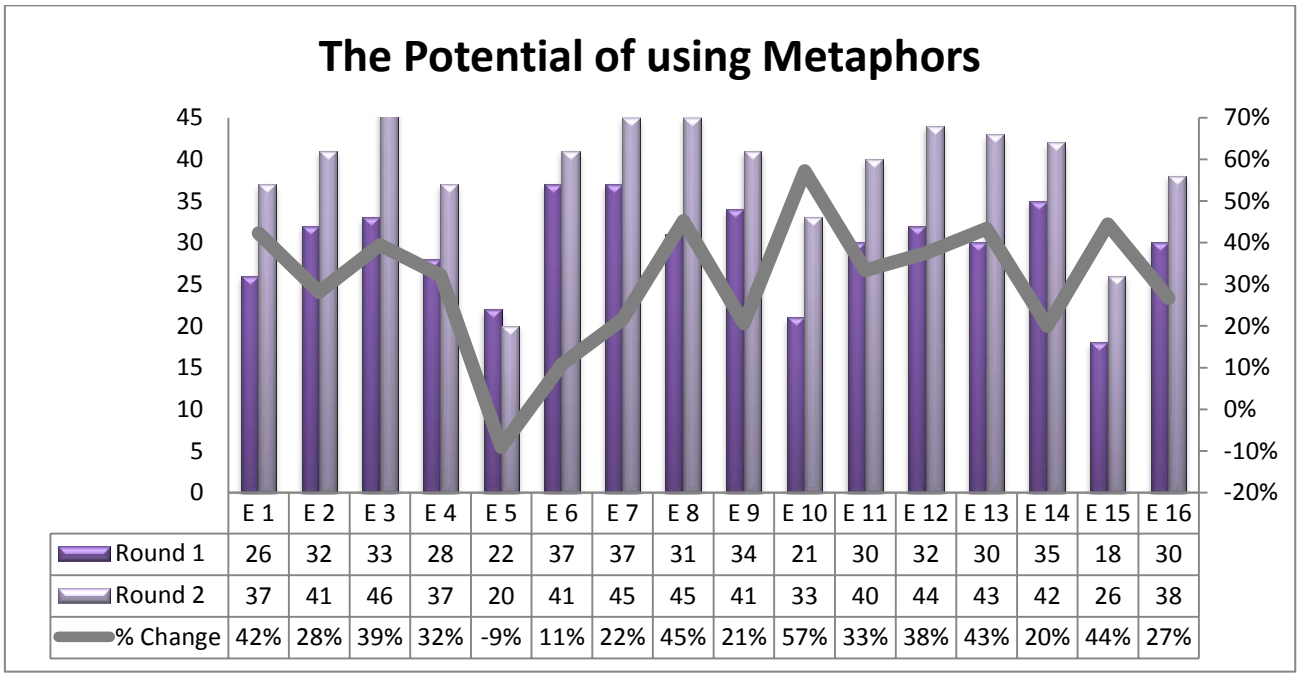
Responders QL comments noted a desire to develop in the PM technique, increase confidence, and noted 'willingness' as important. One responder thought they didn't use metaphor but after the workshop they realised they did. An increased confidence was noted following the workshop…

> *'The pictorial use of image work and metaphor achieved a quicker insight into patient's perception and understanding of patient's problem than communication/talking alone'. (S4-8)*

One responder struggled with the therapist drawing as it clashes with a recent person centred art training (Liesl Silverstone's, 1997 model).

Section E: Metaphor potential

Fig126: Metaphor potential



	E 1	E 2	E 3	E 4	E 5	E 6	E 7	E 8	E 9	E 10	E 11	E 12	E 13	E 14	E 15	E 16
Round 1	26	32	33	28	22	37	37	31	34	21	30	32	30	35	18	30
Round 2	37	41	46	37	20	41	45	45	41	33	40	44	43	42	26	38
% Change	42%	28%	39%	32%	-9%	11%	22%	45%	21%	57%	33%	38%	43%	20%	44%	27%

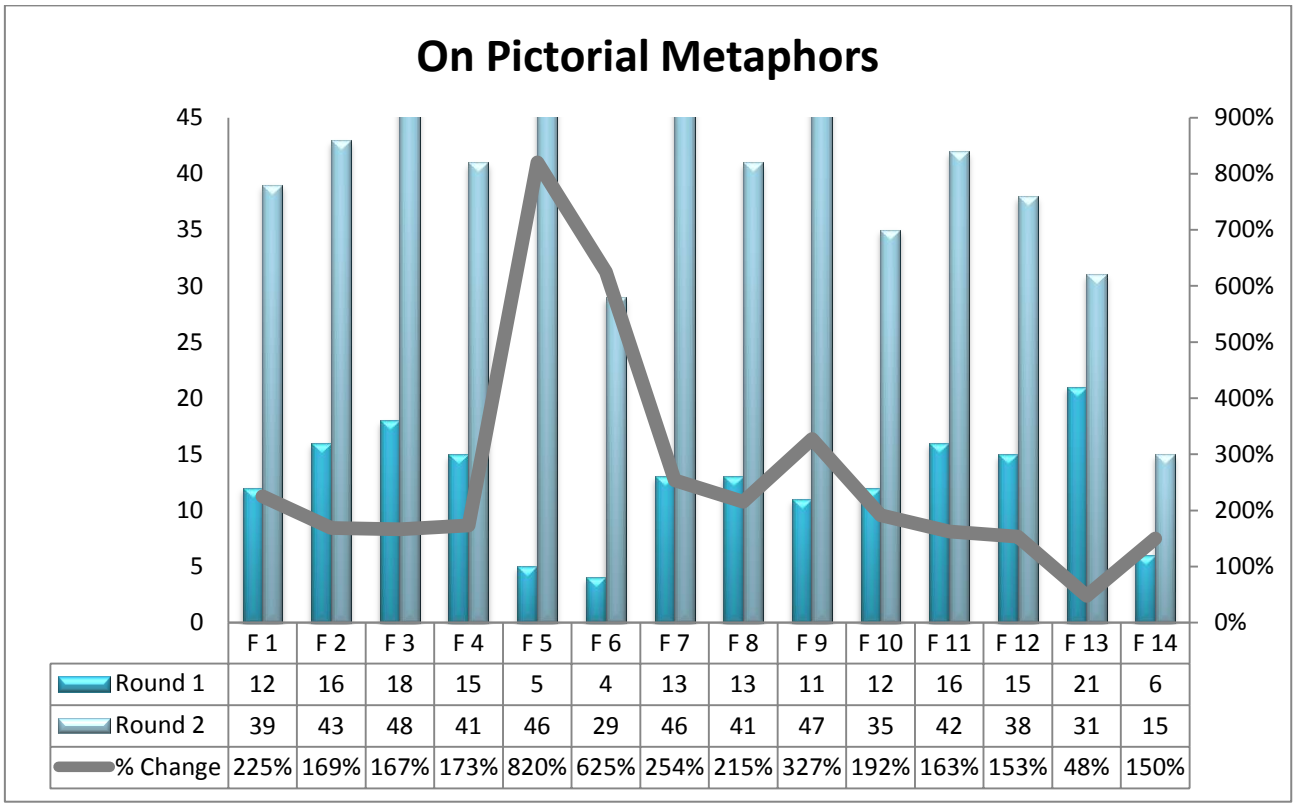
A general increase in scores of 11-57% in rating is noted. E5 '*affect associated with ending*' scored a 9% reduction. This may be difficult to rate in a workshop as the ending is not managed as such and understandably scored low on both responses. Despite 61% of responders noticing metaphor on their clinical work a number of comments related to '*skills accumulation'* and *'excited to learn more'* based on expectations of the workshop and the variable 'occasional' to 'often use' of metaphor were noted. The section '*helped clarify process I feel I need to develop my skills in this area*' (S4-5). Brief therapy was mentioned noting metaphor worked in helping to *'break down defences.'* Metaphor was noted as able to understand emotion quickly, a thread to recall easily, gain clarity and maintain focus on a patient's experience throughout the session 'as a way of processing'…

> *This will enable both myself and patient to work out the formulation and enhance the work through visualisation, resulting hopefully with positive changes, outcomes and endings etc. (S4-10)*

Role play and case study was thought provoking and '*helped the patient understand her situation better and make changes, as well as an unexpected improvement in a difficult relationship'* (S4-8) and identify their problems.

Section F: Pictorial metaphor

Fig127: Pictorial metaphor



	F 1	F 2	F 3	F 4	F 5	F 6	F 7	F 8	F 9	F 10	F 11	F 12	F 13	F 14
Round 1	12	16	18	15	5	4	13	13	11	12	16	15	21	6
Round 2	39	43	48	41	46	29	46	41	47	35	42	38	31	15
% Change	225%	169%	167%	173%	820%	625%	254%	215%	327%	192%	163%	153%	48%	150%

Scores for PM increased as a number of responders had scored based on very limited experience, as the workshop product was for responders to utilise the PM technique during role pay then they were able to rate this at the end of the workshop. F1 saw a 225% increase which relates to playfulness in working with PM; this is encouraging. F2 '*accessible image*,' F3 '*non-judgemental'* and F4 '*simple not perfect drawings'* all achieved a positive increase. F5 *'we worked with images that came from the mind's eye'* scored below the 80% threshold in Delphi R3.

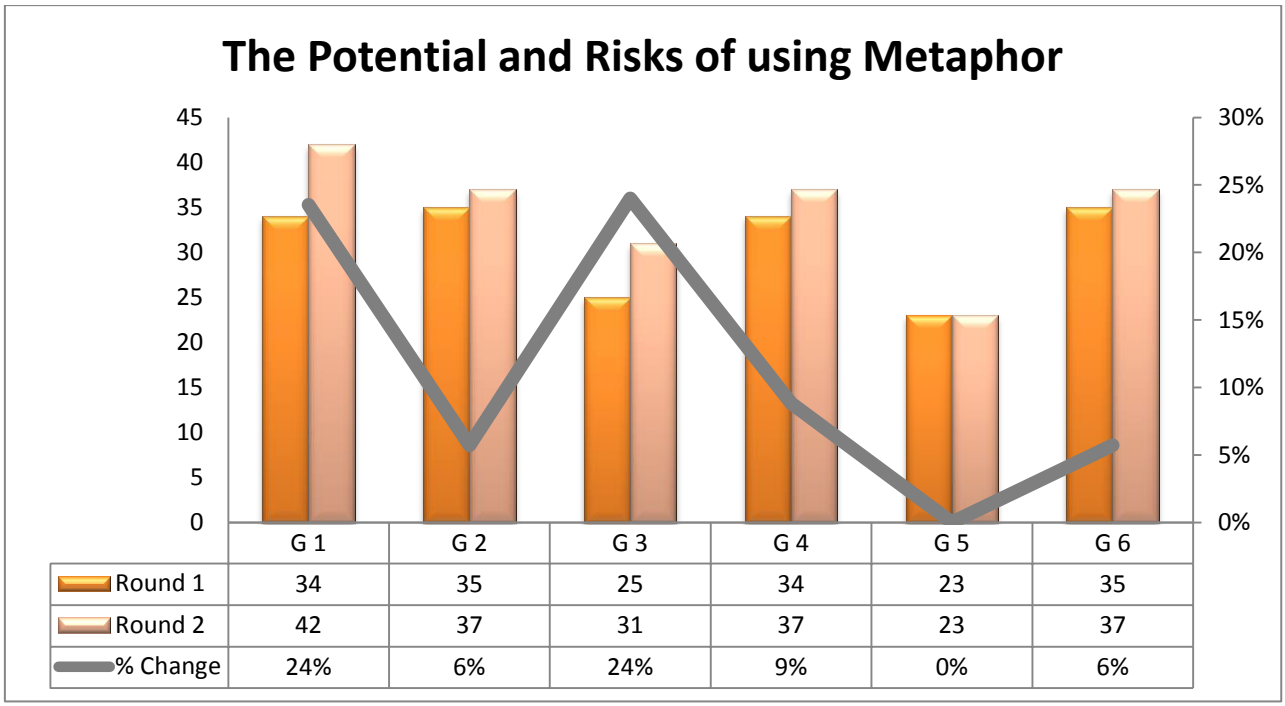
A significant change is noted (820%) indicating that the responders did create the PM from these images. F6 'paying attention to how it came to mind, colours etc.' also scores high on repeat. R1 ratings elicited a number of comments like '*have not used drawings'* and '*want to be able to do this after today'* post session rating noted 'more confidence' in PM working and 'will use more in the future'. S4-13 noted how the picture might help with deeper understanding and formulation. One recognised their inhibition to drawing and another a reliance on verbal or the 'mind's eye' metaphor.

> *'I probably need to use it more and think about how I may present the use of metaphors (pictorial) with the patients I work with. The collaborative image is better than the therapist's interpretation as it's the patient's experience of the issue that you are working with'* (S4-4)

Some comments related to the skills aspect of the workshop, role play was supported and 'in action' reflection '*my drawing….was too big…and restricted her ability to co-create the image and therefore progress her understanding…The tutor intervened to help me understand this*' (S4-8) and '*it was useful to see how the picture can change and develop…not remain static'* (S4-12).

Section G: Limitations

Fig128: Theme G - Risks



	G 1	G 2	G 3	G 4	G 5	G 6
Round 1	34	35	25	34	23	35
Round 2	42	37	31	37	23	37
% Change	24%	6%	24%	9%	0%	6%

Five of the six statements rated noted an increase in score. G5 '*pejorative implications'* noted no change but was rated as being noticed by responders which is worthy of note as it alerts the therapists to this possibility. Reflections on the problems associated with metaphor use were noted. Responders noted a structure forming as to the technique, only used when appropriate, an acceptance of using the technique (being comfortable), one size doesn't fit all, and…

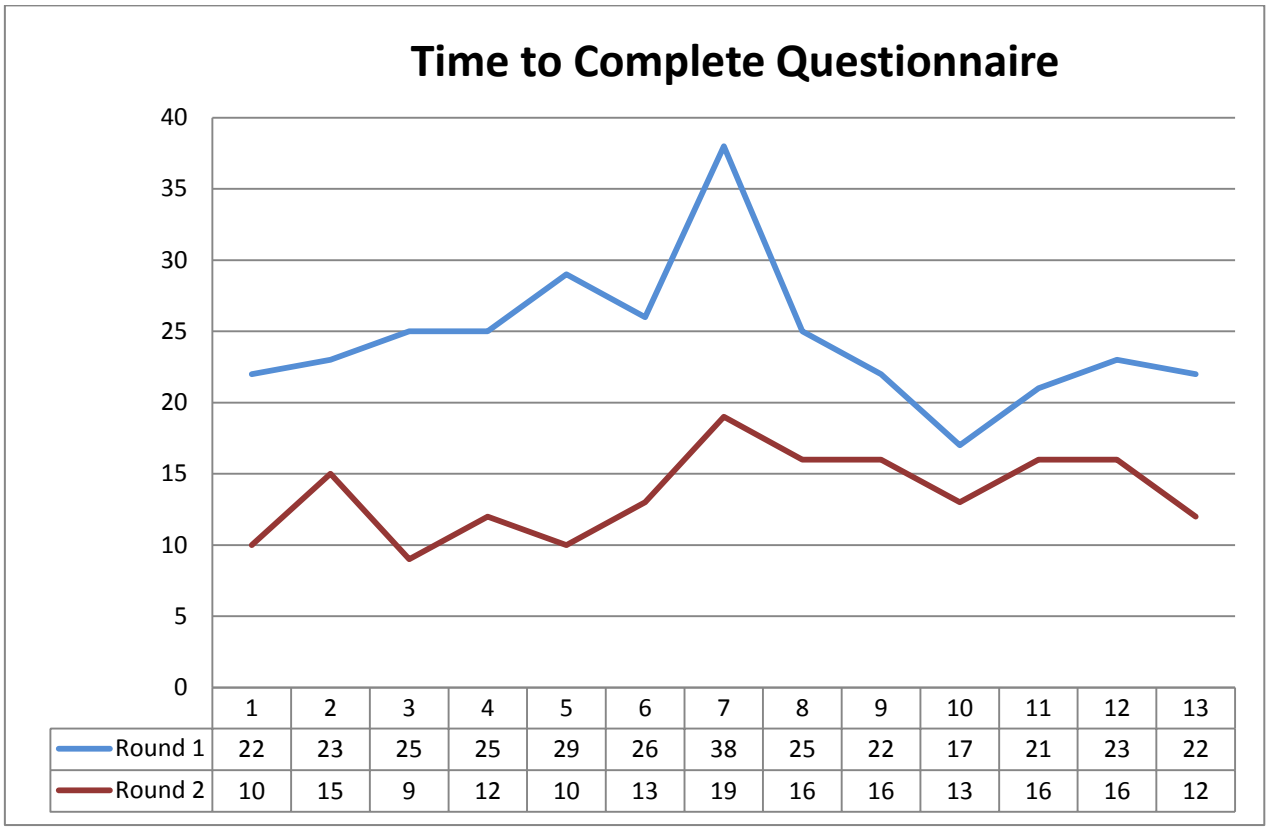
> *'Important to listen to the patient - get the picture right because they may not feel able to challenge what they don't feel looks right'.* (S4-10)

A number of statements could not be answered fully as the responders had not used them in practice so were unsure as to the answer, but responders hoped that they had enough self-awareness to be sensitive to patient's needs…

> *'I will be using/implementing metaphor much more readily and feel more confident to come out of my own comfort zone, encouraging patients to come out of theirs'. (S4-14)*

Timing

Fig129: Time to complete questionnaire



	1	2	3	4	5	6	7	8	9	10	11	12	13
Round 1	22	23	25	25	29	26	38	25	22	17	21	23	22
Round 2	10	15	9	12	10	13	19	16	16	13	16	16	12

Bose et al. (2001) note Mabe and West's (1982) meta-analysis of self-assessment concluding that 'self-evaluations become more accurate as subjects gain experience in evaluating their abilities' (Bose et al 2001, p11). The repeated measure was found to be completed on average 44% quicker with average time 24 minutes in the first measurement and 14 minutes on the second. One responder noted… *'It was really helpful to do the questionnaire before and after to monitor learning and development learning through experience really works for me - thank you'* (81)

A number of responders found it hard to rate some statements. For example, some comments reflected on the statements language such as *'ground rules...what are these*? Or they couldn't rate as they had not had a chance, for example, to utilise the pictorial metaphor for R1. Statements for consideration of rewording are: B2 '*supervision'*, D9 – *'RRP'*, E4 '*signs'*, E5 '*ending*', E10 '*formulatory*', E15 '*RRP'*, F14 '*SDR*', G5 '*pejorative'*, and G6 *'narcissistic admiration'*. It is worthy of note that these statements are all very CAT based in their understanding and as the responders only had a limited knowledge of CAT this might explain the complexity in answering.

Discussion

Whilst this is a small pilot sample evaluation the MaP-SELF valuable insights have been understood both regarding the use of the self-assessment and relating to the training programme. Demographic questions resulted in an understanding that nearly two thirds of the sample were aware of metaphor in their practice and just undersea quarter had used pictures within their work. Responders rated the workshop as excellent to good with no scores lower than this. As this was an early run of the workshop and subsequent evaluations and iterations have refined the materials. It is interesting to note that this one day workshop evaluates as promising especially when considering that in this workshop an hour was set aside for the initial and repeat rating of the self-assessment.

The overall rating of summary measures on repeat, as supported by Lars and Pocock (1992 and Senn et al. (2000), found an increased score across all target areas. However, although the scores have achieved a notable percentage increase the small sample size and the rating of a group of councillors as opposed to CAT therapists leaves the researcher with a question as to the application of the self-assessment within CAT and further work is recommended in this area to develop and refine the measure.

It was promising to note that training achieved and increased in attunement to metaphor as the intention of the TP was to support clinicians notice and work with metaphor in their practice. Responder S4-5 commented on the use of the patient's language which is useful as this was one of the areas of exploration based onStudy2 statement on the use of metaphor being from the patients experience. Overall an increased confidence in noticing and working with metaphor was noted but some responders still wanting more practice. T would have been useful to have had some longitudinal data as to whether the responders were able to take this technique forward in their practice but due to the complexities on con6tactign the staff because of their Trust folding this was not possible despite numerous attempts to do so.

There were some problems noted with the language in the MaP-Self as it was written with CAT therapists in mind so understandably some of the responders, despite having some introductory training in CAT, found answering the initial self-assessment complex. Further reflection is needed here as the results have been swayed by this language barrier as at repeat completion of the measure the responders had been introduced to the language used in the questionnaire so understandably could then answer eth question more fully. It would seem reasonable therefore to look at the wording of the MaP-SELF to develop two

different versions, one for CAT and one for other therapists. It may be that the more generic version also has application for CAT but without further testing this is unknown at this time.

Responders noted that metaphors had been utilised in supervision and supported using metaphor in supervision to bring a patient to mind as noted in the previous studies in this series. One responder noted that they had been using metaphors in supervision but on a more unconscious level and that the training had enabled them to be more conscious of their use. A caution was noted that a supervisor had used a metaphor badly and that this had put them of their use in supervision. The researcher is mindful of Bose et al. (2001) comment that supervision is an expensive resource but also is aware of the importance of supervision in practice (Turner and Hill 2011, Guffrida et al. 2007) and that it is one of the most traditional methods of assessment.

The therapeutic relationship statements scored three of the four as an increase and one decrease. The increases were in noticing the playful nature of working with metaphor (C3) and keeping post session processing in mind (C4). Statement C1 regarding metaphor as helping establish patterns of communicating in the relationship scored the lowest increase of 21% whereas C3 and C4 scored between 37 a 40% increase which is worthy of note. Playfulness is one attitude in therapy as Winnicott (1971) has noted and emerged also in Study3 with the creative use of metaphor and PM being seen to help the patient be less concrete and be more spontaneous. Playfulness came across well in Study3 and Study2 both in the session and when introducing new techniques in training programmes, as responder 048 noted in Study2, playfulness creates a '*to wonder but not to know'* approach. Playfulness was further noted with over 200% increase in scoring when using the PM technique in section E.

The patient's language again caused some reflection as this shared language expectation, although scoring high in both responses scored less on repeat. It will be worth noticing this in future follow up questionnaires to the TP as a number of responses are anticipated as from the planned follow on training programmes. The in-session processes that formed statements for section D all scored higher on repeat suggesting that the statements were workable and reflected clinical practice. In particular the willingness to wok in this way was supported alongside awareness that they had actually been working with metaphor but hadn't realised it until their training. Noticing metaphor was recognised as a positive therapeutic approach and helped manage defences, could be a central theme or thread and was enabling.

With regard pictorial metaphor responders rated the PM statements positively where the image work achieved quick insight into the patient's problems and that the role plays in training helped with this technique. Again, an observation of the importance of playfulness scored high. Responders noted that they had not previously used drawings but would do so after the TP and think about how to introduce this technique in their work. It was interesting to note reflections on responders drawings that they had learned how to do them (by assumption that they made comment) but also they learned some techniques as to how to present images on the blank page so as to enable the image to be added to.

Limitations

As noted in longitudinal studies follow up can be complex and this cohort of responders were unable to be reengaged with the research due to complexities in contact as the Trust disbanded. This also led to problems confirming ethical approval and subsequently time passed adding in another complexity in contacting responders. As a pilot study the results are promising but as the sample was counsellors not CAT then there needs to be some attention paid to using the self-assessment with a CAT cohort. A repeat limitation is noted of this being a researcher led TP at the moment and it will be important as this research progresses to establish a train the trainer's package. The sample size is not significant enough to draw out any further recommendations.

Summary

Results of Study4 corroborate the findings of Study1-3 of this series where an increased awareness of metaphors is noted by responders as is an increased confidence in working with metaphor. Bringing metaphors that resonate with the patients experience to mind in supervision was noted and supported. Metaphor was noted to break down defences and capture a central theme for one session or a series of sessions. On PM responders were able to utilise this technique in the workshop and skills development noted. Of interest is the awareness of managing the drawing by being playful and not being overly concerned about perfect representations. Furthermore, the drawn images need to be drawn in such a way as to facilitate development and expansion so that one image that takes over the page would limit further development/change. It is anticipated that regular use of the measure will improve competence in the PM technique and so warrants further exploration.

Chapter Eight: Discussion and recommendations

The researcher did not enter into this extended study with a view of evaluating efficacy for CAT or any other model but to explore, test and examine the use and focus on metaphor and PM as a technique. Having arisen from the researchers practice it seemed as if a focus on metaphor and PM could enhance the TE. Following dialogue with colleagues and known experts in the field, and a review of the available literature, a research project was constructed using CAT practice as the vehicle for examination. The researcher's exploration and research journey was born out of developing practice but it seemed important to ask whether others might be working with or inclined to work in this way. It seemed that metaphor and PM was an accessible means for patients to grasp complicated formulatory ideas. In sessions, noticing the patient's dialogue and drawing this into a memorable image, seemed to enable the therapy and provide explanation to support the patient in recall and in revision of procedures.

A comprehensive review of the literature, unearthed a rich seam of evidence in support of metaphor, and in support of art as part of the therapeutic encounter. The literature review found that whilst case study and comment was present research was less so. For example Rowan and Thompson (2000) indicate that literature on the use of metaphor in counselling consists mainly of case studies and speculation. McMullen (2008) suggests that research into metaphor has unfortunately not provided enough strong evidence to support a relationship to outcome in psychotherapy. This was born out again by Stott et al. (2010) who note a wealth of clinical theory but a lack of empirical studies. McMullen (2008) observes much has been made of metaphor in psychotherapy but little has been learned.

The literature further suggests that whilst there has been a strong tradition of research in metaphor in cognitive science and linguistics this has not translated to psychotherapy due to having two significant factors, a gulf between the conceptual frameworks employed in laboratory studies, and the highly contextualised nature of metaphor in therapy (Stott et al. 2010). Lakoff and Johnson (2003) have drawn attention to a developing evidence base in psychotherapy and metaphor and this research has added to the body of knowledge providing and testing some key insights into the use of metaphor and PM in CAT.

A critical review of the CAT literature noted that the nature of CAT and the integration of cognitive and psychoanalytical perspectives as well as an understanding of metaphor use in CAT was supported. Metaphor was used to provide commentary for a patient's emotional problems, as well as acting as a memorable image, but that this work had not been deliberately integrated within the CAT model, rather it was an accepted aspect of therapeutic work. The cognitive in CAT was noticed as a means of transforming patterns and these patterns were noticed to be integrated from the OR school of psychoanalysis alongside the recent integration of dialogism. Through integration they lead to unconscious process being conscious.

The critique of the CAT literature, and wider critique of the literature on metaphor and metaphor and art and neuroscience found that metaphor was often present in the TE and that art was a productive means to noticing and managing metaphor. Aspects of the function of metaphor were well developed as a one step removed and vehicle for change. Process factors involved willingness of the therapist and patient to work with metaphor as well as having materials available. The link between research into cognitive neuroscience, metaphor and therapy found that metaphor had an especial place in the right hemisphere and offered support and guidance for understanding the importance of the common factors in the TR.

Findings of the literature review were taken forward and tested using appropriate research methodologies and were directly articulated within the training materials. Based on the literature review, early discussions with experts, and academic supervision a four part study was developed to explore the use of and application of metaphor and pictorial metaphor in CAT. Studies 1-4 make an original contribution as applied research in metaphor and PM and are based on a number of study statements…

1. Is focussing on metaphor and pictorial metaphor a positive therapeutic step for CAT Therapists?
2. Can noticing metaphor and working with it as a central theme be enabling?
3. Can a focus on metaphor and pictorial metaphor enhance the alliance through active listening and checking out that it occurs when working constructively with metaphor in the encounter?
4. Can co-constructing this metaphor into a pictorial metaphor, drawing the patients problems and problematic experiences using images generated collaboratively in

therapy sessions, be enabling?

5. Can the pictorial metaphor, being a representation of the patient's mental health difficulties, have a direct relationship to the problem reformulation and SDR diagram?
6. Can the patient use the pictorial metaphor as a 'short hand' or 'memorable image' to reformulation, recognition and revision of their problem procedures?
7. Can and how is metaphor and pictorial metaphor utilised in CAT and can people be trained in this?
8. Can a 'toolkit' can be developed from the three main data gathering exercises (workshops, lit review and Delphi) to inform a training programme and subsequent evaluation of the effectiveness of the 'pictorial metaphor technique' in clinical practice?
9. Can this approach be taught effectively in a training programme?

Metaphor and pictorial metaphor in CAT

Statement 1: Is focussing on metaphor and pictorial metaphor a positive therapeutic step for CAT Therapists?

Study1 began a dialogue in CAT and provided background and early direction for the research through workshop and conference presentations. Study1 led into Study2, 3 and 4 respectively and is unique in beginning a research dialogue within CAT on metaphor and PM. In coming to an understanding, alongside dialogue with experts, responses to a published article on the study (Turner 2011) by Hughes (2011) developed useful insights.

A review of the literature offered extensive guidance for the use of metaphor in therapy. For example Mio and Katz (1996) found that positive outcomes are achieved if therapists utilise metaphor with their patients but a lack of confidence or expertise can restrict their use (Barker 1999). A wide range of literature was examined into metaphor and psychotherapy finding support for Billow (1977) who noted that there was a scarcity of systematic investigation and a sense lack of clarity as to whether metaphor is a special form of response or whether it can be subsumed under a general psychological theory for example learning, cognitive development, or psychoanalysis. In the CAT literature a number of articles citing metaphors and noting their importance were found but none that indicated a systematic study to date of the use of metaphor and PM in CAT.

Literature results contributed significantly to the research, in particular articulation of some of the cautions and limitations to consider, like the therapist drawing and the potential for over interpretation, that were then included in subsequent studies. Support for a focus on metaphor and the development of a PM were observed. In particular a willingness to work with metaphor was rated high as were being attune to metaphor, allowing time and space for metaphor development,

In Study1and 2 responders noted the importance of therapists and patients willingness to engage in this way which concurs with Barkers (1996) process assumptions when working metaphorically. Using patient derived metaphors is the gold standard (Barker 1996, Kok et al. 2011, Searle 1985) but results from these studies (1-4) support a therapist derived metaphor, if it was collaboratively agreed with patients. Martin et al. (1992), Kok et al. (2011) and Bayne and Thompson (2000) all support the notion of utilising, when appropriate, a therapist derived metaphor but what is important is offering this for co-construction rather than delivering it as an end product. Analysis corroborated Siegelman (1993) and Lakoff and Turner's (1989) position that through metaphor we come to understand the world, seeing something in a new way, enabled knowing it in a new way. In all four studies over three quarters of participants regularly used metaphor in their practice; some were using pictures to support their metaphor and finding metaphor very useful.

Study2 in particular provided a number of useful case examples, guidance from models of intervention using metaphor, rich insight into the use and workings of metaphor and PM from a strong expert panel. A robust set of statements guided the researcher to a better understanding of the factors and processes involved in utilising metaphor and PM in CAT and these were articulated into a TP and a self-assessment. 74 statements emerged after condensing and collapsing and of these 56 stood up to rigorous testing and triangulation with the remainder offering cautions and limitations.

In Study3 analysis of the data found general support for the PM technique and utilising metaphor in practice. Participants noted the workshop having enabled their current practice and validated practice as they themselves were intuitively and creatively using metaphor as part of the TE. Cautions to consider were whether metaphor and PM were out with the ZPD of the patient or therapists. Results suggested that the TP went some way in developing skills and confidence in this area, although a lack of training was not

seen as a complete hindrance and that lack of empirical knowledge in the literature did not impede therapist progress. It is interesting to note that some results supported the introduction of metaphor theory in the TP as some of the participants, prior to TP, were not aware of the depth of literature on the subject.

Another consideration was supervision and that discussing metaphor in supervision can be enabling and bring a patient to mind. Some concerns were expressed regarding the therapists drawing rather than the patient. On testing and retesting it was found that therapist, if taught the technique, became more comfortable with taking the lead in representing a patient's metaphor. All participants at the workshops were able to draw an image that captured the essence of the metaphor case study the participants were using in the workshop. The important aspect of the therapist drawing is the checking for fit and co-constructed way the metaphor comes to be on the page. It did not seem an inferential leap for CAT therapists and indeed counsellors to move from dialogue to drawing.

The self-assessment came out as a promising tool to support practice and self-reflection. However, it remains a limitation of Study4 that the sample was not from a CAT group, rather a counselling sample. It remains to be tested whether the Map-Self has utility for CAT. The researcher would suggest that there is sufficient evidence from the literature and from the Study1-3 analysis to recommend the incorporation of metaphor as part of the creative therapies aspect of CAT training. However, a testing of the self-assessment is needed in CAT.

Metaphor as a central theme

Statement 2: Can noticing metaphor and working with it as a central theme be enabling?

Angus and Rennie (1989) and Martin et al. (1992) noted the importance of a fully and collaboratively developed metaphor acting as a central theme. This series of studies has noted the usefulness of this on a number of occasions. In Study1 responders noted the use of metaphor as a 'stepping on an off' place where the shared language was enabling of therapy. In Study2 expert opinion and subsequent analysis of the results provided a rich understanding of the role of metaphor as a way of managing emotions. In particular support for utilising and noticing metaphor and PM as a central theme emerged (Mann 1973, Martin et al. 1992). A central theme achieved 100% rating in the Delphi and appears

to support the compactness hypothesis that metaphors are memorable, and as a central theme are part of a patient's language (McMullen 1989).

Numerous references to the usefulness of the PM to get to the point and be used creatively in session and across sessions were noted; in fact overall 84 references to the PM as a central theme or accessible image were noted across the Delphi analysis. Lyddon (1990) notes that significant or second-order change in counselling often involves a dramatic shift in a patient's perspective or frame of reference and later It is not unusual for this type of change to be organized around a new or novel metaphor (Lyddon et al. 2001). PM has also been expressed as useful as a central theme in supervision. For example S4-5 in Study4 commented on their frequent use in supervision, an increased awareness of their presence, and usefulness.

Whilst in Study3 and Study4 responders noted the short hand aspect of metaphor, *'a thread to recall easily'* caution was also noted in allowing the metaphor to create too much distance or disassociation of the patient's emotions. One size does not fit all, so therapists need to be prepared to abandon the approach if it does not resonate with the patient. However, in drawing this thesis together it must be remembered that the findings of a Delphi represent expert opinion rather than indisputable fact (Powell 2003). Whilst there is objective and subjective support for metaphor as a central theme it remains to be explored further in practice as to the usefulness of the PM. The PM has not been systematically studied outside this research; the closest model of understating that parallels this technique is David Grove's 'Clean language' (Tompkins and Lawley 2002) and Barker's (1996) work on psychotherapeutic metaphors which, focus on verbal, rather than pictorial representations. Barker (1996) does recognise the usefulness of a drawing to describe the current and then preferred position when working with young people.

On balance there is sufficient evidence to support the usefulness of metaphor and the PM to be used with patients to capture a central theme that can be worked with in one session or translated across the life span of a therapy. It is most important the metaphor and PM is co-constructed with a patient, not given, but offered and explored using where possible the patients language. However, it is acceptable that a therapist derived metaphor can also constitute a central theme and as a memorable image in supervision. Results wold guide a recommendation to further explore the impact of the PM with patients and therapists as well as exploring this further within the supervisory relationship.

Metaphor, pictorial metaphor, and the therapeutic alliance

Statement 3: Can a focus on metaphor and pictorial metaphor enhance the alliance through active listening and checking out that it occurs when working constructively with metaphor in the encounter?

Metaphors are considered to reflect and activate pre-existing conceptual mappings in long term memory (Glucksbeg and Keysar 1990, Stott et al. 2010). Wilkinson (2010) notes, that long term emotional memories can be affected positively through the process of therapy and that art representation of metaphor can be psychologically enabling. Metaphor helps to change perspective, provide a bridge between thought and feeling and provide a consistent language in therapy helping significant events be recalled though the use of metaphor (Fabregat et al. 2004, Stott et al. 2010, Gentile 1997). This bridge between thought and feeling is well documented (Pernicano 2010, Kopp 1995, Strong 1989 and Adams 1997). CAT practice incorporates a patient's story into a conceptual map, an SDR, that provides a similar function. This series of studies has provided strong empirical support for using metaphor showing that metaphor can provide 'ah ha' moments and potentially move patient's on from repeated patterns of behaviour and thinking. Results suggest the map can be augmented by the use of metaphor and pictorial metaphor.

Prior to Study2 a systematic and wide reaching literature review generated themes for the first round of the Delphi study and which were mirrored as the analysis of the Delphi progressed and triangulated across all four studies (Appendix XXXVII). These themes speak of the emerging data but also reflect the therapists approach, process and functional factors important in metaphor use and usefulness, the nature of the therapeutic relationship, models utilising metaphor, PM, and the downside of using metaphors and PMs in clinical practice.

Analysis of Delphi results indicated a high degree of support for the use of metaphor in therapy and 76 statements relating to the use and cautions when utilising metaphor were extrapolated from the data. Three rounds were managed, with an initial 'qualitative' round providing expert opinion based on 48 detailed responses from practitioners that were analysed for content and emerging themes. Results went forward to be tested in a further two rating rounds and emerging statements were examined and analysed. Statistical analyses was undertaken of rounds and within rounds which confirmed the acceptable psychometric properties of the questionnaire (Kilner 2011, George and Mallery 2003).

In all 54 statements achieved consensus providing clear guidance as to the therapist approach, process and functional aspects of utilising metaphor and PM and support some cautions and concerns when applying the technique. Analysis recognised metaphor as helpful, a way of understanding history, likening their emergence to 'kernel statements' as described by Witztum et al. (1988). Developing a shared language and understanding of the metaphor (Angus 1996, McMullen 1985, Levit et al. 2000) checking for fit and a willingness to utilise the technique as part of practice generated a support in all four studies. Having a shared language was considered enhancing of the TR and represents a powerful means of showing the patient they are being heard. The therapeutic alliance (or relationship) was coded as the fourth most frequent node on analysis of R1 of the Delphi with 41 occurrences at triangulation from questions 3 and 4 (see appendix XXIV) and the statement was rated as 93.8% agreement. These results are important as Cappas et al. (2005) note the alliance is considered the most reliable predictor of change in psychotherapy.

Not making assumptions as to knowledge of a patient's metaphors and not interpreting, but checking out, were also cited as important. For example in Study1 responders supported the therapists paying attention to the way the metaphor came to mind, as well as the cultural and context factors. Generally the metaphor supported was patient derived but support for therapist's derived metaphor was also displayed. Playfulness (Winnicott 1971) was noted on a number of occasions where the creative use of metaphor and PM could help the patient be less concrete and be more spontaneous.

It was found important for therapists to be attuned to metaphor and offer the time and space for focus to develop but did not impose this technique if it did not fit. Meira and Ferreira (2008) and Siegelman's (1993) findings were to recognise metaphors as naturally emerging and for the therapists not to interpret and make prior assumptions of the nature and content of metaphor. Study2 results support McIntosh's (2010) findings recognising their representative nature and how the metaphor and PM came to mind. Results support Mair (1997) and Hermans (2003) findings that metaphors are an indispensable structure of human understanding through which we figuratively comprehend our world. The Inexpressibility hypothesis of metaphor, as if they are one step removed, utilises the understanding from language and metaphor to represent something once removed, as if the metaphor is just a story (Abbatielo 2006, Dent-Brown 2011, Dent-Brown and Wang 2006, Barker 1996). Metaphors enable language to move beyond the constraints of speech words that are rich in imagery and resonance (Neimeyer 1999).

In Study4, Theme A, an overall increase in confidence, using metaphors to increase shared understanding, and using patient's language were all reinforced through commentary. Muran and DiGiuseppe's (1990) research, recognised the potential harm of metaphor, and reiterated the importance of explicitness and shared understanding. It is promising to find analysis of Study2 and 3 strongly supporting shared understanding. As the results of this research support metaphor use it seems reasonable to recommend a dissemination of the results to a wider audience through appropriate publications in order to support practice in therapy. The results of this research would indicate that an increase confidence based on training and an understanding of the available evidence can support metaphor use in the therapeutic relationship through practice development.

Are pictorial metaphors enabling?

Statement 4: Can co-constructing this metaphor into a pictorial metaphor, drawing the patients problems and problematic experiences using images generated collaboratively in therapy sessions, be enabling?

Literature on pictures and metaphor found a considerable depth of comment relating to the long tradition of illustrated text alongside the research from art psychotherapy. There was some debate as to the existence of a pictorial metaphor with Forceville (2008) supporting the view of metaphor and language as often seen as images, drawing our attention to the use of movie and drama as well as pictures. These creative expressions also seem to include Bettleheim's (1998) understanding of the complexity of fairy tales, that can help a child understand the world through metaphor. Bion's (1977) view is that metaphor can establish an empathic contact with a patient whilst Lacroix et al. (2011) view art as providing an external voice to emotions, and Hughes (2007) notes they are healing in the therapeutic alliance. Image making is dynamic working with metaphor, either uni-dimensionally as metaphors or as a dialogic, and also inter-dimensionally alongside one another (McIntosh 2010). Leading to Riley's (2004) assumptions that image making offers a means to achieve therapeutic goals, invites personal metaphors and enables changes to the art metaphor, and teaches us to listen.

The researcher found that Study1 realised support for metaphors as images but also some cautions about prefect drawings rather than rudimentary representations. The role of the therapist as the artist and setting principles in place to enable metaphor and PM work

was examined and taken forward for testing in subsequent studies. It seemed important to explore the art making by the therapist as a question to ask subsequent responders. It is interesting to note that in Martin et al.'s (1992) study it was the therapist offering metaphor that stimulated recall.

Other approaches using art were considered such as media and film metaphors (Sharpe et al. 2002), pictures/illustrations from magazines and patient generated images that are brought into session. In keeping with the PM technique all these are 'creative' ways of understanding a patient's narrative. Simple but not too complex drawings rated 83% supporting using images that came to mind from the metaphor. It was noted that too many metaphors would be distracting so limiting their number was important…'keeping it simple'. Simple images reduced the chances of the therapist being seen as too 'expert'.

The PM technique was explored and tested akin to the vividness hypothesis within the literature; that imagery can be brought to mind. As a way of managing the therapeutic encounter it required confidence on the part of the therapists to explore metaphor and in particular apply the PM technique. While only a third of responders rated a lack of confidence as an issue the qualitative comments would seem to suggest that this is an important consideration.

PM did seem to be enabling and a number of comments across the studies were resonant of the power of pictures to be less threatening, get to the heart of the matter, and enable complex formulation to be worked with. Important aspects of the PM were that using images could release a patient from being stuck and were enabling. The PM was viewed as a legitimate creative approach and had support in the literature but importantly appeared to relax and engage patients.

A level of validation of peoples complimentary 'scribbling' was also found as a number of responders were using pictures on the SDR or as support of their therapy. There were however concerns about early life experiences and pejorative memories of not being good at art, self-consciousness, that pictures pushed the ZPD, but on balance there was support for this technique. One responder noted the therapists sensitive attunement would be one way to guard against these potential problems.

The CAT model of therapy was considered 'master' and concerns were expressed about whether the PM might interfere with the fidelity of the model, adding to its busyness. Responders in R1 of Study2 noted that metaphors needed to fit into the overall aim an

purpose of therapy and questioned whether therapists would be more comfortable with words rather than pictures. This transpired as not being the case rather the PM was likened and articulated towards the RF and SDR so further offering explanation to a patient and the therapist of the patient's problem procedures. Results suggest that working with the visual, within the patients ZPD, can support patients who are struggling to connect with their procedures and are 'stuck' whilst recognising the importance of locating the work within the therapist's model. Some patients may find the visual a more acceptable medium to work in and this reflected the collaborative nature of CAT.

Whilst this response to the research statement is about enabling it must also be considered that there are potential downsides to using metaphor. Muran and DiGiuseppe's (1990) concern was regarding a lack of shared understanding whereas Stern (1985) recognises that metaphor cannot fit into an expected format. Neimeyer (1999) guides the therapist to remember it is the individual's interpretation that matters similar to McIntosh's (2010) limitations where metaphors need to be understood in terms of their content as well as the context they arose. Barker's (1996) comments provide a useful summary, he noticed a number of cautions such as trying to work with metaphor in the absence of adequate rapport, using strategic metaphor before an assessment was completed, choosing a story with too many negative associations, overlooking real life situations the metaphor alludes to, allowing time and overlooking patient metaphor.

Results would suggest that these cautions have been noticed by the responders as there is significant support for coming to a shared understanding and managing the TE. The Delphi cautions included statements regarding the pejorative nature of metaphor as well as ensuring the therapist explores how they came to mind. Being mindful of the one step removed nature of metaphor can enable painful metaphors to be worked with but not allow the feelings to become too detached. Results supported the one step removed as being facilitative scoring 88.9% agreement.

Ensuring time and space is allowed to explore the metaphor emerged in all four studies and is fully supported. It may be that the PM further addresses this last caution in more depth as by clarifying the metaphor during drawing the picture the dialogue retraces the verbal steps. A final caution, that the PM can become a repository of many meanings is observed by Henzell (1984), Delphi statement 67 did not agree with the positon that there is a risk of avoiding or un-naming difficult things through using metaphor.

Results supported the use of a PM as part of CAT as well as in counselling with some useful cautions and limitations to bear in mind and it is therefore recommended that the TP be made available within the CAT continuing professional development network and as a workshop TP for other counsellors. It would also be interesting to explore the current use of PM with regard to an visual methodologies analysis of completed PM alongside the patients SDR.

Metaphor, PM and CAT reformulation/SDR

Statement 5: Can the pictorial metaphor, being a representation of the patient's mental health difficulties, have a direct relationship to the problem reformulation and SDR diagram?

