Metaphor and Meaning in a Clinical Interview

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This study examined the narrative features of 20 life histories gathered from psychiatric patients with the Occupational Performance History Interview. The aim was to identify how narrative features were present in the patient interview responses and to illustrate how such narrative features can be located. We found that the patients organized their interview responses with deep metaphors that served to "emplot," or give meaning to, the life story. This article illustrates how patients used the deep metaphors to both circumscribe and frame possible solutions to the problems in their lives. Deep metaphors are consistent, recurring images of a life story that give coherence to, and aid in, the interpretation of the events of that life. Moreover, we explored how metaphors can be located in patient life histories and their implications for occupational therapy.

Recent literature has argued that persons make sense of their occupational lives through narratives and seek to behave within these narratives (Clark, 1993; Helfrich, Kielhofner, & Mattingly, 1994). On the basis of this argument, researchers recommend that occupational behavior be viewed as action that both emanates from and directs where a person's story is going (Kielhofner, Borell, Helfrich, Nygard, & Burke, 1995). The implication of this argument is that if therapists can grasp the narrative within which a patient makes sense of his or her experiences, they can better help that patient (Clark, 1993; Helfrich & Kielhofner, 1994; Mattingly, 1991, 1994a, 1994b).

Despite such calls for narrative understanding in occupational therapy, there exists no formal method explicitly designed for gathering and interpreting patient life stories. We decided to create such a method by examining the narrative features of data collected by an already existing interview, the Occupational Performance History Interview (OPHI). The OPHI is a semistructured interview designed to gather a person's life history as it pertains to work, play, and self-care performance (Kielhofner & Henry, 1988). The interview covers five content areas: organization of daily living routine; life roles; interests, values, and goals; perception of ability and responsibility; and environment. To assist patients in relating their life histories, the therapist and patient identify a turning point that divides the life history into past and present. On the basis of the data gathered, therapists rate the 10 interview items with a 5-point scale that represents the patient's degree of adaptiveness or maladaptiveness. Studies of the OPHI have found modest test–retest and interrater reliability for these ratings (Kielhofner & Henry, 1988; Kielhofner, Henry, Walens, & Rogers, 1991).

Through categorization, the ratings reduce the amount of data. Therefore, the rating scale does not capture everything that patients relate about their lives in the interview, and this is underscored by the fact that therapists who use the OPHI consistently report that the qualitative information gained in the interview is more useful than the scale ratings. Thus, although the rating scale captures something from the interview, it also appears to leave out critical information.

When the OPHI was originally developed, Kielhofner, Henry, and Walens (1989) recognized that the scale needed to be complemented by another method of characterizing the data. Consequently, the OPHI asks therapists to write a brief life history narrative organized around the content of the interview. This portion of the OPHI was created more than a decade before the introduction of narrative concepts into occupational therapy. Although
the OPHI recognized the importance of a narrative representation, it neither was based on a conceptualization of the role of narratives in self-understanding and behavior nor reflected any understanding of methods of narrative interpretation or analysis. Therefore, no instructions or guidelines exist on how the therapist is to interpret or write the patient’s life history data or on how to tell the patient’s life story.

The purpose of this study was to investigate data collected with the OPHI to discover the kinds of interpretive methods that might be useful in understanding patient life stories. We hoped to generate insights into how therapists could better appreciate and use narrative features of patient life histories. To achieve this aim, the following questions guided the study:

- What narrative features can be located in data obtained with the OPHI?
- What did these narrative features reveal about how patients were making sense of their lives?
- What means are useful for locating narrative features in interview responses?
- What is the potential value of this information for understanding patients’ perspectives and for reasoning about their therapy?

Method

Subjects and Data Collection

Data from 20 interviews originally collected for a reliability study of the OPHI (Kielhofner et al., 1991) were analyzed. The subjects (10 men and 10 women) were inpatients at a private psychiatric hospital. Their ages ranged from 19 to 40 years, and they had a variety of psychiatric conditions, most commonly major depression and bipolar disorder. Two occupational therapists operating from the theoretical perspective of the Model of Human Occupation conducted the interviews, which ranged from 40 min to 75 min. Videotapes of the interviews served as the sole source of data for this study.

Data Analysis

The data analysis was an iterative one, which is typical of qualitative research. The process consisted of moving back and forth between various interpretations of the data and the data themselves and included interpretive methods that are best explained through a chronology of the analysis. The following sections discuss how the analytic process unfolded and describe how and why we moved through each successive stage of analysis.

Arranging data into chronologies. The interviews were first transcribed in their entirety. Next, passages from the interviews in which the subjects related what, how, when, and why certain events in their lives happened or what they hoped to happen were selected because they were the