The SDR summarises the patient's problems, how they were developed and how they are maintained, similar to a case conceptualisation (Freeman and Dattilio 1992) where schemas, behaviours, thoughts and actions are understood in the individual's psychological context. Acting as a mind map the SDR allows the therapists to integrate and organise a formulation in an easily adaptable way (Williams et al. 1997). The literature suggested that an image laden metaphor represented as a picture is not such an inferential leap as a means to explore OR. The therapist is already familiar with constructing a picture in the form of a SDR (Ryle 1990, Ryle and Kerr 2002). The SDR is an enabler, as is the PM, they can become a memorable image, can come to mind to create a full stop a pause even in a patient's behaviour, an aha moment (Siegelman 1993), and open up other possibilities for action. The PM is akin to a mind map in a pictorial form, one way of quickly accessing key experiences. In creating a pictorial mind map metaphor such as this they can be quickly updated and amended representing new information and allowing an active focus, in fact it can become a central summary of the case (Williams et al. 1997).

The research found that participants used pictures much less than verbal metaphor but could be taught the technique. What is important to notice is that participants in this study appeared suitably prepared by the workshop, based on the materials delivered, to produce a PM in their group work and examples some of which were provided for inclusion in Study1. Study3 captured data from n=143 participants from both statistical and narrative responses and n=6 reflective questionnaires following the TP. The sample came from three CAT groups as well as groups from counselling and bereavement care (CRUSE).

The responder sample increased as the research progressed as other groups were interested in the subject and findings and asked for their therapists to have access to the research. This seemed reasonable and allows for an understanding and transferability of the wider use of metaphor and PM in the TE. In order to maintain fidelity to the CAT initial gaze data was analysed by 'grouping' so that specific data for each professional group could be understood against the 'whole' group.

Responders noted they had used clip art on the SDR and linked images to the map and that the workshop had rekindled interest in using pictures. Both verbal and pictorial metaphors were linked to the SDR and statements rated in the Delphi achieved 97% agreement and the highest frequency of coding in triangulation across NVIVO. Clearly this is an important aspect of working within the CAT model and applying this PM technique to processes already in place. It would seem fair to say that if the metaphor did not relate then one would suggest that it may be the wrong metaphor. As the metaphor should be jointly arrived at through collaborative understanding it should therefore be representative as McIntosh (2010) has noted.

Responders commented on the PM as being less threatening than other approaches and this may be due to the acceptance of the playfulness and creative articulation of the therapeutic relationship to enable this technique to be collaboratively applied. Responders provided numerous examples of helpful PM they had used. For example, one responder noted the way the picture was containing and enabled the patient to maintain responsibility for their feelings and boundaries. Importantly results indicated a level of acceptance for the PM technique within the ZPD and noted that it offered a way of expressing emotions and ideas that could enhance the TE.

Many responders were noting images on the SDR or were directly relating the PM to the SDR where the picture was a shorthand. One comment is particularly resonant by responder 091 who noted *'Metaphors contribute to the development of more accessible diagrams, diagrams that the patient can revisit and constantly alter while keeping a consistent language.'* It would be interesting to look at completed SDR's alongside the accompanying PM to see which images may relate directly to the target problem procedures or are resonant with them, and how.

Pictorial metaphor as a short hand

Statement 6: Can the patient use the pictorial metaphor as a short hand or memorable image to reformulation, recognition and revision of their problem procedures?

Metaphors have been noted to be empathetic and resonant (Black 1998) and their art representations have inherent strength, producing alternative perspectives for both the patient and observer (Riley 2004). Aldrich (1968) considers metaphor as a fusion (or function) of the object and interpretation whereby a created object holds metaphoric understanding. Freeman and Dattilio's (1992) discuss a sketch made by the therapist to represent the core problem and Lacroix et al (2011) note that bringing an image to conscious awareness can alleviate conflict through the therapeutic relationship.

The PM can facilitate transformation of mental representations that lead to maladaptive behaviours (Francis et al. 2011). Using art techniques suggests that change happens because of the transference of verbal information into visual form offering an alternative means of meeting need (Gentile 1997). The picture is bringing the metaphoric image back to life (Witztum et al. 1988) which can lead the patient to developing transformational plans for life, plans to change if you like, arising from the developing imagery.

This alternative understanding was noticed on analysis in Study2 whereby the metaphor or image, once understood, can be a shorthand and encapsulated rich and important detail, either in one stand-alone session or across sessions. Statement 56, for example, noticed metaphor as a shorthand achieving 86.2% and can be linked to subsequent statements regarding helping the patient to verbalise their thoughts and when they are struggling to verbalise their thoughts (Statements 57 and 63 respectively). These statements suggest the function of a metaphor that can hold complex formulatory experiences and flow though sessions akin to the strategic or tactical use of metaphor. .

I am mindful of some of the key messages from responders arising out of the Study3 reflective commentary but that this study had a limited follow up sample. Analysis of the responses noted that utilising metaphor can free us from expectation, support a sense of knowing a patient, create better understanding and insight, generate illumination, facilitate acceptance and humour, are often used, have power in the noticing, can communicate complex ideas, loosen rigid thinking and help form a useful alliance. These are promising results but need further exploration from a wider sample.

Metaphor and PM training in CAT

Statement 7: Can and how is metaphor and pictorial metaphor utilised in CAT and can people be trained in this?

It seems clear from the results to Study3 and Study4 that you can train individuals to notice metaphor and utilise PM in their clinical work. Using role play, a recognition of learning through playfulness, and the articulating of research literature is supported. This blended learning within the workshop has been supported on evaluation as an appropriate way to develop skills. Importantly both CAT and counselling therapists found the approach useful in their practice and there is an increasing understanding of the transferability of the PM technique.

Results supported the development of training and bringing metaphor and PM to supervision. It was suggested the PM technique being included in core CAT training or as CPD and if so to follow this through in supervision. As responder 058 commented *'Because the approach is a novel one for most CAT practitioners it would be helpful for training not just to be a one-off, but for periodic supervision (even if only peer supervision) to concentrate on and reinforce the metaphorical work.'* As noted, Etherington (2001) and Gil-Rios and Blunden (2012) support supervision as a way of manage complex therapeutic dynamics, with one responder making an observation '*I am going to try this in supervision with my 1-1 supervisees to see if this way of working felt more comfortable'* (305).

A metaphor and pictorial metaphor toolkit

Statement 8: Can a toolkit can be developed from the three main data gathering exercises (workshops, lit review and Delphi) to inform a training programme and subsequent evaluation of the effectiveness of the 'pictorial metaphor technique' in clinical practice?

There are two main considerations for discussing this statement. First, the approach to training and second the self-assessment. A training programme was developed and managed as Study3 which was designed to develop participants knowledge, skills and attitudes in order to support therapist's to notice metaphor and utilise the PM in practice. I wondered if this could be taught effectively. It seems clear from the results obtained that this is the case. Elliott (1991, 1993, and 1994) supports reflective practice and practice based research as an approach to AR. He supports engaging stakeholders in gathering evidence to measure consistency and inconsistency to the aims.

As Markman (2011) has noted metaphors provide an ability to communicate the difficulty of what is really going on in the richly complex interactions patients have throughout their daily lives. They provide and help patients to hold onto a model, an image of how things look and feel. The use of a pictorial metaphor seems to be able to enable this holding on. Whilst this was only a small group of responders the dialogue is rich and rewarding and the researcher's intention and recommendation is to follow up this reflective questionnaire with future cohorts on the training programme. Analysis suggests that the PM technique is a valuable 'tool' for therapists to add to the psychotherapeutic skill set, helping to work with patients in a creative and playful way whilst not neglecting the emotional resonance of their problems, In fact, being one step removed is an important aspect of metaphor and PM work and this has been ably noticed by the responders.

Bose et al. (2001) suggest a that self-assessment improves performance, enabling the participant to learn from experience, function more effectively, shows commitment to competency and fosters self-efficacy. In Study4 developing the MaP-SELF enabled two objectives to be examined, one the use of the self-assessment itself, and second a rating of the workshop's ability to introduce the topic and 'skill up' the participants in the use of pictorial metaphor. Responders rated the workshops highly with 100% of participants objective being met based on a workshop that was delivered at an appropriate pace. General comments were analysed and provided support for self-assessment and showed that skills development occurred based on the training programme. Familiarisation with the self-assessment schedule led to reduced average completion time which is useful to note.

The self-assessment arose directly from the research with each statement organised into themes for rating. Theme B supported supervision as a means to discussing working with and developing shared understanding of metaphor, responders noting that they used metaphor more than they realised. These findings are promising as it is in the noticing of the metaphor that enables the therapist and patient to engage in furthering their understanding. Theme C and D, about the relationship and process factors, showed a general increase in perceived competence. Although using the patients language had reduced whilst playfulness and post session processing were increased. There was no qualitative data to understand the reduction in using a patient's language. Theme D saw very positive change pre and post testing with much support for linking the metaphor to a formulation. The rise in score for formulation may be based of a lack of knowledge of this prior to the workshop. What does stands out is the use of an 'image' that responders noted achieved a quicker insight into a patient perspective than words would have alone.

Theme E increased generally overall but one score, which was for ‘working with endings,’ which would be hard to ‘simulate’ in a short programme, did not. Responders noted a skills accumulation and a desire to undertake this technique in practice and the usefulness of the technique as a central theme. Theme F, on pictorial metaphor, achieved positive change. This can be accounted for by the nature of the TP addressing and supporting responders to develop a PM as an explicit topic for development therefore it is understandable due to the pre workshop limited use of pictorial representations in the group. Theme G rated the same or an increase in all areas which is helpful as with any technique it is important to be aware of the pitfalls and not fall into them.

A limitation of Study4 is that there has only been one iteration of testing undertaken so far, although results to date have already informed modifications to the self-assessment. Two versions have subsequently been developed, one for CAT and one ‘General’ in recognition of the developing transferability of the PM technique (Appendix XXXIII and XXXIV). Some statements were modified, in response to complexities of therapeutic language, for example ‘Reciprocal role procedures’ was modified to ‘formulation’ as these are similar in understanding. Other statements were withdrawn such as ‘*The Metaphor was used to develop effective 'signs' with patients'* as this would prove complex to explain in a short sentence, leaving 56 of the 57 statements.

The MaP-SELF does seem to support both the evaluation of the training programme as well as being a measure of self-assessment. Fidelity of the intervention was maintained throughout iterations (Moncher and Prinz 1991) so a level of reliability across samples may have been achieved if the MaP-SELF was utilised in a subsequent sample. Equally this iteration of testing thus far was with ‘counsellors’ not CAT responders. It remains to be evaluated with the main study model and the researcher is in the process of developing a CAT cohort to progress testing. The researcher would suggest that internal validity of this study is maintained as a similar ‘training programme’ could be delivered to a group of therapist and the self-assessment and workshop evaluation could be administered.

Important and unique insights into the technique and application of the PM have been gained from Study4. Results indicate that the self-assessment was relatively easy to use, was quicker to rerate as the responders were familiar with the technique, and enabled a pre and post evaluation of workshop material and delivery to be assessed. It remains to be used as a reflective assessment in practice, and this is work that the researcher intends to progress in future studies. Results indicate an increased competence and confidence in

the PM technique. The self-assessment was felt to be a useful tool to provide responders with reflection on their developing practice. It is recommended that further testing of the Map-SELF be undertaken with both CAT and counselling groups to further explore its application and that initial findings are shared in the public domain.

Training programme

Statement 9: Can this approach be taught effectively in a training programme?

Study1 realised some early gains in that participants, based on the early literature and researcher practice reflections, found the PM technique able to be used in case studies and produce pictorial metaphors. The drawings were rudimentary and expressed the verbal metaphors used by participants to describe patient case studies. This early study also raised some areas for concern regarding power imbalances, transference, and the role of the therapist as drawer. Questions were posited as to whether the PM could be taught balanced by views that opportunities should be created to teach the technique in such a way as to recognise pejorative early experiences of art making. In fact a lack of training was noted as limiting the approach and training and supervision was seen to open up participants to other possibilities.

A robust review of the literature informed the content and structure of a training programme. Case examples, role plays and valuable insights into the function and processes involved in utilising metaphor and PM were further gained from Study2 a Delphi study of expert practice. Based on an N=48 response to a questionnaire a rich and dialogic understanding of CAT and metaphor emerged and was taken forward for testing and retesting. Results enabled a training programme to be developed which had a balance of taught aspects, in delivering key messages from the literature, and from expert opinion woven into the training materials. Responders in Study2 noted that metaphor could be part of the creative approach in CAT and that the capacity to use metaphor and PM can be taught.

Key findings were that a minimum of a half day enables participants to have the confidence to practice the PM in their work and that supervision helped to encourage and reflect on this work. Increased confidence and having the confidence to work with metaphor was noted by Barker (1996) and arose from all four studies. Confidence was increased through the training but seems to need to be noticed and worked with. This is

worth further exploration. CAT therapists found the PM way of working supportive and congruent with the CAT model. Other therapists found the work enriching and enabling and a way with working with their patient groups that fostered a positive TR.

Study3 explored participant's experience of a TP and Study4 further realised insights into the effectiveness of the TP as well as an evaluation of a self-assessment. Results support incorporating evidence of the literature within the workshop, providing clarity and teaching new perspectives. For some participants it validated their current practice as many were using metaphor but not consciously. This research has itself generated literature which is now incorporated in evidence as four academic resources have been published (or submitted for publication) so far on the topic (Appendix I) and are receiving citations and comment.

Results indicated a minimum of a half day workshop be managed to introduce the metaphor and PM technique using a blended learning approach. Content needs to incorporate best evidence didactic teaching as well as role play, case studies and group exercises. A two stage approach seems to be best with seminar 1 focussing on techniques and literature relating to work with verbal metaphor. Group work in seminar 1 would develop case examples of metaphor in practice and these would be progressed as examples for exploration as pictorial metaphors in seminar 2. Seminar 2 would focus on PM and is designed to enable the participants to have a go and create a developed metaphor to sketch out. A blended learning approach works for both seminars.

Results are sufficiently supportive to suggest that the researcher articulates the training materials into a manual and a train the trainers programme to enable the uptake of this research to a wider audience. This would also achieve a wider future sample base to explore the technique in practice, answering one of the limitations of this research, which is the single researcher led aspects of the training to date.

Conclusions and recommendations

There is considerable debate in AR regarding reliability and validity, as there is in all methods of research. Reason and Bradbury in their informative conclusion to AR comment 'it is not about getting the labels of criterion 'very right' but with extending a useful conversation about getting valuable work done well' (2001, p343). Other limitations within AR in health are the 'instability' of the NHS and working environment. Because of this there

may be limited time for an action researcher to complete a project, or to allow for the continuity of staff development over time (Hart and Bond 1995). The researcher's experience is that organisations might restructure but often the staff approach to patients and teams delivering this approach remain intact.

AR involves working with people as opposed to working on them, and aims to empower them to change practice, it is anticipated 'subjects' will continue in work even if their structure alters. If one adopts a strong collaborative approach in engaging the subject then changes can be agreed and accepted despite organisational fluidity (Williamson and Prosser 2002). With this in mind this research, because it involved multiple studies attempted to support longitudinal continuity by managing discreet aspects of the whole whilst maintaining dialogue with the whole. One feels that 'instability' was lessened as it relied on a predetermined intervention once developed and a strong 'expert' cohort and robust literature review to inform the intervention (technique). This approach should have transcended organisational change and it did to a reasonable extent but unfortunately there were a number of limitations that have affected the overall progress which I have noted within each study.

The researcher has explored the topic in depth and developed some informative and insightful understanding of the available literature and data. In four studies metaphor and PM has been repeatedly tested and examined, articulated into a training resource and self-assessment and triangulated to the available literature. Each study led into and informed the next as is appropriate in action research and this was anticipated to be an iterative process leading to recommendations for practice and further study (Wallis 1998).

Utilising metaphor and in particular PM as a central theme arose in all studies with patients and responders able to access the picture easily in his mind's eye, perhaps more easily than a written reformulation and SDR. Data suggests the PM can enable recognition and revision of problem procedures providing an 'in' to their SDR and reformulation. I am mindful that what I need now is an analysis of existing 'PMs' to analyse what is metaphor, what is a reciprocal role, what is a felt sense and so on.

One of the early concerns expressed by participants was the therapist drawing the metaphoric picture and indeed the therapist offering a metaphor. What is important is the collaborative co-construction of the PM. There was agreement therapists can offer metaphor, in fact Martin et al. (1992) reinforce the therapists noticing and offering metaphor which was a distinguishing aspect of their research. Training materials and a self-

assessment developing out of the emerging data were tested in practice on CAT groups as well as snowballing groups as the researcher put his theories out into the public domain. Data was promising in its support for the training programme and the self-assessment and provided further insight for examination.

There have been a number of limitations noted as applying to this research that have been explored earlier in each study chapter. In Study1 the early findings could have benefitted from a more robust data capture as only 22 responses were gained. In Study2 some of the data was lost through return problems; other data was lost due to the technology used and the researcher's familiarity with the technology. Decisions therefore decisions had to be made in managing the responses and the sample. Research methods were applied to support internal and external validity which have supported the approach to analysis and subsequent discussions that have lessened the limitations. In Study3, whilst the responses are robust and the data managed congruently with research methodologies it remains a researcher led initiative. For example, whilst a reasonable sample attended the workshops and provided data for analysis, at follow up only a small cohort of responders were able to utilise the PM technique in their practice. They did find it useful for the encounter but it remains a small response. In Study4 the self-assessment was administered to a group of counsellors and follow up opportunities were lost due to reconfiguration of services, also as this was a counselling sample the results cannot be generalised CAT.

However, this series of studies are unique in that they have explored and analysed an innovative technique developing intuitively from the researchers practice. Findings are that the technique has congruity within CAT but also within other models of therapy intervention. Rigorous methods of data collecting and analysis have been undertaken on the data collected and have been externally validated as an ongoing process to ensure reliability of findings. A depth of understanding has emerged for the research studies based on considerable clinical experience of responders. The combined samples represent the views of 192 people with over 2110 years of mental health working experience between them. This represents a considerable body of practice and knowledge to drawn inferences from. I am indebted to the study participants and hope that in some way, reflecting on their journey and assisting the researcher in his, helping to understand the role of metaphor and PM more clearly, has been, and can continue to be, a positive experience.

Both positive and negative aspects of the approach have been explored in depth leading to an appropriate detachment and objective analysis of the data and a balanced appraisal of

evidence. Whilst there were limitations in each of the studies, overall the evidence stands up to scrutiny and leads to a number of recommendations…

- To make available to ACAT the metaphor and PM workshop as part of the creative therapies aspect of CAT training.
- To further explore the impact of the PM with patients and therapists through follow up via reflective commentary.
- To explore the use of metaphor and PM in the supervisory relationship.
- To progress publications as outlined in appendix 1.
- To explore the current use of PM with regard to an visual methodologies analysis of completed PM alongside the patients SDR.
- To undertake further testing of the Map-SELF with both CAT and counselling groups to further explore its application and that initial findings are shared in the public domain.
- Refine training programme into a resource manual and develop a train the trainers programme.

References

Abbatielo, G. (2006). Cognitive Behavioural Therapy and Metaphor, *Perspectives in Psychiatric Care,* 42 (3), pp208-211

ACAT (1995). Informed consent, http://www.acat.me.uk/document_download.php/15 (Accessed July 2009)

ACAT (2009). www.acat.me.uk Ethical standards. (Accessed July 2009)

Adams, M.V. (1997). Metaphors in psychoanalytic theory and therapy. *Clinical Social Work Journal*, 25:1, pp 27-39.

Adam, R., Tilley, S. and Pollock, L. (2003) Person first: what people with enduring mental disorders value about community psychiatric nurses and CPN services. *Journal of Psychiatric and Mental Nursing*. Volume 10, Issue 2, pages 203–212. Wiley Online Library.

Aldrich, V. (1968). Visual Metaphor. *Journal of Aesthetic Education*, VOl2, No1, pp73-86.

Altschul, A. (1957). *Psychiatric Nursing*. London. Balliere, Tindall & Cassell.

Altschul, A. (1962). *Aids to Psychology for Nurses*. London. Balliere, Tindall & Cassell.

Altschul, A. (1964). Group Dynamics and Nursing Care. *International Journal of Nursing Studies*, 1; 151-158.

Altschul, A. (1978). A Systems Approach to the Nursing Process. *Journal of Advanced Nursing*, 3; 333-340.

Anderson, N.M. (2009). International ACAT Conference "What Constitutes a CAT Group Experience?". *Reformulation*, Winter, pp.25-26.

Andrew, S. and Halcomb, E. (Eds.). (2009). *Mixed methods research for nursing and the health sciences*. Wiley-Blackwell Pub..

Angus, L.E. and Rennie, D.L. (1988). Therapist participation in metaphor generation: Collaborative and noncollaborative styles. *Psychotherapy: Theory, Research, Practice, Training,* 25(4), 552.

Angus, L.E. and Rennie, D.L. (1989). Envisioning the representational world: The patient's experience of metaphoric expression in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 26(3), 372.

Angus, LE. (1996). An intensive analysis of metaphor themes in psychotherapy. Metaphor: Implications and applications, 73-84.

Ardern, M. (2004). Book Review: Cognitive Analytic Therapy and Later Life by Sutton and Hepple. *Reformulation*, Summer, pp.28-29.

Atkins, S. and Murphy, K. (1994). Reflective Practice. *Nursing Standard* 8 390: 49-54.

Aveline, M. (1980). Making a psychodynamic formulation. *Bulletin of The Royal College of Psychiatrists*, 192-193.

Aveyard, H. (2010). *Doing a literature review in health and care: a practical guide*. 2nd edition. Dawsonera, London.

BACP (2009). *Code of ethics* www.bacp.co.uk

Baker, C. (1997) Membership Categorisation and Interview Accounts, In: Silverman, D. ed., *Qualitative research: Theory, Method and Practice*, Sage Publications.

Baker, J., Lovell, K., and Harris, N. (2006) How expert are the experts? An exploration of the concept of 'expert' within Delphi panel techniques. *Nurse Researcher*, 14, 1.

Bakhtin, M.M. (1984) cited Leiman, M. (1992). The concept of a sign in the work of Vygotsky, Winnicott and Bakhtin: Further integration of object relations theory and activity theory, *British Journal of Medical Psychology*, 65, 209-221.

Bakhtin, M.M. (1984). *Rabelais and his World* (Vol. 341). Indiana University Press.

Bakhtin, M.M (1984b). Problems of Dostoevsky's poetics. (C. Emerson, Ed. and Trans.), Minneapolis, MN: University of Minnesota Press

Barker, P. (1985). *Using Metaphors in Psychotherapy*, Brunner/Mazel, New York

Barker P. and Baldwin S. (1991). *Ethical Issues in Mental Health*, Chapman and Hall.

Barker, P. (1996). *Psychotherapeutic Metaphors: a guide to theory and practice*. New York Brunner/Mazel.

Barker, P. (2000). From chaos to complex order: personal values and resources in the process of psychotherapy, *Perspectives In Psychiatric Care*, Vol 36, No 2, pp51- 57.

Barker, P. (2001). The Tidal Model: developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, 8(3), 233-240.

Barker, P. and Buchanan-Barker, P. (2005). *The Tidal Model: A guide for mental health professionals*. Bruner Routledge.

Barker, P. (2008). *Psychiatric and mental health nursing: the craft of caring*. CRC Press.

Basch, C.E. (1987). Focus Group Interview: An Underutilized Research Technique for Improving Theory and Practice in Health Education. *Health Education Behaviour* 1987; 14; 411

Bateman, A., Brown, D., and Pedder, J. (2010). *Introduction to Psychotherapy: An Outline of Psychodynamic Principles and Practice*. Fourth Edition. Routledge.

Bateson, G. (1979). *Mind and nature: A necessary unity* (p. 238). New York: Dutton.

Bayne, R. and Thompson, K. (2000). Counsellor response to patients metaphors: an evaluation and refinement of Strong's model, *Counselling Psychology Quarterly*, 13 (1)

pp37-49.

Battino, R. (2002). *Metaphoria: Metaphor and guided metaphor for psychotherapy and healing*, Carmarthan: Crown House Publishing.

Battino, R. (2007) Expectation: principles and practices of very brief therapy, *Contemporary hypnosis*, 24(1), pp 19-29

Beauchamp, L. and Childress, JF. (2001) *Principles of Biomedical Ethics, Fifth Edition.* Oxford, Oxford University Press

Beard, H., Marlowe, M. and Ryle, A., (1990). The Management and Treatment of Personality-Disordered Patients The Use of Sequential Diagrammatic Reformulation. *British Journal of Psychiatry*, 156, pp 541-545.

Beck, A.T. (1979) *Cognitive Therapy of Depression*. New York: Guildford Press.

Beck, A.T., Emery, G., and Greenberg, R.L. (1985) *Anxiety Disorders and Phobias: a cognitive perspective.* New York: Basic Books.

Beckett, S. (1957). *Murphy.* 1938. New York: Grove.

Beech, B. (2001) The Delphi approach: recent applications in health care. *Nurse Researcher*.
8, 4, 38-48.

Benner, P. (1982). From novice to expert. *American Journal of Nursing, Mar.*, 1982, pp.402-7.

Bennett. D. and Parry, G. (1998). The accuracy of reformulation in cognitive analytic therapy: A validation study. *Psychotherapy Research*, 8, *405-22.*

Bennett, D. (2003) *Evaluation of Local Implementation Team (LIT) Funded Project: Skills in Cognitive Analytic Therapy (CAT) for working with complex mental health issues. A course designed for nursing staff in in-patient services*. ACAT Library.

Bennett, D. (2004). Summary Report on ACAT Training and Trainer Development Conference. *Reformulation*, Summer, p.6.

Bennett, D. and Parry, G. (2004). Maintaining the therapeutic alliance: Resolving alliance-threatening interactions related to the transference. pp 251-272. In D. Charman (Ed.) Core *Processes in Brief Psychodynamic Psychotherapy*. Lawrence Erlbaum

Bennett, D. and Parry, G. (2004a). A measure of psychotherapeutic competence derived from Cognitive Analytic Therapy. *Psychotherapy Research 14, 176-192.*

Bennett, D. and Ryle, A. (2005). The characteristic features of common borderline states: a pilot study using the states description procedure. *Clinical Psychology and Psychotherapy, 12, 58-66.*

Bennett, D., Parry, G., and Ryle, A. (2006). Resolving threats to the therapeutic alliance in cognitive analytic therapy of borderline personality disorder: A task analysis. *Psychology and Psychotherapy: Theory, Research and Practice,* 79(3), 395-418.

Bennett, M.R. and Hacker, P.M.S. (2008). *History of Cognitive Neuroscience*, Wiley Blackwell.

Beretta, R. (1996). A critical review of the Delphi Technique, *Nurse Researcher*, 3(4) pp79-89.

Bermingham, D. (2006). Reflections on the Second International CAT Conference Maynooth, Ireland 15 - 17 June 2006. *Reformulation*, Winter, p.22.

Bettelheim, B. (1989). *The Uses of Enchantment: The Meaning and Importance of Fairy Tales* (Vintage).

Bettelheim, B. (1998). *The Uses of Enchantment. The Practical Stylist with Readings and Handbook*, 130.

Beutal, M.E., Stern, E. and Silbersweig, D.A. (2003). The emerging dialogue between psychoanalysis and neuroscience: Neuroimaging perspectives. *Journal of the American Psychoanalytic Association,* 51:3, pp 773- 801.

Beutler, L.E., and Harwood, T. M. (2002). What is and can be attributed to the therapeutic relationship? *Journal of Contemporary Psychotherapy*, 32(1), 25-33.

Biernacki, P. and Waldorf, D. (1981). Snowball sampling: Problems and techniques of chain referral sampling. *Sociological methods and research*, *10*(2), 141-163.

Billings, C. (1991). Metaphor and Fables, *Issues in Mental Health Nursing*, 12:1-8.

Billow, RM. (1977). Metaphor: A review of the psychological literature. *Psychological Bulletin,* 84(1), 81.

Bion, W. (1977). Learning from experience. In *Seven Sisters*, New York: Jason Aronson.

Björkdahl, A., Palmstierna, T., and Hansebo, G. (2010). The bulldozer and the ballet dancer: aspects of nurses' caring approaches in acute psychiatric intensive care. *Journal of Psychiatric and Mental Health Nursing*, 17(6), 510-518.

Black, M. (1998). More about Metaphor. In A. Ortony (Ed.), *Metaphor and Thought* (2nd Edition.), Cambridge: Cambridge University Press.

Blackburn, I.M. and Davidson, K. (1995). *Cognitive therapy for depression and anxiety*. Blackwell.

Blatner, A. (2006). http://www.blatner.com/adam/level2/metaphors.htm

Bloch, S. and Chodoff, P. (1984). *Psychiatric Ethics*, Oxford Medical Publications, OUP.

Bond, T. (2004). Ethical guidelines for researching counselling and psychotherapy. *Counselling and Psychotherapy Research*, Vol 4, No 2, pp. 10 -19

Boot, J., Barber, R., and Cooper, C. (2006) Principles and indicators of successful consumer involvement in NHS research: Results of a Delphi study and sub group analysis, *Health Policy*, 75, pp 280-297.

Bose, S., Oliveras, E., and Edson, W. N. (2001). How can self-assessment improve the quality of healthcare. *Operations Research Issue Paper*, 2(4), 1-27.

Boud, D., Keogh, R. and Walker, D. (1985). *Reflections: Turning experience into learning*. Kogan Page, London.

Bowers, J.S (2009). On the Biological Plausibility of Grandmother Cells: Implications for Neural Network Theories in Psychology and Neuroscience. *Psychological Review* American Psychological Association, Vol. 116, No. 1, 220–251

Bower, P., Brueton, V., Gamble, C., Treweek, S., Smith, C. T., Young, B., and Williamson, P. (2014). Interventions to improve recruitment and retention in clinical trials: a survey and workshop to assess current practice and future priorities. *Trials,* 15(1), 399.

Bowlby, J. (1969). *Attachment and Loss, Vol 1 Attachment*. New York: Basic Books.

Bowling, A. (1997). *Research Methods in Health: Investigating health and health services*, Open University Press: Buckingham.

Bowling, A. (2009). *Research Methods in Health: Investigating health and health services,* Open University Press: Buckingham. 2nd edition.

Boyne, R. (1990). *Foucault and Derrida: The Other Side of Reason*, Routledge, Redwood Books ltd, Trowbridge.

Bloor, M. (1997). Addressing Social Problems through qualitative Research, In: Silverman, D. ed., *Qualitative research: Theory, Method and Practice*, Sage Publications.

Bristow, J. (2006). Change of State: Learning How To Manage Unmanageable Feelings and States. *Reformulation*, Summer, pp.6-7.

Brockman, B., Poynton, A., Ryle, A. and Watson, J.P. (1987). Effectiveness of time-limited therapy carried out by trainees. Comparison of two methods. *The British Journal of Psychiatry.* 151: 602-610.

Bruscia, K., and Grocke, D.E. (2002). *Guided Imagery and Music: The Bonny Method and Beyond*. Barcelona Publishers.

Bruner, J. S. (1966). *Toward a theory of instruction* (Vol. 59). Harvard University Press.

Buckley, M. (2002). Psychotherapy with compulsively striving professional women 2: Clinical issues. *Psychodynamic Practice,* 8.1, pp 85-98.

Burns, N. and Grove, S.K. (2001). *The Practice of Nursing Research. Conduct, Critique and Utilization*. 4th ed. USA. WB Saunders Company.

Burns-Lundgren, E., (2004). Review of "Writing Cures 'An Introductory Handbook Of Writing In Counselling And Therapy"'. *Reformulation,* Autumn, pp.30-31.

Campbell, M., Fitzpatrick, R., Harris, A., Kinnock, A., Sandercost, P., Speiglehoth, D and Tyrier, P. (2000). Framework for design and evaluation of complex interventions to

improve health, *British Medical Journal*, 321, 694-696.

Cantrill, J., Sibbald, B. and Buetow, S. (1996). The Delphi and nominal group techniques in health services research. *International Journal of Pharmacy Practice*. 4, 67-74.

Cappas, N.M., Andreas-Hyman, R. and Davidson, L. (2005). What psychotherapists can begin to learn from neuroscience: seven principles of a brain based psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, Vol 42(3), pp374-383.

Carswell, M.A. and Magraw, K., (2003). *The Body Talks: Using Psychodrama and Metaphor to Connect Mind and Body.* Psychodrama in the 21st Century: Clinical and Educational Applications. Springer Publishing Co, New York, NY, pp. 63-79.

Calvert, R. and Kellett, S. (2014). Cognitive analytic therapy: A review of the outcome evidence base for treatment. *Psychology and Psychotherapy: Theory, Research and Practice*. Volume 87, Issue 3, pages 253–277, September 2014.

Carter, S. (2003). The nature of feelings and emotion based learning within psychotherapy and counselling: neuroscience is putting the heart back into emotion. *European Journal of Psychotherapy, Counselling and Health*, Vol 6, No 3, pp225-241.

Carroll, N. (1996). A Note on Film Metaphor, *Journal of Pragmatics*, 26 , pp809-822.

Carroll, R. in Corrigall, J. and Wilkinson, H. (2003). *Revolutionary Connections: Psychotherapy and Neuroscience*. Karnac Books.

Carroll, R., Elia, I., Compton Dickinson, S. and Webster, M., (2005). Workshop Presentation Synopses from the 2005 ACAT Annual Conference. Reformulation, Spring, pp.7-9.

Carroll, R. (2005). *Affect Regulation and the body in psychotherapy*, Body Brain and Beyond and CAT, 4th March 2005, Conference Presentation.

Carruthers, P. (1995). *Introducing persons: Theories and arguments in the Philosophy of Mind,* Routledge.

Chanen, A., Mc Cutcheon L, Germano, D., Nistico,H., Jackson, H., .McGorry P, Franz C.P. (2009). The HYPE Clinic: An Early Intervention Service for Borderline Personality Disorder, *Journal of Psychiatric Practice* Vol. 15, No. 3,163-169.

Charnay, K. (1990). Discovering Chronic illness using grounded theory. *Social Science Medicine*, 30 (11), p1162-1172.

Cheyne, J. A., and Tarulli, D. (1999). Dialogue, difference and voice in the zone of proximal development. *Theory and Psychology*, 9(1), 5-28.

Child, D. (2004). *Psychology and the Teacher.* 7th ed. London: Continuum.

Cirillo, L. and Cryder, C. (1995) Distinctive Therapeutic Use of Metaphor. *Psychotherapy,* 32, 511-519.

Clark, K., and Holquist, M. (1984). *Mikhail Bakhtin*. Harvard University Press.

Clark, J. (2000). Action research *In:* Cormack, D. (ed) (2000) *The Research Process in Nursing. 4th Edition* Oxford, Blackwell Publishing.

Close H.T. (1998) *Metaphor in Psychotherapy: Clinical Applications of stores and allegories.* San Luis Obispo, CA: Impact.

Coatsworth-Puspoky, R., Forchuk, C., & Ward-Griffin, C. (2006). Nurse–client processes in mental health: recipients' perspectives. *Journal of Psychiatric and Mental Health Nursing*, 13(3), 347-355.

Combs, G. and Freidman, J. (1990). *Symbol story and ceremony: Using metaphor in individual and family therapy.* New York: W.W.Norton and Company.

Conway, J. (1994). Reflection, the art and science of nursing and the theory-practice gap. *British Journal of Nursing* 3 (3): 114-118.

Cook, S. and Birrell, M. (2007). Defining occupational interventions with people with psychosis, *British Journal of occupational Therapy*, Vol 70 (3), pp 96-106. http://www.blatner.com/adam/level2/metaphors.htm

Cooperrider, D. L., and Srivastva, S. (1987). Appreciative inquiry in organizational life. Research in organizational change and development, 1(1), 129-169. in Reason P and Bradbury H (2001) *Handbook of action research*. Sage. p131.

Cormack, D. (ed) (2000). *The Research Process in Nursing*. 4th ed. United Kingdom. Blackwell Science.

Cortright, B. (1997). *Psychotherapy and Spirit: Theory and Practice in Transpersonal Psychotherapy*. State University of New York press, Albany.

Coulter, N., Rushbrook, S., (2010). Playfulness in CAT*. Reformulation*, Winter, pp.24-27.

Coulter, N. and Rushbrook, S. (2012). Sleep Tight: Working Creatively with Dreams in CAT. *Reformulation*, Summer, pp.7-12.

Cowan, T., Wilson-Barnett, J., Norman, J.I. and Murrells, T. (2008). Measuring nursing competence development of a self-assessment tool for general nurses across Europe. *International Journal of Nursing Studies*, 45, 902-914.

Cox, M. and Theilgaard, A. (1987). *Mutative Metaphors in Psychotherapy: The Aeolian mode*. Jessica Kinsley publishers.

Cox, T., Hassard, J., Keaney, D and Hardy C (2012). Appendix 1- Self Assessment: An Introduction. In De Normanville et al. (2012) *Literature Review and Technical Development to support the Making Every Contact Count Assessment Tool*, Sheffield Hallam University. ISBN 978-84387-353-2.

Cresswell, J.W (2003) *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches.* Second Edition. Sage Publications.

Crick F.H. (1994). *The astonishing hypothesis: The scientific search for the soul*. New York: Scribner.

Cronin, P., Ryan, F. and Coughlan, M. (2008). Undertaking a literature review: A step by step approach. *British Journal of Nursing*, 17 (1): 38-43.

Crookes, P.A. and Davies, S. (eds) (2004*). Research into Practice*. London. Bailliere Tindall. 2nd edition.

Crossley, N. (1996). *Intersubjectivity; The fabric of social becoming, Philosophy and Social Criticism*, Sage.

Cutcliffe, J. and McKenna, H. (1999). Establishing the creditability of qualitative research findings: the plot thickens. *Journal of Advanced Nursing* 30(2) 374-380.

Czechmeister, C.A. (1994). Metaphor in illness and nursing: a two-edged sword. A discussion of the social use of metaphor in everyday language, and implications of nursing and nurse education. *Journal of advanced nursing*, 19: 1226–33.

Dallos, R. and Vetere, A. (2005). *Researching psychotherapy and counselling*. Open University Press.

Dallos, R. (2006). *Attachment Narrative Therapy: Integrating narrative, Systematic and Attachment Therapies*. Open University Press.

Damasio, A.R. (2003). *Looking for Spinoza: Joy, sorrow and the Feeling Brain*. London: Henimann.

Dare, C., Eilsler, I., Russell, G., Treasure, J and Dodge, l. (2001). Psychological therapies for adults with anorexia nervosa: Randomised controlled trial of out-patient treatments *The British Journal of Psychiatry*. 178: 216-221.

Das, M., D. Mpofu, E. Dunn, and J.H. Lanphear. (1998). Self and tutor evaluations in problem-based learning tutorials: Is there a relationship? *Medical Education*, 32(4):411–18.

Davidson, J.R., Book, J.T., Colket, L.A., Tupler, S., Roth, D., David, M. and Hertzberg et al.. (1997) "Assessment of a new self-rating scale for post-traumatic stress disorder." *Psychological medicine* 27, no. 01: 153-160.

Delbecq, A. Van de Ven, A., Gustafson, D. (1975). *Group Techniques for Program planning: A guide to nominal group techniques and Delphi processes,* Scott Forsman and Co., Illinois.

Dent-Brown, K. and Wang, M. (2006) The mechanism of storymaking: A Grounded Theory Study of the 6-part Story Method. *The Arts in Psychotherapy*, 33, 316-330.

Dent-Brown, K. (2011). Six-Part Storymaking – a tool for CAT practitioners. *Reformulation, Summer,* pp.34-36.

Dent, C. and Rosenberg, L. (1990), Visual and Verbal Metaphors: Developmental Interactions. *Child Development*, 61: 983–994. doi: 10.1111/j.1467-8624.1990.tb02836.x

Denzin .N.K. (1970). *The Research Act. A theoretical Introduction to Sociological Methods*. Aldine publishing.

Department of Health (2001). Research Governance Framework for Health and Social Care. Department of Health, London.

Department of Health (2005). Report of the Ad Hoc Advisory Group on the Operation of *NHS Research Ethics Committees*, Department of Health, London.

DerSimonian, R., and Laird, N. (1986). Meta-analysis in clinical trials. *Controlled clinical trials,* 7(3), 177-188.

Dickerson, P. (1996). Discourse Analysis: A Possible Solution, *Counselling Psychology Review,* Vol. 11, Feb. 1996, pp 29-34.

Dilman, I. (1984). *Freud and the Mind*, Blackwell.

Domino,G., Affonso, DA., and Hannah, MT. (1992). Assessing the imagery of cancer: the cancer metaphor test. *Journal Psychosocial Oncology* 9(4): 103–21.

Dorst, A. and Pasma, T. (2010) The Cambridge handbook of metaphor and thought review, *Mataphor and Symbol*, 26:1, 96-103.

Duffield, C. (1989). The Delphi technique. *Australian Journal of Advanced Nursing.* 6, 2, 41-45.

Duffield, C. (1993). The Delphi technique: a comparison of results obtained using two expert panels. *International Journal of Nursing Studies*. 30, 3, 227-237.

Dunn, M and Ryle, T. (1993). Tony Ryle Briefly Interviewed by Mark Dunn. *Reformulation*, ACAT News Autumn, p.x. http://www.acat.me.uk/reformulation.php?issue_id=35andarticle_id=343

Dunn, M. (1997). Do we allow CAT to have a heart? Is it soft and wet? A Response.. *Reformulation*, ACAT News Winter, p.x. http://www.acat.me.uk/reformulation.php?issue_id=36&article_id=341

Dunn, M. and Parry, G.(1997). A formulated care plan approach to caring for people with borderline personality disorder in a community mental health service setting, *Clinical Psychology forum*, 104, June.

Dunn, M. (2005). ACAT Chair's AGM Report. *Reformulation*, Autumn, pp.34-35.

Dunn, M. (2007). In the Beginning was the Conversation 'Process' Spirituality and CAT. *Reformulation*, Winter, pp.16-19.

Dutton, D. (1998). *The Abusive personality: Violence and control in intimate relationships*, Guildford press.

Ekman, P. (1992). An argument for basic emotions. *Cognition and emotion*, *6*(3-4), 169-200.

Edwards, P., Roberts, I., Clarke, M., DiGuiseppi, C., Pratap, S., Wentz, R and Kwan, I., (2002) Incresing Response Rate to postal questionnaires: systematic review, *British Medical Journal*, Vol 324, pp1-9.

Edwards, D. (2010). Play and metaphor in clinical supervision: Keeping creativity alive. *The arts in Psychotherapy*. Doi:10.1016/j.aip.2010.04.011.

Elliott, J. (1990). Teachers as researchers: Implications for supervision and for teacher education. *Teaching and Teacher Education*, 6(1), 1-26.

Elliot, J. (1991). *Action research for educational change*. McGraw-Hill Education (UK).

Elliott, J. (1993). What have we learned from action research in school-based evaluation?. *Educational Action Research*, 1(1), 175-186.

Elliott, J. (1994). Research on teachers' knowledge and action research. *Educational Action Research,* 2(1), 133-137.

Etherington, K (1996). The counsellor as researcher: Boundary issues and critical dilemmas. *British Journal of Guidance and Counselling*, Vol 24, No 3, pp. 339 – 346.

Etherington, K (2001) Research with ex-patients: a celebration and extension of the therapeutic process. *British Journal of Guidance and Counselling*, Vol 29, No 1, pp. 5 –19.

Eynon, T. (2002). Cognitive linguistics*. Advances in psychiatric Treatment.* 8:399-407*.*

Ewart, C. (2015). 15 How I can go on. Disability, *Avoidance and the Academy: Challenging Resistance*, 164.

Fabregat, M., Krause, R., Prof. Dr. Dekan., Lindenberger, U. and Fonagy, P. (2004). *Metaphors in Psychotherapy*: From Affect to Mental Representations. Dissertation. der Universität des Saarlandes. Accessed http://www.google.co.uk/search?sourceid=navpatientandaq=tandie=UTF-8andrls=GGLD,GGLD:2004-22,GGLD:enandq=pictures+as+metaphor+in+psychotherapy

Falck, M.J. (2010). Metaphors dead and alive, sleeping and waking: A dynamic view by Cornelia Muller. *Metaphor and Symbol*, 25:2, 114-121.

Farrell, B.A. (1981). *The Standing of Psychotherapy,* Oxford University Press.

Faugier, R. (2005). Praxis problems and promise, grounded theory on counselling psychotherapy research, *Journal of counselling psychotherapy*, 52(3), pp156-166

Fawkes, L. and Fretten, V. (2003). Two different presentations with Borderline Personality Disorder. *Reformulation,* Summer, pp.32-39.

Field, P. A. and Morse, J. M. (1985). *Nursing Research. The application of qualitative approaches*. London. Croom Helm.

Fine, H. J., Pollio, H. R., and Simpkinson, C. H. (1973). Figurative language, metaphor and psychotherapy. Psychotherapy: Theory, Research and Practice, 10(1), 87.

Fitzsimmons, M. (2000). A credit-card sized SDR and its use with a patient with limited language skills. *Reformulation*, ACAT News Autumn, p.x.

Flaskerud, J. H. (1990). Matching patient and therapist ethnicity, language, and gender: A review of research. *Issues in mental health nursing,* 11(4), 321-336.

Fonargy, P. and Ryle A. (1995). Psychoanalysis, cognitive analytic therapy, mind and self. BJO annual lecture. *British Journal of Psychotherapy*, Vol 11 (4), 567-574.

Fonargy, P. (2004). Psychotherapy meets Neuroscience: A more focussed future for psychotherapy research, *Psychiatric bulletin*, 28, 357-359.

Fozooni, B. (2010). Cognitive analytic therapy: a sympathetic critique. *Psychotherapy and Politics International,* 8(2), 128-145.

Forceville, C. (2002). The identification of target and source pictorial metaphors. *Journal of Pragmatics,* Vol 34, Issue 1, p1-14.

Forceville, C. (2008). Metaphor in Pictures and multi modal representations. In R.W.Gibbs (2008). The Cambridge handbook of metaphor and thought. Cambridge: Cambridge University Press.

Forchuk, C., & Brown, B. (1989). Establishing a nurse-client relationship. Journal of psychosocial nursing and mental health services, 27(2), 30-34.

Forchuk, C., Jewell, J., Schofield, R., Sircelj, M., & Valledor, T. (1998). From hospital to community: bridging therapeutic relationships. *Journal of Psychiatric and Mental Health Nursing*, 5(3), 197-202.

Forchuk, C. (2001). Evidence-based psychiatric/mental health nursing*. Evidence Based Mental Health,* 4(2), 39-40.

Forchuk, C., martin, M. L., Chan, Y. L., & Jensen, E. (2005). Therapeutic relationships: From psychiatric hospital to community. *Journal of psychiatric and mental health nursing,* 12(5), 556-564.

Fox, R. (1989). What is meta for? *Clinical Social Work Journal*, *17*(3), 233-244.

Freud, S. (1925). The Negation (Die Verneinung). Penguin.

Freud, S. (1960). *The ego and the id* (J. Reviere, trans., J. Strachey, Ed) New York: W W Norton (Original work published in 1923), p60.

Freud, S. (1908). Creative writers and day-dreaming. *Standard edition*, 9, 141-153. http://www.kleal.com/AP12%20member%20area%20pd2%202013/Freud%20and%20Frye.pdf

Freud, S. (1973). *New Introductory Lectures In Psychoanalysis* (trans J. Stachey) London, Pelican.

Freud, S. (1986). *The Essentials Of Psychoanalysis; The Definitive Collection of Sigmund Freud's Writings*, Ed. Anna Freud, Penguin.

Freud, S. (1991). *The essentials of psychoanalysis: the definitive collection of Sigmund Freud's writings,* Penguin.

Francis, D., Kaiser, D. and Deaver, S. (2011) Representations of attachment security in the Bird's Nest Drawings of Patient with Substance Abuse Disorders. *Journal of the American Art Therapy Association*, 20:3, 125-137.

Fraser, E. (1998). The Use of Metaphors with African-American Couples, *Journal of couples Therapy*, 7:3, 137-148.

Freeman, A and Dattilio F.M. (1992). *Comprehensive casebook of Cognitive Therapy*, Plenum Press.

Fuchs, T. (2004). Neurobiology and psychotherapy: an emerging dialogue. *Current Opinion in Psychiatry*, 17: 479-485.

Fuller, P. (1980). *Art and psychoanalysis* . London: Writers and Readers.

Garfinkel, H. (1967). *Studies in Ethnomethodology*, Englewood Cliffs, NJ: Prentice hall.

Gastmans, C. (1998). Interpersonal relations in nursing: a philosophical-ethical analysis of the work of Hildegard E. Peplau. Journal of Advanced Nursing, 28(6), 1312-1319.

Gendlin, E.T. (1982). *Focussing*. Second edition, Bantam Books.

Gentile, M. (Ed.). (1997). Functional visual behaviour: A therapist's guide to evaluation and treatment options. *American Occupational Therapy Association*.

Gentner, D., Bowdle, B., Wolff, P., and Boronat, C. (2001). Metaphor is like analogy. In Gentner, D., Holyoak, K.J., and Kokinov, B.N. (Eds.), *The analogical mind: Perspectives from cognitive science* (pp. 199-253). Cambridge MA, MIT Press.

Georgaca, E & Lopez, A. (1994). *Subjectivity and psychotic discourse.* Unpublished Sheffield University.

George, D. and Mallery, P. (2003). *SPSS for windows step by step: A simple guide and reference. 11.0 Update (4th Ed)*. Boston: Allyn and Bacon.

Gibbs, R.W. (1992) Categorization and metaphor understanding. *Psychological Review*, Vol 99(3), Jul 1992, 572-577. doi: 10.1037/0033-295X.99.3.572

Gibbs, R.W. and Matlock, T. (2008). Metaphor, imagination, and simulation: Psycholinguistic evidence. In Gibbs, R. W. Jr. (ed.) *The Cambridge Handbook of Metaphor and Thought*. Cambridge: Cambridge University Press, 161-76.

Gibbs, R.W. (2008). *The Cambridge handbook of metaphor and thought*. Cambridge: Cambridge University Press.

Gil-Rios, Dr. C., M., and Blunden, Dr. J. (2012). Reflections on a Dilemma in a Supervision group: Caught between a Rock and a Hard Place. *Reformulation*, Summer, pp.23-25.

Gillies, A. (2002). *Using research in nursing. A workbook for practitioners*. United Kingdom. Radcliffe Medical Press Ltd.

Glaser, B., and Strauss, A. (1967). The discovery grounded theory: strategies for qualitative inquiry. *Aldin, Chicago*.

Gliem, J. and Gliem, R. (2003). Calculating , interpreting and reporting Cronbachs Alp-ha Reliability coeffecient for Likert-Type Scales. 2003 *Midwest Research to practice Conference, Ohio State Uiversity*, Oct 8-10.

Glucksberg, S. and Keysar, B. (1990). Understanding metaphorical comparisons: Beyond similarity. *Psychological Review*, Vol 97(1), Jan 1990, 3-18. doi: 10.1037/0033-295X.97.1.3

Gobfert, M. and Barnes, B (1995). The Therapeutic relationship and Therapy Outcomes, *Reformulation*. Accessed ACAT Library http://www.acat.me.uk/article.php?_id=170andstyle.

Goldschmidt, P. (1975). Scientific Enquiry or Political Critique: Remarks on Delphi assessment Expert opinion, Forecasting and group process by H Sackman, *Technolgical Forecasting and Social Change*, 195-213.

Goncalves, O.F. and Machado, P. (1999). Cognitive Narrative Psychotherapy: Research Foundations. *Journal of Clinical Psychology*. 55: 1179-1191. Accessed 10/9/14 http://repositorium.sdum.uminho.pt/bitstream/1822/3008/1/oscar.pdf

Gonçalves, O. F., and Craine, M. H. (1990). The use of metaphors in cognitive therapy. *Journal of Cognitive Psychotherapy,* 4(2), 135-149.

González Ferrer, A., and Beauchemin, C. (2011). Sampling international migrants with origin-based snowballing method. *New evidence on biases and limitations*.

Good, TL., and Brophy, JE. (1990). *Educational psychology: A realistic approach.* (4th ed.).White Plains, NY: Longman.

Good, D. and Watts, F. (1997). Qualitative Research. In: Parry, G. and Watts, F. (1997) *Behavioural and Mental Health Research: A handbook of Skills and Methods*, second edition, Earlbaum (UK),Taylor and Francis.

Grant, M.J. and Booth, A. (2009). A typology of reviews: an analysis of 214 review types and associated methodologies. *Health Information and libraries Journal*, 26, pp91-108.

Gray, J.R. (2004). Integration of emotion and cognitive control. *Current Directions in Psychological Science*.

Greatorex, J. and Dexter, T. (2000). An accessible analytical approach for investigating what happens between the rounds of a Delphi study, *Journal of advanced Nursing*, 32, 1016-1024.

Greenhalgh, T. and Peacock, R. (2005). Effectiveness and efficiency of search methods in systematic reviews of complex evidence: audit of primary sources. *British Medical Journal*, 331: 1064-1065.

Greenwood, H. (2011). Long Term individual Art psychotherapy: Art for Arts sake: The effect of early relational trauma. *International Journal of Art Therapy*. Vol 16(1):41-51.

Gritton, J. (2007). Of serendipity, free association and aimless browsing: do they lead to serendipitous learning. Retrieved March, 20, 2012.

http://online.education.ed.ac.uk/gallery/gritton_serendipitous_learning/conclusion/assets/assignment_print_version.pdf

Guba, E.G., and Lincoln, YS. (1994). Competing paradigms in qualitative research. H*andbook of qualitative research*, *2*(163-194), 105.

Guiffrida, D. A., Jordan, R., Saiz, S., and Barnes, K. L. (2007). The use of metaphor in clinical supervision. *Journal of Counseling and Development,* 85(4), 393-400.

Guerin, B. (2003). Language use as social strategy: A review and analytic framework for the social sciences. *Review of General Psychology*, 7, 251-298.

Guillemin, M. (2004). Understanding illness: Using drawings as a research method. *Qualitative Health Research*, *14*(2), 272-289.

Hacker, P.M.S. (1997). *Wittgenstein on human nature*, Phoenix pubs.

Hackmann, A., Bennett-Levy, J., Holmes, E. (2011). *Oxford Guide to Imagery in Cognitive Therapy.* Oxford University Press*.*

Halcomb, E. and Andrew, S. (2005). Triangulation as a method for contemporary nursing research. *Nurse Researcher.* 13 (2): 71-82.

Hall, J.M. (1997). Safe Closure of therapeutic relationships with abuse survivors, *Journal of psychosocial nursing,* vol 35(11), pp 7-13.

Hardy, D., O'Brien, A., Gaskin, C. *et al.* (2004). Practical application of the Delphi technique in a bicultural mental health nursing study in New Zealand. *Journal of Advanced Nursing*. 46, 1, 95-109.

Hart, E. and Bond, M. (1995). *Action research for health and Social care*, Open University press.

Hartrick, G. and Schrieber, R. (1998). Nurses' metaphors of practice. *Journal of Holistic Nursing*, 16(4): 420–34.

Hasson, F., Keeney, S., and Mckenna, H. (2000). Research Guidelines for the Delphi survey technique, *Journal of advanced Nursing*, 32(4), pp1008-1015.

Hass-Cohen, N and Carr, R (2008). *Art Therapy and Clinical Neuroscience*. London and Philadelphia.Jesica Kingsley Publishers.

Hausman, C.R. (1983). Metaphors, referants and individuality. *The journal of Aesthetics and Art Criticism,* Vol 42, No.2, Winter, pp181-195.

Hawker, S., Payne, S., Kerr, C., Hardy, M. and Powell, J. (2002). Appraising the evidence: Reviewing disparate data systematically. *Qualitative health research*, 12: 1284-1299.

Hawton, K., Salkovskis, P., Kirk, J, and Clark, D. (2002). *Cognitive Behavioural Therapy for psychiatric problems: A practical guide*, Oxford medical publications. P66-70.

Hayes, S. Follette, V., and Linehan, M. (2004). *Mindfulness and acceptance: Expanding the Cognitive behavioural Tradition*, Guildford.

Hayward, M. and McCurrie, C. (2008). Metaprocedures in Normal Development and in Therapy. *Reformulation,* Summer, pp.42-45.

Heaton, J. and Groves, J. (1994). *Wittgenstein for Beginners*, Icon books

Heiney, S. (1995). The healing power of story. *Oncology Nursing Society*, Vol 22 (6), pp899-903

Hek, G., Judd, M. and Moule, P. (2002). *Making sense of research.* Second Edition London, Sage Publications

Hemingway, S., Hazel Baxter, H., Smith, G., Burgess-Dawson, R., Dewhirst, K., White, J., Turner, J., (2012). Implementing a Competence Framework for Administering Medication: Reporting the experiences of Mental Health Nurses. *Issues in Mental Health Nursing.*

Henzell, J. (1984). Art, psychotherapy, and symbol systems. *Art as Therapy: an introduction to the use of art as a therapeutic technique*, p15-29.

Hepple, J. (2010). A little bit of Bakhtin–from inside to outside and back again, *Reformulation*, Winter, PP 17-18.

Hepple, J. (2011). The Chicken and the Egg. *Reformulation,* Winter, p.19.

Hermans, H.J.M. (2002). The Dialogical Self as a society of Mind. *Theory and Psychology*, Vol 12(2), 147-160.

Hermans, H.J.M. (2003). The construction and reconstruction of a dialogical self. *Journal of Constructivist Psychology*, 16:89-130.

Heron, J. (1979). *Co-counselling*. Human Potential Research Project, University of Surrey.

Heron, J. (1990). *Helping the Client: A Creative Practical Guide*. Sage Publications. London.

Heron, J. (1996). *Co-operative inquiry: Research into the human condition*. Sage.

Heron, J., and Reason, P. (2001). The practice of cooperative inquiry: Research “with” rather than “on” people. In Reason, P. and Bradbury, H. (2001) *Handbook of Action Research*, London:Sage.

Hill, C. E., and Regan, A. M. (1991). The use of metaphors in one case of brief psychotherapy. *Journal of Integrative and Eclectic Psychotherapy*, 10(1), 56-67.

Hill, A and Turner, J (2011). Implementing clinical supervision Part 3: An evaluation of a clinical supervisor’s recovery-based resource and support package. Mental Health Nursing. 31(5): 14-18.

Hinschelwood, R. D. (1991), *A Dictionary of Kleinian Thought*, 2nd edition, p216, Free Association Books, London.

Hirschon, L. (1997). *The workplace within: Psychodynamics of organisational life*, 1st Ed 1990, Seventh impression 1997, The MIT press.

Hobson, R.F. (1985). *Forms of Feeling: the Heart of Psychology.* London: Tavistock.

Høglend, P., Sørlie, T., Sørbye, Ø., Heyerdahl, O., and Amlo, S. (1992). Long-term changes after brief dynamic psychotherapy: symptomatic versus dynamic assessments. *Acta Psychiatrica Scandinavica*, *86*(2), 165-172.

Holloway, I. and Wheeler, S. (2002). *Qualitative Research in Nursing*. 2nd ed. United Kingdom. Blackwell Publishing.

Holmes, J. and Bateman, A.W. (eds) (2002). *Integration in psychotherapy: models and methods*. OUP, Oxford.

Holstein, J. and Gubrium, J. (1997). Active Interviewing, In: Silverman, D. ed. (1997) *Towards and Aesthetics of Research, Qualitative research: Theory, Method and Practice*, Sage Publications, pp113-129.

Hondereich, T. (1995). *The Oxford Companion to Philosophy*, Oxford University press.

Honigman, J.J. (1994). Sampling in Ethnographic Fieldwork. In: *Field Research: A Sourcebook and Manual*. Chapter 12 p79-89. Ed: R.G. Burgess. Routledge: London.

Hope, K. (1998). Starting out with action research. *Nurse Researcher*, *6*(2), 16.

Horsburgh, D. (2003). Evaluation of qualitative research *Journal of Clinical Nursing* 12(2) 307-312.

Hubbuck, J. (2008). Draft States of Mind Inventory. *Reformulation,* Winter, pp.15-25.

Hubble, M., Duncan, B., and Miller, S. (2000). *The Heart and Soul of Change: What Works in Psychotherapy.* Washington DC: American Psychological Association.

Hundert, E. (1989). *Philosophy, Psychiatry and Neuroscience: Three Approaches to the Mind; A synthetic Analysis of the varieties of human experience*, Clarendon press, Oxford.

Hughes, P. and Kerr, I. (2000). Transference and Countertransference in communication between doctor and patient. *Advances in Psychiatric Treatment,* 6, 57-64.

Hughes, R. (2007). An enquiry into an integration of cognitive analytic therapy with art therapy. *International Journal of Art Therapy*, 12(1), 28-38.

Hughes, R. (2011). Comment on James Turner's article on Verbal and Pictorial Metaphor in CAT. Reformulation, Winter, pp.24-25.

Hurley, J., Barrett, P. and Reet, P. (2006). Let a hundred Flowers Bloom, Let a hundred Schools of Thought Contend: a case for therapeutic pluralism in mental health nursing. *Journal of Psychiatric and Mental Health Nursing* 13(2) 173-179 .

Hutchings, M., Scammell, J., and Quinney, A. (2013). Praxis and reflexivity for interprofessional education: towards an inclusive theoretical framework for learning. *Journal of interprofessional care*, *27*(5), 358-366.

Hyman, HH., Cobb, W.J., Feldman, JJ., Hart, CW. and Stember, CH. (1975) *Interviewing in Social research, Chicago*: University of Chicago Press.

Innes, R. (1985). *Semiotics: An Introductory Anthology*, Bloomsbury, Indiana University Press.

Irvine, F. (2004). Exploring District Nurses Competencies in health promotion: the use of the Delphi technique, *Journal of Clinical Nursing*, 14, pp965-975.

Jenny, J. and Logan, J. (1996). Caring and comfort metaphors used by patients in critical care. *Journal of School Nursing*, 28(4): 349–52.

Jacobs, M. (1998). *The Presenting Past: the Core of Psychodynamic Counselling and Therapy.* 2nd edn. Open University Press, Buckingham.

Jeffery, D., Ley, A., Bennun, I. and McLaren, S. (2000). Delphi survey of opinion on interventions, service principles and service organisation for severe mental illness and substance misuse problems. *Journal of Mental Health*. 9, 4, 371-384.

Jefferis, S. (2011). Memoirs, Myths and Movies: Using Books and Film in Cognitive Analytic Therapy. *Reformulation*, Summer, pp.29-33.

Jenkins, S., Price, C. J., Straker, L. (1998). Planning for ethical research. In *The Researching Therapist*. Churchill Livingstone.

Johnson, S. (1998). *Who moved my cheese*. Random House.

Jonassen, D. H. (1991). Objectivism versus constructivism: do we need a new philosophical paradigm? *Educational Technology Research and Development,* 39 (3), 5-14.

Jung, C.G. (1966). The aim of psychotherapy. In R.F.C.Hull (Trans.) *The collected works of C.G. Jung:Vol 16. The Practice of Psychotherapy.* Princeton, NJ: Princeton University Press.

Kandel, E.R. (1998). A new intellectual framework for psychiatry. *American journal of Psychiatry.*

Keeney, S., Hasson, F., McKenna, H. (2001). A critical review of the Delphi panel technique as a research methodology for nursing. *International Journal of Nursing Studies*. 38, 195-200.

Keeney, S., Hasson, F., McKenna, H. (2006). Consulting the Oracle: ten lessons from using the Delphi technique in nursing research, *Methodological Issue in Nursing research*, *Journal of Advanced Nursing. Pp205-212.*

Keeney, S., Hasson, F., McKenna, H. (2011). *The Delphi Technique in Nursing and Health Research.* Wiley-Blackwell.

Keijsers, G. P. J., Schaap, C. P. D. R., and Hoogduin, C. A. L. (2000). The impact of interpersonal patient and therapist behavior on outcome in cognitive-behavior therapy a review of empirical studies. *Behavior Modification*, *24*(2), 264-297.

Kellett, S. (2004). Process Issues in Conducting CAT with Dissociative Identity Disorder. Reformulation, Autumn, pp.11-15.

Kellett, S. (2005). The treatment of dissociative identity disorder with cognitive analytic therapy: experimental evidence of sudden gains. *Trauma and Dissociation* (in press).

Kellett, S. (2012). Cognitive analytic therapy. *Handbook of counselling and psychotherapy. Hove: Wiley*.

Kennedy, V. (1994). *Metaphor and Symbol*, Volume 9, Issue 2, June 1994, p 135-147.

Kennedy, H.P. (2004). Enhancing Delphi research: methods and results. *Journal of Advanced Nursing*. 45:5, 504-511.

Kennedy, J.M. (2008). Chapter 25, Metaphor and Art. In Gibbs, R.W. (2008). *The Cambridge handbook of metaphor and thought.* Cambridge: Cambridge University Press.

Kernberg, O.F. (1995). *Object relations theory and clinical psychoanalysis*. Jason Aronson.

Kernberg, O. F. (2004). *Object-Relations Theory and Clinical Psychoanalysis*. Rowman and Littlefield Publishers, Inc, New York.

Kerr, I.B. (1999). Cognitive-analytic therapy for borderline personality disorder in the context of a community mental health team: individual and organizational psychodynamic implications. *British Journal of Psychotherapy, 15,* 425-438.

Kerr, I. B. (2001). Brief cognitive analytic therapy for post-acute manic psychosis on a psychiatric intensive care unit. *Clinical Psychology and Psychotherapy*, 8(2), 117-129.

Kidd, P. and Parshall, M. (2000). Getting the Focus and the Group: Enhancing Analytical Rigor in Focus Group Research, *Qualitative Health Research,* 2000; 10; 293.

Kilner, T. (2011). Desirable attributes of the ambulance technician paramedic, and clinical supervisor: findings from a Delphi study, *Emergency Medical Journal online*, Nov 3, p 374-378.

Kim, Y.M., Putjuk, F., Kols, A. and Basuki, E. (2000). *Improving provider-patient communication: Reinforcing IPC/C training in Indonesia with self-assessment and peer review. Operations Research Results 1(6).* Bethesda, MD: Published for the U.S. Agency for International Development (USAID) by the Quality Assurance Project.

Kirkland, J. (2010). When I'm the dark angel I feel worthless and don't deserve love, *Reformulation* (53), pp19-23.

Kitzinger, J. (1995). Qualitative Research: Introducing focus groups, *British Medical Journal,* 1995;311:299-302 (29 July).

Klein, M. (1975). *The Writings of Melanie Klein: Envy and gratitude and other works* (No. 22). Hogarth Press and the Institute of Psycho-Analysis.

Klein, M. (1980). *Envy and Gratitude: Notes on some schizoid mechanisms* (1946), Hogarth press.

Klein, M. (1997). Envy and gratitude and other works 1946-1963. Random House.

Kok, J.K., Lim, C.M., and Low, S.K. (2011). *Attending to metaphor in counselling*. In 2011

International Conference on Social Science and Humanity (Vol. 5, pp. V1-54).

Kopp, R. (1995). *Metaphor Therapy: Using patient generated metaphors in psychotherapy, Brunner*, New York.

Kotter, J.P., and Rathgeber, H. (2006). *Our iceberg is melting: Changing and succeeding under any conditions*. Macmillan.

Kovecses, Z. (2000). *Metaphor and Emotion: Language, culture and body in human feeling*. Cambridge: Cambridge university Press.

Kovecses, Z., Benczes, R., Bokor, Z., Csabi, S., and Lazanyi, E. (2010). *Metaphor – A practical introduction.* Oxford University Press

Kris, E. (1952). *Psychoanalytic explorations in art.*

Kristal, A., Beresford, SAA. and Lazovich, D. (1994). Assessing change in diet-intervention research. *American Journal of Clinical Nutrition.* 59 (Suppl. 1): 185S–189S, 1994.

Kuhn, T. S. (1970). Logic of discovery or psychology of research. *Criticism and the Growth of Knowledge*, 1-23.

Lahad, M. and Aylon, B. (1993). in Dent-Brown, K. and Wang, M. (2006). The mechanism of storymaking: A Grounded Theory Study of the 6-part Story Method. The Arts in Psychotherapy, 33, 316-330.

Laing, R.D. (1990). *Self and Others,* first ed. 1961, Penguin Books.

Lakoff, G. and Johnson, M. (1980). *Metaphors We Live By*. Chicago: University of Chicago Press.

Lakoff, G. (1993). The contemporary theory of metaphor. In Ortney, A (1993) *Metaphor and Thought*, Second Edition. Chapter 1. 202-251.

Lakoff, G. (1997). The internal structure of the self. In: Neisser, U., Jopling, D.A. (Eds.), *The Conceptual Self in Context: Culture, Experience, Self-Understanding*. Cambridge University Press, Cambridge, pp. 92–113.

Lakoff, G. and Johnson, M. (2008). *Metaphors We Live By*. Afterword. Chicago: University of Chicago Press

Lakoff, G., and Turner, M. (2009). *More than cool reason: A field guide to poetic metaphor*. University of Chicago Press.

Lacroix, L., Peterson, L and Verrier, P. (2011). Art Therapy, Somatizatrion, and narcissistic Identification. *Journal of the American Art therapy Association*. 18:1, 20-26.

Lane, R.D. and Nadel, L. (2002). *Cognitive Neuroscience of Emotion*. Oxford University press.

Langer, S. K. (2009). *Philosophy in a new key: A study in the symbolism of reason, rite, and art*. Harvard University Press.

Larkin, D. and Zabourek, R. (1988). Therapeutic storytelling and metaphor. *Holistic Nursing Practice.* May 1988, Volume 2, Issue 3: p45-53.

Larkin, D. (1990). Metaphor, Mythology, and Spiritual Development. *Journal of Addictions Nursing,* 2(4), 11-13.

Lars, F. and Pocock, S. (1992). Repeated measures in clinical trials: analysis using mean summary statistics and its implications for design. *Statistics in medicine* 11, no. 13: 1685-1704.

Leach, C., Lucock, M., Iveson, S., and Noble, R. (2004). Evaluating Psychological Therapies Services: A review of outcome measures and their utility. *Research and Practice*, 53.

LeDoux, J. (2000). Emotion circuits in the Brain. *Annual review of Neuroscience*, 23, pp155-184.

LeDoux, J.E. (2002). *The synaptic self: How are brains become who we are*. Harmondsworth: Penguin.

LeDoux, J. (2003). The emotional brain, fear, and the amygdala. *Cellular and molecular neurobiology*, *23*(4-5), 727-738.

Lego, S. (1980). The One-to-One Nurse-Patient Relationship. *Perspectives in Psychiatric Care,* 18(2), 67-89.

Lego, S. (1998). The application of Peplau's theory to group psychotherapy. *Journal of Psychiatric and Mental Health Nursing*, 5(3), 193-196.

Leiman, M. (1992). The concept of sign in the work of Vygotsky, Winnicott and Bakhtin: Further integration of object relations theory and activity theory, *British Journal of Medical Psychology*, 65, 97-106.

Leiman, M. (1993). Words as interpsychological mediators of psychotherapeutic discourse, *Semiosis in Psychotherapy Symposium*, Finland.

Leiman, M. (1994).The development of CAT, *International journal of Short Term psychotherapy,* 9, 2, pp 67-82.

Leiman, M. (1996). Early signs of dialogical sequences in CAT, *ACAT Conference*, March.

Leiman, M. (1997). Early Signs of Dialogical Sequences in CAT. *Reformulation*, ACAT News Winter, p.x.

Leiman, M. (1997a). Procedures as Dialogical Sequences: A Revised Version of the Fundamental Concept in Cognitive Analytic Therapy. *British Journal of Medical Psychology,* 70, pp 193-207.

Leiman, M. (2001). Toward Semiotic Dialogism: the role of sign mediation in the dialogical self. Theory and psychology. 12(2), p 221-236.

Leiman, M. (2002). Rigs, Reciprocal Roles and semiotic positions: interpersonal approaches to early experiences and therapy, *ACAT News*, Summer, 10-13.

Leiman, M. (2004). *Dialogical Sequence Analysis*, University of Joensuu.

Leurent, B., Killaspy, H., Osborn, DP., Crawford, MJ., Hoadley, A., Waller, D. and King, M. (2014) Moderating factors for the effectiveness of group art therapy for schizophrenia: secondary analysis of data from the MATISSE randomised controlled trial. *Soc Psychiatry Psychiatr Epidemiol*. Nov, 49(11):1703-10.

Levit, H., Korman, Y. and Angus, L. (2000). A metaphor analysis in treatment of depression: metaphor as a marker of change, *Counselling Psychology Quarterly*, 13 (1) pp23-35.

Lenninger, M. (1985). Nature, Rationale, and Importance of Qualitative Research Methods in Nursing. Qualitative *Research Methods in Nursing*. Saunders Company. 1985 p1-7.

Leuner, H. (1966). *Guided Affective Imagery: A method of intensive psychotherapy*, Abbreviation of a lecture given to the New Jersey Neuropsychiatric institute, Princeton, N.J. May 16, 1966, reprinted from the *American Journal of Psychotherapy*, Vol XXII, No 1, pages 4-22.

Lipsey, MW. and Wilson, DB. (2001). *Practical meta-analysis (Vol. 49).* Thousand Oaks, CA: Sage publications.

Lodge, D. (1988). *Modern Criticism and Theory: A reader*. Longman , London and new York.

Loock, A.C., Myburgh, C.P.H and Poggenpoel, M. (2003). Art as projective medium: An educational psychological model to address unresolved trauma in young adults. *Education,* 123(4), pp 705-713.

Loue, S. (2008). *The Transformative Power of Metaphor in Therapy*. Springer Publishing Company.

Luker, KA., Beaver, K., Leinster, SJ. and Owens, RG. (1996). Meaning of illness for women with breast cancer. *Journal of Advanced Nursing.* 23: 1194–201.

Ludema, J., Cooperrider, D. and Barrett, F. (2001). Appreciative enquiry: The power of the unconditional positive question, Chapter 13 in Reason P and Bradbury H (2001) *Handbook of action research*. Sage.

Lundin, S. C. (2009). *Fish!: a remarkable way to boost morale and improve results*. Hachette UK.

Lyddon, W.J. (1990). First- and second-order change: Implications for rationalist and constructivist cognitive therapies. *Journal of Counseling and Development*, 69, 122–127.

Lyddon, W.J., Clay, A.L. and Sparks, C.L. (2001). Metaphor and Change in Counselling. *Journal of Counselling and Development*, 79, 267-274.

Lyon, J (1996). Applying Hart and Bond Typology: Implementing clinical supervision in an acute setting, *Nurse researcher*, Vol 6, no 2, p39-56.

Mace, C., Beeken, S. and Embleton, J. (2006). Beginning therapy: clinical outcomes in brief treatments by psychiatric trainees. *Psychiatric Bulletin*. 30:7-10.

Mair, J.M.M. (1977). Metaphors for living. In Nebraska Symposium on Motivation 1976, vol. 24 in the series *Current theory and research in motivation*. Lincoln: University of Nebraska Press.

MacLean, P.D. (1990). The triune brain in evolution. Role in paleocerebral functions. London, UK: Plenum

Mann, J. (1973). *Time limited psychotherapy, Chapter 4 The sequence of dynamic events*. Cambridge, MA: Harvard University Press.

Margison, F.R. (2000). Editorial Cognitive Analytic Therapy: a case study in treatment development. *British Journal of Medical Psychology*. 73, 145-149.

Margison, F.R., McGrath, G., Barkham, M., Clark, J.M., Audin, K., Connell, J. and Evans, C. (2000). Measurement and psychotherapy. *The British Journal of Psychiatry,* 177(2), 123-130.

Markman, M.D. (2011). Metaphors we live by: Commentary on paper by Stephen H. Knoblauch. *Psychoanalytic Dialogues*, 21:437-445.

Martin, J. and Stelmaczonek, K. (1988). Participants'' identification and recall of important events in counselling. *Journal of counselling psychology*, 35, 385-390.

Martin, J., Paivio, S. and Labadie, D. (1990). Memory-enhancing characteristics of patient-recalled important events in cognitive and experiential therapy: Integrating cognitive experimental and therapeutic psychology. *Counselling Psychology Quarterly*, 3(3), 239-256.

Martin, J., Cummings, A. and Hallberg, ET. (1992). Therapists' intentional use of metaphor: Memorability, clinical impact, and possible epistemic/motivational functions. *Journal of Consulting and Clinical Psychology*, Vol 60(1), Feb 1992, 143-145. doi: 10.1037/0022-006X.60.1.143.

Mays, N. and Pope, C. (1996). Rigour and qualitative research. In Mays, N. and Pope, C. (eds.) *Qualitative Research in Health Care.* London: British Medical Journal Publishing group.

Marrow, C. (1998). Keeping above the surface in an action research study. *Nurse Researcher*. 6 (2): 57-70.

Marshall, C. and Rossman, G. (1999). *Designing Qualitative Research.* 3rd edition, Sage publications, London.

Marshall, N. and Faust, M. (2008). Right hemisphere sensitivity to novel metaphoric relations: Application of the signal detection theory, *Brain and Language*, 104, pp103-112.

McAllister, M. and Mclaughlin, D. (1996). Teaching metaphors of student nurses. *Journal of Advanced Nursing.* 23: 1110–20

McCabe, T. (2005). How to conduct an effective literature search. *Nursing Standard,*

20(11) 41-47.

McColl, E., Jacoby, A., Thomas, L., Soutter, J., Bamford, C., Steen, N., Thomas, R., Harvey, E., Garratt, A. and Bond, J. (2001). Design and use of questionnaires: a review of best practice applicable to health service staff and patients, *Health Technology Assessment*, Vol 5, No 31, NHS RandD HTA Programme.

McDonald, SD., Beckham, JC., Morey, RA. and Calhoun, PS. (2001) The validity and diagnostic efficiency of the Davidson Trauma Scale in military veterans who have served since September 11th, *Journal of anxiety disorders* 23, no. 2 (2009): 247-255.

McFarlane, P. and Harvey, J. (2012). *Drama therapy and Family Therapy in Education: Essential Pieces of the Multi-Agency Jigsaw.* Jessica Kingsley Publishers.

McGee, P. and Notter, J. (1995) *Research Appreciation: An initial Guide for Nurses and Health Care Professionals,* Central Health Studies, Mark Allen Publishing Ltd.

McGilchrist, I. (2009). *The master and his emissary: the divided brain and the making of the western world*. Yale University Press.

McGuire, J. (1999). Pictorial Metaphors: A reply to Sedivy. *Metaphor and Symbol*, 14(4), 293-302.

McHaffie, H. (2000). *Ethical issues in research In: Cormack D (ed) The Research Process in Nursing Fourth Edition* Oxford, Blackwell Publishing

McHugh, RK. and Barlow, DH. (2010). The dissemination and implementation of evidence-based psychological treatments: a review of current efforts. *American Psychologist,* 65(2), 73.

McIntosh, P., & Sobiechowska, P. *(2009).* Creative Methods: problematics for inquiry and pedagogy in health and social care. *Power and Education, 1(3), 295-306.*

McIntosh, P. (2010). The puzzle of metaphor and voice in arts-based social research. *International journal of social research methodology*, 13(2), 157-169.

McKee, M., Priest, P., Ginzler, M. and Black, N. (1991). How representative are members of expert panels? *Quality Assurance in Health Care*. 3, 2, 89-94.

McKenna, H. (1994). The Delphi technique: a worthwhile research approach for nursing? *Journal of Advanced Nursing*. 19, 6, 1221-1225.

McLeod, J. (1994) Ethical Issues in Counselling Research. In Doing Counselling Research. London Sage, pp. 165 – 175.

McLeod, J. (1999). *Practitioner research in counselling*, Sage, UK.

McMullen, L.M. (1985). Methods for studying the use of novel figurative language in psychotherapy. *Psychotherapy: Theory, Research, Practice*, Training, 22(3), 610.

McMullen, L.M. (1989). Use of figurative language in successful and unsuccessful cases of psychotherapy: Three comparisons. *Metaphor and Symbol,* 4(4), 203-225.

McMullen, L.M. (1996). Studying the use of figurative language in psychotherapy: The search for researchable questions. *Metaphor and Symbol*, 11(4), 241-255.

McMullen, L.M. (2008). Putting It in Context: metaphor and Psychotherapy. In Raymond, W. Gibbs (Ed) *The Cambridge handbook of Metaphor and Thought.* Cambridge University Press. 397-411.

McNiff, J. and Whitehead, J. (2011). *All you need to know about action research*, 2nd Edition. Sage.

Mead, D. and Moseley, L. (2001). The use of Delphi as a research approach. *Nurse Researcher*.8, 4, 4-23.

Mead, D. and Moseley, L. (2001b). Considerations in using the Delphi: design, questions and answers, *Nurse Researcher*, 8(4), pp24-37.

Meehl, P. E. (1978). Theoretical risks and tabular asterisks: Sir Karl, Sir Ronald, and the slow progress of soft psychology. *Journal of consulting and clinical Psychology*, *46*(4), 806.

Meira, L. and Ferreira, T. (2008). Narrative and image: Metaphors of the dialogical self and the problem of spatiality (commentary on Ruck and Slunecko), *International Journal for Dialogical Science*. Vol 3(1), pp 291-300.

Meyer, J.E. (1993). New paradigm research in practice: the trials and tribulations of action research. *Journal of Advanced Nursing*. 18: 1066-1072.

Milioni, D. (2007). Oh, Jo! You can't see that real life is not like riding a horse!' Patients' constructions of power and metaphor in therapy. *Radical Psychology*, *6*(1).

Mio, J. and Katz, A. (1996). *Metaphor: Implications and applications*, Lawrence Earlbum associates.

Michels, R. (2007). Commentary on the teaching alliance: a perspective on the good teacher and effective learning, *Psychiatry*, 70(3), pp203-204.

Miller, J. and Glassner, B. (1997). The 'Inside' and 'Outside': Finding Realities in Interviews, In: Silverman, D. ed., *Qualitative research: Theory, Method and Practice,* Sage Publications.

Mills, J. C., and Crowley, R. J., in collaboration with M. O. Ryan. (1986). *Therapeutic metaphors for children and the child within.* New York: Brunner/MazelMills and Crowley (1986)

Milner, M. (2010). *On not being able to paint*. Routledge.

Mindell, A. (1987). *The Dreambody in Relationships*, Routledge and Kegan Paul.

Mir, G., Salway, S., Kai, J., Karlsen, S., Bhopal, R., Ellison, G., and Sheikh, A. (2012). Principles of research on ethnicity and health: the Leeds Consensus Statement. *The European Journal of Public Health,* May 2, pp1-7.

Mitchell, J. ed (1991). *The Selected Melanie Klein*. Penguine Books. London.

Mitchell, R.L., and Crow, T.J. (2005). Right hemisphere language functions and Schizophrenia: the forgotten hemisphere? *Brain*, *128*(5), 963-978.

Mitroff, I. and Turoff, M. (1975). Philosophical and Methodological Foundations of Delphi, in Tinstone, H. and Turoff, M. (1975) *The Delphi Method: Techniques and applications*, Addison-Wesley Publishing Co, Reading Massachusetts. Chapter IIB, pp 17- 36.

Mitzman, SF. (2010). Cognitive Analytic Therapy and the Role of Brief Assessment and Contextual Reformulation: The Jigsaw Puzzle of Offending. *Reformulation*, Summer, pp.26-30.

Modell, A. H. (2009). Metaphor—The bridge between feelings and knowledge. *Psychoanalytic Inquiry*, 29(1), 6-11.

Moon, B. (2007). *The Role of Metaphor in Art Therapy: Theory, Method, and Experience*. Charles C Thomas Publisher.

Monk, G., Winslade, J., Crocket, K. and Epston, D. (1997). *Narrative therapy in practice: The archaeology of hope.* The Jossey-Bass psychology series., (pp. 3-31). San Francisco, CA, US: Jossey-Bass, xxviii, 320 pp.

Moss, M., Moss, S., Rubinstein, R. and Black, H. (2003). The Metaphor of 'family' in staff communication about death and dying. *Journal of gerontology*, Vol 56b, No 5, S290-s296.

Morse, J. and Field, A. (1996). *Nursing Research: The application of qualitative approaches*. Second edition, Chapman and Hall.

Mulder, R., and Chanen, A. M. (2013). Effectiveness of cognitive analytic therapy for personality disorders. *The British Journal of Psychiatry*, 202(2), 89-90.

Moncher, F.J., and Prinz, R.J. (1991). Treatment fidelity in outcome studies. *Clinical psychology review,* 11(3), 247-266.

Mullen, P. (2003). Delphi: myths and reality. *Journal of Health Organisation and Management*. 17, 1, 37-52.

Mulgrave, N. and Ducanis, A. (1975). A Propensity to change responses in a Delphi round as a function of dogmatism in Tinstone, H. and Turoff, M. (1975) *The Delphi Method: Techniques and applications*, Addison-Wesley Publishing Co, Reading Massachusetts.

Munall, P. (1988). Ethical considerations in qualitative research. *Western Journal of Nursing Research* Vol 10, pp. 150 - 162

Muran, J.C. and DiGiuseppe, R.A. (1990). Towards a cognitive formulation of metaphor use in psychotherapy. *Clinical Psychology Review*, 10(1), 69-85.

Murphy, M.K., Black, N.A., Lamping, D.L., McKee, C.M., Sanderson, L.F.B., Askham, J. and Mateau, T. (1998). Consensus development methods and their use in clinical guideline development, *Health Technology assessment*, 1998, Vol 2 (3), NHS RandD HTA Programme.

Murphy, N. (2008). CAT Used Therapeutically and Contextually. *Reformulation,* Summer,

pp.26-30.

Nahid, G. (2003). Understanding Reliability and Validity in Qualitative research, *The Qualitative Report*, Vol 8, No 4, Dec, pp597-607.

Nehmad, A. (1993). CAT and its Relationships to Non-CAT - Preliminary Thoughts About Annalee's Diagram. *Reformulation,* ACAT News Winter, p.x.

Neimeyer, R.A., and Mahoney, M.J. (1995). *Constructivism in psychotherapy.* Washington, DC: American Psychological Association.

Neimeyer, R.A. (1998). Social constructionism in the counselling context. *Counselling Psychology Quarterly, 11*(2).

Neimeyer, R.A., Keesee, N.J. and Fortner, B.V. (1998). Loss and meaning reconstruction: Propositions and procedures. In R. Malkinson, S. Rubin, and E. Wiztum (Eds.), *Traumatic and non-traumatic loss and bereavement*. Madison, CT: Psychosocial Press.

Neimeyer, R.A. (1999). Narrative Strategies in Grief Therapy. ournal of Constructivist Psychology, 12:1, 65-85. Online 2010.

Neimeyer, R.A. (2010). Grief, Loss and the quest for meaning: Narrative contributions to bereavement care, *Bereavement Care,* Vol 24, No 2, P 27-30.

Nevo, O. and Wiseman, H. (2002). Incorporating Short Term Dynamic psychotherapy Principles into Career Counseling: A Theoretical and Practical Approach. *Journal of Career Development,* June 2002, Volume 28, Issue 4, pp 227-245.

Newall, R. and Burnard, P. (2006). *Research for evidenced based practice.* Vital notes for Nurses. Blackwell.

Norcross, J. and Goldfried, M. (2005). *Handbook of Psychotherapy Integration. Second Edition,* Oxford University Press.

Norcross, J. C., Hedges, M., and Prochaska, J. O. (2002). The face of 2010: A Delphi poll on the future of psychotherapy. *Professional Psychology: Research and Practice*, *33*(3), 316.

Norcross, J. C., Koocher, G. P., and Garofalo, A. (2006). Discredited psychological treatments and tests: A Delphi poll. *Professional Psychology: Research and Practice*, *37*(5), 515.

de Normanville (Turner), J. and Kerr, I.B. (2003). Initial experiences of a CAT skills level training in a CMHT. *Reformulation,* 18; 25-27. (Available through acat.me.org.uk).

Öhman, A. (2009). Of snakes and faces: An evolutionary perspective on the psychology of fear. *Scandinavian journal of psychology*, *50*(6), 543-552.

Okoli, C. and Pawlowski, SD. (2004). The Delphi Method as a research Tool: an example, design considerations and applications. *Information and Management* 42, 15-29.

Olds, L.E. (1992). *Metaphors of Interrelatedness: Toward a Systems Theory of Psychology*. State University of New York Press, Albany.

Ortony, A. (Ed) (1993). *Metaphor and Thought* (2nd edition). New York: Cambridge University Press.

Ortigue, S., Michel, C. M., Murray, M.M., Mohr, C., Carbonnel, S., and Landis, T. (2004). Electrical neuroimaging reveals early generator modulation to emotional words. *Neuroimage*, *21*(4), 1242-1251.

Packer, M. J. (1985). Hermeneutic inquiry in the study of human conduct. *American Psychologist*, *40*(10), 1081.

Padulo, M. and Rees, A. (2006). Motivating Women with disordered eating towards empowerment and change using narratives of archetypal metaphor. *Woman and Therapy*. Vol 29 (1/2) pp 63-81.

Paley, G. and Shapiro, D. (2002). Lessons from psychotherapy research for psychological interventions for people with schizophrenia. *Psychology and Psychotherapy: Theory, Research and Practice,* 75, 5-17.

Pally, R. (2000). *The Mind–Brain Relationship*. New York: Karnac Books.

Palmer, B. (2006). Winding up knots and tangles, *European eating disorders review*, 14, 278-279.

Panksepp, J. (1998). *Affective Neuroscience, The Foundations of Human and Animal Emotion.* Oxford University Press, New York.

Parahoo, K. (1997). *Nursing Research: Principles, Process, and Issues*. London: Macmillan.

Parahoo, K. (2014). *Nursing research: principles, process and issues*. Palgrave Macmillan.

Parente, FJ. and Parente, JK. (1987). Delphi Inquiry Systems, in Wright, G. and Ayton, P. Eds Chapter 7, *Judgemental Forecasting*, John Wiley and Sons.

Parry, G. and Watts, F. (1997). *Behavioural and Mental Health Research: A handbook of Skills and Methods*, second edition, Earlbaum (UK),Taylor and Francis.

Patton, M.Q. (2005). *Qualitative research*. John Wiley and Sons, Ltd.

Pearce, S.S. (1996). *Flash insight: Metaphor and narrative in therapy*. Needham Heights: MA: Allyn and Bacon.

Peplau, H. E. (1988). A Definition of Nursing*. In Interpersonal Relations in Nursing* (pp. 3-16). Macmillan Education UK.

Peplau, H. E. (1986). The nurse as counselor. *Journal of American College Health*, 35(1), 11-14.

Perakyla, A. (1997). Reliability and Validity in Research Based on Tapes and Transcripts, In: Silverman, D. ed., *Qualitative research: Theory, Method and Practice*, Sage Publications

Pernicano, P. (2010). *Metaphorical Stories for Child Therapy: Of Magic and miracles*. Jason Aronson publishers (Lanham MD, IN, US).

Persons, R.W., Persons, M.K., and Newmark, I. (1974). Perceived helpful therapists' characteristics, patient improvements, and sex of therapist and patient. *Psychotherapy: Theory, Research and Practice,* 11(1), 63.

Person, E.S. (1983). Women in therapy: Therapist gender as a variable. *The International Journal of Psychoanalysis.*

Pettifer, M. (2003). Psychological Therapies Research: which way next, *Counselling and Psychotherapy Research,* Vol 3(1), pp 49-54. BACP.

Phillips, DC. and Soltis, JF. (1998). *Perspectives on Learning.* New York: Teachers College Press

Phillips, J. and Davidson, P. (2009). Action research as a mixed methods design. In: Sharon, A. and Halcomb, E. (2009) *Mixed Methods for Nursing and health Sciences*. Wiley-Blackwell.

Pill, J. (1970). The Delphi method: substance, context, a critique and annotated bibliography, *Socio-economic planning Science*, Vol 5, Pp57-71.

Pistole, M.C. (2003). Dance as a Metaphor: Complexities and Extensions in Psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 40(3), 232.

Pollard, R., (2003). Book Review: 'Language for those who have nothing. Mikhail Bakhtin and the Landscape of Psychiatry' Peter Good (2001). Reformulation, Summer, pp.40-43.

Pollard, R. (2004). Are there limits to the Dialogical approach to psychotherapy, *Reformulation.* June 2004. Pp8-14.

Pollard, R., Hepple, J., and Elia, I. (2006). A dialogue about the dialogical approach. ACAT reference library. *Reformulation*, Autumn, pp.18-24.

Pollard, R. (2008). *Dialogue and desire: Mikhail Bakhtin and the linguistic turn in psychotherapy.* Karnac Books.

Pollock, P. (2001). *Cognitive Analytic Therapy for Adult Survivors of Childhood Abuse: Approaches to Treatment and Case Management*. Chichester: Wiley.

Polgar, S. and Thomas, S. (1995). *Introduction to Research in the Health Sciences*, Third Edition, Churchill Livingstone.

Polit, DF. and Hungler, BP. (1995). *Nursing Research: Principles and Methods*, 5th edition. Philadelphia:JB Lippincott.

Polit, DF., Beck, CT. and Hungler, BP. (2001). *Essentials of Nursing Research Methods, Appraisal and Utilisation*. 5th ed. USA. Lippincott.

Pollio, H. R. (1977). *Psychology and the poetics of growth: Figurative language in psychology, psychotherapy, and education*. Lawrence Erlbaum Associates.

Pontalis J.B. (1968). *The problem of the Unconscious in Merleau-Ponty's thought*. Translated from; "La position du probleme de l'inconscient chez Merleau-Ponty " in Apres Freud, Paris, Guillimard, pp76-97.

Potter, S. (2004). Untying the knots: relational states of mind in Cognitive Analytic Therapy?. *Reformulation,* Spring, pp.14-21.

Potter, S. and Sutton, L. (2006). Making the Dialogic Clearer in the Practice of Cognitive Analytic Therapy. *Paper presented at the ACAT International Conference, Maynooth University, Ireland. June 2006.*

Potter, S. (2010). Words with Arrows: the benefits of mapping whilst talking. *Reformulation*, April, p 1-14.

Powell, C. (2003). The Delphi technique: myths and realities. *Journal of Advanced Nursing*. 41, 4, 376-382.

Prochaska, J.O., and DiClemente, C.C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: theory, research and practice*, *19*(3), 276.

Raphael, DD. (1994). *Moral Philosophy*, Second edition, Opus.

Rasmussen, B., and Angus, L. (1996). Metaphor in psychodynamic psychotherapy with borderline and non-borderline patients: A qualitative analysis. *Psychotherapy: Theory, Research, Practice, Training,* 33(4), 521.

Rayner, K., Thompson, AR. and Walsh, S. (2011). Patients' experience of the process of change in cognitive analytic therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 84, pp 299-313.

Reason, P. and Bradbury, H. (2001). *Handbook of Action Research*, London:Sage

Richardson, G. and Maltby, H. (1995). Reflection-on-practice: Enhancing student learning. *Journal of advanced nursing*, 22(2), 235-242.

Riley, S.F. (2004). Reflections on reflecting art therapy team in education and treatment. *Journal of the American Art Therapy Association*, 21:2, 88-94.

Riley-Doucet, C. and Wilson, S. (1997). A three step method of self-reflection using reflective journal writing. *Journal of Advanced Nursing* 25: 964-968.

Robert, T. and Kelly. V.A. (2010). Metaphor as an Instrument for Orchestrating Change in Counsellor Training and Counselling Process. *Journal of Counselling and Development* (88): 182 – 188.

Rogers, MR. and Lopez, EC. (2002). Identifying Criti8cal; Cross Cultural School psychology Competencies. *Journal of School Psychology*, 40:2, pp115-141.

Rogoff, B. (1999). Cognitive development through social interaction: Vygotsky and Piaget. In: Murphy, P. (ed.). *Learners, Learning and Assessment*, pp. 69-82. London: Paul Chapman.

Rolls, E.T. (1999). *The Brain and Emotion*. Oxford, UK: Oxford Univ. Press.

Rose, S. (1993). *The Making of Memory*. Toronto, O:Bantam Books.

Rosenblatt, P. (2007). Recovery following bereavement: Metaphor, phenomenology, and culture. *Death Studies,* 32:1, 6-16.

Roth, A., and Fonagy, P. (1996). *What Works for Whom?" A Critical Review of Psychotherapy Research*. New York: The Guilford Press.

Roth, P. and Parry, G. (1997). The implications of psychotherapy research for clinical practice and service development. *Journal of Mental Health*, Aug 97, Vol 6, Issue 4, P367, 14p)

Roth, A.D. and Pilling, S. (2008). A competence framework for the supervision of psychological therapies. Retrieved August, 18, 2011. http://scholar.google.co.uk/scholar?q=competency+based+trainings+in+psychological+therapiesandbtnG=andhl=enandas_sdt=0%2C5andas_vis=1

Rubin, J.A. (2001). *Approaches to Art Therapy: Theory and technique*, Second edition Brunner-Routledge.

Rustin, M., & Rustin, M. (2001). *Narratives of love and loss: studies in modern children's fiction.* Karnac Books.

Ryena, V.F. (1996). Meaning, Memory and Interpretation of Metaphors. In Mio, J. and Katz, A. (eds) Metaphor: *Pragmatics and Applications*. Hillside, NJ; Lawrence Earlbaum Associates.

Ryle, A. (1975). Self-to-Self, Self-to-Other: The World's Shortest Account of Object Relations Theory. *New Psychiatry*, pp 12-13

Ryle, A. (1990). *Cognitive-analytic therapy: Active participation in change. Chichester*: John Wiley and Sons.

Ryle, A. (1994). Projective Identification: A Particular Form of Reciprocal Role Procedure. *British Journal of Medical Psychology*, 67, pp 107 - 114.

Ryle, A. (1995). *Cognitive Analytical Therapy: Developments in theory and practice*. John Wiley and Sons.

Ryle, A. (1995b). Transference and Counter Transference variations in the course of the cognitive analytic therapy of two borderline patients. *British Journal of Medical Psychology*, 68*, 109-124.*

Ryle, A. (1997). *Cognitive Analytic Therapy and Borderline Personality Disorder; The Model and the Method.* Chichester, J. Wiley and Sons.

Ryle, A. (2000). CAT, Attachment Theory and Cognitivism. *Reformulation,* ACAT News Autumn, p.x.

Ryle, A. and Golynkina, K. (2000). Effectiveness of time-limited cognitive analytic therapy of borderline personality disorder: Factors associated with outcome. *British Journal of medical Psychology*, 73, 197-210.

Ryle, A. and Kerr, IB. (2002). *Introducing Cognitive Analytic Therapy; Principles and Practice. .* Chichester, J. Wiley and Sons.

Ryle, A. (2003). History and Use of the SDR. *Reformulation*, Autumn, pp.18-21.

Ryle, A. (2010). A dialogue with Tony Ryle, Unpublished, notes from a *CAT Training Group-Brighton*.

Ryle, A. (2012). *A dialogue regarding CAT and Metaphor*. CAT Scotland Training , Stirling.

Ryle, A., Kellett, S., Hepple, J. and Calvert R. (2014).*Cognitive analytic therapy at 30*. *Advances in Psychiatric Treatment*. July 2014 20:258-268.

Saban, A. (2006). Functions of metaphor in teaching and teacher education: A review. *Teaching Education*, Vol 17, No 4, 299-315.

Sackman, H. (1975). *Delphi Critique: Expert Opinion, Forecasting, and Group Process*. Lexington Books, Massachusetts.

Salka, S. (1997). Enlisting the unconscious as an ally to grief therapy: The creative use of affirmations, metaphors, and guided imagery. *The Hospice Journal*, Vol 12(3), pp17-30.

Salkovskis, P. M. (1995). Demonstrating specific effects in cognitive and behavioural therapy. *Research foundations for psychotherapy research*, 191-228.

Samples. B. (1976). *The metaphoric Mind: A celebration of creative consciousness*. Reading, Mass., Addison-Wesley Pub.

Samuels, A. (1985). Symbolic dimensions of eros in transference–countertransference: Some clinical uses of Jung's alchemical metaphor. *International review of psycho-analysis*.

Sayers, J. (2000). *Kleinians: Psychoanalysis Inside and Out.* Polity Press. Cambridge.

Schaverien, J. (1999). *The revealing image: Analytical art psychotherapy in theory and practice*. Jessica Kingsley Publishers.

Scott Peck, M. (2012). *The Road Less Travelled*. Penguin. Random House.

Scott Stewart, M., (2001). Reconstructing the Infant : Review of 'The Interpersonal World of The Infant' by Daniel Stern. *Reformulation,* ACAT News Autumn, p.x

ScHARR (1996). *Introduction to Systematic Reviews, School of Health and Related Research*, Clinical Advisory Group, University of Sheffield, Dec 1996.

Scheele, D. (1975). Reality Construction. in Tinstone, Harold and Turoff, Murray (1975) *The Delphi Method: Techniques and applications*, Addison-Wesley Publishing Co, Reading Massachusetts. Chapter IIC, pp 37- 71

Schön, DA. (1983). *The reflective practitioner: How professionals think in action* (Vol. 5126). Basic books.

Schore, A.N. (2003). In Hermans, HJM. (2003). The construction and reconstruction of a

dialogical self. *Journal of Constructivist Psychology*, 16:89-130.

Schore, A.N. (2008). *Paradigm shift: The right brain and the relational unconscious*. Paper presented at the 28th Spring Meeting of the American Psychological Association, New York.

Schutte, N.S., Malouff, J.M., Hall, L.E., Haggerty, D.J., Cooper, J.T., Golden, C.J. and Doernheim l. (1998). Development and validation of a measure of emotional intelligence. *Personality and Individual Differences,* 25, 167-177.

Searle, J. (1985). Metaphor. In A.P.Martinich (Ed.), *The philosophy of language* (pp416-437). Oxford, England, OUP.

Sedivy, S. (1997). Metaphoric pictures, pulsars, platypuses. *Metaphor and Symbol,* 12, 95-112.

Senn, S., Stevens, L. and Chaturvedi, N. (2000). Repeated measures in clinical trials: simple strategies for analysis using summary measures. *Statistics in medicine* 19, no. 6 (2000): 861-877.

Serig, D. (2008). Understanding the conceptual landscape of visual metaphors. *Teaching Artist Journal,* 6:1, 41-50.

Serig, D. (2008a). *Visual Metaphor and the Contemporary Artist: Ways of Thinking and Making*. VDM Publishing.

Sharkey, S. and Sharples, A. (2001). An approach to consensus building using the Delphi technique: developing a learning resource in mental health. *Nurse Education Today*. 21, 5, 398-408.

Sharpe, C., Smith, JV. and Cole, A. (2002) Cinematotherapy: metaphorically promoting change, *Counselling Psychology Quarterly*, Vol 15 93), pp 269-276.

Schroots, J.J.F., Birren, J.E. and Kenyon, G.M. (1991). *Metaphors and aging: An overview.* In G.M. Kenyon, J.E. Birren, and J.J.F. Schroots (Eds.), *Metaphors of aging in science and the humanities* (pp. 1-16). New York: Springer.

Siegelman, E. Y. (1993). *Metaphor and meaning in psychotherapy*. Guilford Press.

Silverman, D. (1993) Interpreting *Qualitative Data: Methods for Analysing Talk, Text and Interaction,* London, Sage.

Silverman, D. ed. (1997). *Towards and Aesthetics of Research, Qualitative research: Theory, Method and Practice*, Sage Publications, pp239- 251.

Silverman, D. (2006). *Interpreting qualitative data: Methods for analyzing talk, text and interaction*. Sage.

Silverstone, L. (1997). *Art Therapy: The Person-centred Way: Art and the Development of the Person*. J. Kingsley Publishers.

Skarderund, F. (2007). Eating ones words, part 1: concretised metaphors and reflective function in anorexia nervosa- an interview study, *European Eating Disorders review*, 15,

163-174.

Skellern, E. (1955). A Therapeutic Community.'. *Nursing Times*, April-June.

Smith, M.L. and Glass, G.V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist* 32:752–760, 1977

Soanes, C. and Stevenson, A. (2003). *The New Oxford English Dictionary*. Second edition. Oxford English Press, Oxford.

Spall, B., Read, S. and Chantry, D. (2001). Metaphor: exploring its origins and therapeutic use in death, dying and bereavement. *International Journal of Palliative Nursing*. 7)(7):345-53.

Spence, D. P. (1987). *The Freudian metaphor: Toward paradigm change in psychoanalysis*. WW Norton and Co.

Spector, P.E. and Jex, S.M. (1998). Development of four self-report measures of job stressors and strain: Interpersonal conflict at work scale, organisational constraints scale, quantitative workload inventory, and physical symptoms inventory. *Journal of Occupational Health Psychology*, Vol 3 (4), pp 356-367.

Staudinger, U.M. (1999). Older and wiser? Integrating results on the relationship between age and wisdom-related performance. *International Journal of Behavioral Development*, 23(3), 641-664.

Steele, M.A. (2013). So how truly collaborative are we?. *Reformulation,* Summer, p.33-35.

Stern, D. (1985) and (2004) *The interpersonal world of the infant*. New York: Basic Books. 2nd edition.

Sternberg, RJ. (2005). Older but not wiser? The relationship between age and wisdom. *Ageing International,* 30(1), 5-26.

Stevens, R. (1993). *Freud and Psychoanalysis; an Exposition and Appraisal, 5th impression*, Oxford University Press.

Stevens, V. (2005). Nothingness, no-thing, and nothing in the work of Wilfred Bion and in Samuel Beckett's Murphy. The Psychoanalytic Review, 92(4), 607-635.

Stevenson, L. (1987). *Seven theories of human nature*, 2nd edition, Oxford University press.

Stiles, W. (1997). Signs and voices: joining a conversation in progress, *British Journal of Medical Psychology,* 70, 169-176, GB.

Stott, R., Mansell, W., Salkovskis, P., Lavender, A and Cartwright-Hatton, S. (2010). *Oxford Guide to Metaphors in CBT: Building Cognitive Bridges*. Oxford University press.

Strauss, A. and Corbin, J. (1997). *Basics of Qualitative research: Grounded Theory, procecedures and techniques,* California: Sage.

Sumsion, T. (1998). The Delphi technique: an adaptive research tool. *British Journal of*

Occupational Therapy. 61, 4, 153-156.

Strong, T. (1989). Metaphors and patient change in counselling. *International Journal for the Advancement of Counselling,* 12(3), 203-213.

Stuart, MR., Goldstein, HS. and Snope, FC. (1980). Self-evaluation by residents in family medicine. *The Journal of Family Practice* 10(4):639–42.

Sullivan, W. and Rees, J. (2008). *Clean Language: Revealing metaphors and opening minds*. Crown house, Carmarthen.

Sutherland, D. (1980). The British Object Relations Theorists: Balint Winnicott, Fairbairn, Guntrip. *Journal of American Psychological Association*, Vol. 28#4, 829-860.

Szasz T. (1979). *The Myth of Psychotherapy; Mental healing as Religion, Rhetoric and Repression,* Oxford university press.

Tantum, D. (1997), *Understanding Fairbairn: Transmuting Emotional experiences,* Distance Learning Series, Centre for Psychotherapeutic Studies, Sheffield University

Thielsen, V.A., and Leahy, M.J. (2001). Essential knowledge and skills for effective clinical supervision in rehabilitation counseling. *Rehabilitation Counseling Bulletin*, *44*(4), 196-208.

Thomas, P (1997). *The Dialectics of Schizophrenia*, Free Association Books, Chase,

Thompson, A., Donnison, J., Warnock-Parkes, E., Turpin, G., Turner, J. and Kerr, I. (2008). Multidisciplinary community mental health team staff's experience of a 'skills level' training course in cognitive analytic therapy. *International Journal of Mental Health Nursing* 17, 131–137.

Tillett, R. (1996). Psychotherapy assessment and treatment selection. *The British Journal of Psychiatry,* 168(1), 10-15.

Tinstone, HA. and Turoff, M. (1975). *The Delphi Method: Techniques and Applications*. Addison-Wesley, Reading, MA.

Toobert, D. J., Hampson, S. E., and Glasgow, R. E. (2000). The summary of diabetes self-care activities measure: results from 7 studies and a revised scale. *Diabetes care*, 23(7), 943-950.

Toomey, B., and Ecker, B. (2009). Competing visions of the implications of neuroscience for psychotherapy. *Journal of Constructivist Psychology*, *22*(2), 95-140.

Tompkins, P and Lawley, J. (2002). The Magic of Metaphor, Online resource 'The Clean language Collection' assessed 21/10/13 Http://www.clean language.co.uk/articles/articles/21/1/The-magic-of metaphor/Page 1- 5. First published in *The Caroline Myss Newsletter*, March 2002.

Toye, J. (2003). Cultural Diversity and CAT. *Reformulation,* Autumn, pp.25-29.

Treasure, J., Todd, G., Brolly, M., Tiller, J., Nehmed, A. and Denman, F. (1995). A Pilot Study of a Randomised Trial of Cognitive Analytic Therapy Vs Educational Behavioural Therapy for Adult Anorexia Nervosa. *Behavioural Research Therapy*, Vol 33, No 4, pp363-

367.

Trope, Y., and Pomerantz, E. M. (1998). Resolving conflicts among self-evaluative motives: Positive experiences as a resource for overcoming defensiveness. *Motivation and Emotion*, *22*(1), 53-72.

Turbayne, C.M. (1962). *The Myth of Metaphor*. Yale University press, New Haven.

Turner, B. (1995). *Medical Power and Social Knowledge*, 2nd edition, Sage publications

Turner, J., Gardner, B., Staples, P. and Chapman, J. (2007). Medicines with Respect: developing an integrated collaborative approach to medication management, *Mental Health Nursing,* 27(6):16-19.

Turner, J. Gardner, B. Staples, P. and Chapman (2008). Medicines with respect: developing an integrative collaborative approach to medication management (2). *Mental Health Nursing*, 28 (7) 11-14.

Turner, J., and Hill, A. (2011). Implementing clinical supervision (part 1): a review of the literature. *Mental Health Nursing (Online)*, *31*(3), 8.

Turner, J and Hill, A (2011a). Implementing clinical supervision (part 2): using Proctor's model to structure the implementation of clinical supervision in a ward setting. *Mental Health Nursing* 31(4): 14.

Turner, J. (2011). CAT Metaphor and Pictures: An exploration of the views of CAT Therapists into the use of metaphor and pictorial metaphor (part 1). *Reformulation*, 36, p 37-41.

Turner, J. (2012). CAT, Metaphor and Pictures (part 2): An outline of the use of a pictorial metaphor in Cognitive Analytic Therapy. *Reformulation*, Winter 2011, Issue 37, pp39-43.

Turner, J. (2014). Metaphors and Therapeutic Encounters in Mental Health Nursing. *Mental Health Nursing*. JUNE/JULY 2014 • VOL 34 • NUMBER 3.

Turner, J. and Wren, J. (2014). *Psychoanalytical and Other Therapeutic Interventions in Mental Health Nursing.* In: Hemingway et al. Fundamentals of psychiatric Nursing. Wiley.

Turner, J. and Wilson, J. (2016) Metaphor and Pictorial Metaphor in Bereavement Care, CRUSE *Bereavement Care*. Submitted Feb 2016.

Turpin, C., Adu-White, D., Barnes, P., Chalmers-Woods, R., Delisser, C., Dudley, J. and Mesbahi, M. (2011). What are the important ingredients of a CAT goodbye letter?. *Reformulation,* Winter, pp.30-31.

UKCP (2008) UKCP ethical code
http://www.psychotherapy.org.uk/c2/uploads/scpti%20research%20in%20psychotherapy.doc

Ultanir, E. (2012). An epistemological glance at the constructivist approach: Constructivist learning in Dewey, Piaget and Montessori. *International Journal of Instruction*, Vol 5, No2, pp 195-212.

Van Earden, M. (2010). *The creative space of play:* D W Winnicott. Online. http://onluminousgrounds.wordpress.com/2010/09/19/the-creative-space-of-play/ last accessed 7/5/14

Vygotsky, L.S. (1962). *Thought and Language*. Cambridge, MA: MIT Press.

Vygotsky, L.S. (1978). In Cole, M., John-Steiner, V., Scribner, S and Souberman, E. (Eds.) (2003) *Mind in society: The development of higher psychological processes.* Cambridge, MA: Harvard University press. *www.psy.gla.ac.uk/~steve/courses/cereRefsVyg.html*

Waller, D., & Mahony, J. (Eds.). (2002). *Treatment of Addiction: Current Issues for Arts Therapists*. Routledge.

Waller, D., & Sibbett, C. (2005). *Art therapy and cancer care*. McGraw-Hill Education (UK).

Waller, D. (2013). *Art therapy: A handbook (No. 2nd).* McGraw-Hill Education/Open University Press UK.

Walker, A.M. and Selfe, J. (1996). The Delphi method: a useful tool for the allied health researcher. *British Journal of Therapy and Rehabilitation*. 3, 12, 677-681.

Walker, L., Barker, P. and Pearson, P. (2000). The required role of the psychiatric-mental health nurse in primary health care: an augmented Delphi study. *Nursing Inquiry*. 7, 2, 91-102.

Wallis, S. (1998). Changing practice through action research, *Nurse researcher*, Vol 6, No 2, pp5-15

Walsh, S. (1996). Adapting Cognitive Analytic Therapy to Make Sense of Psychologically Harmful Work Environments. *British Journal of Medical Psychology*, 69, pp 3-20.

Watts, D. and Morgan, G. (1994). Malignant Alienation: Dangers for patients who are hard to like, *British Journal of Psychiatry.* 164, 11-15.

Weaver, K. and Olsen, J. (2006). Understanding paradigms used for nursing research. *Journal of Advanced Nursing*, 53(4), 459-469.

Welch, M. (1984). The use of metaphor in psychotherapy, *Journal of psychosocial nursing*, 22 (11), pp13-18.

West, W. (2002) Some ethical dilemmas in counselling and counselling research. *British Journal of Guidance and Counselling*, Vol 39, No 3, pp. 261 – 268.

Whitehead, J. and McNiff, J. (2006). *Action research living theory*. Sage

Wilde McCormick, E. (1990) and (2012). *Change for the better: A life-changing self-help psychotherapy.* Continuum Publishing.

Wilde McCormick, E. (2008). How to Enjoy Writing a Prose Reformulation. *Reformulation,* Summer, pp.16-17.

Wilde McCormick, E. (2011). Compassion in CAT. *Reformulation,* Winter, pp.32-38.

Wilkinson, D. Ed (2000). *The Researchers Toolkit,* London, Routledge Falmer.

Wilkinson, M. (2006). *Coming into Mind: the min-brain relationship: a Jungian clinical perspective.* Routledge.

Wilkinson, M. (2010). *Changing minds in therapy: emotion, attachment and neurobiology*, Norton.

Williams, C., Williams, S., and Appleton, K. (1997). Mind Maps: An aid to Effective Formulation. *Behavioural and Cognitive Psychotherapy*, 25, 261-267.

Williams, M. and Haverkamp, BE. (2010). Identifying critical competencies for psychotherapeutic practice with eating disordered patients: A Delphi study. *Eating disorders,* 18(2), 91-109

Williamson, G. and Prosser, S. (2002). Action research: politics, ethics and participation *Journal of Advanced Nursing* 40(5) 587-593

Williams, P. and Webb, C. (1994). The Delphi technique: a methodological discussion. *Journal of Advanced Nursing* 19, 180–186.

Wilson, J., Steers, J., Steele, K., Turner, J., and Tinker, A. (2015). Service evaluation of community-based palliative care and a hospice-at-home service. *End of Life Journal*, *5*(1),

Winnicott, D.W. (1968). Playing: its theoretical status in the clinical situation. *International Journal of Psychoanalysis*. . 49:591-599.

Winnicott, D.W. (1969). The Use of an Object. *International Journal of Psycho-Analysis*, 50:711-716.

Winnicott, D.W. (1971). *Playing and Reality.* Tavistock Publications/Routledge publications.

Winship, G. (1995). Nursing and psychoanalysis—Uneasy alliances?. *Psychoanalytic Psychotherapy*, *9*(3), 289-299.

Winship, G., Bray, J., Repper, J., & Hinshelwood, R. D. (2009). Collective biography and the legacy of Hildegard Peplau, Annie Altschul and Eileen Skellern; the origins of mental health nursing and its relevance to the current crisis in psychiatry‡. *Journal of research in nursing*, 14(6), 505-517.

Winship, G. (2011). Chess & Schizophrenia: Murphy v Mr Endon, Beckett v Bion. *Journal of Medical Humanities*, 32(4), 339-351.

Witztum, E., Van der Hart, O., and Friedman, B. (1988). The use of metaphors in psychotherapy. *Journal of Contemporary Psychotherapy*, 18(4), 270-290.

Wood, D., Bruner, J.S. and Ross, G. (1976). The role of tutoring in problem solving. *Journal of Child psychology and Psychiatry,* 17, 89-100.

Wood, H. (1997). *CAT guidelines, 1997/98. ACAT Handout*. Unpublished. www.acat.me.uk

Wright, K. (2005). Researching Internet based Populations: Advantages and

disadvantages of online survey research, Online questionnaire authoring software packages, and web survey services, *Journal of Computer Mediated Communication*, 10(3), article 11.

Wurzbach, ME. (1999).The moral metaphor of nursing. *Journal of Advanced Nursing* 30(1): 94–9.

Yamaguchi, T., Todoroki, S., and Nishikawa, Y. (1974). The Use of Metaphoric Illustrations in Psychotherapy*. *Psychiatry and Clinical Neurosciences*, 28(3), 153-159.

Young, J.S. and Borders, L.D. (1998). The impact of metaphor on clinical hypothesis formation and perceived supervisor characteristics . *Counsellor Education and Supervision,* 37, 238–256 .

Young , J. S. , and Borders , L. D. (1999). The intentional use of metaphor in counselling supervision . *The Clinical Supervisor* , 18 (1), 139 – 149 . [Taylor and Francis Online]

Zlotnick, C., Elkin, I., and Shea, M. T. (1998). Does the gender of a patient or the gender of a therapist affect the treatment of patients with major depression?. *Journal of Consulting and Clinical Psychology*, 66(4), 655.

Appendixes

Appendix I Publications and workshop/conference presentations

Publications

Turner, J. (2011). CAT, Metaphor and Pictures: An exploration of the views of CAT Therapists into the use of metaphor and pictorial metaphor (part 1), *Reformulation*, 36, p 37-41

Turner, J. (2012). CAT, Metaphor and Pictures (part 2): An outline of the use of a pictorial metaphor in Cognitive Analytic Therapy. *Reformulation*, Winter 2011, Issue 37, pp39-43.

Turner, J. (2014). Metaphors and Therapeutic Encounters in Mental Health Nursing. *Mental Health Nursing*. JUNE/JULY 2014 • VOL 34 • NUMBER 3

Turner, J. and Wren, J. (2014). Psychoanalytical and Other Therapeutic Interventions in Mental Health Nursing. In: Hemingway et al. *Fundamentals of psychiatric Nursing*. Wiley.

Turner, J. and Wilson, J. (2016). Metaphor and Pictorial Metaphor in Bereavement Care, *CRUSE Bereavement Care. Submitted Feb 2016.*

Pending Publications

Turner, J. (2016). Cognitive neuroscience, metaphor and the therapeutic encounter. *Mental Health Nursing*. Summer 2016.

Turner, J and Garth, A. (2016). Using the Delphi technique to explore metaphor and pictorial metaphor in the therapeutic encounter'. *Journal of psychiatric and Mental Health Nursing.*

Turner, J and Garth, A. (2016). Findings of a Delphi study into the use of metaphor and pictorial metaphor in Cognitive Analytic Therapy*. Reformulation*

Turner, J. (2017). M*etaphor and Pictorial Metaphor Technique in Cognitive Analytic Therapy: Skills Manual*. Sheffield Hallam University Enterprise Centre.

Turner, J. and Garth, A. (2017). An exploration of the use of metaphor and pictorial metaphor in Cognitive Analytic Therapy: Implications for the therapeutic encounter. *International Journal of Mental Health Nursing*

Appendix II Conference and Workshop Presentations

Cognitive Analytic Therapy (North) Conference (September 2009). University of Manchester. Workshop presentation 'The use of metaphors in psychotherapy'.

Cognitive Analytic Therapy (July CAT) International Conference. University of Warwick. 1st-4th July (2009). Workshop presentation 'The development and evaluation of the pictorial metaphor technique in Cognitive Analytic Therapy'

17th Annual ACAT Conference (June 2010) British Library, London. Workshop presentation 'Working with Metaphor and Pictorial Metaphor in CAT and Psychotherapy'

National Cruse Conference (July 2011) University of Warwick. 12-13th July. Workshop presentation 'Metaphor and pictorial metaphor in therapy'

Northern Ireland CRUSE Conference (March 2012) Belfast. 3rd March. Plenary Sessions 'What works for whom: an exploration of Cognitive and analytical approaches to bereavement care' and Conference Workshop 'Metaphor and pictorial metaphor in bereavement care'

Network for Psychiatric Nursing Research Conference (Sept 2012) University of Oxford. Poster presentation. Research poster – 'Metaphors and pictorial metaphor in Cognitive Analytic Therapy'

National CRUSE Conference. (July 2013) University of Warwick. Workshop presentation 'Metaphors and the therapeutic encounter'

Network for Psychiatric Nursing Research Conference (Sept 2013) University of Warwick. Workshop accepted. 'Using metaphors in the therapeutic encounter'

CRUSE South East Regional Conference. (March 2014) Redhill Methodist Centre. Workshop Presentation 'Metaphor and pictorial metaphor in bereavement care'

Network for Psychiatric Nursing Research Conference (Sept 2014) University of Warwick. Workshop presentation. 'Metaphors and pictorial metaphor in the therapeutic encounter'.

CRUSE Sheffield (South Yorkshire) AGM. (November 2014). Millennium Centre. Guest Speaker: 'The therapeutic encounter, metaphor and bereavement care'

National CRUSE Conference (July 2015) University of Warwick. 12-13th July. Plenary Session 'Creative methods in the therapeutic encounter a Delphi Study', Workshop presentation 'Metaphor and pictorial metaphor in therapy'

Isle of Man 'Mental health' Conference, (February 2016) Plenary session: 'The magic of Metaphor. ' Workshop presentation: 'Metaphor and pictorial metaphor in bereavement care'.

Lancashire CRUSE (March 2016) Annual Business Conference, DW Stadium, Wigan, Lancs. 12th March 2016. Plenary session 'Development and evaluation of a pictorial metaphor technique'

Belfast CRUSE (April 2016) 'Living beyond Loss; creative approaches to managing loss

and bereavement' – 'Beyond Words' project, incorporating art and creative approaches to forming a new narrative'. Keynote lecture. University of Belfast.

Northern Ireland CRUSE (April 2016). Workshop: Metaphor and pictorial metaphor in the therapeutic encounter. Regional conference/AGM

Appendix III CAT Literature review case examples

- Ardern's (2004) an individual 'can act as a metaphorical Thames barrier', holding back the tide so to speak.
- Beard et al.'s (1990) a patient 'might be a ship of fools but you can be the captain'.
- Buckley (2002) 'one woman brought me a drawing of herself portrayed as a small figure of uncertain gender being crushed by an enormous boulder, and was surprised by her creative associations to it. Another brought me poems, which at times expressed very beautifully her yearning for a spiritual rebirth' (p92).
- Coulter and Rushbrook (2011) on playfulness and the 'dance' of therapy…'A new therapist, when learning how to lead the dance for the first time, needs to concentrate on the steps. As their skill increases, they can then begin incorporating more creative steps in the dance allowing for greater expression, flexibility and flow. With time, experience and competence, if the therapist stumbles, misses a beat or misplaces a step, then they have developed the skills necessary to rectify quickly, easily and smoothly without distracting or ruining the dance' (p9).
- Dunn (2007) The metaphor of seven dwelling places. The first three dwelling places in The Interior Castle are focused outwards, and the 'call from God is mediated through sermons, books, people and events in one's life'. From the fourth dwelling place, 'people allow themselves to be decentred'. The ego ceases to be the centre of life, and turns toward the Divine in a relationship with the Living God where 'one's responses are elicited by the reality of the Other' (p17).
- Fawkes and Fretten (2003) 'It may be that these patients were literally crushed during the abuse, but whether that was the case or not, the weight of the oppression they experienced psychically led, metaphorically at least, to a fight for breath'.
- Fitzsimmons (2000) 'I now feel like the good seed from a bad apple' and 'I feel like a snake that has shed its skin'.
- Hubbuck (2008) Steven Spielberg's film 'AI: Artificial Intelligence' is a memorable futuristic fairy tale, which captures, metaphorically, the human child's universal search for perfect attachment, or ideal love and care.
- Kellett (2004) 'The patient requested in metaphor that I hold the door to the cellar open in order to allow the light in so that she would not get lost and trapped'.
- Ryle (2003) depression…led to the deep sadness expressed in your dream of yourself as a frozen chicken (Patients metaphor) which provoked the depression which brought you to therapy.
- Winstanley (2013) on the wounded healer where 'metaphor of the hero-innovator being eaten by the dragon for breakfast springs to mind'.

Appendix IV Models incorporating metaphor 'therapeutic steps'

Acceptance and Commitment Steps (Hayes et al. 2004, p15)
Group 1 – Acceptance and mindfulness skills - Acceptance, defusion, contact with the present moment and self as context Group 2 – Commitment and behaviour change skills - Contact with the present moment, self as context, values, and committed action.

Clean Language (Tompkins and Lawley 2002, p2)
Exercise 1 a) identify a metaphor for when you are angry and act inappropriately as a result b) identify a second metaphor for how you prefer to respond c) explore how you can convert or evolve the first metaphor into a second d) translate your insights into how you can change your behaviour in your everyday life e) Rehearse this new behaviour.
Exercise 2 A) Identify a metaphor for when you are angry and act inappropriately as a result - ask yourself 'when I am angry and act inappropriately what is it like -draw the metaphor that comes to mind - look at your drawing and ask yourself the following questions so you get to know more about the symbols and the metaphor…'What kind of …?' and 'Is there anything else about the ….?' B) Identify a second metaphor for how you prefer to respond -ask yourself how would I prefer to respond is like what? - draw the metaphor that comes to mind - for each part of the drawing ask yourself 'What kind of ….?' And 'Is there anything else about the ….?' c) Explore how you can convert or evolve the first metaphor into a second - place the drawings in front of you - consider how metaphor 1 can evolve into metaphor 2 - Notice…'What is the first thing that needs to happen for metaphor 1 to start becoming metaphor 2' and 'What's the last thing that needs to happen before metaphor 1 becomes metaphor 2?' D) Translate your insights into how you can change your behaviour in your everyday life, how will this information guide your behaviour next time you are in a similar situation? E) Rehearse this new behaviour. Rehearse being metaphor 2 by embodying its characteristics now... What is your posture? What do you feel inside? What is your focus of attention? What do you say and how are you saying it?

Six Part Stories (Dent-Brown and Wang 2006, p317)
A main character and some setting; A task for the main character; Obstacles in the main characters way; Things that help the main character; The climax or action of the story; The consequences or aftermath of the story The story is drawn out in six pictures illustrating the 6 elements. This (metaphoric) story is then explored and relevance to the individuals circumstances discussed.

Guided Effective Imagery Steps - Essentially ten scenarios (Witztum et al. 1988)

The patient is asked to imagine, whilst being supported and prompted by the therapist, to consider ten scenarios. These include; the meadow; the mountain; a stream; a house; a close relative; a situation; the lion; the patients ego; symbolic figures; and the swamp. In all cases guided imagery seeks to lead to desirable changes in both affect and attitudes towards life situations.

Guided Metaphor Steps (Battino 2002,p24)

a) Telling their life story, distilling it into a few phrases the asking for the story to be rewritten again, distil this into a few memorable words or phrases (metaphors).
b) The next step is to understand the 'difference (similar to the 'miracle question in SFT).
c) The life story is retold back to the patient (in a hypnotic state) and it is as if the new story and its implications have 'reframed' the patient's life.

Box 6: Person Centred model (Kopp 1995, p5-6)

Step 1: Notice metaphor
Step 2a: Explore the metaphoric image
When you say ….. What image/picture comes to mind?
What do you see in your mind's eye?
Could you describe?
Step 2a: If patient does not respond
If I were seeing it (the metaphor) the way you see it what would I see?
May I tell you what image occurs to me?
Step 3: Exploration of the metaphor as sensory image
What else can you see?
Describe the scene?
What else is going on?
What are the other people doing/saying?
What happens next?
Step 4: Explore and define feeling in relation to the metaphoric image
Drawing image – agree not to intrude but to create and explore
Step 5: Revision
If you could change the image in any way how would you change it?
What if the e.g. 'x' part of the metaphor were an '?'
What would the image look like if you were feeling better?
What do you need to do to get there, what shall I draw on the picture to represent this 'exit'
Step 6: Back to the tea party
What parallels do you see between the image of picture and original picture/metaphor?

Appendix V Ethical approval ACAT

ACAT Administration
Association for Cognitive Analytic Therapy

Research Support and Sponsorship letter

To: Sheffield Hallam University November 2009

Project title: The development and evaluation of the 'pictorial metaphor technique' in Cognitive Analytic Therapy.

Project type: Research

Researcher Name: James Turner

Full information about this project has been provided, in the form of a written proposal, and the project has been approved, within appropriate governance frameworks, as meeting quality and ethical standards required by this organisation.

The above project is in line with the normal role and responsibilities of James Turner and will be carried out as part of his/her academic studies and Clinical activity.

I note that appropriate organisational and managerial support is provided by Research Supervisors at Sheffield Hallam University. The project will be carried out within organisational Risk and Research management guidelines. NHS Ethical approval will be required.

It is understood that a written report of this Research will be submitted in part fulfilment of a PhD and publications will be forthcoming at appropriate milestones disseminating results as an indication of the effectiveness of CAT and the pictorial metaphor approach.

Yours faithfully

Dr Jason Hepple
Chair ACAT Research and Communication Committee

Appendix VI Ethical Approval SHU

centre for
health and social care
research

Peter Allmark
Chair Faculty Research Ethics Committee
Faculty of Health and Well-being
Sheffield Hallam University
32 Collegiate Crescent
S10 2BP

0114 225 5727
p.allmark@shu.ac.uk

28/03/2012

Dear Jim Turner

I have received the details of your project *Development and Evaluation of a pictorial metaphor technique in CAT Cycle 3.* From this description I agree with you that this is service evaluation or audit and that as such it does not require approval from the Faculty REC. You will of course need to comply with the law and your codes of professional conduct. Good luck with the project.

Yours sincerely

Peter Allmark

Centre for Health and Social Care Research
Faculty of Health and Wellbeing Montgomery House 32 Collegiate Crescent Sheffield, S10 2BP UK
Telephone +44 (0) 114 225 5854 Fax +44 (0) 114 225 4377
Email: chscr@shu.ac.uk www.shu.ac.uk/chscr
Executive Dean of Faculty Professor Rhiannon Billingsley
Sheffield Hallam University

Appendix VII Ethical Approval NHS

Rotherham Doncaster and South Humber NHS Foundation Trust

Doncaster Clinical Research
Tel: 01302 366666 Ext: 4708
Email: emma.hannaford@dbh.nhs.uk

Research Governance office, based at:
Doncaster Royal Infirmary
Armthorpe Road, Doncaster
South Yorkshire
DN2 5LT
Tel: 01302 366666
Fax: 01302 320098
Minicom: 01302 553140
(only for people who are deaf)

30 May 2014

CONFIDENTIAL

James Turner
Sheffield Hallam University

Dear James,

Project Title: Development and Evaluation of a pictorial metaphor technique in Cognitive Analytic Therapy

Please note the proposal has been considered by the Research Management and Governance office and I can confirm that the above project fulfils the criteria of service evaluation for the purpose of the Research Governance Framework (2005). The evaluation can proceed without formal organisational approval from the Trust, on the understanding that changes to the proposal will be reported to the Research Governance Department within the Trust.

Please note the project should be registered accordingly with the Audit Department within the Trust, and the Evaluation Lead within this Department has been copied into this letter for information.

It is understood that the evaluation will meet standards of good practice for information governance, and these will be arranged through line managed monitoring, and protocols established with your learning institution.

I would like to take this opportunity to wish you well with your project. If you have any questions or I can be of any further assistance to you, please do not hesitate to contact me.

Yours sincerely

Emma Hannaford
Research Management & Governance Manager

Appendix VIII Ethical Approval CRUSE

Cruse Bereavement Care

Central Office:
PO Box 800
Richmond
TW9 1RG
Tel: 020 8939 9532
Fax: 020 8940 1671

3rd November 2015

James Turner
12 Bingham Park Road
SHEFFIELD
S11 7BD

Dear James

RESEARCH REQUEST – 15 12 – TURNER

Further to recent correspondence with Cruse Bereavement Care, I am writing on behalf of the Cruse Research Group to confirm support of the research project you are undertaking, as part of a PhD. We understand you are requesting evaluation of a workshop training programme, with associated materials. Your request is for attendees of the July 2015 Cruse national Conference held at the University of Warwick to complete a follow-up questionnaire.

Cruse gives permission for details to be passed on, with attendees having the opportunity to get involved in your research.

Please get in touch if you need any further information at this stage.

Yours sincerely

Marion Wilson

Cruse Research Group

Appendix IX Study1 Consent and information forms

EXPLANATORY LEAFLET AND CONSENT FORM

Project title: ***The development and evaluation of the pictorial metaphor technique in Cognitive Analytic Therapy***

Chief investigator: **James Turner, Sheffield Hallam University**

I would like to invite you to take part in this study which will contribute towards a research degree in CAT.
The study initially involves collecting workshop and group exercise materials regarding the use of metaphor in CAT and in particular the development of an understanding around using a pictorial metaphor in CAT. The data collection will be at the ACAT international conference 1st-4th July 2009.

The aim of the study is to develop and evaluate the effectiveness of the pictorial metaphor technique in CAT. Initial stages concern a set of consensus development exercises from across the CAT community; the first one being this CAT Conference workshop. By doing this my objective is to develop an understanding and to refine current methods in relation to working with metaphor and pictorial metaphor in CAT.

Your participation following this workshop is entirely voluntary but by the nature of your attendance at this workshop you are already involved in the first stage of the study. This involves information from the workshop contributing towards the initial 'consensus development' and refining of the research 'gaze'. Subsequent workshops and training events are being arranged. You are invited to be involved on a number of levels:

- To work with and provide the researcher with written materials from this workshop at the ACAT International Conference workshop (July 2009). Details which might identify you will be altered or omitted
- To complete questionnaires sent out from ACAT administration (electronic version) and returned to the researcher
- To be involved in a subsequent consensus development exercise/group
- To be involved in a Training Group
- To utilise the pictorial metaphor technique with at least two patients in your normal 16 session CAT clinical work who have a diagnosis of DSMIV 'Depression' and/or problems with managing their anger. Both you and the patients are asked to complete questionnaires at stages in the therapy and at the beginning and end of each session of CAT. These will be concerned with your patients symptoms and with how you both experience the therapy process.

The researcher will make sure your results are anonymous. The questionnaires will be identified by a code number only. The findings from the research will be reported through peer reviewed publications. Your participation will be much appreciated. If you would like to take part please sign the Consent Form.

CONSENT
Name ……..

I have read and understood the above and I am willing to take part in the ways described (see page 2)
Signed .....…… Date ……..

Sheffield Hallam University

Project title: ***The development and evaluation of the pictorial metaphor technique in Cognitive Analytic Therapy***

Chief investigator: **James Turner, Sheffield Hallam University**

Further Involvement

I have read and understood the information regarding this study. I would like to be involved further in this study. Please can you invite me to be involved (circle yes or no for each statement)

- To be involved in a consensus development group (YES / NO)
- To be involved in a Training Group (YES / NO)
- To utilise the pictorial metaphor technique with at least two patients in your normal 16 session CAT clinical work who have a diagnosis of DSMIV-Tr 'Depression'.

or *(YES / NO)*

- To utilise the pictorial metaphor technique with at least two patients in your normal 16 session CAT clinical work who have a specified problem with 'anger'.

(YES / NO)

Name ……

Address (work) ……

……

NHS Trust/Other ……..

Contact Details Tel: ……..

Mobile: ……

E-Mail: …….

Thank you for your support. I look forward to working with you in the near future.

Faculty of Health and Wellbeing

PARTICIPANT INFORMATION SHEET – CAT and Metaphor

As a member of this workshop the information gained will form part of a consensus development exercise into a study entitled:

"Why have I been asked me to take part in this study?"
I am inviting all participants at the CAT International conference Metaphor workshop to take part with this exploratory work. I have designed a study to gain information regarding the use of pictorial metaphor in Cognitive Analytic Therapy.

"How long will the study last?"
The whole study will last about 4 years with this workshop forming part of the initial stages of understanding the use of metaphor and in particular pictorial metaphor in CAT.

"What will it involve?"
As a participant I will be collecting all the worksheets and flip chart work from the workshops and analysing the information. Initially to feedback to the plenary session on Saturday 4th July and later to inform the development of the overall aims of the study into investigating the usefulness of utilising a pictorial metaphor in CAT. The workshop is designed to collect information on an individual and a group consensus into Metaphor practice in CAT/psychotherapy.

After I have analysed all of the questionnaires I will be happy to let you have the anonymisd report for you to further reflect on and comment should you wish.

"What is the treatment and are there side-effects?"
There is no 'treatment and therefore there should be no side effects. However, an effect would be achieving the aims of the workshop:

- an increased knowledge of the use of metaphor in CAT,
- had an opportunity to discuss and debate the use of metaphor in CAT,
- develop possible steps towards utilising metaphor to pictorial metaphor in CAT,
- begin to develop a consensus as to the use of metaphor and pictorial metaphor in CAT.

"How often will I be involved?"
Initially for the workshop and if you wish to continue through a further group exercise at a date to be arranged and in the training programme to be developed as part of this study. The final stage is a small evaluative study of clinical work utilising pictorial metaphor in a CAT case. I am asking participants at the workshop for expressions of interest in taking the work forward. If you wish to be involved further please let the workshop lead know.

"What if I do not wish to take part?

"What will happen to the information from the study?"
All information will be kept entirely confidential. The data will be stored at all times in a secure condition; iIn a secure case or in a secure filing cabinet or password protected technology. No individuals will be identifiable in the report. You will be informed of the results of the study if you wish.

"What if I have further questions"
Please contact James Turner at james.turner@shu.ac.uk or at SHU on 0114 2252480

SHEFFIELD HALLAM UNIVERSITY
Faculty of Health and Wellbeing

CONSENT FORM

Please give your consent to participating in the study by answering the following questions

Have you read the information sheet about this study?	Yes	☐	No	☐
Have you been able to ask questions about this study?	Yes	☐	No	☐
Have you received answers to all your questions?	Yes	☐	No	☐
Have you received enough information about this study?	Yes	☐	No	☐

Which investigator have you spoken to about this study? ……

Are you involved in any other studies?	Yes	☐	No	☐
• If you are, how many?		☐		

Do you understand that you are free to withdraw from this study:

• At any time?	Yes	☐	No	☐
• Without giving a reason for withdrawing?	Yes	☐	No	☐

Do you agree to take part in this study?	Yes	☐	No	☐

Your signature will certify that you have had adequate opportunity to discuss the study with the investigator and have voluntarily decided to take part in this study. Please keep your copy of this form and the information sheet together.

Signature of participant: ……

Date: ……

Name *(Block Letters*): ……

Appendix X Study1 Example worksheet/Questionnaire

Sheffield Hallam University

Date 9/7/10

The use of metaphor in Cognitive Analytic Therapy - Worksheet
Small Group exercise (30 mins)

In groups of three set up a scenario with a client, a therapist and an observer.

The client describes a problem (imaginary or non-fictional) and uses metaphor in describing their experience.

The therapist is alert to this and looks to utilising the metaphor more directly in the session and towards developing a 'picture' that is shared with the client.

The observer makes notes on the process and sketches out the 'picture' (Worksheet 2)

What metaphors are you seeing/hearing?

being scared of own mind.
mole behind the picture

What does the picture look like? *(draw it in the box below)*

What key points come up in your discussion?

Final Thoughts…?

Thank you for completing this form and taking part in this workshop.
James Turner, Sheffield Hallam University

Appendix XI Study2 R1Consent and information forms

Delphi Expert Consultation

Development and Evaluation of a pictorial metaphor technique in Cognitive Analytic Therapy

Information, Consent and R1 Questionnaire

James Turner
Sheffield Hallam University

Round One Delphi Consultation – Information and Consent

About the study - This Delphi consultation is part of the researcher's PhD studies in Cognitive Analytic Therapy (CAT) that has four cycles. The study has been established following background and preliminary work from the CAT community and based on developing clinical practice (Cycle 1). Supervision is from a number of senior researchers with advice from CAT 'experts'. The Delphi study (Cycle 2) is anticipated to run and be completed during 2011/12.

The study is seeking to understand the techniques involved with therapeutic use of 'metaphor' in CAT and in utilising 'pictorial metaphor' in CAT.

- Metaphor - *In CAT sessions the researcher has been listening for and actively working with the patients metaphoric language as a means to inform, support and work with the patients mental health problems within the CAT model.*

- Pictorial metaphor - *In CAT sessions the researcher has been using art techniques to draw out a pictorial representation of the patients metaphors they speak in session as well as encapsulating in these metaphors some key aspects of the reformulation.*

The aim of the study is to attempt to establish an understanding of the key theoretical and practical steps involved in utilising 'metaphor' in CAT and in the development of a 'pictorial metaphor' in CAT. It is planned to establish this understanding through informed expert consensus prior to staff training and testing in the field. Subsequent developments include the development of a clinical 'guide'' and training programme (Cycle 3). Leading to a small 'n' study (Cycle 4) evaluating the effectiveness of this clinical 'guide' and training in practice.

About the Delphi Expert Consultation - The Delphi exercise will involve a wide-ranging consensus-building exercise with a panel of experts from the CAT community. Focusing especially on CAT I am consulting with CAT therapists and trainees about what works in the use and development of metaphor and pictorial metaphor in clinical practice.

Delphi is a robust research methodology with a substantial literature to support it. The Delphi approach involves identifying experts and obtaining their views anonymously. This provides qualitative and quantitative information on expert views. This Delphi consultation exercise will involve three rounds of consultation with experts.

About Your Contribution - Participation in this Delphi consultation will involve you giving the benefit of your expertise by taking part in one or more of the Delphi consultation rounds based on initial response. As there are approximately 750 CAT therapists in the international community, who can be reached by the ACAT list serve, it may be necessary to sample responses to gain a manageable panel for the second and third iteration (minimum n=30). It is anticipated that the Delphi rounds will take approximately a year to complete and analyse. Data will be gathered and analysed within specific time periods:

R1 – June 2011
R2 – Approx September 2011
R3 – Approx November 2011

The first questionnaire should take you about one hour to complete. Subsequent questionnaires may take less time.

R1 - In R1 you will be invited to complete a questionnaire designed to capture your views based on your knowledge and experience obtained through research, study, practice or personal experience in your particular area(s) of expertise on the use of metaphor and pictorial metaphoric/art/pictures in clinical practice. Your answers can be as long as you want: the electronic boxes will expand to any length.

- I would prefer it if you could manage your response in an electronic form by saving the attached questionnaire and when completed send back to me at james.turner@shu.ac.uk

- Each questionnaire has a unique identifier/code so that when the questionnaire is used for analysis the respondents name will be anonymised

- If you are completing this questionnaire in paper copy, please continue on separate sheets as required and attach these to the questionnaire if necessary (my address is on the e-mail I sent out)

The success of the Delphi will be dependent upon the quality of answers people provide for this first round of the consultation. I would like you to support your answers with examples and evidence where relevant and possible. The Round One questionnaire is attached to this e-mail. Subsequent rounds will use an electronic survey system held securely at Sheffield Hallam University with each participant being identified by a unique 'code' randomly assigned.

R2 - The responses to Round One are analysed, summarised and then in Round Two fed back anonymously to a sample of the group for further comment. Experts will be asked to rate their level of agreement using a 7 point ordinal scale with the issues identified in Round One. The results are then analysed sent out to form the third 'iterative' round.

R3 - In Round Three, based on the analysis of Round Two, you will receive some feedback on the overall results and your results in order to further identify areas of consensus. Experts will again be asked to rate their level of agreement using a 7 point ordinal scale. Issues that have achieved consensus in R2 will not be rated again.

Results - A final report on the Delphi findings will be produced. The report will be used to inform further practice development. The findings will also be published in relevant academic and practitioner journals. A summary of the findings will be sent to all Delphi participants at the end of the project.

Statement of Ethical Practice - Practitioners who work within CAT may have concerns regarding ethical principles of research studies and in taking part in this Delphi consultation might compromise their confidentiality. Every practical effort will be taken to ensure that information collected from you will be kept confidentially and securely by the research team within their offices and computers. Contributions will be anonymised and no one involved in the consultation will be mentioned by name in any of the reports, or be identifiable for other reasons. SHU and ACAT ethical and governance procedures have been followed and permission granted to proceed.

How will this work in practice?

Securing informed consent from participants - your participation is voluntary and you can withdraw for the study at any time without giving a reason. Written consent will be obtained at the start of the study. Information about the Delphi consultation will be given to each participant to enable them to give, or withhold consent, on an informed basis.

Protecting the privacy and confidentiality of participants - All identifying details of participants in the Delphi consultation will only be known to the researcher.

Minimising any risks of harm to participants that may result from their involvement in the Delphi consultation - The Delphi is about the participants individual clinical practice and knowledge. The risk of harm to participants in this study is low, however if you find you are experiencing difficulties please contact the researcher.

Providing information on the outcomes of the Delphi consultation - Selected Delphi participants will be given anonymised feedback on the findings for R2 and 3. A summary of the findings will be sent to all Delphi participants at the end of the project.

Complaints - If you have any concerns about the conduct of this study please contact the researchers supervisor on 0114 2255672 or sarah.cook@shu.ac.uk

This is an opportunity for you to develop and influence practice in these areas and for others to benefit from your experience. Please take this opportunity to feed into the Delphi Round One everything you can about your areas of expertise. I thank you in advance for your commitment and willingness to contribute in this way.

Further Information

If you have any questions about the Delphi or need advice on completing this questionnaire please contact the researcher by telephoning: James Turner 01142252480 or 07841237377 or e-mail james.turner@shu.ac.uk

With thanks and best wishes, *Jim*

Sheffield Hallam University

Faculty of Health and Wellbeing - Consent Form

Development and evaluation of a pictorial metaphor technique in Cognitive Analytic Therapy - a Delphi Study

Please give your consent to participating in the study by answering the following questions (Mark appropriate box with an x''). Please return this form by e-mail to the researcher with your completed questionnaire.

I have read the information sheet about this study	Yes		No	
I understand that relevant sections of my data collected during the study may be looked at by individuals from the Sheffield Hallam University Ethics and supervisory team or regulatory authorities. I give permission for these individuals to have access to my data.	Yes		No	
I agree to my responses being used for verbatim quotes, provided they are anonymous	Yes		No	
I understand that all information I provide the researcher with will remain confidential. Confidentiality will only be breached if the researcher has concerns for my safety or the safety of another person. The researcher will inform me of their plan of action should this situation arise	Yes		No	
Have you received enough information about this study?	Yes		No	
Are you involved in any other studies?	Yes		No	
• If you are, how many?				
Do you understand that you are free to withdraw from this study:				
• At any time?	Yes		No	
• Without giving a reason for withdrawing?	Yes		No	
I agree to take part in this study?	Yes		No	

Your signature/name below will certify that you have had adequate information to understand the study and have voluntarily decided to take part in this study. Please keep your copy of this form and the information sheet together. This questionnaire should take about 1 hour to complete.

Name: …… Date: ……

If you have any questions about the Delphi or need advice please contact the researcher by telephoning: James Turner 0114 2252480 or 07841237377 or by e-mail james.turner@shu.ac.uk

Sheffield Hallam University

Delphi Expert Consultation

Development and Evaluation of a pictorial metaphor technique in Cognitive Analytic Therapy

Monday, 13 June 2011

Round One Questionnaire

James Turner
Sheffield Hallam University

Round One Delphi Questions

Before you answer these questions, it is important that you have read the accompanying 'Information and Consent form'.

Location (Country/Region) [ ] **Nationality** [ ]

Ethnic Origin [ ] **Age** [ ]

Please indicate your current level of CAT training
[ ] CAT Practitioner [ ] CAT psychotherapist [ ] CAT Trainee

Please indicate time since initial qualification training in CAT
[ ] years

Please indicate length of time working in mental health/therapy
[ ] years

Please indicate your core professional background
[ ] Art psychotherapy
[ ] Medicine
[ ] Nursing
[ ] Psychology
[ ] Social work
[ ] Other (Please state)

Patient Group (please state) [ ]

Do you have experience of working with metaphors in clinical practice?
[ ] **yes** [ ] **no**

Do you have experience of working with 'art/pictures' in clinical practice ?
[ ] **yes** [ ] **no**

Have you undertaken scholarly work in the field? (CAT/Metaphor/Art)
CAT [ ] yes [ ] no
Metaphor [ ] yes [ ] no
Art/pictures in therapy [ ] yes [ ] no

E-mail address
[ ]

Phone Number (please include international code)
[ ]

Delphi Questions Round One

Please read before completing the questionnaire

Please type within the boxes. These will expand to take any amount of text.

Please comment on BOTH your knowledge and understanding of:

- ***the use of metaphor in CAT***
- ***the use of pictorial metaphor/art/pictures in CAT***

Please list as many ideas, thoughts and responses as you can

Principles and Core Beliefs

Q1) What do you see as the most important principles when working with metaphor in CAT?

(*please include rationale, models you use, when you might work with metaphor ,your views about these and any specific experiences*)

Q2) What do you see as the most important principles when working with pictorial metaphor/Art/Pictures in CAT?

(*please include rationale, models you use, when you might work with pictures, your views about these and any specific experiences*)

Effective Interventions

Q3) What do you think are the 10 most important factors when working effectively with metaphor in CAT

(If you don't use 'metaphor' in CAT could you try to 'imagine' what would be important when using this technique and answer based on this)

Q4) What do you think are the 10 most important factors when working effectively with pictorial metaphor in CAT

(If you don't use 'art/pictures' in CAT could you try to 'imagine' what would be important when using this technique and answer based on this)

Q5) What obstacles might get in the way of working effectively with and developing metaphor and pictorial metaphor in CAT and how can they be addressed?

Training

Q6) What should be included in a training programme for metaphor and pictorial metaphor in CAT?

Thank you for completing this questionnaire.

Appendix XII Study2 R1 Example completed questionnaire

Sheffield Hallam University

Delphi Expert Consultation

Development and Evaluation of a pictorial metaphor technique in Cognitive Analytic Therapy

Monday, 13 June 2011

Round One Questionnaire

James Turner
Sheffield Hallam University

Round One Delphi Questions

Before you answer these questions, it is important that you have read the accompanying 'Information and Consent form'.

Location (Country/Region) [Sussex Uk] **Nationality** [British]

Ethnicity [English] **Age** [68]

Please indicate your current level of CAT training
[ ] CAT Practitioner [X] CAT psychotherapist [ ] CAT Trainee

Please indicate time since initial qualification training in CAT
[16] years

Please indicate length of time working in mental health/therapy
[18] years

Please indicate your core professional background
[ ] Art psychotherapy
[ ] Medicine
[ ] Nursing
[ ] Psychology
[ ] Social work
[Organisational Psychologist] Other (Please state)

Patient Group/s (please state) [All ex Psychotic]

Do you have experience of working with metaphors in clinical practice?
[X] Yes [ ] No

Do you have experience of collaborative working with 'art/pictures' in clinical practice ?

Patient led [X] **yes** [ ] **no**

Therapist led [X] **yes** [ ] **no**

Have you undertaken scholarly work in the field? (CAT/Metaphor/Art)
CAT [X] yes [ ] no
Metaphor [ ] yes [ ] no
Art/pictures in therapy [ ] yes [ ] no
E-mail address []

Delphi Questions Round One

Please read before completing the questionnaire

Please type within the boxes. These will expand to take any amount of text.

Please comment on BOTH your knowledge and understanding of:

- ***the use of metaphor in CAT***
- ***the use of pictorial metaphor/art/pictures in CAT***

Please list as many ideas, thoughts and responses as you can

Principles and Core Beliefs

Q1) What do you see as the most important principles when working with metaphor in CAT?

(*please include rationale, models you use, when you might work with metaphor ,your views about these and any specific experiences*)

Ask patient for a way of representing a state or attitude/position/voice/role as an or image, picture or sound first. Also for coping procedure/strategy (TPP)
Possibly share one of these that comes to my mind and see if it resonates with patient.
Refine it with the patient and then use it to describe state or role or procedure.
Metaphor or picture seen as a bridge between what is known subconsciously and what can then be made explicit verbally.
Usually use verbal pictures or metaphors.
Can be preceded by showing me the state or voice by enacting or recalling it, or by recalling a memory or expectation of an experience and then noting sensations and thoughts and feelings that go with it. (Eugene Gendlin *Focusing*)
The idea of a bridge between implicit and explicit knowing from experience (original meaning of cognition) and the use of art and metaphor for this made clearer to me by the work of John Heron and Peter Reason on action learning and action research.
Metaphor in Greek means to carry across just as transfer does, derived from Latin. That means to me to carry a pattern across from one context to another. Ryle uses the word metaphor as synonymous with transference in his paper on transference as metaphor.
Seeing and recognising patterns (without words initially) is linked to the original meaning of
of intuition by Jung (intuition derived from the Latin for a kind of perception or seeing).
From R Ornstein onwards in the 80s this form of knowing or cognition was seen to be accompanied by activity in the right or non-verbal hemisphere of the brain. Sperry I think it was who studied knowing or cognition in patients who had for medical reasons had their corpus callosum cut and could be presented with stimuli to each hemisphere separately. The verbal part did not know what the non-verbal part knew.
Jung used a model of cognition using the 4 functions of sensing and intuition for perception and thinking and feeling for judging.

Q2) What do you see as the most important principles when working with pictorial metaphor/Art/Pictures in CAT?

(*please include rationale, models you use, when you might work with pictures, your views about these and any specific experiences*)

meant to say that pattern seeing and recognition is like what Gregory Bateson called reasoning by analogy to go alongside reasoning with logic. In tradition the metaphor is the hare for intuitive perception of essential meaning and pattern perception that needs to work with the tortoise - more pedestrian logic.

One last point. I use traditional short stories and sometimes symbols to show how their experience has been shared by others (they are not alone - normalising) and capture or check the pattern and associated feelings and make them even more memorable. Their metaphors makes it memorable and available for recognition. Teaching stories have many functions. One has been likened to dried fruit (pattern stored) which can resemble the actual fruit when soaked in the water of the experience of experience.

Effective Interventions

Q3) What do you think are the 10 most important factors when working effectively with metaphor in CAT

(If you don't use 'metaphor' in CAT could you try to 'imagine' what would be important when using this technique and answer based on this)

Use patients images and language
Ask the patient to interpret them or put them into words

Link what is being made explicit and then described in words to the focus of the therapy – what is behind the presented problems
Use the metaphors to describe the key elements of the patterns emerging that are repeated across time and context when similar felt experiences are provoked
"Can you think of other times that you have felt this" (state specific memory)
Check that the metaphors used to name or describe in picture form the states and procedures are memorable.
Use state description questions to help the patient to make the links between states and to see states as patterns of relating (others to self,, self to others, self to self and the world etc) that are behind the focus of the therapy
e.g. how do you feel in this state? How do you experience others behaving towards you, how do you feel in relation to them? How do you respond? How do you cope with any painful or frightening or unmanageable feelings?
What are the consequences of that? How do you feel about yourself as a result?
Etc.

Metaphor and picture or image are ways of expressing feelings that some people find easier and/or safer. But important to check their readiness and their capability in both experiencing feelings fully and then making sense of them and how you can meet them where they are at and help them take a step further (Zone of Proximal Development) which they can later use by themselves for coping with similar feelings in the future.

Work with relevant dream images or with guided fantasy

Check if metaphor and relational pattern to which it is linked are memorable and

Q4) What do you think are the 10 most important factors when working effectively with pictorial metaphor in CAT

(If you don't use 'art/pictures' in CAT could you try to 'imagine' what would be important when using this technique and answer based on this)

make it easier to recognise when it is repeated in everyday life.

Q5) What obstacles might get in the way of working effectively with and developing metaphor and pictorial metaphor in CAT and how can they be addressed?

Patient's readiness or self-protective defences – and CAT approach is to help them to approach these (c.f. trauma work) rather than just name the defense
Patient may feel inadequate at drawing or using metaphors – and so need to find a medium that fits them and not use abstract words like "metaphor".
Can use posture or positions of the body for example.

<u>Training</u>

Q6) What should be included in a training programme for metaphor and pictorial metaphor in CAT?

Experiential sessions in small groups for using different media and kinds of metaphor to widen the range and heighten awareness of the function of the bridge between implicit and explicit knowing (see models of cognition and learning style preferences)

Spotting metaphors in everyday conversation that can easily be missed – work in trios.
Working from a state described as an image or metaphor to reciprocal roles and procedures (in original 3 step model of need/aim and strategy and consequence) derived from cases. Using simple state description questions, with each question helping to fill in a space, as it were, in the emerging diagram. A feeling, role of other and of self, need and aim, way of coping and consequence – and where that leads in terms of self-to-self or enacting a role or triggering another state.
Theory behind metaphor, forms of knowing and cognition (ie not just having thoughts as CBT reduces it to in its simplest forms).

Link to Ryle papers and published CAT cases

Thank you for completing this questionnaire.

Appendix XIII Study2 R2 example Questionnaire

Sheffield Hallam University

A Delhi survey of expert practitioners in Cognitive Analytic Therapy

Title: Development and evaluation of a pictorial metaphor technique in Cognitive Analytic Therapy

Information sheet (By e-mail)

Dear Colleague,

I am inviting you to continue onto Round 2 of a three part Delphi Process. You will remember that in the Summer of 2011 I sent you a questionnaire asking for your views and experience of working with metaphors and pictorial metaphors in Cognitive Analytic Therapy, which you kindly completed and returned to me. The study, as I am sure you will remember, is a Delphi designed to reach consensus on aspects of working with metaphor and pictorial metaphor in Cognitive Analytic Therapy. You are being asked to respond to this second questionnaire following the contribution you made to the first round questionnaire.

I am sorry it has taken such a period of time from your initial contribution to when this questionnaire has been developed. I apologise for the delay in sending you this second questionnaire and hope the delay has not inconvenienced you.

Thank you for your round 1 contribution it was really helpful in forming this study, has guided me in my thinking and where to go for reading further on the subject.

When I have analysed all the responses from this round I will send you out a repeat survey for aspects that may require further thought to generate consensus.

On completion of all three rounds and analysis of them I will produce a report/paper which I will send to you.

Please find attached

1) Information Sheet for Round 2
2) Study Update

Please click on this link to go to the survey-

Survey URL: https://ds.shu.ac.uk/survey2/?q=4F27B874V64C

With thanks and Best wishes

James (Jim) Turner

A Delhi survey of expert practitioners in Cognitive Analytic Therapy

Title: Development and evaluation of a pictorial metaphor technique in Cognitive Analytic Therapy

Update

I received a total of 49 completed questionnaires from 101 CAT Therapists and Trainees who expressed an interest in taking part in the study. The questionnaires were analysed for content and then categorised using traditional methods of qualitative data analysis as well as Nvivo (a computer based data management programme) in order to cross reference and provide validation for the statements developed. Some of the statements are verbatim from respondents questionnaires and others are an amalgam/distillation of a number of similar statements. Statements were then triangulated with 'main text', 'factors metaphor' and 'factors pictorial'. This generated 116 initial statements that were then distilled to 77. The plan of analysis was as follows…

Step 1) All statements derived directly from Round 1 questionnaire (Questions 1-3, the what, how when and why of using metaphor and pictorial metaphor) with themes generated from the data and then respondents comments currently coded as 'items' to these themes…

a. CAT and Metaphor (105 items)
b. Helpfulness of metaphor (76 items)
c. Principles in metaphor (117 items)
d. Barriers in metaphor working (75 items)
e. Process of metaphor working (181 items)
f. Pictorial metaphor working (102 items)
g. Supervision (22 items)
h. Neuroscience (4 items)
i. Models (37 items)
j. Case examples (43 items)
k. Training programme (55 items)

Step 2) A separate analysis of question 4 and 5 (10 most important factors when working with metaphor and pictorial metaphor in CAT), generating themes, coding items to these themes…

a. Question 4 – metaphor 10 factors (23 themes, 336 items)
b. Question 5 – pictorial metaphor 10 factors (26 themes, 324 items)

Step 3) Step 1 and Step 2 statements and themes correlated with each other for similarity and repetition and then condensed to form a new set of statements and themes (116 statements from 37 themes). Statements were distilled, if required reworded, then organised into themes and statements for the Round 2 questionnaire (77 statements).

Three of the questions you answered (questions 6-8) have been used to directly inform the metaphor workshop and so show up less in the categorised statements than other questions (the what, how, when and why of using metaphor and pictorial metaphor). These questions covered models' people use when working in this way, your case examples and what you felt should be in a workshop.

With thanks and Best wishes

James (Jim) Turner

Sheffield Hallam University

Title: Development and evaluation of a pictorial metaphor technique in Cognitive Analytic Therapy

A Delphi survey of expert practitioners in Cognitive Analytic Therapy – by E-mail

Instructions for completing Round 2 of the Delphi

Dear Colleague,

You have been selected out of the respondents to Round 1 of this Delphi because your answers and experience met the short listing criterion for this study. Thank you for your participation and contribution.

Just to remind you a Delphi study has been selected for its 'utility for building consensus among a group of individuals who have expertise in a given topic area' (Merris and Haverkamp 2010). Delphi employs a series of iterative questionnaires (rounds) in order to poll and organise opinions of a sample of expert individuals (panellists) enabling a decision making process to occur among a sample (Delbecq 1975).

Delphi is increasingly being utilised in nursing and health related areas and increasing in popularity across many scientific disciplines as a method of inquiry (Keeney et al. 2001, Kennedy 2004). In counselling and psychotherapy there is also a developing history as Merris and Haverkamp (2010, p94) note and cite 4 important studies as evidence of this: Norcross Hedges and Prochascka (2002); Norcross Koocher and Garfalo (2006); Spinelli (1983) and Thielson and Leahy (2001).

The aims of this Delphi are to explore expert opinion in order to:

- develop and evaluate a consensus through a 'Delphi' study of CAT practitioners internationally.
- Review and refine existing ideas and notions with respect to the pictorial metaphor technique.
- generate a range of principles, approaches, practices, theoretical models and factors when working with and developing metaphor in CAT
- reach an expert consensus on the most important approaches, practices, theoretical models and factors when working with and developing metaphor in CAT

Your Round 1 contributions have been analysed in a variety of ways and categorised into a number of statements that I would now like your opinion on.

Round 2

In this second round you will be asked to rate your level of agreement on a 7 point scale to each of the statements that have been developed from Round 1. These are categorised on three differing Likert scales…

AGREEMENT	IMPORTANCE	LIKELIHOOD
• In all cases • Strongly Agree • Agree • Undecided • Disagree • Strongly Disagree • Literally under no circumstances	• Always important • Very Important • Important • Moderately Important • Of Little Importance • Unimportant • Never important	• Almost Always True • Usually True • Often True • Occasionally True • Sometimes But Infrequently True • Usually Not True • Almost Never True

Please consider the full range of each scale. Please do not leave any questions blank. There is a space for a comment should you wish to make one after each question and for an overall comment at the end of the questionnaire should something come to mind you feel has a bearing on this study. The questionnaire is set out similarly to the following example format. Please rate your level of agreement with the statement by clicking on the button below the statement that most represents your personal opinion.

See the 'example' below where a rating for 'agreement' has been indicated.

Round 2 Rating question - ***Please rate your level of agreement with the statement below***

Q 1 – CAT therapists should have training in metaphor working when using metaphor in their clinical work?

In all cases	strongly agree	agree	undecided	disagree	Strongly disagree	literally under no circumstance
		x				

Comment_____

To rate each question, click on the appropriate box and the button will darken. You can only indicate one preference per question. If you wish to change your mind click on the button again and the selection will disappear.

Please draw on your full knowledge and/or experience of metaphors and pictorial/art metaphors to help you reach a judgement on each statement and make a comment if you feel it may help at the end of the survey.

Please click on the hyperlink here to access the online Round 2 questionnaire and follow instructions provided:

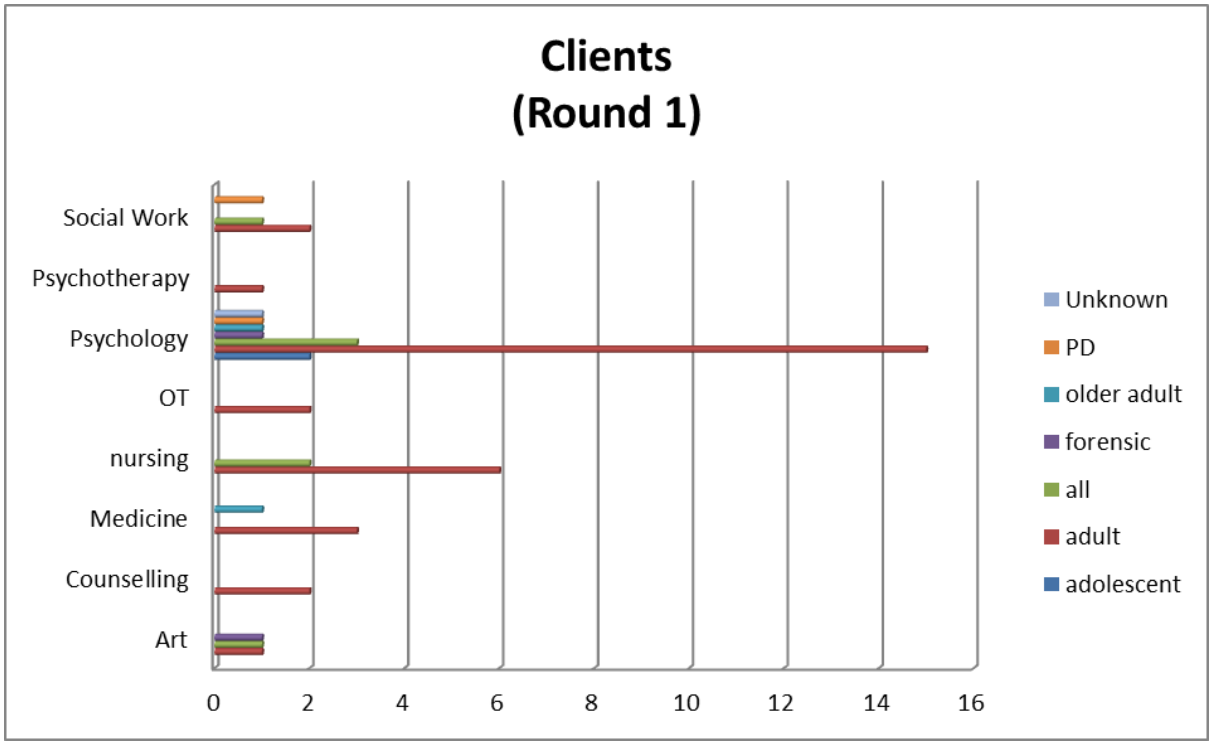
Survey URL: https://ds.shu.ac.uk/survey2/?q=4F27B874V64C

With thanks and Best wishes

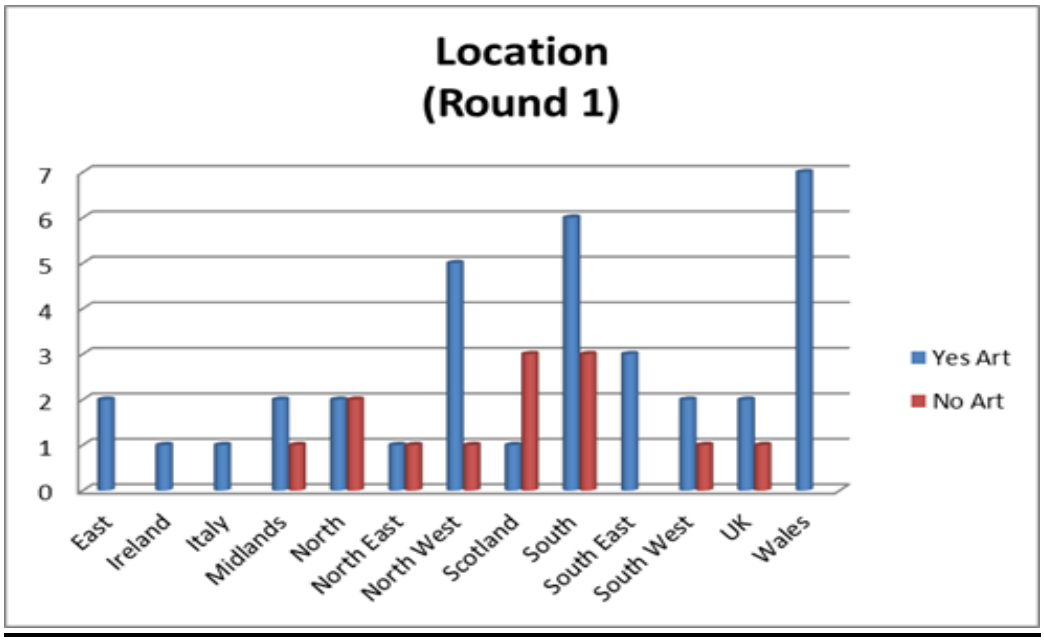
James (Jim) Turner

Appendix XIV Study2 Additional demographic detail Delphi Study

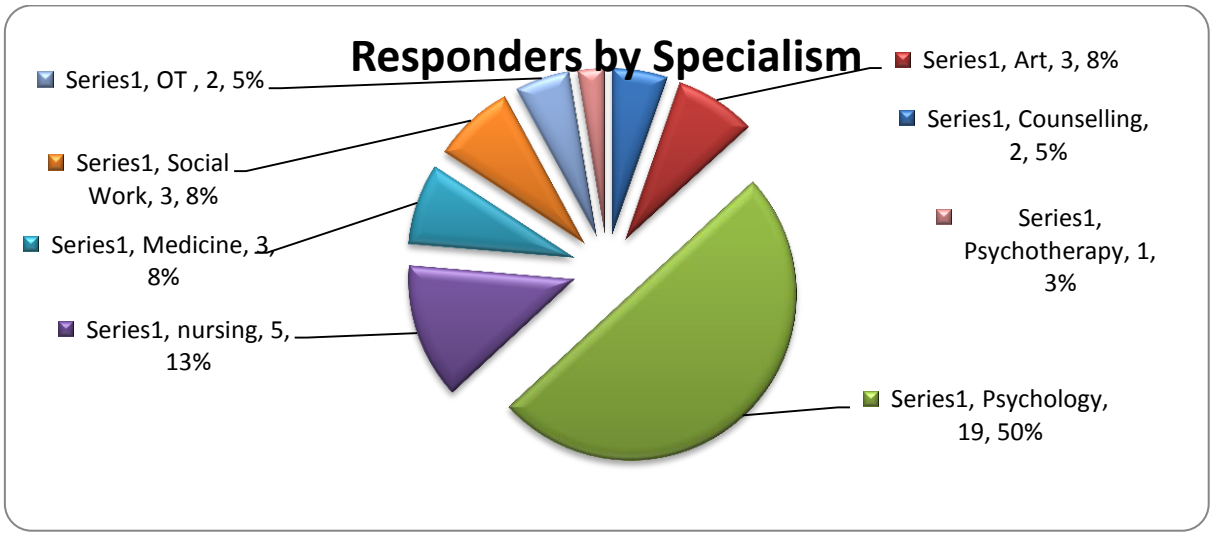
Patient Base of responders



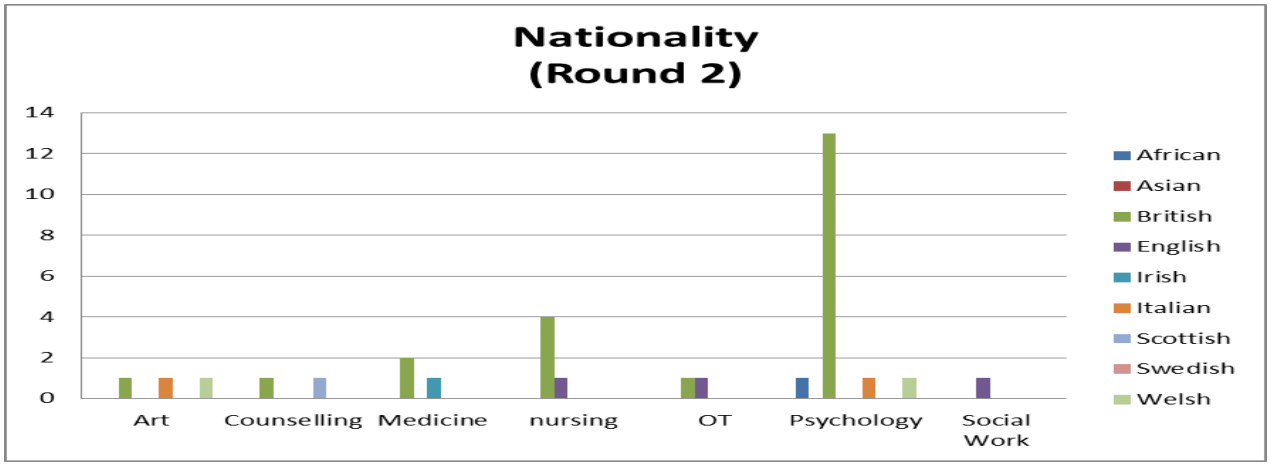
R1 Location art/no art experience

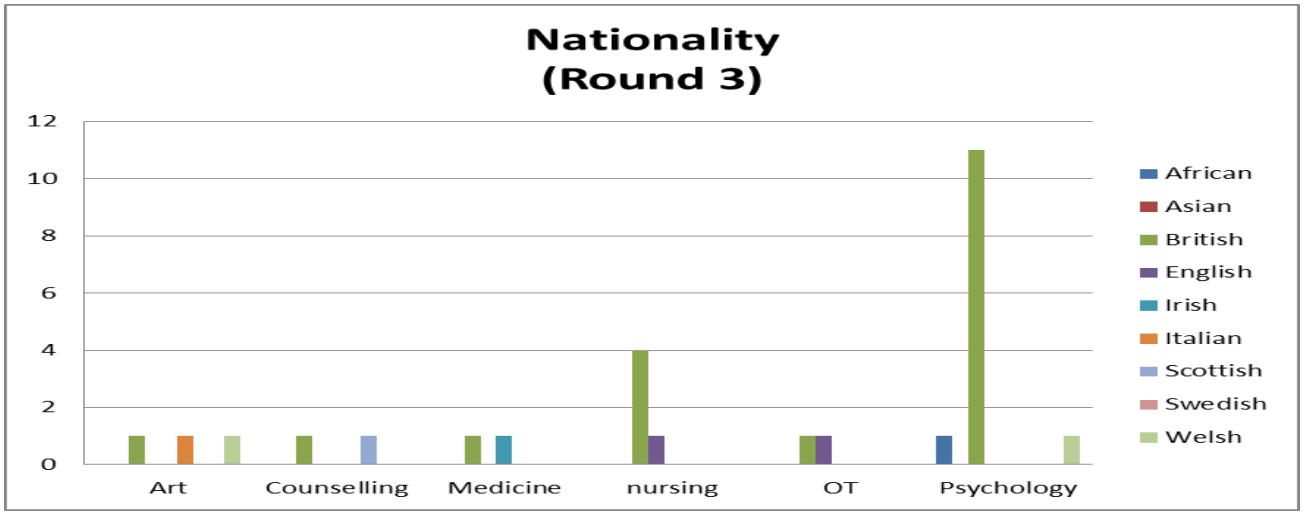


Responders by specialism (R2)

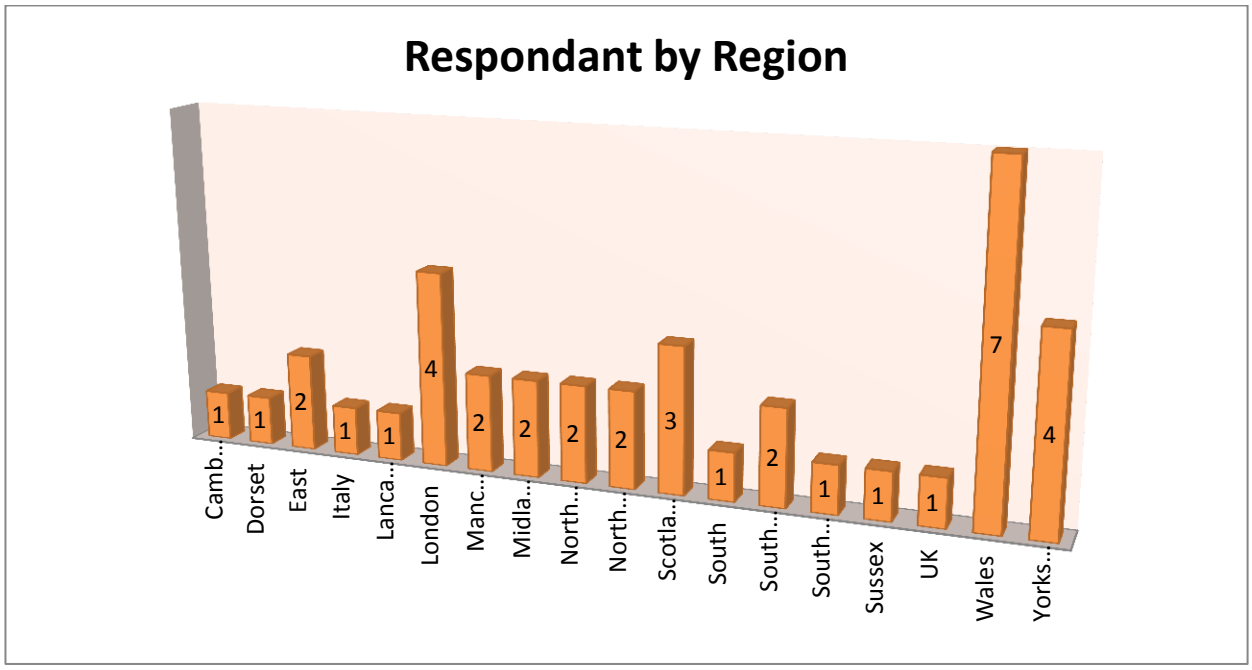


Nationality attrition between R2 and 3

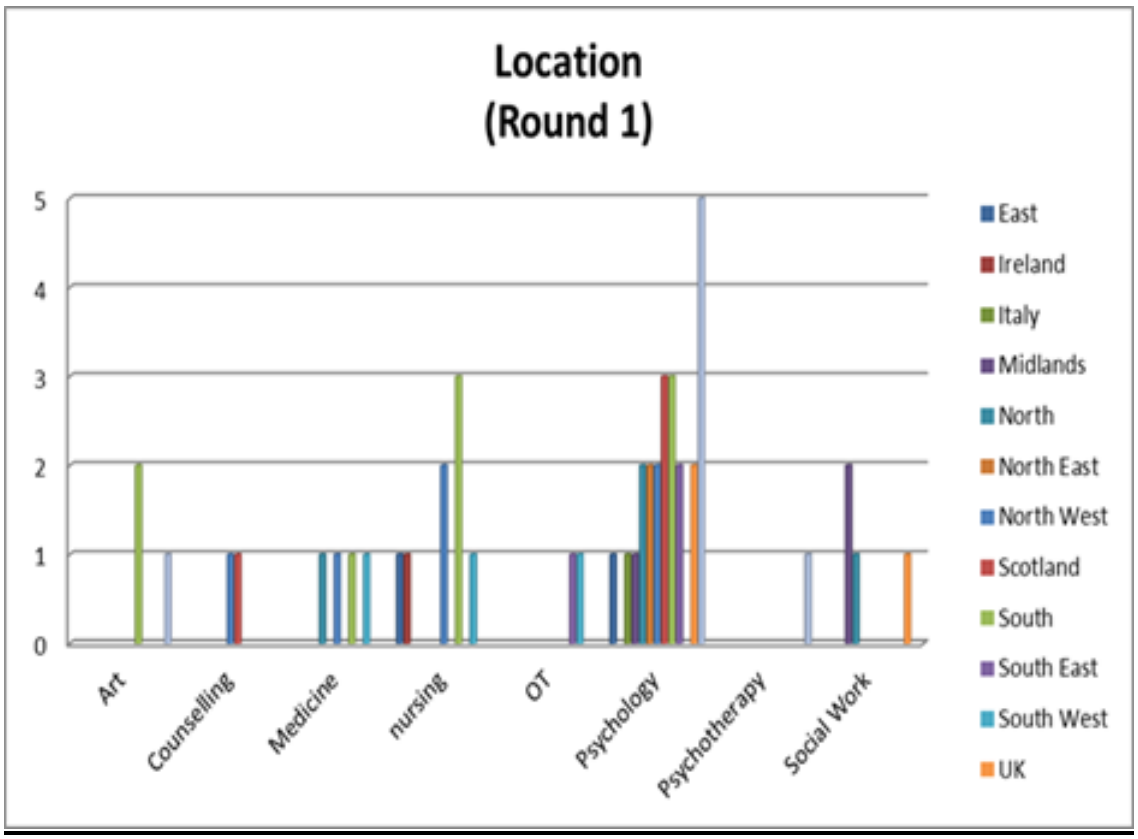




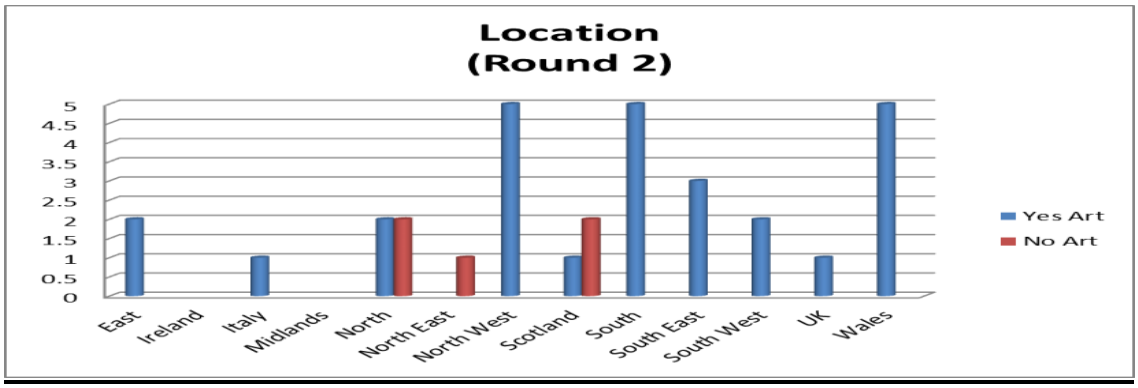
Respondent by region (R1)



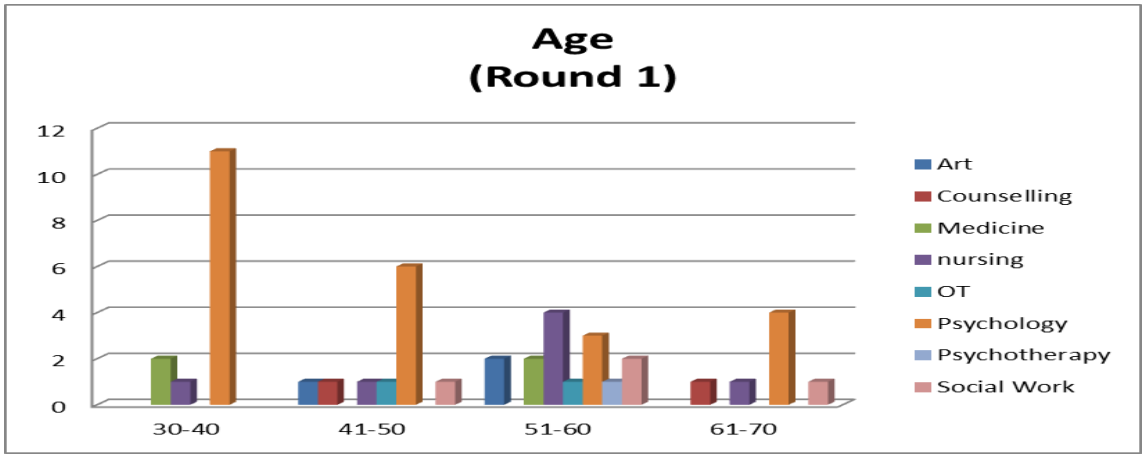
Location R2 Art/no art experience



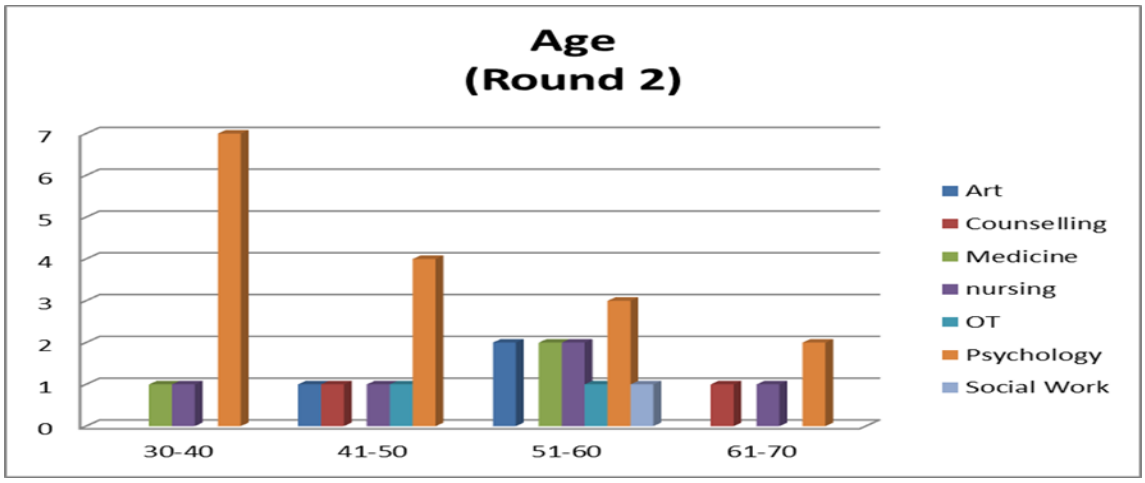
Location R1 by specialism



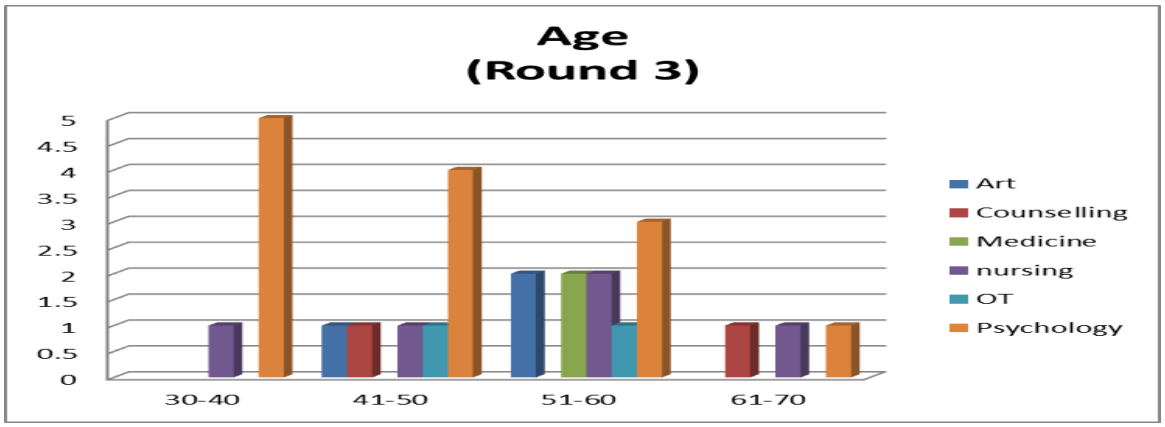
All rounds responders by age (Round1)+specialism



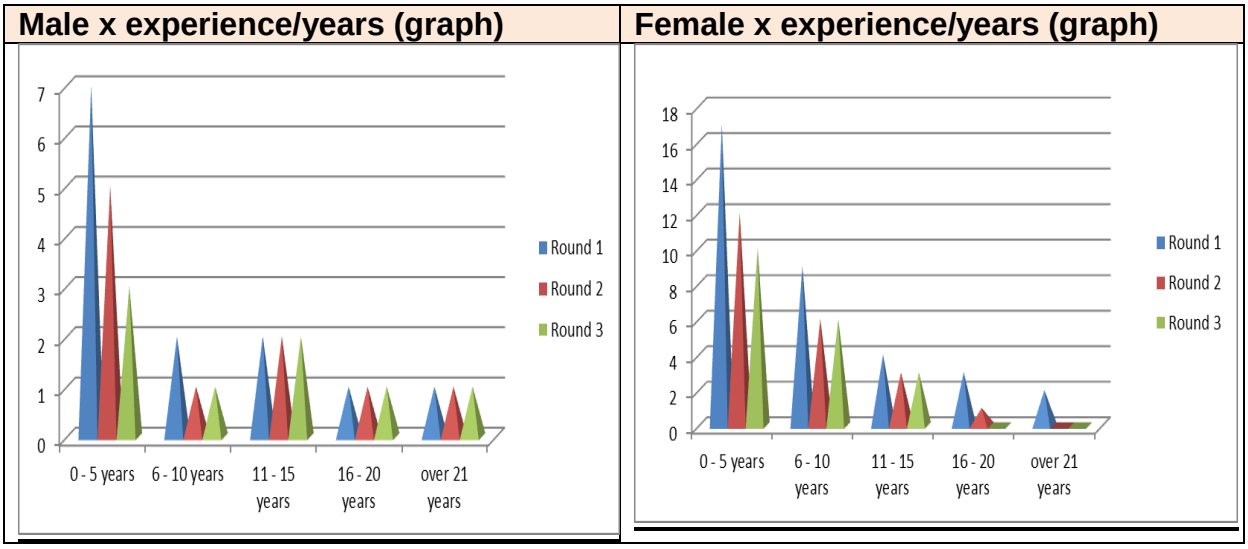
All rounds responders by age (R2)+specialism



All rounds responders by age (Round3)+specialism



Male experience all rounds (graphs)



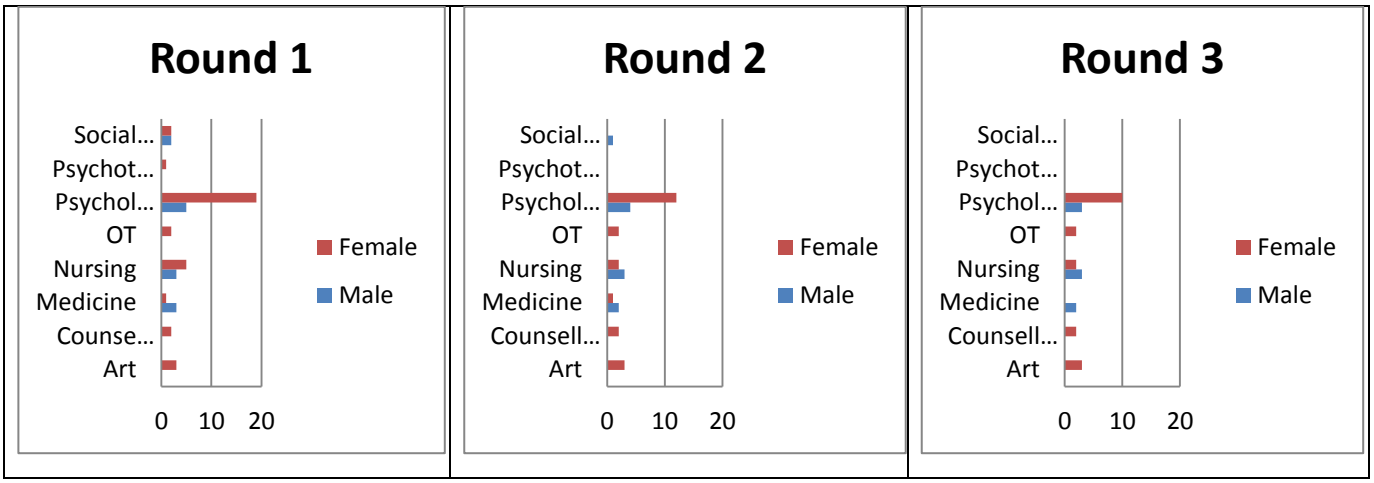
Speciality and Gender (Numerical)

R1		
	M	**F**
Art	0	3
Counselling	0	2
Medicine	3	1
Nursing	3	5
OT	0	2
Psychology	5	19
Psychotherapy	0	1
Social Work	2	2
	13	**35**

R2		
	M	**F**
Art	0	3
Counselling	0	2
Medicine	2	1
Nursing	3	2
OT	0	2
Psychology	4	12
Psychotherapy	0	0
Social Work	1	0
	10	**22**

R3		
	M	**F**
Art	0	3
Counselling	0	2
Medicine	2	0
Nursing	3	2
OT	0	2
Psychology	3	10
Psychotherapy	0	0
Social Work	0	0
	8	**19**

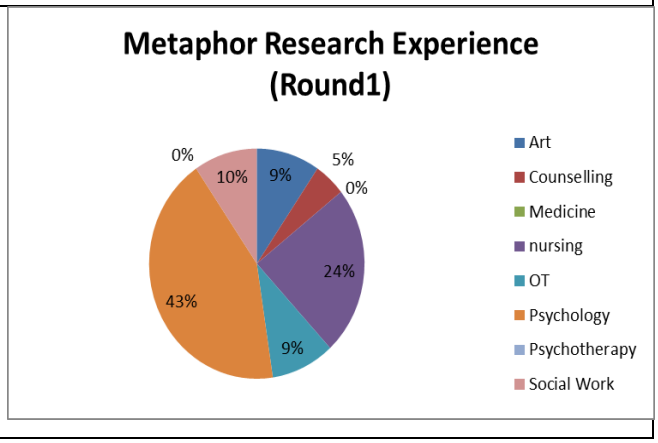
Speciality and gender (bar)



Metaphor Research R1

Metaphor research experience R1 data			
R1		**Yes**	**No**
Art	4%	2	1
Counselling	2%	1	1
Medicine	0%		2
nursing	10%	5	3
OT	4%	2	
Psychology	18%	9	15
Psychotherapy	0%		1
Social Work	4%	2	2
		21	**25**

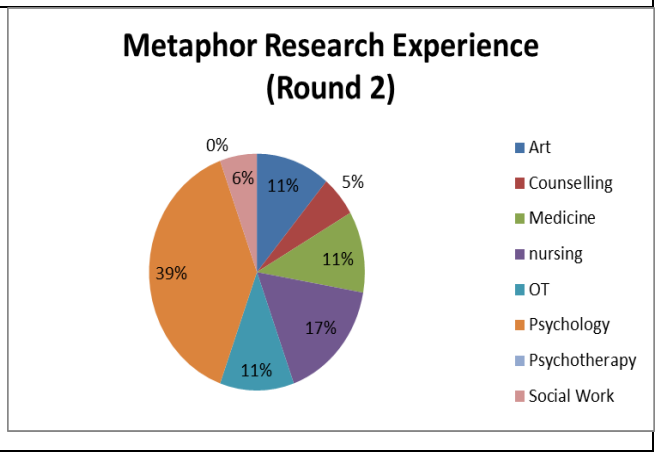
Metaphor research experience R1 graph



Metaphor Research R 2

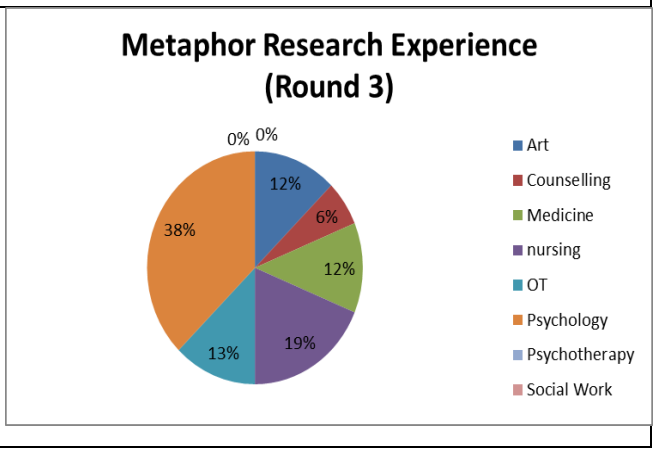
Metaphor research experience R2 data			
R2		**Yes**	**No**
Art	6%	2	1
Counselling	3%	1	1
Medicine	6%	2	1
nursing	9%	3	2
OT	6%	2	
Psychology	22%	7	9
Psychotherapy	0%		
Social Work	3%	1	
		18	14

Metaphor research experience R2 graph



Metaphor research experience R3 data			
R3		**Yes**	**No**
Art	7%	2	1
Counselling	4%	1	1
Medicine	7%	2	
nursing	11%	3	2
OT	7%	2	
Psychology	22%	6	7
Psychotherapy	0%		
Social Work	0%		
		16	**11**

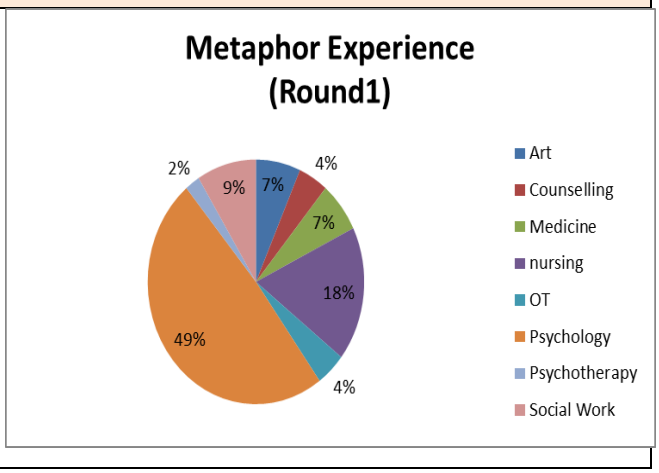
Metaphor research experience R3 graph



Metaphor R1

Metaphor experience R1 data			
R1		**Yes**	**No**
Art	6%	3	
Counselling	4%	2	
Medicine	6%	3	1
nursing	16%	8	
OT	4%	2	
Psychology	45%	22	3
Psychotherapy	2%	1	
Social Work	8%	4	
		45	**4**

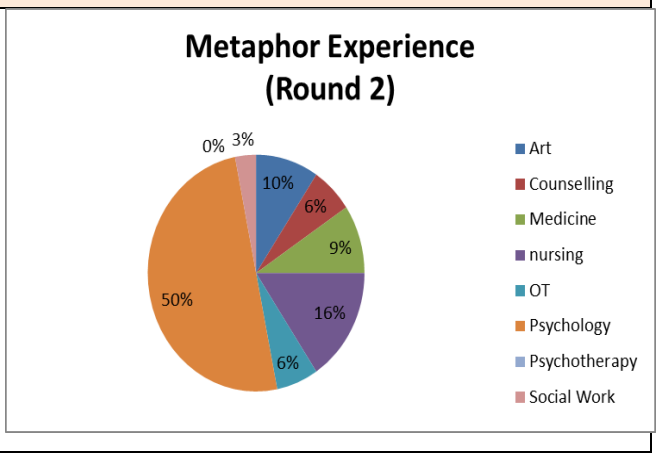
Metaphor experience R1graph



Metaphor R2

Metaphor experience R2 data			
R2		**Yes**	**No**
Art	9%	3	
Counselling	6%	2	
Medicine	9%	3	
nursing	16%	5	
OT	6%	2	
Psychology	50%	16	
Psychotherapy	0%		
Social Work	3%	1	
		32	

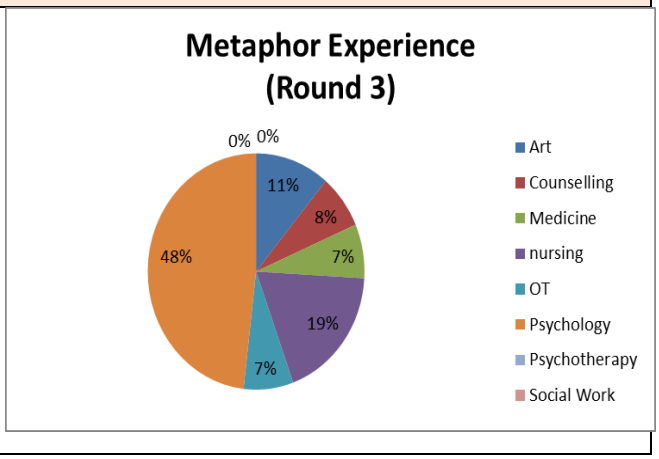
Metaphor experience R2 graph



Metaphor R3

Metaphor experience R3 data			
R3		**Yes**	**No**
Art	11%	3	
Counselling	7%	2	
Medicine	7%	2	
nursing	19%	5	
OT	7%	2	
Psychology	48%	13	
Psychotherapy	0%		
Social Work	0%		
		27	

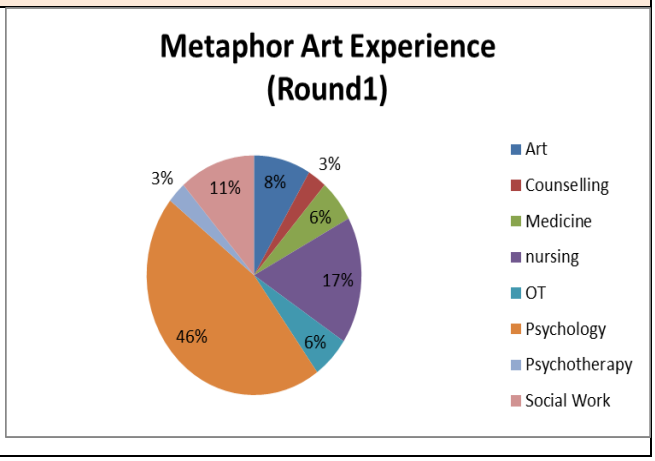
Metaphor experience R3 graph



Metaphor art R1

Metaphor art experience R1 data			
R1		**Yes**	**No**
Art	6%	3	
Counselling	2%	1	1
Medicine	4%	2	2
nursing	12%	6	2
OT	4%	2	
Psychology	33%	16	7
Psychotherapy	2%	1	
Social Work	8%	4	
		35	**12**

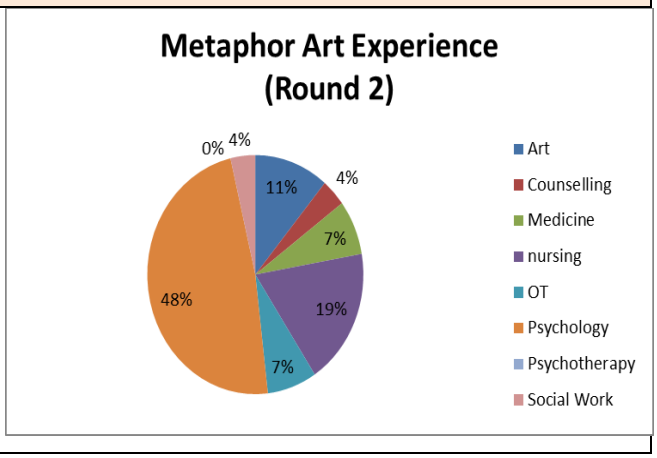
Metaphor art experience R1 graph



Metaphor art R2

Metaphor art experience R2 data			
R2		**Yes**	**No**
Art	9%	3	
Counselling	3%	1	1
Medicine	6%	2	1
nursing	16%	5	
OT	6%	2	
Psychology	41%	13	3
Psychotherapy	0%		
Social Work	3%	1	
		27	

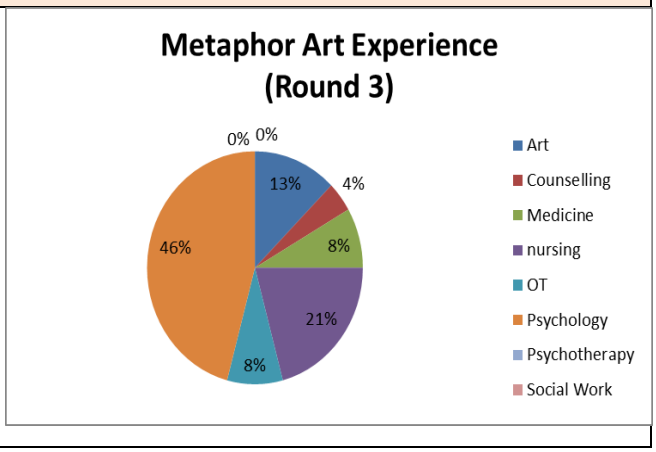
Metaphor art experience R2 graph



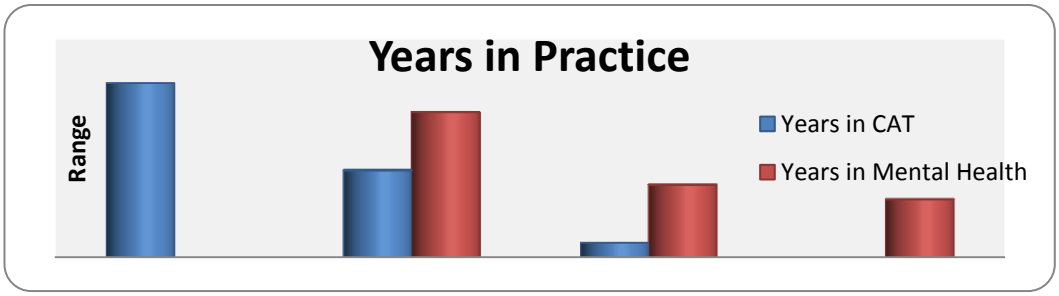
Metaphor art R3

Metaphor art experience R3 data			
R3		**Yes**	**No**
Art	11%	3	
Counselling	4%	1	1
Medicine	7%	2	
nursing	19%	5	
OT	7%	2	
Psychology	41%	11	2
Psychotherapy	0%		
Social Work	0%		
		24	**3**

Metaphor art experience R3 graph



Years in practice (a)



Appendix XV Study2 Theme 3 R1 statements 'Barrier's

Theme 3 Barriers	Occurrence
B1 It is important to notice the relational/social/cultural context of the metaphor	8
B2 Lack of training opportunities would limit the use of this metaphor method in practice	10
B3 Therapists 'closeness of mind' or self-conscious anxiety would limit the approach	13
B4 The centrality of the CAT model and focus on verbal expressions	8
B5 There is a potential risk of using metaphor to avoid or unname difficult things (I believe metaphors can allow the patient to feel more distanced from their emotions and clearly this may or may not be desirable).	6
B6 Lack of space or materials	7
B7 Moving out of the ZPD of the therapist and patient especially if have difficult educational experience of 'art'	9
B8 I haven't used pictorial metaphor because I think I don't think pictorially myself	3
B9 Considerations of age need to be inherent as some 'ages' did not have a foundation in the 'arts'	2
B10 Important not to make prior assumptions and jump to conclusions when working with a patients metaphor	17
B11 Patient discomfort at the use of pictorial imagery may be off-putting for the therapist leading to avoidance of the technique	6
B12 A therapist may feel that they have to be artistic to employ this strategy, but inviting the patient to draw would embrace the collaborative nature of CAT.	9
B13 I suspect I have seen patients who would have been happy to work like that and probably ones who talked about artwork and drawing, but I didn't pick up on it.	5
B14 Be very aware of how metaphors may have pejorative implications or symbolism and avoid colluding with that (demonstrate to the patient that you are aware of this and do not fully accept the metaphor though you can see why it feels useful/apt to them	3
B15 I find it difficult to transfer my experiences working more fluidly in other modalities to working in CAT where there are timescales and a specific process I am trying to keep to	1
B16 Even reading about artwork say in Reformulation or at poster presentations it comes across to me as a specialised "branch" of CAT rather than fully integrated	5
B17 The patient could create a metaphor which is not understood by therapist and it is important that space is allowed to explore this	7
B18 You can't just use metaphors – there needs to be some concrete/actual descriptions too or some everyday examples of experiences that are related to the metaphor	5
B19 Pressure to reduce waiting lists etc prevent therapists from working creatively and tend to emphasise working on symptoms rather than taking a holistic approach to psychological recovery (busyness of CAT?)	3
B20 If you are working with a patient who is particularly concrete in his or her way of thinking it may be hard to connect with them with ideas that are not familiar to them though all of these difficulties can be managed by keeping things simple and checking out with the particular patient f it is making sense to them and what would make it easier or better.	5

B21 If the first metaphor does not succeed in furthering understanding, be prepared to use an alternative, or to use a different approach.	11
B22 I think the major obstacle would be a mis-match between the patient and therapist understanding of the metaphor.	4
B23 I also don't have any theoretical framework for understanding how to use metaphors and would really benefit from discussion of this in training/Reformation magazine	1
B24 Knowing how to judge who it would be useful with; metaphor is not for every patient and in fact for some it would be experienced very negatively.	1
B25 Caution against narcissistic admiration of how arty and clever the therapist is	7
B26 Needs reassurance that most patients find it enjoyable, and that there will be no judgments based on quality of drawings.	1
B27 Lack of empirical evidence that metaphorical approaches are anything other than a diverting side-line	1
B28 Patients may not feel they have the skills and therefore are self- critical as well as fearing judgement or criticism from the therapist.	7
B29 Lack of rationale, so patient doesn't understand why being asked to engage in this activity, or what the potential benefits could be.	3
B30 Often patients have negative associations with their image making capacity and anxiety needs to be averted.	6

Appendix XVI Study2 Theme 5 CAT Model and Metaphor

Theme 5 CAT Model and Metaphor	Number of occurrences
M1 Metaphors can provide a **link to a patient's reciprocal roles**	16
M2 The use, understanding and development of metaphor **establishes the patterns of communicating** in the relationship	2
M3 Metaphors allow space for the **transference and counter transference** to emerge	3
M4 Using **patients language** shows they are being heard and understood and that the therapist language has not been imposed	7
M5 Metaphors can capture a **central theme** in the patients dialogue	5
M6 It is important to work within the patients **ZPD**	3
M7 Metaphors can support '**playfulness**' in therapy and lead to initial insight into a patient's problems	3
M8 Metaphors can create new possibilities and potential exits (**unstuckness!)**	6
M9 It is useful to name and explain patients metaphors in their **reformulation letter**	2
M10 Metaphors can be a means of **containing painful emotions** in response to reciprocal roles	4
M11 A picture of the metaphor is useful to put on the **SDR**	10
M12 Metaphors can be used to develop **effective 'signs'** with patients'	1
M13 Provide a **scaffolding**	1

Appendix XVII Study2 Theme 6 Helpfulness

Theme 6 helpfulness	occurrences
H1 A metaphor may be helpful to succinctly **sum up an overall theme** in the reformulation.	4
H2 A metaphor may acknowledge and contain **affect associated with ending**	1
H3 Therapist and patient being caught in **enacting damaging/self-limiting RRPs** that - use of SDR, metacommunication around the dynamics in the therapeutic relationship	2
H4 Their power lies in their ability to combine and express complex and often contradictory issues within an easily **accessible image**, where using words you could get bogged down in detailed descriptions	8
H5 I use it because it is **one step removed** from the actual experiences of the patient and so I hope that it might be easier to wonder about as a first step	6
H6 Demonstrates to the patient that the details of their experiences are important and worthy of note, that we have time to **look at these details together**.	5
H7 Metaphors and imagery we have **constructed together** have led to them feeling particularly understood, valued and validated.	4
H8 **Play and creativity**	4
H9 Extends and develops **therapeutic understanding**	4
H10 Helps in establishing **collaborative** working relationship with patient	5
H11 A bridge or **link between thought and feeling**	2
H12 Metaphors stemming **from the therapist** can be powerful	1
H13 Enable working with **the ZPD**	4
H14 Can **provide distance** enable observation of problems	1
H15 Can contribute to more **accessible diagrams**	3
H16 **Unstick**	2

Appendix XVIII Study2 Theme 8 Pictorial Metaphor

Theme 8 Pictorial metaphor	occurrence
PM1 Some patients may find pictorial ways of working a more acceptable medium but important that generated from the patients dialogue	10
PM2 Using pictures and images could be particularly useful when working with children and with patients who have difficulties expressing their thoughts	5
PM3 In developing a pictorial metaphor it is useful work with 'images ' that come from the verbal metaphor in the mind's eye then sketch this out on paper with the patient	6
PM4 Using a picture may open a dialogue and extend awareness, particularly with patient who struggle to verbalise inner thoughts.	13
PM5 Pictures may be an opportunity to create an image of difficult experiences in a less painful way for the patient	3
PM6 It is important to pay attention not only to the representative aspect of a pictorial metaphor but the colours used, the way it comes to mind and the way in which it was made.	7
PM7 Co-constructing a picture mirrors the collaborative nature of CAT and can lead to shared understanding	27
PM8 CAT therapists need to pay attention as to whether developing a pictorial metaphor is out with their and/or the patients ZPD	11
PM9 Sometimes the picture can be an add on and not necessarily fully integrated therefore it is important to link them to a patient's reformulation (SDR and TPP's)	12
PM10 Important that the process of developing the pictorial metaphor is not patronising and judgemental	5
PM11 Useful to have drawing and art materials available	1
PM12 Providing simple not 'perfect' drawings can help to reduce transference issues of the therapist being seen as the 'expert'	6
PM13 Metaphors and working with pictorial metaphors should be encouraged to be discussed in supervision	1
PM14 A pictorial metaphor can act like a shorthand to TPP's when the pattern is repeated in everyday life	3
PM15 One reason CAT therapists don't work more with pictorial metaphor is a lack of confidence in artistic ability	6
PM16 Caution should be applied to working with metaphors as they can distance a patient from their emotions	1
PM17 Introducing a metaphorical way of working needs to be done quickly and confidently and can be lightened by describing it as fun, experimental, light-hearted process.	3
PM18 CAT therapist must be cautions and indeed avoid interpreting patients metaphors	3
PM19 The pictorial metaphor must be meaningful and accessible to the patient and must resonate with the patients experience	2

Appendix XIX Study2 Theme 9 Principles relationship

Theme 9 Principles Relationship and Metaphor	occurrences
PR1 Capture something of the **context** in which the metaphor arises	4
PR2 **Shared understanding**	16
PR3 Metaphors can deepen the therapeutic alliance	3
PR4 Can become a shorthand to access problems and understandings	3
PR5 Attune to metaphor	7
PR6 Patient derived	10
PR7 The aim of using the metaphor is to further develop the patients' capacity to think about their difficulties from a range of perspectives.	4
PR8 Therapists derived, sometimes I will provide the word/s, and use them if they feel right with the patient.	4
PR9 They can often engender powerful emotions and once acquired they may be hard to contain	1
PR10 Be selective with the patients you use metaphor with, one size does not fit all	2
PR11 Work in ZPD	5
PR12 Metaphors can conjure up images	4
PR13 Can be linked to the SDR and RRP's	8
PR14 Have to be non-judgemental	2
PR15 Can allow distance between emotions because of their sometimes abstract nature	1
PR16 Can enable recognition of collusion with patients RRP's	2
PR17 Can help when we are stuck	1
PR18 Have to be relevant	2
PR19 Can become a central theme	1
PR20 Must not compromise the fidelity of the CAT model.	1

Appendix XX Study2 Theme 10 Process practice

Theme 10 Process practice	Occurrences
PP1 The **therapist may offer their own metaphor** as a means of creating a 'sign' **i**n which old meanings may become decontextualized and new meanings found	9
PP2 It is helpful to link the metaphor to the **patients RRP's** as they can allow you to represent complex formulatory ideas	13
PP3 It is important to be **creative and playful** when co constructing the pictorial metaphor and reassure that they only have to be 'good enough' drawings	3
PP4 Important to have a **shared understanding** of the metaphor	18
PP5 Work within the patients and therapists **ZPD,** I push where it moves	8
PP6 Allow **time and space** for patient to describe and develop image/metaphor before moving to analysis and process work	5
PP7 **Acknowledge metaphor** as naturally occurring and be open the their expression and exploration	16
PP8 Metaphor is a powerful method of communication and **can get 'behind' defences**	4
PP9 Metaphors have the potential to **enhance the therapeutic alliance**	5
PP10 Important to use words and **images the patient has brought** to the session and that have been jointly created	9
PP11 It is important to recognise the impact of metaphors and the verbal **processing** of metaphors **after therapy session**	1
PP12 **Take care** when working with metaphors that contain graphic, sexual or violent connotations	1
PP13 **Cliché metaphors** alive or dead and that could come alive? they can be **too sapped of meaning** to carry much power in therapy	2
PP14 Important **to let go** of the metaphor when it loses connection for the patient	2
PP15 Metaphors are memorable and available for recognition, **the 'yes that's it**!' moments helping to summarise the patient's experience in a way that can feel more accessible to them rather than mountains of prose or lengthy descriptions	3
PP16 Not all therapists will be comfortable with nonverbal metaphors so it would be important to **check for fit** whenever nonverbal tools are being used.	3
PP17 Link to SDR, drawing metaphors on them can be a way to get to **unattainable places**	4
PP18 **Non judgemental**	1
PP19 It is as if we (patient and therapist) can both pretend that the story (metaphor?) **is just a story**	1
PP20 I think pictorial metaphors are most effective when developed **collaboratively**	1
PP21 Use proximal material from the **social and cultural** world of the patient	2
PP22 The use of metaphor should **not compromise the fidelity of the CAT model**	1

Appendix XXI Study2 Theme 11 Supervision

Theme 11 Supervision	occurrence
S1 Bringing patient's metaphors to supervision and enabling a supervisor to see what is happening in the room can often give you a chance to see that you may be **colluding with a patient's RRP**.	6
S2 In supervision an image or metaphor can often help bring a supervisee's **patient to mind in an instance**	3
S3 Asking supervisees to draw how they perceive their patients can help them reflect on where they are in therapy, particularly if they are feeling **stuck**.	3

Appendix XXII Study2 Theme 12 What is metaphor

Theme 12 What is metaphor	Occurrence
W1 I would say that metaphors used would best be drawn from the **patient's own expressions and utterances**	7
W2 Metaphor or picture can be seen as **a bridge** between what is known subconsciously and what can then be made explicit verbally	6
W3 Utilising metaphors re-enforces the patients **feeling of being understood**, and therapists sense that s/he has a handle on what's going on.	4
W4 Metaphors contribute to the development of **more accessible diagrams**, diagrams that the patient can revisit and constantly alter while keeping a consistent language	6

Appendix XXIII Study2 Question 3 and 4 frequency

Ten factors metaphor nodes frequency combined

Question 3 Coding Summary 10 factors metaphor	Question 4 Coding Summary 10 factors pictorial metaphor	Total
Shared Understanding 58 references	Shared Understanding 33 references	92
Patient Derived 40 references	Patients words 22 references	66
Locate to CAT model 34 references	Locate to CAT model 26 references	60
Therapeutic Alliance 21 references	Therapeutic alliance 20 references	41
Collaborative 13 references	Collaborative 23 references	36
Willingness to work with metaphor 13 references	Willingness active listening 20 references	33
Simplicity 17 references	Accessible image 14 references	31
Work within ZPD 14 references	Work within ZPD 15 references	29
Ongoing 16 references	Enables 'moving on' 12 references	28
Non judgemental 10 references	Non judgemental 19 references	29
Metaphors are adaptive 23 references		23
Playfulness and fun 10 references	Playfulness and fun 8 references	18
Transference 11 references	Counter transference 5 references	16
	Enables verbalisation 15 references	15
	Harness creativity 14 references	14
Cultural aspect 8 references	Cultural aspects 4 references	12
Be prepared to abandon 7 references	Be prepared to abandon 5 references	11
Materials available 2 references	Materials available 8 references	10
Anxiety re using metaphors 5 references	Therapist confidence 5 references	10
Supervision 5 references	Supervision 2 references	7
Therapist Derived 7 references		7
Imaginative capacity 7 references		7
Sign mediation 4 references	Sign mediation 3 references	7
Agreed rules 2 references	Intellectual property 3 references	5
Understand research and literature 2 references	Understanding theory 1 reference	3
	Not too liberally 3 references	3
	Mutual admiration 1 reference	1
23	24	

Appendix XXIV Study2 Statements Frequency Data - Data for all themes combined and compared

Question 3 Coding Summary 10 factors metaphor	Question 4 Coding Summary 10 factors pictorial metaphor	Theme 3 Barriers	Theme 5 Cat Model and Metaphor	Theme 6 Helpfulness	Theme 7 neuroscience	Theme 8 Pictorial metaphor principles	Theme 9 Principles relationship and metaphor	Theme 10 Metaphor and pictorial metaphor practice	Theme 11 Supervision	Theme 12 What is metaphor	total
Shared Understanding 58 references	Shared Understanding 33 references	Mis-match between understanding 4 references Don't make prior assumptions 17 references		particularly understood 4 references		Shared understanding 27 references	Shared understanding 16 references	Shared Understanding 18 references		Understood and has a 'handle' 4 references	181
Locate to CAT model 34 references	Locate to CAT model 26 references	CAT model and verbalisation 8 references	Reciprocal roles 16 references Link to SDR 10 references Reformulation letter 2 references	Accessible diagrams 3 references		Link to reformulation and SDR 12 references	Link to sdr/rrp 8 references	Link to SDR/RRP's 13 references		More accessible diagrams 6 references	138
Patient Derived 40 references	Patients words 22 references	Patient created metaphor 7 references	Patients language 7 references			Patients dialogue 10 references	Patient derived 10 references	Patient derived 9 references		Patient derived 7 references	116
Therapeutic Alliance 21 references	Therapeutic alliance 20 references		Establishes patterns of communication 2 references	Develop Therapeutic understanding 4 references			Therapeutic alliance 3 references	Therapeutic alliance 5 references			55
Collaborative 13 references	Collaborative 23 references			Collaborative 5 references		Avoid interpreting 3 references		Collaborative 1 references			45
Willingness to work with metaphor 13 references	Willingness active listening 20 references	Therapists 'closeness of mind' 13 references		We have time (willingness) 5 references			Attune 7 references	Acknowledge as naturally occurring 16 references			84

		Didn't pick it up 5 references						Allow time and space 5 references			
Simplicity 17 references	Accessible image 14 references		Central theme 5 references Scaffolding 1 reference	Accessible image 8 references Sum up overall theme 4 references		link them to a patient's reformulation 12 reference Image form 'mind's eye' 6 references short hand 3 references	Central theme 1 references Shorthand 3 references Conjure up images 4 references	Summarise 'yes that's it' 3 references	Bring to mind in an instance 3 references		84
Work within ZPD 14 references	Work within ZPD 15 references	Moving out of ZPD 9 references	Work within ZPD 3 references	ZPD 4 reference		Work within ZPD 11 references	Work with ZPD 5 references	Work with ZPD 8 references			69
Ongoing 16 references	Enables 'moving on' 12 references		Potential exits – unstuckness 6 references				Stuck 1 references		Feeling stuck 3 references		38
Metaphors are adaptive 23 references		Avoid or un name 6 references		Link between thought and feeling 2 reference	Emotional connectedness 4 references	Difficulty expressing thoughts 5 references	Develop thinking capacity 4 references			Bridge between Ucs and verbalisation 6 references	50
Non judgemental 10 references	Non judgemental 19 references	Fear judgement 7 references Anxiety with image making capacity 6 references				Non judgemental 4 references	Non judgemental 2 references	Non judgemental 1 references			49
Playfulness and fun 10 references	Playfulness and fun 8 references	Enjoyable 1 reference	Playfulness 3 references	Play and creativity 4 references		Fun and light-hearted 3 references		Playfulness 3 references			32
Transference 11 references	Counter transference 5 references	Avoid collusion 3 references Patient discomfort 6 references	Transference and counter transference 3 references	Enacting damaging rrp's 2 references		Reduce transference of 'expert' 6 references	Collusion with rrp's 2 references	Behind defences 4 references	Collusion with RRPs noticed 6 references		49
	Enables verbalisation 15 references		Contain powerful emotions 4 references			Can distance from emotions (Caution) 1 reference	Powerful emotions 1 references	Unattainable paces 4 references			24
	Harness creativity										14

	14 references										
Cultural aspect 8 references	Cultural aspects 4 references	Relational/cultural 8 references				Representative and cultural aspects 7 references	Context 4 references	Social and cultural 2 references			33
Be prepared to abandon 7 references	Be prepared to abandon 5 references	Use alternative 11 references Not for everyone 1 reference					Relevant 2 references	Let go 2 references			28
Materials available 2 references	Materials available 8 references	Lack of space or materials 7 references				Materials available 1 reference					18
Supervision 5 references	Supervision 2 references					Discuss in supervision 1 reference					8
Therapist Derived 7 references				Therapist derived 1 reference			Therapist derived 4 references	Therapist derived 9 references			21
Imaginative capacity 7 references		I don't think pictorially 3 references Concrete thinking 5 reference				Extend awareness 13 references	Images 4 references	Is just a story 1 references			34
Anxiety re using metaphors 5 references	Therapist confidence 5 references	Confidence in art work 9 references Art experience (age) 2 references				Therapist confidence 6 reference					27
Sign mediation 4 references	Sign mediation 3 references		Effective signs with patients 1 references								8
Understand research and literature 2 references	Understanding theory 1 reference	Theoretical framework 1 reference									4
	Not too liberally 3 references						Be selective 2 references	Cliché metaphors 2 references			7
		Timescales within					Fidelity of CAT	Fidelity of CAT			8

		CAT model 1 reference Metaphor 'specialised' 5 references					1 references	1 references			
				One step removed 6 references Provide distance 1 reference		Difficult experiences in less painful way 3 references	Distance from emotions 1 references	Verbal processing 1 references			6
Agreed rules 2 references	Intellectual property 3 references	Rationale for use 3 references						Take care- Graphic content 1 references			9
	Mutual admiration 1 reference	Narcissistic admiration 7 references				Meaningful and accessible 2 references		Check for fit 3 references			13
		Lack of training opportunities 10 references									10
											1
		Need some actual descriptions 5 references									5
		Pressure of time 3 references									3
				Manage ending 1 reference							1
		Lack of empirical evidence 1 reference									1
23	24	30	13	15	1	20	20	22	3	4	595

Appendix XXV Study2 Statement generation categorising and collapsing

process	principles	helpfulness	CAT	Pictorial	barriers	Supervision and cognitive neuroscience comments	10 factors nodes Metaphor	10 factors nodes pictorial Metaphor	Final statement
The therapist may offer their own metaphor as a means of creating a 'sign' in which old meanings may become decontextualised and new meanings found	Therapists derived, sometimes I will provide the word/s, and use them if they feel right with the patient.						therapist derived		The therapist may offer their own metaphor if they feel right with the patient
It is helpful to link the metaphor to the patients RRP's as they can allow you to represent complex formulatory ideas	Can be linked to the SDR and RRP's	A metaphor may be helpful to succinctly sum up an overall theme in the reformulation.	Metaphors can be a means of containing painful emotions in response to reciprocal roles Metaphors can provide a link to a patients reciprocal roles It is useful to name and explain patients metaphors in their reformulation letter	Sometimes the picture can be an add on and not necessarily fully integrated therefore it is important to link them to a patients reformulation (SDR and TPP's) A pictorial metaphor can act like a shorthand to TPP's when the pattern is repeated in every day life					It is helpful to link the metaphor to the patients RRP's. Metaphors can allow you to represent complex formulatory ideas It will be important to link the 'picture' to the SDR to ensure integration with reformulation Metaphors can be a means of containing painful emotions in response to RRP's A metaphor may be helpful to succinctly sum up an overall theme in the reformulation. A pictorial metaphor can act like a shorthand to TPP's when the pattern is repeated in every day life
It is important to be		Play and creativity	Metaphors can	Introducing a			playfulness	playfulness	It is important to be

creative and playful when co constructing the pictorial metaphor and reassure that they only have to be 'good enough' drawings			support 'playfulness' in therapy and lead to initial insight into a patients problems	metaphorical way of working needs to be done quickly and confidently and can be lightened by describing it as fun, experimental , light-hearted process.			and fun	and fun	creative and playful when co constructing the pictorial metaphor It is important to reassure that they only have to be 'good enough' drawings Metaphors can support 'playfulness' in therapy and lead to initial insight into a patients problems
Important to have a shared understanding of the metaphor	Shared understanding			Co-constructing a picture mirrors the collaborative nature of CAT and can lead to shared understanding CAT therapist must be cautions and indeed avoid interpreting patients metaphors	If you are working with a patient who is particularly concrete in his or her way of thinking it may be hard to connect with them with ideas that are not familiar to them though all of these difficulties can be managed by keeping things simple and checking out with the particular patient f it is making sense to them and what would make it easier or better. Important not to make prior assumptions and jump to conclusions when working with a patients metaphor			shared understanding	Co-constructing a picture mirrors the collaborative nature of CAT and can lead to shared understanding Checking out with the particular patient if the metaphor is making sense to them. CAT therapist must avoid interpreting patients metaphors Important not to make prior assumptions and jump to conclusions when working with a patients metaphor
Work within the patients and therapists ZPD, I push where it	Work in ZPD		It is important to work within the patients ZPD	CAT therapists need to pay attention as to whether developing a pictorial metaphor is	Moving out of the ZPD of the therapist and patient especially if have difficult		ZPD	work within ZPD	CAT therapists need to pay attention as to whether developing a pictorial metaphor is out

moves				out with their and/or the patients ZPD	educational experience of 'art' Considerations of age need to be inherent as some 'ages' did not have a foundation in the 'arts' Often patients have negative associations with their image making capacity and anxiety needs to be averted.				with their and/or the patients ZPD Consideration of the patients previous experience with 'art' should be made as their previous experience may be a block
Allow time and space for patient to describe and develop image/metaphor before moving to analysis and process work		Extends and develops therapeutic understanding			You can't just use metaphors – there needs to be some concrete/actual descriptions too or some everyday examples of experiences that are related to the metaphor				Allow time and space for patient to describe and develop image/metaphor before moving to analysis and process work Metaphors develop and extend therapeutic understanding Metaphors must be grounded in actual experience of the patient
Acknowledge metaphor as naturally occurring and be open to their expression and exploration	Attune to metaphor				Therapists 'closeness of mind' or self conscious anxiety would limit the approach I suspect I have seen patients who would have been happy to work like that and probably ones who talked about artwork and drawing, but I didn't pick up on it.		willingness to work with metaphor	harnesses creativity willingness active listening	Acknowledge metaphor as naturally occurring and be open to their expression and exploration Willingness to work with metaphor is an important factor If I am not attune to metaphors in the therapy session I may miss them

Metaphor is a powerful method of communication and can get 'behind' defences	Can help when we are stuck	A bridge or link between thought and feeling	Metaphors can create new possibilities and potential exits (unstuckness!)			Utilising metaphors in CAT enables different emotional connectedness to the patients problems (left to right brain thinking)		enables 'moving on'	Metaphors can be powerful and get behind defences Metaphors can be a bridge between thought and feeling Metaphors can help when we are 'stuck' and create new possibilities
Metaphors have the potential to enhance the therapeutic alliance	Metaphors can deepen the therapeutic alliance	Demonstrates to the patient that the details of their experiences are important and worthy of note, that we have time to look at these details together. Metaphors and imagery we have constructed together have led to them feeling particularly understood, valued and validated. Helps in establishing collaborative working relationship with patient		The pictorial metaphor must be meaningful and accessible to the patient and must resonate with the patients experience				therapeutic alliance	Working with Metaphors has the potential to enhance the therapeutic alliance The pictorial metaphor must be meaningful and accessible to the patient and must resonate with the patients experience Metaphors can help in establishing collaborative working relationship with patient Demonstrates to the patient that the details of their experiences are important and worthy of note, that we have time to look at these details together.
Important to use words and images the patient has brought to the session and that have been jointly created	Patient derived		Using patients language shows they are being heard and understood and that the therapist language has not been imposed	Some patients may find pictorial ways of working a more acceptable medium but important that generated from the patients dialogue	The patient could create a metaphor which is not understood by therapist and it is important that space is allowed to explore this		simplicity	patients words	Important to use words and images the patient has brought to the session Using patients language shows they are being heard and understood The patient could create a

					I think the major obstacle would be a mis-match between the patient and therapist understanding of the metaphor.				metaphor which is not understood by therapist and it is important that space is allowed to explore this Some patients may find pictorial ways of working a more acceptable medium
It is important to recognise the impact of metaphors and the verbal processing of metaphors after therapy session								enables verbalisation	It is important to recognise the impact of metaphors and the verbal processing of metaphors after therapy session
Take care when working with metaphors that contain graphic, sexual or violent connotations	They can often engender powerful emotions and once acquired they may be hard to contain								Metaphors can often engender powerful emotions and once acquired they may be hard to contain
Cliché metaphors alive or dead and that could come alive? they can be too sapped of meaning to carry much power in therapy	Have to be relevant							not too liberally	Metaphors have to be relevant to the patient Working with too many metaphors can hinder understanding
Important to let go of the metaphor when it loses connection for the patient					If the first metaphor does not succeed in furthering understanding, be prepared to use an alternative, or to use a different approach.		be prepared to abandon metaphor	be prepared to abandon	Important to let go of the metaphor when it loses connection for the patient
Metaphors are memorable and available for recognition, the 'yes that's it!' moments helping to summarise the	Metaphors can conjure up images The aim of using the metaphor is to further develop the			Using a picture may open a dialogue and extend awareness, particularly with patient who struggle to verbalise inner thoughts.			imaginative capacity	accessible image	Metaphors can become a shorthand to access problems and understandings Metaphors are memorable and available

patient's experience in a way that can feel more accessible to them rather than mountains of prose or lengthy descriptions	patients' capacity to think about their difficulties from a range of perspectives. Can become a shorthand to access problems and understandings								for recognition helping to summarise the patient's experience in a way that can feel accessible to them Using a picture may open a dialogue and extend awareness, particularly with patient who struggle to verbalise inner thoughts.
Not all therapists will be comfortable with non verbal metaphors so it would be important to check for fit whenever non verbal tools are being used.				One reason CAT therapists don't work more with pictorial metaphor is a lack of confidence in artistic ability	Lack of training opportunities would limit the use of this metaphor method in practice I haven't used pictorial metaphor because I think I don't think pictorially myself Even reading about artwork say in Reformulation or at poster presentations it comes across to me as a specialised "branch" of CAT rather than fully integrated I also don't have any theoretical framework for understanding how to use metaphors and would really benefit from discussion of this in training/Reformation magazine		anxiety re using metaphors	therapist confidence	One reason CAT therapists don't work more with pictorial metaphor is a lack of confidence in artistic ability Lack of training opportunities would limit the use of this metaphor method in practice Not all therapists will be comfortable with non verbal metaphors so it would be important to check for fit whenever non verbal tools are being used.

Link to SDR, drawing metaphors on them can be a way to get to unattainable places			A picture of the metaphor is useful to put on the SDR						Drawing metaphors on the SDR can be a way to get to unattainable places
Non judgemental	Have to be non judgemental			Important that the process of developing the pictorial metaphor is not patronising and judgemental	Needs reassurance that most patients find it enjoyable, and that there will be no judgments based on quality of drawings Patients may not feel they have the skills and therefore are self- critical as well as fearing judgement or criticism from the therapist.		non judgemental	non judgemental	Important that the process of developing the pictorial metaphor is not judgemental
It is as if we (patient and therapist) can both pretend that the story (metaphor?) is just a story	Can allow distance between emotions because of their sometimes abstract nature	I use it because it is one step removed from the actual experiences of the patient and so I hope that it might be easier to wonder about as a first step		Pictures may be an opportunity to create an image of difficult experiences in a less painful way for the patient Caution should be applied to working with metaphors as they can distance a patient from their emotions	There is a potential risk of using metaphor to avoid or unname difficult things (I believe metaphors can allow the patient to feel more distanced from their emotions and clearly this may or may not be desirable). Be very aware of how metaphors may have pejorative implications or symbolism and avoid colluding with that (demonstrate to the patient that you are aware of this and do				There is a potential risk of using metaphor to avoid or unname difficult things It is as if we (patient and therapist) can both pretend that the story (metaphor?) is just a story Metaphors can be facilitative because they are one step removed from the actual experiences of the patient and so I hope that it might be easier to wonder about as a first step Important to be aware of how metaphors may have pejorative implications or symbolism and avoid

					not fully accept the metaphor though you can see why it feels useful/apt to them				colluding with that
I think pictorial metaphors are most effective when developed collaboratively					A therapist may feel that they have to be artistic to employ this strategy, but inviting the patient to draw would embrace the collaborative nature of CAT.		collaborative	Collaborative	I think pictorial metaphors are most effective when developed collaboratively
Use proximal material from the social and cultural world of the patient				It is important to notice the relational/social/cultural context of the metaphor			cultural aspect	cultural aspects	It is important to notice the relational/social/cultural context of the metaphor
The use of metaphor should not compromise the fidelity of the CAT model	Must not compromise the fidelity of the CAT model.				The centrality of the CAT model and focus on verbal expressions			locating to CAT model	The use of metaphor should not compromise the fidelity of the CAT model The centrality of the CAT model and focus on verbal expressions might hinder working with (pictorial) metaphor
	Can become a central theme		Metaphors can capture a central theme in the patients dialogue		The use, understanding and development of metaphor establishes the patterns of communicating in the relationship		ongoing		The use, understanding and development of metaphor establishes the patterns of communicating in the relationship Metaphors can capture a central theme in the patients dialogue
	Can enable recognition of collusion with	Therapist and patient being caught in enacting	Metaphors allow space for the transference and		Caution against narcissistic admiration of how		transference	mutual admiration	Metaphors allow space for the transference and counter transference to

	patients RRP's	damaging/self-limiting RRPs that - use of SDR, metacommunication around the dynamics in the therapeutic relationship	counter transference to emerge		arty and clever the therapist is			counter transference	emerge Caution against narcissistic admiration of how arty and clever the therapist is Can enable recognition of collusion with patients RRP's
	Be selective with the patients you use metaphor with, one size does not fit all				Patient discomfort at the use of pictorial imagery may be off-putting for the therapist leading to avoidance of the technique Knowing how to judge who it would be useful with; metaphor is not for every patient and in fact for some it would be experienced very negatively.				Be selective with the patients you use metaphor with, one size does not fit all
	Capture something of the context in which the metaphor arises			It is important to pay attention not only to the representative aspect of a pictorial metaphor but the colours used and the way it comes to mind and the way in which it was made					It is important to pay attention not only to the representative aspect of a pictorial metaphor but • the colours used • the way it comes to mind • the way in which it was made • the context in which they arise
		A metaphor may acknowledge and contain affect associated with ending							A metaphor may acknowledge and contain affect associated with ending
			Metaphors can be				sign mediation	sign mediation	Metaphors can be used to

			used to develop effective 'signs' with patients'						develop effective 'signs' with patients'
				Using pictures and images could be particularly useful when working with children and with patients who have difficulties expressing their thoughts					Using pictures and images could be particularly useful when working with children and with patients who have difficulties expressing their thoughts
				In developing a pictorial metaphor it is useful work with 'images ' that come form the verbal metaphor in the minds eye then sketch this out on paper with the patient					In developing a pictorial metaphor it is useful work with 'images ' that come form the verbal metaphor in the minds eye then sketch this out on paper with the patient
				Useful to have drawing and art materials available	Lack of space or materials		materials	materials available	Useful to have drawing and/or art materials available
				Providing simple not 'perfect' drawings can help to reduce transference issues of the therapist being seen as the 'expert'					Providing simple not 'perfect' drawings can help to reduce transference issues of the therapist being seen as the 'expert'
				Metaphors and working with pictorial metaphors should be encouraged to be discussed in supervision		Bringing patients metaphors to supervision and enabling the supervisor to see what is happening in the room can often give you a chance to see that you may be colluding with the patients RRP's	supervision	supervision	Metaphors and working with pictorial metaphors should be encouraged to be discussed in supervision In supervision an image or metaphor can often help bring a supervisees patient to mind in an instance

						In supervision an image or metaphor can often help bring a supervisees patient to mind in an instance Asking supervisees to draw how they perceive their patients can help them reflect on where they are in therapy particularly if they are feeling stuck.			
					Pressure to reduce waiting lists etc prevent therapists from working creatively and tend to emphasise working on symptoms rather than taking a holistic approach to psychological recovery (business of CAT?)				
					Lack of rationale, so patient doesn't understand why being asked to engage in this activity, or what the potential benefits could be.				Metaphor working might be hindered if there is a lack of rationale as to the reasons why this approach is being used.
					Lack of empirical evidence that metaphorical approaches are anything other than a diverting sideline		understand research and literature	understand theory of metaphor	Understanding research an literature can enhance metaphor working It may be that metaphors are nothing but a diverting

									sideline
								intellectual property	Important to ensure materials are kept confidential
							agreed rules		It will be useful to set some ground rules
22	20	10	11	20	29	4			

28/11/2011 – Plan of analysis

1) All questions derived directly from free nodal analysis of the questionnaires, broadly collected under
    a. CAT and Metaphor
    b. Helpfulness of metaphor
    c. Principles in metaphor
    d. Barriers in metaphor working
    e. Process of metaphor working
    f. Pictorial metaphor working
    g. Supervision
    h. neuroscience
2) Correlated with
    a) Question 4 – metaphor 10 factors
    b) Question 5 – pictorial metaphor 10 factors
3) Questions then re categorised against each other for repetition and condensed (116- 36 areas)
4) Questions reworded and organised into ‘themes for R2 questionnaire.

Appendix XXVI R2 percentage change

Statement	R2	R3	change
2	61.3	70.4	+9
6	56.3	63	+7
13	77.4	81	+4
23	43.8	74.1	+31
25	68.8	74.1	+6
30	78.1	70.4	-8
32	75	88.9	+13
36	34.4	14.8	-20
40	68.8	92.6	+24
41	53.1	74.1	+21
55	35.5	33	+3
58	65.6	59.3	-6
59	61.3	63	+2
61	74.2	88.9	+14
64	49.4	63	+14
66	28.1	40.7	+12
67	43.8	55.6	+12
69	59.4	55.6	-4
70	61.3	74.1	+13
71	71.9	73.1	-2
75	72	85.2	+13
76	65.7	74	+9

Appendix XXVII Study2 R1 Final Statements

Theme a - Qualities of the therapist

1. Willingness to work with metaphor is an important factor
2. Working with metaphor is enhanced by an understanding of the relevant research literature
3. CAT therapists need to consider whether developing a pictorial metaphor is out with their and/or patient's ZP
4. It is important to be attuned to metaphor in therapy sessions
5. Allow time and space for patient to describe and develop image/metaphor before moving to analysis and process work

Theme B - Training and Supervision

6. Lack of training in metaphor working limits the use of metaphor in practice
7. Metaphors and working with pictorial metaphors need to be discussed in supervision
8. In supervision an image or metaphor can often help bring the supervisee's patient to mind in an instance

Theme C - about the therapeutic relationship

9. The use, understanding and development of metaphor establishes the patterns of communicating in a relationship
10. Metaphors can support 'playfulness' in therapy and lead to insights into a patient's problems
11. Using a patient's language shows they are being heard and understood
12. It is important to recognise the impact of the verbal processing of metaphors after therapy session
13. It is important to be creative and playful when co-constructing the pictorial metaphor

Theme D - 'In session' process of using metaphor

14. It is important to acknowledge metaphors as naturally occurring and be open to their expression and exploration
15. It is important to check out with the particular patient if the metaphor is making sense to them
16. It is important that metaphors are relevant to the patient

17. It is important to ensure materials are kept confidential

18. It is important to notice the relational context of the metaphor

19. It is important to notice the social context of the metaphor

20. It is important to notice the cultural context of the metaphor

21. The therapist may offer their own metaphor if they feel it is right with the patient

22. The patient could create a metaphor which is not understood by the therapist so important to allow space to explore this

23. Metaphors must be grounded in the actual experience of the patient

24. The pictorial metaphor must be meaningful and accessible to the patient and must resonate with the patients experience

25. Use of metaphor should not compromise fidelity of the CAT model e.g. Used as a way to explore/link patterns to SDR

26. It is helpful to link the metaphor to the patient's reciprocal role procedures

27. Drawing metaphors on the Sequential Diagrammatic Reformulation can be a way to get to unattainable places

Theme E - The potential of using metaphors

28. Metaphors can become a shorthand to access problems and understandings

29. Metaphors are memorable and available for recognition helping to summarise the patient's experience in an accessible way

30. A metaphor may acknowledge and contain affect associated with ending

31. Metaphors can allow you to represent complex formulatory ideas

32. Metaphors can be facilitative because they are one step removed from the actual experiences of the patient

33. Metaphors can be powerful and get behind defences

34. Metaphors can be a bridge between thoughts and feelings

35. A metaphor may be helpful to succinctly sum up an overall theme in the reformulation

36. It is as if we (patient and therapist) can both pretend that the story (metaphor) is just a story

37. Metaphors can help when we are 'stuck' and create new possibilities

38. Metaphors can be a means of containing powerful emotions in response to reciprocal role procedures

39. Focussing on metaphors demonstrates to the patient that the details of their experience are important and worthy of note

40. Metaphors allow space for transference and counter transference to emerge

41. Metaphors can enable recognition of collusion with patients' reciprocal role procedures

42. Working with metaphors has the potential to enhance the therapeutic alliance

43. Metaphors can help in establishing a collaborative working relationship with the patient

44. Metaphors can develop and extend our therapeutic understanding

45. Metaphors can capture a central theme in the patient's dialogue

Theme F - On Pictorial metaphors

46. It is important that the process of developing the pictorial metaphor is not judgemental

47. It's important to pay attention to the representative aspect of a pictorial metaphor as well as the colours used

48. It's important to pay attention to the representative aspect of a pictorial metaphor as well as the way it comes to mind

49. It's important to pay attention to the representative aspect of a pictorial metaphor as well as the way it was made

50. It's important to pay attention to the representative aspect of a pictorial metaphor as well as the context it arose

51. It is important to use words and images that the patient has brought to the session

52. It is important to reassure the patient that they only have to be 'good enough' drawings

53. It is important to link the 'picture' to the SDR and reformulation to ensure integration

54. Providing simple not 'perfect' drawings can help to reduce transference of the therapist being seen as the expert

55. One reason CAT therapists don't work with pictorial metaphor is a lack of confidence in their artistic ability

56. A pictorial metaphor can act like a shorthand to Target Problem Procedures when the pattern is repeated

57. Pictures may open a dialogue and extend awareness, particularly with patient's struggling to verbalise inner thoughts

58. Some patient's may find pictorial ways of working a more acceptable medium

59. In developing a pictorial metaphor it is useful to work with 'images' that come from the verbal metaphor and sketch out

60. It is useful to have drawing/art materials available

61. Pictorial metaphors are most effective when developed collaboratively

62. Not all therapists will be comfortable with non verbal metaphors so it is important to check for fit when they are used

63. Using pictures/images can be useful when working with children and patient's having difficulty expressing their thoughts

Theme G - The potential downside of using metaphors and necessary cautions

64. Metaphor working might be hindered if there is no clear rationale for using this approach

65. Working with too many metaphors can hinder understanding

66. Metaphors can often engender powerful emotions and once acquired they may be hard to contain

67. There is a potential risk of using a metaphor to avoid or unname difficult things

68. It is necessary to caution against narcissistic admiration of how 'arty and clever' the therapist is

69. CAT therapists must avoid offering interpretation of a patient's metaphors but seek to deepen the patient's description

70. Consideration of the patient's previous experience with 'art' should be made as their previous experience may be a block

71. It is important to be aware that metaphors may have pejorative implications or symbolism and avoid collusion with that

72. It is important not to make prior assumptions and jump to conclusions when working with a patient's metaphor

73. It is important to let go of the metaphor when it loses connection for the patient

74. It is important to be selective with the patients' you use metaphor with as one size does not fit all

75. It may be that metaphors are nothing but a diverting sideline

76. The centrality of the CAT model and its focus on verbal expressions might hinder working with pictorial metaphor

Appendix XXVIII Study3 and 4 Consent and information forms

Sheffield Hallam University

Faculty of Health and Wellbeing – Research Project Information Sheet

Study3 - Delivery and evaluation of a metaphor and pictorial metaphor workshop and related materials

About the study - This Workshop is part of the researcher's PhD studies. The study has been established following preliminary work and a Delphi study of expert practice from the Cognitive Analytic Therapy (CAT) community and based on developing clinical practice. The study is seeking to understand the use of 'metaphor' and support staff in developing a 'pictorial metaphor'. Supervision is from an experienced supervisory team with advice from CAT 'experts'. The aim of the study is to establish the usefulness of a workshop designed to 'enable' clinical practice in metaphor working and evaluate some associated materials. Results will go on to inform the development of a self report rating measure and a programme of evaluation of the pictorial metaphor in practice. The objective is to continue to develop an understanding of the use of metaphor and pictorial metaphor approaches.

About Your Contribution - Participation will involve you giving the benefit of your expertise by taking part in the workshop and feeding back through completing a standard evaluation questionnaire and a follow up questionnaire. The Questionnaires are designed to capture your views based on your developing knowledge and experience obtained through the workshop using both numerical scores and a comments section. If you wish to comment further I would welcome e-mail reflections on completion of the workshop (james.turner@shu.ac.uk)

Results - A final report on the Workshop findings will be produced. Findings will also be published in relevant academic and practitioner journals. A summary of the findings will be sent to all Workshop participants at the end of the project.

A Unique Opportunity - This is a unique opportunity for you to directly influence practice in this area and for others to benefit from your experience. I thank you in advance for your commitment and willingness to contribute in this way.

Statement of Ethical Practice - Practitioners who work within psychotherapy may have concerns regarding ethical principles of research studies and in taking part in this Workshop might compromise their confidentiality. Every practical effort will be taken to ensure that information collected from you will be kept confidential and securely by the research team within their offices and computers. Contributions will be anonymised and no one involved in the consultation will be mentioned by name in any of the reports, or be identifiable for other reasons.

Complaints If you have any concerns about he conduct of this study please contact the researchers main supervisor on annmacaskill@shu.ac.uk

Further Information - If you have any questions about the evaluation or need advice on completing this questionnaire please contact the researcher by telephoning: James Turner 01142252480 or 07841237377 or e-mail james.turner@shu.ac.uk

Faculty of Health and Wellbeing - Consent Form

Cycle 3 - Delivery and evaluation of a metaphor and pictorial metaphor workshop and related materials

Please give your consent to participating in the study by answering the following questions (Mark appropriate box with an x''). Please return this form to the researcher once you have completed it.

	YES	NO
I have read the information sheet about this evaluation		
I understand that relevant sections of my data collected during the evaluation may be looked at by individuals from the Sheffield Hallam University Ethics and supervisory team or regulatory authorities. I give permission for these individuals to have access to my data.		
I agree to my responses being used for verbatim quotes, provided they are anonymous		
I understand that all information I provide the researcher with will remain confidential. Confidentiality will only be breached if the researcher has concerns for my safety or the safety of another person. The researcher will inform me of their plan of action should this situation arise		
Have you received enough information about this evaluation?		

If you have any questions about the evaluation or need advice please contact the researcher by telephoning: James Turner Tel:01142252480 or e-mail james.turner@shu.ac.uk

	YES	NO
Are you involved in any other studies?		
u are, how many?		

Do you understand that you are free to withdraw from this study:

ny time?		
out giving a reason for withdrawing?		

I agree to take part in this evaluation?		

Your signature/name below will certify that you have had adequate information to understand the evaluation and have voluntarily decided to take part in this evaluation. Please keep a copy of the information sheet.

Appendix XXIX Study3 Workshop evaluation

Sheffield Hallam University

WORKSHOP EVALUATION

Cycle 3 - Delivery and evaluation of a metaphor and pictorial metaphor workshop

Location

Your Patient Group (please state)

Please indicate your current level of therapeutic training
[ ]

Please indicate length of time working in mental health/therapy
[ ] years

Please indicate time since qualification
[ ] years

Please indicate your core professional background
[ ] Counselling
[ ] Art psychotherapy
[ ] Medicine
[ ] Nursing
[ ] Psychology
[ ] Social work
[ ] Psychotherapy
[ ] Other ……..

Do you have experience of working with metaphors in clinical practice?
[ ] **yes** [ ] **no**

If yes please describe:

……
……
……

Do you have experience of working with 'pictures and metaphor' in clinical practice ?
[ ] **yes** [ ] **no**

……
……
……

Workshop Title ; Metaphors and pictorial metaphors in the clinical encounter
Facilitator : James Turner

Place a tick in the appropriate box below using the following scale:

Very Poor 1	**Poor 2**	**Acceptable 3**	**Good 4**	**Excellent 5**

Workshop Programme		**1**	**2**	**3**	**4**	**5**
Facilitator	Communication Skills					
	Time keeping					
	Level of Knowledge					
Workshop	Level of Detail					
	Visual Presentation					
	Handouts					
Overall	Content					
	Design of Workshop					
	Pace of the Training (circle one)	Too Slow just Right Too Fast				

Did this workshop meet your expectations/objectives?	**Not at all**	**To some extent**	**Yes – Fully met**

ANY OTHER COMMENTS Please feedback as much information as possible. Your comments are important and will be used to improve future workshops.

Thank you for your feedback

Appendix XXX Study3 Follow up Questionnaire

Sheffield Hallam University

Metaphor and pictorial metaphor evaluation: Impact of training programme and evaluation of pictorial metaphor in practice

Name: Date:

On Pictorial Metaphor…

If you have noticed a *metaphor* and sketched a *pictorial metaphor* with a patient since your workshop: Following Gibbs reflective cycle please …

Describe what happened….

Feelings (What were you thinking and feeling?**)….**

Evaluation (What was helpful or less helpful about the experience?**)….**

Description (What sense can you make of the situation**?)….**

Conclusion…

Action Plan (If it arose again what would you do**?)…**

How helpful was the metaphor in the session you introduced it?
(*Circle the score that most applies)*

1	2	3	4	5
Very helpful	Fairly helpful	Neither helpful nor unhelpful	fairly unhelpful	Very unhelpful

Comment:

How helpful was using metaphor in therapy overall:
(Circle the score that most applies)

1	2	3	4	5
Very helpful	Fairly helpful	Neither helpful nor unhelpful	fairly unhelpful	Very unhelpful

Comment:

How helpful was the pictorial metaphor in the session you introduced it?
(*Circle the score that most applies)*

1	2	3	4	5
Very helpful	Fairly helpful	Neither helpful nor unhelpful	fairly unhelpful	Very unhelpful

Comment:

How helpful using pictorial metaphor was overall:
(*Circle the score that most applies)*

1	2	3	4	5
Very helpful	Fairly helpful	Neither helpful nor unhelpful	fairly unhelpful	Very unhelpful

Comment:

Please rate how helpful the training programme was in supporting your practice:
(Circle the score that most applies)

1	2	3	4	5
Very helpful	Fairly helpful	Neither helpful nor unhelpful	fairly unhelpful	Very unhelpful

Comment:
Have you any other comments that you would like to add on working with metaphor and pictorial metaphor?

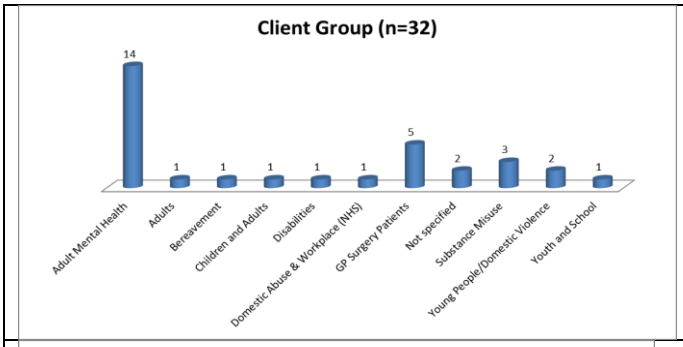
Where there any problems or concerns when using either metaphor or pictorial metaphor you could share? *(How might you overcome these?)*
Have you any other comments that might be relevant to consider?

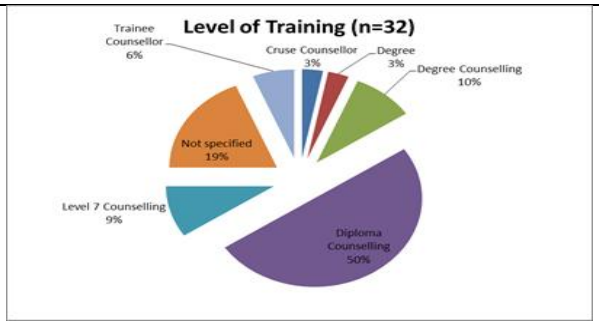
Many thanks for taking the time to respond to this questionnaire your input is really appreciated and valuable.

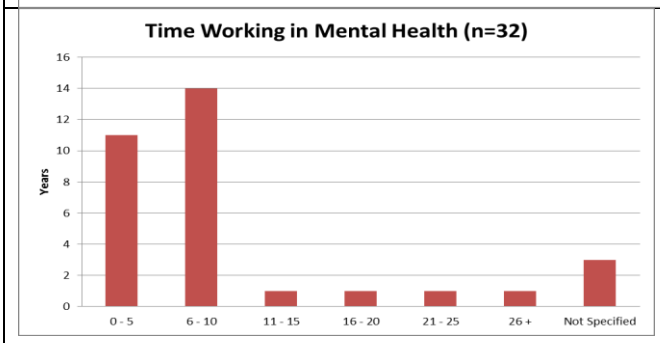
Please email your response to:

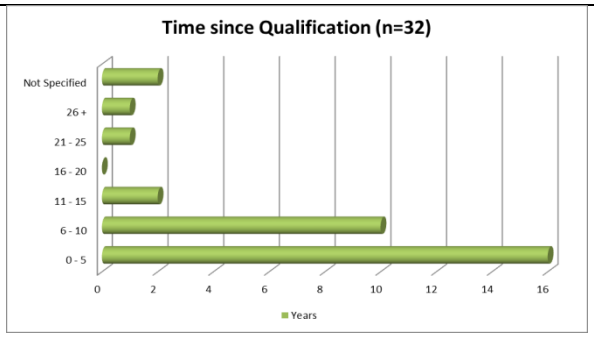
Jim Turner (james.turner@shu.ac.uk)

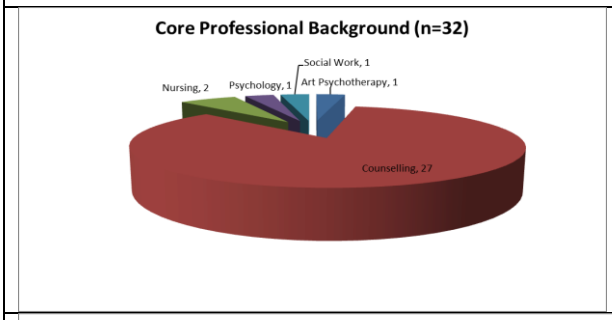
Appendix XXXI Study3 Graphs for COUNSELLING (N=32)

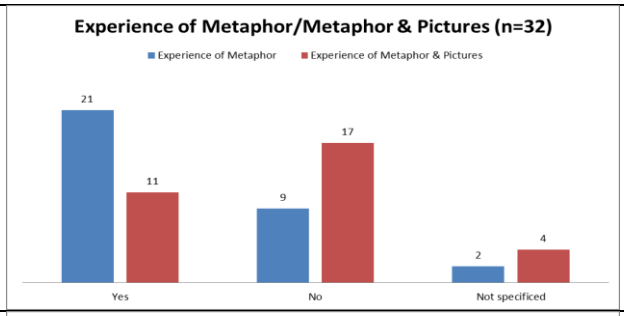


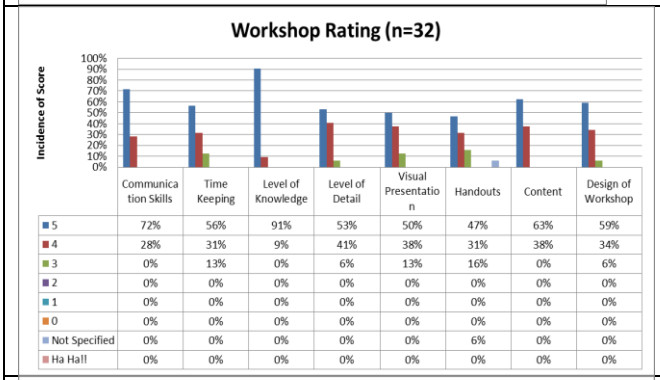




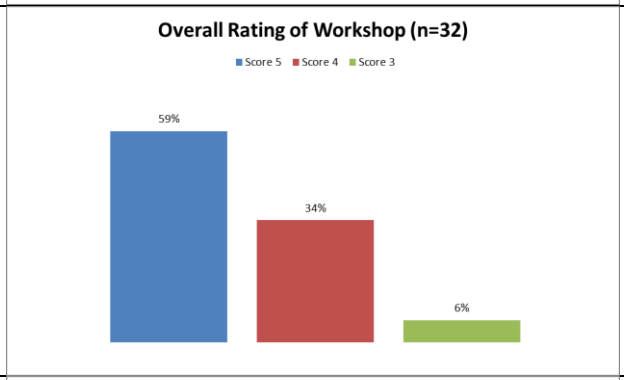


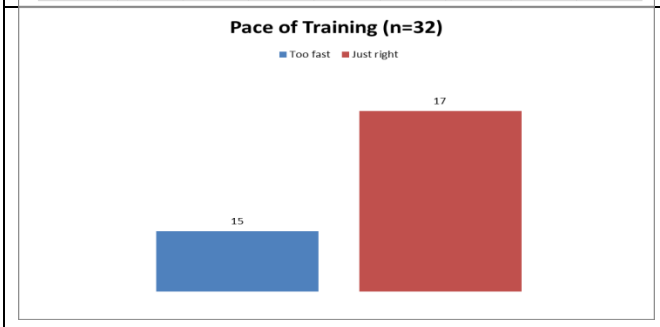


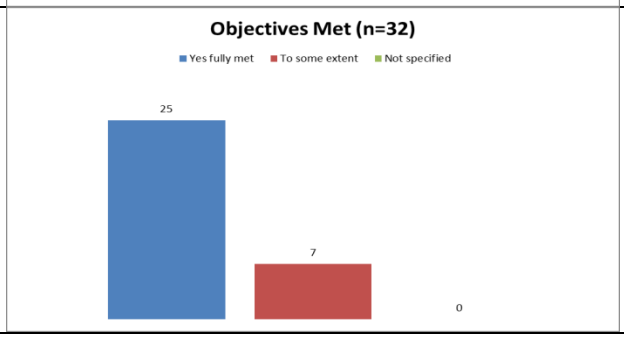




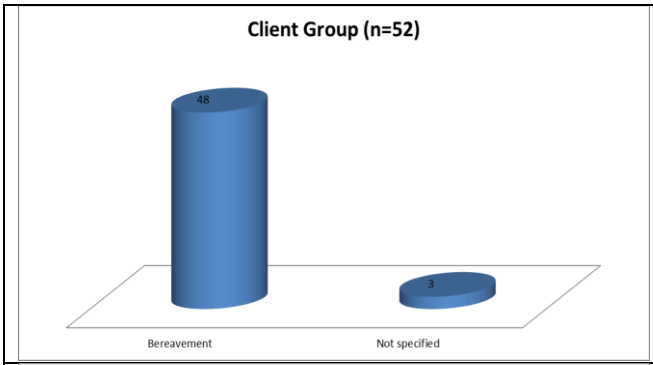
	Communication Skills	Time Keeping	Level of Knowledge	Level of Detail	Visual Presentation	Handouts	Content	Design of Workshop
5	72%	56%	91%	53%	50%	47%	63%	59%
4	28%	31%	9%	41%	38%	31%	38%	34%
3	0%	13%	0%	6%	13%	16%	0%	6%
2	0%	0%	0%	0%	0%	0%	0%	0%
1	0%	0%	0%	0%	0%	0%	0%	0%
0	0%	0%	0%	0%	0%	0%	0%	0%
Not Specified	0%	0%	0%	0%	0%	6%	0%	0%
Ha Ha!!	0%	0%	0%	0%	0%	0%	0%	0%

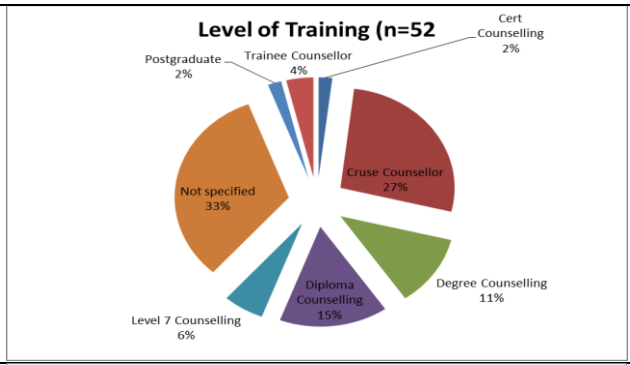


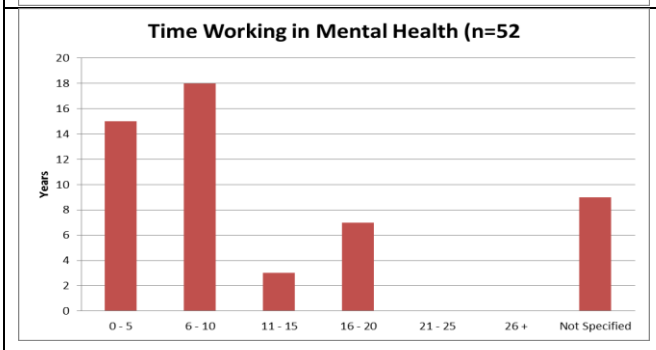


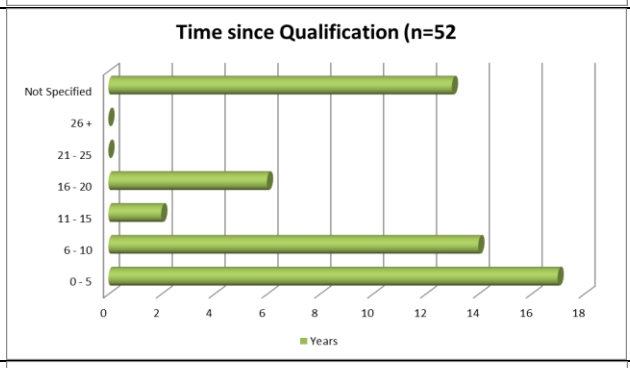


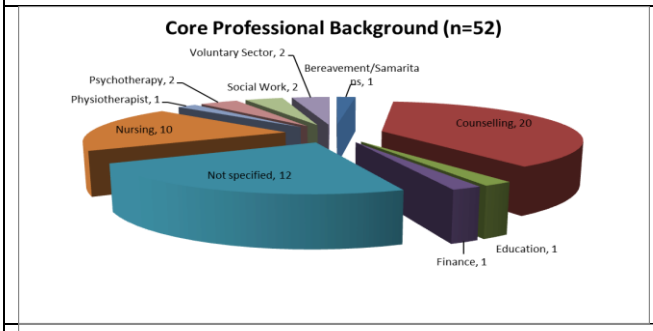
Study3 Graphs for CRUSE (N=52)

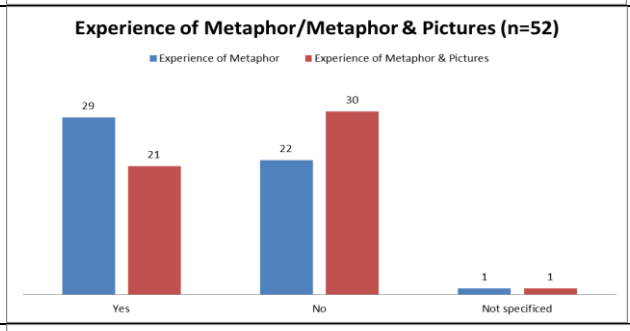


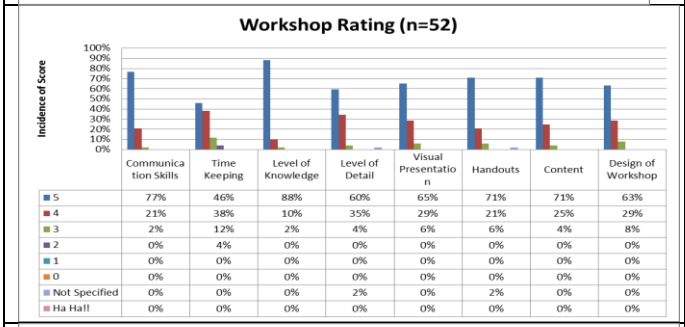


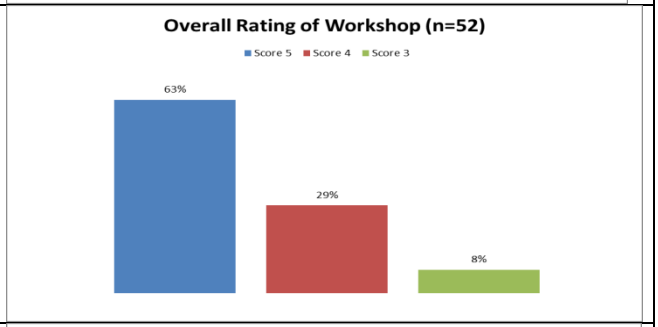


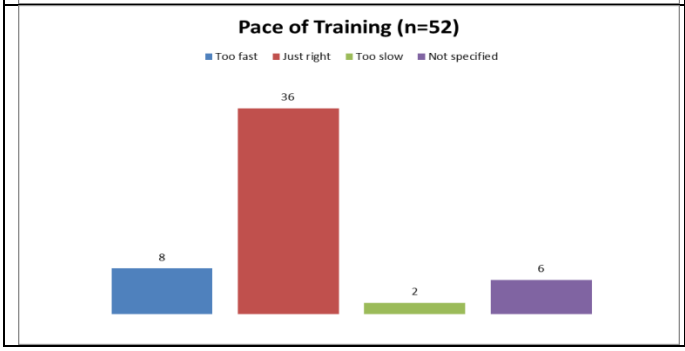


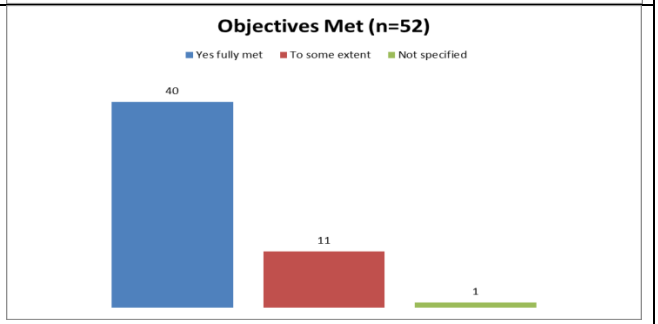




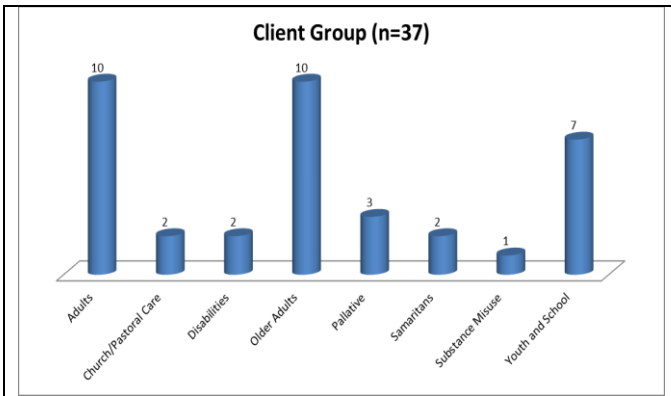


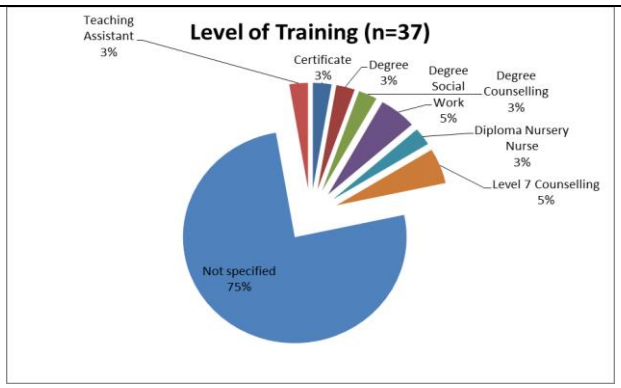


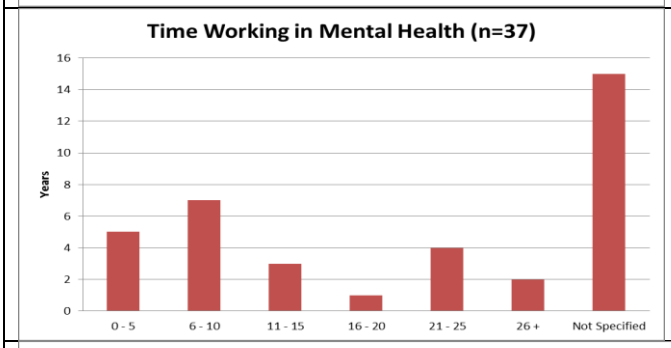


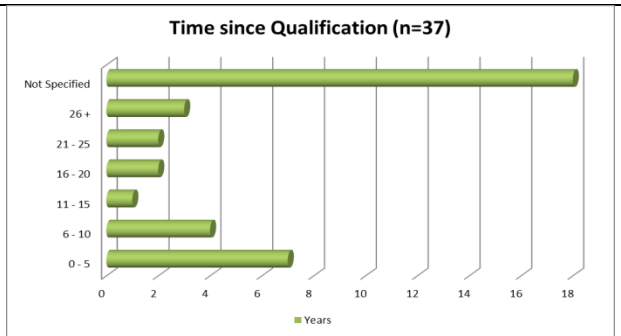


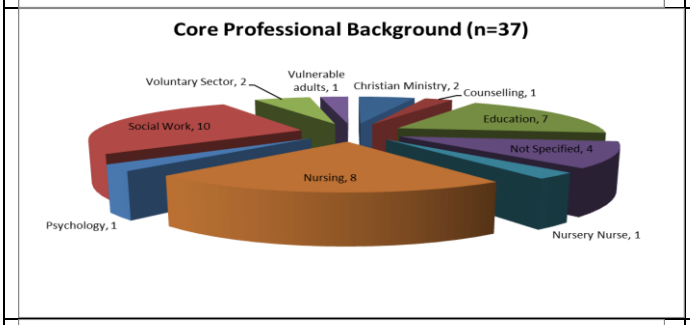
Study3 Graphs for OTHER (N=37)

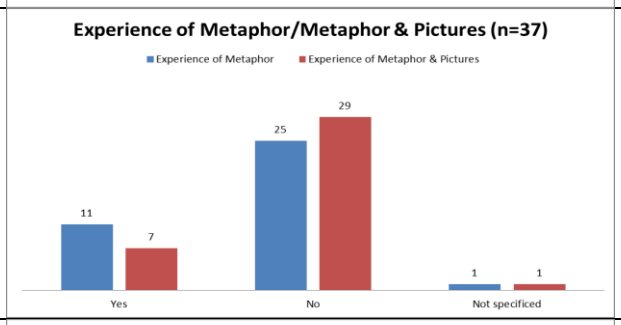

Client Group (n=37)
10
2
2
10
3
2
1
7
Adults
Church/Pastoral Care
Disabilities
Older Adults
Palliative
Samaritans
Substance Misuse
Youth and School

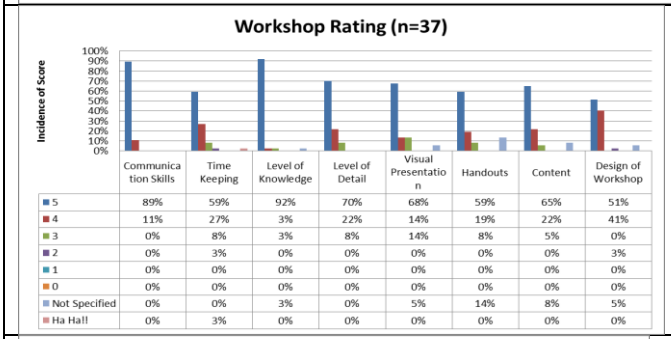

Level of Training (n=37)
Teaching Assistant 3%
Certificate 3%
Degree 3%
Degree Social Work 5%
Degree Counselling 3%
Diploma Nursery Nurse 3%
Level 7 Counselling 5%
Not specified 75%

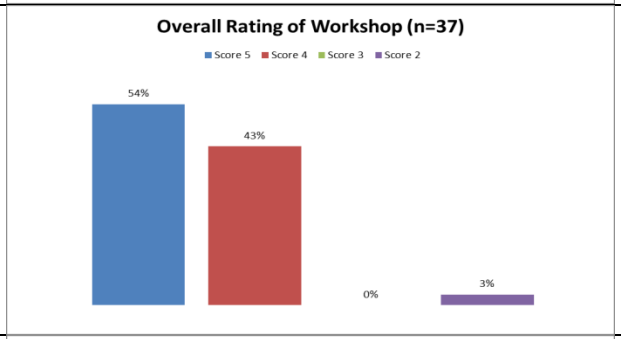

Time Working in Mental Health (n=37)
Years
0 - 5
6 - 10
11 - 15
16 - 20
21 - 25
26 +
Not Specified

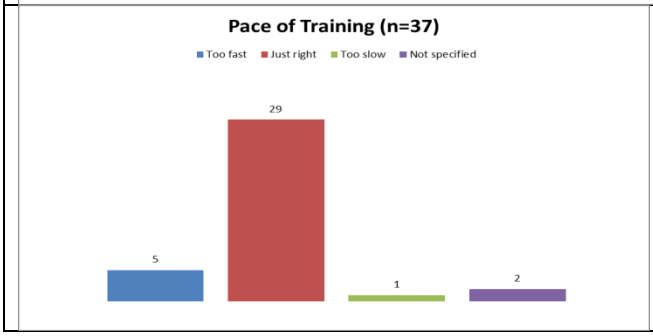

Time since Qualification (n=37)
Not Specified
26 +
21 - 25
16 - 20
11 - 15
6 - 10
0 - 5
Years

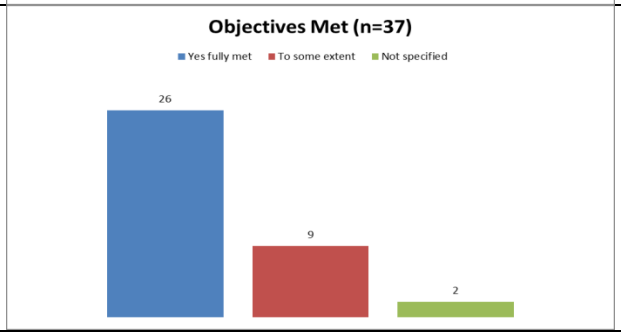

Core Professional Background (n=37)
Voluntary Sector, 2
Vulnerable adults, 1
Christian Ministry, 2
Counselling, 1
Social Work, 10
Education, 7
Not Specified, 4
Nursing, 8
Psychology, 1
Nursery Nurse, 1


Experience of Metaphor/Metaphor & Pictures (n=37)
Experience of Metaphor
Experience of Metaphor & Pictures
11
7
25
29
1
1
Yes
No
Not specificed


Workshop Rating (n=37)
Incidence of Score
Communication Skills
Time Keeping
Level of Knowledge
Level of Detail
Visual Presentation
Handouts
Content
Design of Workshop
5 89% 59% 92% 70% 68% 59% 65% 51%
4 11% 27% 3% 22% 14% 19% 22% 41%
3 0% 8% 3% 8% 14% 8% 5% 0%
2 0% 3% 0% 0% 0% 0% 0% 3%
1 0% 0% 0% 0% 0% 0% 0% 0%
0 0% 0% 0% 0% 0% 0% 0% 0%
Not Specified 0% 0% 3% 0% 5% 14% 8% 5%
Ha Ha!! 0% 3% 0% 0% 0% 0% 0% 0%


Overall Rating of Workshop (n=37)
Score 5
Score 4
Score 3
Score 2
54%
43%
0%
3%


Pace of Training (n=37)
Too fast
Just right
Too slow
Not specified
5
29
1
2


Objectives Met (n=37)
Yes fully met
To some extent
Not specified
26
9
2

Appendix XXXII Study4 Map-Self vs Delphi findings

Delphi Theme a - Qualities of the therapist (n=5)	MAP-SELF Theme a - Qualities of the therapist (n=4)
D1. Willingness to work with metaphor is an important factor 2. Working with metaphor is enhanced by an understanding of the relevant research literature (R2 61.3% R3 70.4%) 3. CAT therapists need to consider whether developing a pictorial metaphor is out with their and/or patient's ZPD 4. It is important to be attuned to metaphor in therapy sessions 5. Allow time and space for patient to describe and develop image/metaphor before moving to analysis and process work	1. SR1 I felt I created a space where the willingness to work with metaphor was present 2. I was able to consider and work within the patients and my own Zone of Proximal Development 3. I felt attuned to metaphor in therapy sessions 4. I allowed time and space for my patient to describe and develop image/metaphor before moving to analysis and process work
Theme B - Training and Supervision (n=3)	Theme B - Training and Supervision (n-2)
6. Lack of training in metaphor working limits the use of metaphor in practice (R2 56.3% R3 63%) 7. Metaphors and working with pictorial metaphors need to be discussed in supervision 8. In supervision an image or metaphor can often help bring the supervisee's patient to mind in an instance	5. I have found that Metaphors and working with pictorial metaphors can be taken to supervision 6. In supervision an image or metaphor can often help bring a patient to mind readily
Theme C - about the therapeutic relationship (n=5)	Theme C - about the therapeutic relationship (n=4)
9. The use, understanding and development of metaphor establishes the patterns of communicating in a relationship 10. Metaphors can support 'playfulness' in therapy and lead to insights into a patient's problems (R3 96.9%) 11. Using a patient's language shows they are being heard and understood 12. It is important to recognise the impact of the verbal processing of metaphors after therapy session 13. It is important to be creative and playful when co-constructing the pictorial metaphor (R2 77.4% R3 81.5%)	7. The use, understanding and development of metaphor helped established the patterns of communicating in the relationship 8. Metaphors were managed in a 'playful' way in therapy and led to an initial insight into my patients problems 9. I made a point of using my patients language showing they are being heard and understood 10. I kept in mind the impact of the verbal processing of metaphors after therapy session
Theme D - 'In session' process of using metaphor	Theme D - 'In session' process of using metaphor
14. It is important to acknowledge metaphors as naturally occurring and be open to their expression and exploration	11. I acknowledged metaphor as naturally occurring and was open to their expression and exploration

15. It is important to check out with the particular patient if the metaphor is making sense to them	12. I regularly checked out with the patient if the metaphor was making sense to them
16. It is important that metaphors are relevant to the patient	13. I Checked out that the metaphor was relevant to the patient
17. It is important to ensure materials are kept confidential	14. I ensured the patient of confidentiality
18. It is important to notice the relational context of the metaphor	15. I noticed the relational/social/cultural context of the metaphor
19. It is important to notice the social context of the metaphor	
20. It is important to notice the cultural context of the metaphor	
21. The therapist may offer their own metaphor if they feel it is right with the patient	16. I was able to offer my own metaphor as it felt right with the patient
22. The patient could create a metaphor which is not understood by the therapist so important to allow space to explore this	17. If I did not understand a patient's metaphor I allowed space for it to be explored
23. Metaphors must be grounded in the actual experience of the patient (R2 43.8% R3 74.1%)	18. I was able to draw attention to the relationship of the metaphor to the patient's problem procedures.
24. The pictorial metaphor must be meaningful and accessible to the patient and must resonate with the patients experience	19. The use of metaphor did not seem to compromise the fidelity of my therapeutic model
D25. Use of metaphor should not compromise fidelity of the CAT model e.g. Used as a way to explore/link patterns to SDR (R2 68.8% R3 74.4%)	20. I was able to link the metaphor to the patients Reciprocal Role Procedures
26. It is helpful to link the metaphor to the patient's reciprocal role procedures	21. I set some ground rules
27. Drawing metaphors on the Sequential Diagrammatic Reformulation can be a way to get to unattainable places	
Theme E - The potential of using metaphors	Theme E - The potential of using metaphors
28. Metaphors can become a shorthand to access problems and understandings	22. The Metaphor has become a shorthand to access problems and understandings
29. Metaphors are memorable and available for recognition helping to summarise the patient's experience in an accessible way	23. The Metaphor is memorable and available for recognition helping to summarise the patient's experience
30. A metaphor may acknowledge and contain affect associated with ending (R2 78.1% R3 70.4%)	24. The metaphor acknowledged and contained affect associated with ending
31. Metaphors can allow you to represent complex formulatory ideas	25. The Metaphor seemed to represent complex formulatory ideas
32. Metaphors can be facilitative because they are one	26. The Metaphor was facilitative because it

step removed from the actual experiences of the patient (R2 75% R3 88.9%) 33. Metaphors can be powerful and get behind defences 34. Metaphors can be a bridge between thoughts and feelings 35. A metaphor may be helpful to succinctly sum up an overall theme in the reformulation 36. It is as if we (patient and therapist) can both pretend that the story (metaphor) is just a story (R2 59.4% R3 44.4%) 37. Metaphors can help when we are 'stuck' and create new possibilities 38. Metaphors can be a means of containing powerful emotions in response to reciprocal role procedures 39. Focussing on metaphors demonstrates to the patient that the details of their experience are important and worthy of note 40. Metaphors allow space for transference and counter transference to emerge (R2 68.8% R3 92.6%) 41. Metaphors can enable recognition of collusion with patients' reciprocal role procedures (R2 53.1% R3 74.1%) 42. Working with metaphors has the potential to enhance the therapeutic alliance 43. Metaphors can help in establishing a collaborative working relationship with the patient 44. Metaphors can develop and extend our therapeutic understanding 45. Metaphors can capture a central theme in the patient's dialogue	seemed one step removed from the actual experiences of the patient 27. The Metaphor enabled me to get behind defences 28. The Metaphor was a bridge between thought and feeling 29. The metaphor was helpful to succinctly sum up an overall theme in the reformulation 30. The Metaphor helped because we were 'stuck' and created new possibilities 31. The Metaphor can be a means of containing painful emotions in response to Reciprocal Role Procedures 32. Focussing on metaphor demonstrated to the patient that the details of their experiences are important and worthy of note 33. The Metaphor was used to develop effective 'signs' with patients' 34. The Metaphors seemed to enhance the therapeutic alliance 35. The Metaphor helped in establishing a collaborative working relationship with the patient 36. The Metaphor developed and extended our therapeutic understanding 37. The Metaphor captured a central theme in the patients dialogue
Theme F - On Pictorial metaphors	Theme F - On Pictorial metaphors
46. It is important that the process of developing the pictorial metaphor is not judgemental 47. It's important to pay attention to the representative aspect of a pictorial metaphor as well as the colours used 48. It's important to pay attention to the representative aspect of a pictorial metaphor as well as the way it comes to mind	38. The process of developing the pictorial metaphor was not judgemental 39. I paid attention not only to the representative aspect of a pictorial metaphor but also… the colours, how it came to mind, was drawn and the context in which it arise

49. It's important to pay attention to the representative aspect of a pictorial metaphor as well as the way it was made 50. It's important to pay attention to the representative aspect of a pictorial metaphor as well as the context it arose 51. It is important to use words and images that the patient has brought to the session 52. It is important to reassure the patient that they only have to be 'good enough' drawings 53. It is important to link the 'picture' to the SDR and reformulation to ensure integration 54. Providing simple not 'perfect' drawings can help to reduce transference of the therapist being seen as the expert 55. One reason CAT therapists don't work with pictorial metaphor is a lack of confidence in their artistic ability (R2 74.2% R3 81.5%) 56. A pictorial metaphor can act like a shorthand to Target Problem Procedures when the pattern is repeated 57. Pictures may open a dialogue and extend awareness, particularly with patient's struggling to verbalise inner thoughts 58. Some patient's may find pictorial ways of working a more acceptable medium (R2 65.6% R3 59.3%) 59. In developing a pictorial metaphor it is useful to work with 'images' that come from the verbal metaphor and sketch out (R2 61.3% R3 63%) 60. It is useful to have drawing/art materials available 61. Pictorial metaphors are most effective when developed collaboratively (R2 74.2% R3 88.9%) 62. Not all therapists will be comfortable with non verbal metaphors so it is important to check for fit when they are used 63. Using pictures/images can be useful when working with children and patient's having difficulty expressing their thoughts	40. I made a point of using the words and images that the patient brought to the session 41. I created a 'playful' space when co constructing the pictorial metaphor 42. It is important to link the 'picture' to the Sequential Diagrammatic Reformulation to ensure integration with reformulation 43. Providing simple not 'perfect' drawings helped to reduce transference issues of the therapist being seen as the 'expert' 44. I reassured the patient that they only have to be 'good enough' drawings 45. The pictorial metaphor was meaningful and accessible to the patient and seemed to resonate with the their experience 46. Using a picture seemed to help our dialogue and extend awareness, particularly with a patient who struggles to verbalise his/her inner thoughts 47. We worked with 'images' that came from the verbal metaphor in 'the minds eye' then sketched these out on paper 48. I believe I developed the pictorial metaphor collaboratively 49. Co constructing a picture seemed collaborative and led to shared understanding 50. Not all therapists will be comfortable with non verbal metaphors so it is important to check for fit whenever non verbal tools are being used. 51. Using pictures and images can be particularly useful when working with children and with patients who have

	difficulties expressing their thoughts
Theme G - The potential downside of using metaphors and necessary cautions	Theme G - The potential downside of using metaphors and necessary cautions
64. Metaphor working might be hindered if there is no clear rationale for using this approach (R2 59.4% R3 63%)	
65. Working with too many metaphors can hinder understanding	52. Working with too many metaphors can hinder understanding
66. Metaphors can often engender powerful emotions and once acquired they may be hard to contain (R2 28.1% R3 40.7%)	
67. There is a potential risk of using a metaphor to avoid or unname difficult things R2 43.8% R3 55.6%)	
68. It is necessary to caution against narcissistic admiration of how 'arty and clever' the therapist is	53. It is necessary to caution against narcissistic admiration of how 'arty and clever' the therapist is
69. CAT therapists must avoid offering interpretation of a patient's metaphors but seek to deepen the patient's description (R2 59.4% R3 55.6%)	
70. Consideration of the patient's previous experience with 'art' should be made as their previous experience may be a block (61.3% R3 74.1%)	
71. It is important to be aware that metaphors may have pejorative implications or symbolism and avoid collusion with that (R2 71.9% R3 73.1%)	54. It is important to be aware of how metaphors may have pejorative implications or symbolism and avoid colluding with that
72. It is important not to make prior assumptions and jump to conclusions when working with a patient's metaphor	55. I was aware of not wanting to make prior assumptions and jump to conclusions when working with the patients metaphor
73. It is important to let go of the metaphor when it loses connection for the patient	56. I was able to let go of the metaphor when it loses connection for the patient
74. It is important to be selective with the patients' you use metaphor with as one size does not fit all	57. It is important to be selective with the patients you use metaphor with, as one size does not fit all
75. It may be that metaphors are nothing but a diverting sideline (R3 14.8%) 76. The centrality of the CAT model and its focus on verbal expressions might hinder working with pictorial metaphor (R3 25.9%)	

Appendix XXXIII Study4 MaP-SELF Version 5

Metaphor and Pictures – Self Evaluation Learning Framework

INFORMATION

This measure has been developed following a Delphi Study of expert practice and a number of workshop evaluations.

The scale is designed for use within self-reflection and/or peer and group supervision. The purpose being to enhance the therapists attunement to metaphors and recognise their developing skill.

The measure contains 7 domains which include 57 elements of therapist competence in Metaphor and Pictorial metaphor working. The 7 domains are:

- **Theme a- Qualities of the therapist**
- **Theme b - Training and supervision**
- **Theme c - About the therapeutic relationship**
- **Theme d- 'In session' process of using metaphor**
- **Theme e - The potential of using metaphors (theory practice links)**
- **Theme F - On pictorial metaphors**
- **Theme G - The potential and risks of using metaphor**

Whilst most reflect generic competencies (e.g. common factors: basic supportive good practice) some of the domains are CAT specific (e.g. CAT specific tools and techniques such as relating the metaphor to the SDR and ZPD)

INSTRUCTIONS

You are able to rate yourself in 3 different ways…Work through the 7 domains, look at each element of competence and decide if it was **present or absent** in the session, what degree of agreement do you think the competence related to your practice and if not present what were the factors.

Ratings:

- Have you noticed this competence in your session: rate Yes or No
- If 'yes' and the competence was **present** rate how well it was demonstrated. Rate each element of competence in the following way indicating your agreement with how you managed the metaphor or your approach to metaphor in session:

  4 – Strongly agree
  3 – Agree
  2 – Undecided
  1 – Disagree
  0 – Strongly disagree

- If the competence was **absent,** consider the following points:
  - Sometimes it is *inappropriate* for a particular competence to be demonstrated. Code this **XI next to the 'N'**
  - The competence should have happened and didn't – the therapist failed to respond to a cue and there was a *missed opportunity*. Code this **XM next to the 'N'**
  - If the competence was absent for some other reason, please specify XO **next to the 'N'**
- Make an overall rating of your competence in this domain:

very competent	**good**	**satisfactory**	**unsatisfactory**	**incompetent**	**Unable to rate**
4	3	2	1	0	X

***T*heme A - Qualities of the therapist**	**Present (Y/N)**	**Rating (0-4)**
I felt I created a space where the willingness to work with metaphor was present (1)	**Y N**	**0 1 2 3 4**
I felt attuned to metaphor in therapy sessions (3)	**Y N**	**0 1 2 3 4**
I allowed time and space for my patient to describe and develop image/metaphor before moving to analysis and process work (4)	**Y N**	**0 1 2 3 4**
I was able to consider and work within the patients and my own Zone of Proximal Development (2)	**Y N**	**0 1 2 3 4**
Make an overall rating of your competence in this domain **very competent** **good** **satisfactory** **unsatisfactory** **incompetent** **Unable to rate** 4 3 2 1 0 X		
Comments/Self-reflective notes		

Theme B - Training and supervision	**Present (Y/N)**	**Rating (0-4)**
I have found that Metaphors and working with pictorial metaphors can be taken to supervision (5)	**Y N**	**0 1 2 3 4**
In supervision an image or metaphor can often help bring a patient to mind readily(6)	**Y N**	**0 1 2 3 4**
Make an overall rating of your competence in this domain **very competent** **good** **satisfactory** **unsatisfactory** **incompetent** **Unable to rate** 4 3 2 1 0 X		
Comments/Self-reflective notes:		

Theme C - About the therapeutic relationship	**Present (Y/N)**	**Rating (0-4)**
The use, understanding and development of metaphor helped established the patterns of communicating in the relationship (7)	**Y N**	**0 1 2 3 4**
I made a point of using my patients language showing they are being heard and understood (9)	**Y N**	**0 1 2 3 4**
Metaphors were managed in a 'playful' way in therapy and led to an initial insight into my patients problems (8)	**Y N**	**0 1 2 3 4**
I kept in mind the impact of the verbal processing of metaphors after therapy session (10)	**Y N**	**0 1 2 3 4**
Make an overall rating of your competence in this domain **very competent** **good** **satisfactory** **unsatisfactory** **incompetent** **Unable to rate** 4 3 2 1 0 X		
Comments/Self-reflective notes:		

Theme D - 'In session' process of using metaphor	**Present (Y/N)**	**Rating (0-4)**
I acknowledged metaphor as naturally occurring and was open to their expression and exploration (11)	**Y N**	**0 1 2 3 4**
I was able to offer my own metaphor as it felt right with the patient (16)	**Y N**	**0 1 2 3 4**
If I did not understand a patient's metaphor I allowed space for it to be explored (17)	**Y N**	**0 1 2 3 4**
I regularly checked out with the patient if the metaphor was making sense to them (12)	**Y N**	**0 1 2 3 4**
I set some ground rules (21)	**Y N**	**0 1 2 3 4**
I Checked out that the metaphor was relevant to the patient (13)	**Y N**	**0 1 2 3 4**
I reassured the patient of confidentiality (14)	**Y N**	**0 1 2 3 4**
I noticed the relational/social/cultural context of the metaphor (15)	**Y N**	**0 1 2 3 4**
I was able to link the metaphor to the patients Reciprocal Role Procedures (20)	**Y N**	**0 1 2 3 4**
The use of metaphor did not seem to compromise the fidelity of my therapeutic model (19)	**Y N**	**0 1 2 3 4**
I was able to draw attention to the relationship of the metaphor to the patient's problem procedures.(18)	**Y N**	**0 1 2 3 4**
Make an overall rating of your competence in this domain **very competent** **good** **satisfactory** **unsatisfactory** **incompetent** **Unable to rate**		

4	3	2	1	0	X

Comments/Self-reflective notes:

Theme E - The potential of using metaphors (theory practice links)	**Present (Y/N)**	**Rating (0-4)**
The Metaphor has become a shorthand to access problems and understandings (22)	**Y N**	**0 1 2 3 4**
The Metaphor captured a central theme in the patients dialogue (37)	**Y N**	**0 1 2 3 4**
The Metaphor is memorable and available for recognition helping to summarise the patient's experience (23)	**Y N**	**0 1 2 3 4**
The Metaphor was used to develop effective 'signs' with patients'(33)	**Y N**	**0 1 2 3 4**
The metaphor acknowledged and contained affect associated with ending (24)	**Y N**	**0 1 2 3 4**
The Metaphors seemed to enhance the therapeutic alliance (34)	**Y N**	**0 1 2 3 4**
The Metaphor helped in establishing a collaborative working relationship with the patient(35)	**Y N**	**0 1 2 3 4**
Focussing on metaphor demonstrated to the patient that the details of their experiences are important and worthy of note (32)	**Y N**	**0 1 2 3 4**
The Metaphor developed and extended our therapeutic understanding (36)	**Y N**	**0 1 2 3 4**
The Metaphor seemed to represent complex formulatory ideas (25)	**Y N**	**0 1 2 3 4**
The Metaphor was facilitative because it seemed one step removed from the actual experiences of the patient (26)	**Y N**	**0 1 2 3 4**
The Metaphor enabled me to get behind defences (27)	**Y N**	**0 1 2 3 4**
The Metaphor was a bridge between thought and feeling (28)	**Y N**	**0 1 2 3 4**
The Metaphor helped because we were 'stuck' and created new possibilities(30)	**Y N**	**0 1 2 3 4**
The Metaphor can be a means of containing painful emotions in response to Reciprocal Role Procedures (31)	**Y N**	**0 1 2 3 4**
The metaphor was helpful to succinctly sum up an overall theme in the reformulation (29)	**Y N**	**0 1 2 3 4**

Make an overall rating of your competence in this domain

very competent	**good**	**satisfactory**	**unsatisfactory**	**incompetent**	**Unable to rate**
4	3	2	1	0	X

Comments/Self-reflective notes:

Theme F - On pictorial metaphors	**Present (Y/N)**	**Rating (0-4)**
I created a 'playful' space when co constructing the pictorial metaphor (41)	**Y N**	**0 1 2 3 4**
The pictorial metaphor was meaningful and accessible to the patient and seemed to resonate with the their experience (45)	**Y N**	**0 1 2 3 4**
The process of developing the pictorial metaphor was not judgemental (38)	**Y N**	**0 1 2 3 4**
Providing simple not 'perfect' drawings helped to reduce transference issues of the therapist being seen as the 'expert' (43)	**Y N**	**0 1 2 3 4**
We worked with 'images' that came from the verbal metaphor in 'the mind's eye' then sketched these out on paper (47)	**Y N**	**0 1 2 3 4**
I paid attention not only to the representative aspect of a pictorial metaphor but also… the colours, how it came to mind, was drawn and the context in which it arise (39)	**Y N**	**0 1 2 3 4**
Using a picture seemed to help our dialogue and extend awareness, particularly with a patient who struggles to verbalise his/her inner thoughts (46)	**Y N**	**0 1 2 3 4**
It made a point of using the words and images that the patient brought to the session (40)	**Y N**	**0 1 2 3 4**
Co constructing a picture seemed collaborative and led to shared	**Y N**	**0 1 2 3 4**

understanding (49)		
I reassured the patient that they only have to be 'good enough' drawings(44)	**Y N**	**0 1 2 3 4**
Using pictures and images can be particularly useful when working with children and with patients who have difficulties expressing their thoughts(51)	**Y N**	**0 1 2 3 4**
I believe I developed the pictorial metaphor collaboratively (48)	**Y N**	**0 1 2 3 4**
Not all therapists will be comfortable with non-verbal metaphors so it is important to check for fit whenever non-verbal tools are being used.(50)	**Y N**	**0 1 2 3 4**
It is important to link the 'picture' to the Sequential Diagrammatic Reformulation to ensure integration with reformulation (42)	**Y N**	**0 1 2 3 4**
Make an overall rating of your competence in this domain **very competent** **good** **satisfactory** **unsatisfactory** **incompetent** **Unable to rate** 4 3 2 1 0 X		
Comments/Self-reflective notes:		

Theme G - The potential and risks of using metaphor	**Present (Y/N)**	**Rating (0-4)**
I was aware of not wanting to make prior assumptions and jump to conclusions when working with the patients metaphor (55)	**Y N**	**0 1 2 3 4**
I was able to let go of the metaphor when it loses connection for the patient (56)	**Y N**	**0 1 2 3 4**
Working with too many metaphors can hinder understanding (52)	**Y N**	**0 1 2 3 4**
It is important to be selective with the patients you use metaphor with, as one size does not fit all (57)	**Y N**	**0 1 2 3 4**
It is important to be aware of how metaphors may have pejorative implications or symbolism and avoid colluding with that (54)	**Y N**	**0 1 2 3 4**
It is necessary to caution against narcissistic admiration of how 'arty and clever' the therapist is(53)	**Y N**	**0 1 2 3 4**
Make an overall rating of your competence in this domain **very competent** **good** **satisfactory** **unsatisfactory** **incompetent** **Unable to rate** 4 3 2 1 0 X		
Comments/Self-reflective notes:		

Appendix XXXIV Study4 MaP-SELF G Version 6

Metaphor and Pictures – Self Evaluation Learning Framework

INFORMATION

This measure has been developed following a Delphi Study of expert practice and a number of workshop evaluations.

The scale is designed for self-reflection and/or peer and group supervision with the aim to enhance the therapists attunement to metaphors and reflect on their developing competence.

The measure contains 7 domains and 58 elements of therapist competence in Metaphor and Pictorial metaphor working. The 7 domains are:

- **Theme a- Qualities of the therapist**
- **Theme b - Training and supervision**
- **Theme c - About the therapeutic relationship**
- **Theme d- 'In session' process of using metaphor**
- **Theme e - The potential of using metaphors (theory practice links)**
- **Theme F - On pictorial metaphors**
- **Theme G - The potential and risks of using metaphor**

The domains reflect generic competencies (e.g. common factors: basic supportive good practice).

INSTRUCTIONS

You are able to rate yourself in 3 different ways…Work through the 7 domains, look at each element of competence and decide if it was **present or absent** in the session, what degree of agreement do you think the competence related to your practice and if not present what were the factors.

Ratings:

- Have you noticed this competence in your session: rate Yes or No
- If 'yes' and the competence was **present** rate how well it was demonstrated. Rate each element of competence in the following way indicating your agreement with how you managed the metaphor or your approach to metaphor in session:

  4 – Strongly agree
  3 – Agree
  2 – Undecided
  1 – Disagree
  0 – Strongly disagree

- If the competence was **absent,** consider the following points:
  - Sometimes it is *inappropriate* for a particular competence to be demonstrated. Code this **XI next to the 'N'**
  - The competence should have happened and didn't – the therapist failed to respond to a cue and there was a *missed opportunity*. Code this **XM next to the 'N'**
  - If the competence was absent for some other reason, please specify **XO next to the 'N'**
- Make an overall rating of your competence in this domain:

very competent	good	satisfactory	unsatisfactory	incompetent	Unable to rate
4	3	2	1	0	X

MaP- SELF G (Version 6) - Metaphor and Pictures – Self Evaluation Learning Framework

***T*heme A - Qualities of the therapist**	**Present (Y/N)**	**Rating (0-4)**
I created a space where the willingness to work with metaphor was present	**Y N**	**0 1 2 3 4**
I felt attuned to metaphor in therapy sessions	**Y N**	**0 1 2 3 4**
I allowed time and space for my patient to describe and develop image/metaphor before moving to analysis and process work	**Y N**	**0 1 2 3 4**
I was able to consider and work within the patients and my own Zone of Proximal Development	**Y N**	**0 1 2 3 4**
Make an overall rating of your competence in this domain **very competent** **good** **satisfactory** **unsatisfactory** **incompetent** **Unable to rate** 4 3 2 1 0 X		
Comments/Self-reflective notes		

Theme B - Training and supervision	**Present (Y/N)**	**Rating (0-4)**
I have found that Metaphors and working with pictorial metaphors can be taken to supervision	**Y N**	**0 1 2 3 4**
In supervision an image or metaphor can often help bring a patient to mind readily	**Y N**	**0 1 2 3 4**
Make an overall rating of your competence in this domain **very competent** **good** **satisfactory** **unsatisfactory** **incompetent** **Unable to rate** 4 3 2 1 0 X		
Comments/Self-reflective notes:		

Theme C - About the therapeutic relationship	**Present (Y/N)**	**Rating (0-4)**
The use, understanding and development of metaphor helped established the patterns of communicating in the relationship	**Y N**	**0 1 2 3 4**
I made a point of using my patients language showing they are being heard and understood	**Y N**	**0 1 2 3 4**
Metaphors were managed in a 'playful' way in therapy and led to an initial insight into my patients problems	**Y N**	**0 1 2 3 4**
I kept in mind the impact of the verbal processing of metaphors after therapy session	**Y N**	**0 1 2 3 4**
Make an overall rating of your competence in this domain **very competent** **good** **satisfactory** **unsatisfactory** **incompetent** **Unable to rate** 4 3 2 1 0 X		
Comments/Self-reflective notes:		

Theme D - 'In session' process of using metaphor	**Present (Y/N)**	**Rating (0-4)**
I acknowledged metaphor as naturally occurring and was open to their expression and exploration	**Y N**	**0 1 2 3 4**
I was able to offer my own metaphor as it felt right with the patient	**Y N**	**0 1 2 3 4**
If I did not understand a patient's metaphor I allowed space for it to be explored	**Y N**	**0 1 2 3 4**
I regularly checked out with the patient if the metaphor was making sense to them	**Y N**	**0 1 2 3 4**
I set some ground rules	**Y N**	**0 1 2 3 4**
I checked out that the metaphor was relevant to the patient	**Y N**	**0 1 2 3 4**
I reassured the patient of confidentiality	**Y N**	**0 1 2 3 4**
I noticed the relational/social/cultural context of the metaphor	**Y N**	**0 1 2 3 4**
I was able to link the metaphor to the patients formulation	**Y N**	**0 1 2 3 4**

The use of metaphor did not seem to compromise the fidelity of my therapeutic model	**Y N**	**0 1 2 3 4**
I was able to draw attention to the relationship of the metaphor to the patient's problem procedures.	**Y N**	**0 1 2 3 4**

Make an overall rating of your competence in this domain

very competent	**good**	**satisfactory**	**unsatisfactory**	**incompetent**	**Unable to rate**
4	3	2	1	0	X

Comments/Self-reflective notes:

Theme E - The potential of using metaphors (theory practice links)	**Present (Y/N)**	**Rating (0-4)**
The Metaphor became a shorthand to access problems and understandings	**Y N**	**0 1 2 3 4**
The Metaphor captured a central theme in the patients dialogue	**Y N**	**0 1 2 3 4**
The Metaphor is memorable and available for recognition helping to summarise the patient's experience	**Y N**	**0 1 2 3 4**
The Metaphor seemed to be a means of containing painful emotions	**Y N**	**0 1 2 3 4**
The Metaphors seemed to enhance the therapeutic alliance	**Y N**	**0 1 2 3 4**
The Metaphor helped in establishing a collaborative working relationship with the patient	**Y N**	**0 1 2 3 4**
Focussing on metaphor demonstrated to the patient that the details of their experiences are important and worthy of note	**Y N**	**0 1 2 3 4**
The Metaphor developed and extended our therapeutic understanding	**Y N**	**0 1 2 3 4**
The Metaphor seemed to represent complex formulatory ideas	**Y N**	**0 1 2 3 4**
The Metaphor was facilitative because it seemed one step removed from the actual experiences of the patient	**Y N**	**0 1 2 3 4**
The Metaphor enabled me to get behind defences	**Y N**	**0 1 2 3 4**
The Metaphor was a bridge between thought and feeling	**Y N**	**0 1 2 3 4**
The Metaphor helped because we were 'stuck' and created new possibilities	**Y N**	**0 1 2 3 4**
The metaphor acknowledged and contained affect associated with ending	**Y N**	**0 1 2 3 4**
The metaphor was helpful to succinctly sum up an overall theme in the formulation	**Y N**	**0 1 2 3 4**

Make an overall rating of your competence in this domain

very competent	**good**	**satisfactory**	**unsatisfactory**	**incompetent**	**Unable to rate**
4	3	2	1	0	X

Comments/Self-reflective notes:

Theme F - On pictorial metaphors	**Present (Y/N)**	**Rating (0-4)**
I created a 'playful' space when co- constructing the pictorial metaphor	**Y N**	**0 1 2 3 4**
The pictorial metaphor was meaningful and accessible to the patient and seemed to resonate with the their experience	**Y N**	**0 1 2 3 4**
The process of developing the pictorial metaphor was not judgemental	**Y N**	**0 1 2 3 4**
Providing simple not 'perfect' drawings helped to reduce transference issues of the therapist being seen as the 'expert'	**Y N**	**0 1 2 3 4**
We worked with 'images' that came from the verbal metaphor in 'the mind's eye' then sketched these out on paper	**Y N**	**0 1 2 3 4**
I paid attention not only to the representative aspect of a pictorial metaphor but also… the colours, how it came to mind, was drawn and the context in which it arise	**Y N**	**0 1 2 3 4**
Using a picture seemed to help our dialogue and extend awareness	**Y N**	**0 1 2 3 4**
I made a point of using the words and images that the patient brought to	**Y N**	**0 1 2 3 4**

the session		
Co constructing a picture seemed collaborative and led to shared understanding	**Y N**	**0 1 2 3 4**
I reassured the patient that they only have to be 'good enough' drawings	**Y N**	**0 1 2 3 4**
Using pictures and images can be particularly useful when working with children and with patients who have difficulties expressing their thoughts	**Y N**	**0 1 2 3 4**
I believe I developed the pictorial metaphor collaboratively	**Y N**	**0 1 2 3 4**
Not all therapists will be comfortable with non-verbal metaphors so it is important to check for fit whenever non-verbal tools are being used.	**Y N**	**0 1 2 3 4**
It is important to link the 'picture' to the formulation to ensure integration	**Y N**	**0 1 2 3 4**

Make an overall rating of your competence in this domain

very competent	**good**	**satisfactory**	**unsatisfactory**	**incompetent**	**Unable to rate**
4	3	2	1	0	X

Comments/Self-reflective notes:

Theme G - The potential and risks of using metaphor	**Present (Y/N)**	**Rating (0-4)**
I was aware of not wanting to make prior assumptions and jump to conclusions when working with the patients metaphor	**Y N**	**0 1 2 3 4**
I was able to let go of the metaphor when it lost connection for the patient	**Y N**	**0 1 2 3 4**
Working with too many metaphors can hinder understanding	**Y N**	**0 1 2 3 4**
It is important to be selective with the patients you use metaphor with, as one size does not fit all	**Y N**	**0 1 2 3 4**
It is important to be aware of how metaphors may have pejorative implications or symbolism and avoid colluding with that	**Y N**	**0 1 2 3 4**
It is necessary to caution against narcissistic admiration of how 'arty and clever' the therapist is	**Y N**	**0 1 2 3 4**

Make an overall rating of your competence in this domain

very competent	**good**	**satisfactory**	**unsatisfactory**	**incompetent**	**Unable to rate**
4	3	2	1	0	X

Comments/Self-reflective notes:

Appendix XXXV Study4 Key words – cross reference for 'Socratic questioning model'

Willingness	patterns of communicating	confidential	Drawings get to unattainable places
research literature (70%)	'playfulness'	relational social cultural context	shorthand
patients ZPD	patient's language/being heard	therapist own metaphor	summarise
attuned	verbal processing	allow space to explore	affect associated with ending (70%)
Allow time and space	creative and playful	grounded in patients experience (74%)	complex formulatory ideas
Training (63%)	naturally occurring	meaningful and accessible	one step removed
discussed in supervision	check out if making sense	not compromise model (74%)	get behind defences
bring the patient to mind	relevant	link to reciprocal role procedures	bridge between thoughts and feelings
succinctly sum up	establishing a collaborative relationship	simple not 'perfect' drawings	check for fit
Pretend that the story (metaphor) is just a story (15%)	develop and extend our therapeutic understanding	lack of confidence in artistic ability (33%)	difficulty expressing their thoughts
'stuck'	central theme	shorthand to Target Problem Procedures	hindered if no rationale
containing powerful emotions	non judgemental	struggling to verbalise inner thoughts	too many hinders understanding
their experience important and worthy of note	representative aspect of a pictorial metaphor (colours, way it comes to mind, way it was made, context	Pictures more acceptable medium (59%)	hard to contain
transference and counter transference	use patients words and images	Sketch out 'images'	avoid or unname
recognition of collusion (74%)	'good enough' drawings	drawing/art materials available	narcissistic admiration
enhance the therapeutic alliance	link the 'picture' to the SDR	developed collaboratively	avoid interpretation
experience with 'art'	prior assumptions	be selective	model might hinder
pejorative implications	let go if loses connection	diverting sideline	

Appendix XXXVI Study4 Suggested Socratic questions and guidance

Therapist's orientation

- **Recognise that metaphors are naturally occurring** (*willingness)*
- **Listen out for them in the patients dialogue** (*attunement/naturally occurring/verbalise inner thoughts*)
- **Notice metaphor** (*being heard/allow space*)
- **Explore the meaning of the metaphor for the patient** (*making sense/central theme/patterns of communication*)
- **Can offer a therapists metaphor if it feels right** (*Therapist derived*)
- **Be prepared to abandon metaphor if it doesn't make sense** (*relevant/let go*)
- **One metaphor at a time** (*not too many/be selective*)
- **Don't over interpret, check out with patient their meaning** (*avoid interpretation/prior assumptions*)
- **Metaphor can be useful in managing complex emotions** (*bridge/defences/one step removed/powerful emotions*)

Regarding metaphor

- **Do you mind if we explore this metaphor a bit more** (*allow time and space/therapeutic alliance/collaborative*)
- **What does it mean for you exactly (thoughts, feelings)** (*makes sense/patients words/validate experience*)
- **What else is around the metaphor, what else comes to mind** (*ZPD*)
- **Listen out for relational, social and cultural aspects of the metaphor** (*relationa*l)
- **Listen out for other metaphors…Notice these** (*collaborative relationship/shared understanding*)

Regarding pictorial metaphor

- **What image comes to mind when you think of this metaphor** (*creative and playful*)
- **Do you mind if I draw it, it might help us in therapy** (*keep it simple/good enough/rationale*)

- **Don't worry if it's a bit 'simple' it's only meant to capture the main 'sense' of your metaphor** (*non-judgemental/simple/materials available*)

- **Does it look like this: show patient initial rudimentary sketch** (*sketch out/non-judgemental/check for fit*)

- **Is there any colour we should put on** (*representative*)

- **What else comes to mind, shall I draw that as well** (*Link to SDR/complex formulation/link to RRP's/model*)

- **Imagine if this metaphor was to change, what would it look like then** (Meaningful and accessible/stuck/unattainable places)

Post session

- **Is it ok if we make a copy of this if that's ok so that you can use it during the week to reflect on what we discussed (is that ok?)** (*sum up/summarise/shorthand/pejorative/collaborative*)

- **Discuss in supervision** (*Supervision/bring patient to mind/hard to contain*)

- **Reflect on 'containing aspect of metaphor** (*hard to contain/side-line/avoid or unname*)

- **Complete MaP-Self G**

Cautions

- **Reassure patient simple not perfect drawings** (*experience with art/pejorative implications/narcissistic admiration/transference/hard to contain*)

Appendix XXXVII Findings cross referencing

	Literature	Study1	Study2	Study3	Study4
1	Barker (1996) Kok et al. (2011) Searle (1985)	Patient derived/ Patient led	Patient language Experience of the patient Patient words and images		Patients language
2	Barker (1996)	Confidence	Confidence art Pejorative Art experience	Lack of confidence	Confidence Increased confidence
3	Central theme (Mann Mio and Katz)	Central theme	Central theme		Thread to recall easily
4	Stott et al. (2010)	New understandings	Activates conceptual structure		
5	Fabregat (2004) Stott et al. (2010) Gentile (1997) Pernicano (2010) Kopp (1995) Strong (1989) Adams 1997	Ah ha/stuck	Bridge between thought and feeling Stuck change		
6	Meira and Ferreira (2008) Seigleman(1990)	emerge	Time and space Naturally emerging Avoid interpretations Prior assumptions	Notice metaphor	
7	Potter (2010) Barker (1996) Martin et al. (1992) Kok et al. (2011) Bayne (2000)	Therapist led	Therapists derived		
8		Link to TPP	Link to RRP's Draw on SDR/link to SDR		
9	Gentile (1997) Rubin (2001) Looke et al. (2003) Cappas et al. 2005 Hass-Cohen (2008) Carr (2008) Hughes (2007, 2011) Bayne (2000), Moon (2007) Forceville (2008) Wilkinson (2010)	Art making 'locus of control'	Transference and collusion Simple not too complex drawings Images that come to mind Not too many metaphors		
10	Falck (2010)	Core pain	Get behind defences		
11	Leiman (1992) Ryle (2001) Fozooni (2010) Hayes et al. (2004) Martin and Halberg's (1992)	Change	Non permanence Good enough ZPD	ZPD	
12	Angus 1996, McMullen 1985, Levit et al. 2000	Shared understanding	Being heard Making sense Relevant Validates patients experience		Attuned Understand better leading to changes
13		CAT model	Models fidelity CAT model	Model fidelity	
14	Wilde McCormick 2012 Falck (2010) Francis et al. (2003) Stott et al. (2010) Beck et al. 1985	summarise	Recall Meaningful and accessible Shorthand Summarise/sum up		Understand emotion quickly
15			willingness		willingness
16			literature	Research literature	

				Case studies	
17			Lack of training	Training CDP/CORE Role play	
18	Etherington 2001 Gil Rios and Blunden (2012)	supervision	supervision	supervision	supervision
19	Stott et al. (2010)		Naturally occurring		
20	Coulter and Rushbrook (2011) Winnicott (1971)		Creative and playful	playfulness	playfulness
21	Close (1998), Combs and Freidman (1990) Pearce (1996) (Liberating from preconceived notions)		Post session processing Processing Containing		
22			confidentiality		
23	McIntosh (2010)		How they come to mind Representative		
24	Abbatielo 2006 Dent Brown (2011) Dent-Brown and Wang (2006) Barker (1996)		One step remove d/perception and reality divergent Just a story		
25	Ryle (1995) Mann (1973)		endings		Affect associated with ending
26	Keijser et al. 2000 Ryle and Kerr 2002 Wood (1997) Kerr (1999) Angus (1996) McMullen (1985) Levit et al. (2000) Holmes and Bateman (2002) Gobfert and Barnes 1995 Roth and Parry (1997) Blatner 2006 Hughes 2007	Therapeutic Relationship alliance	Collaborative relationship collaborative		Enhanced patient work
27			Struggling to verbalise		
28			More acceptable medium		
29			Let go/selective		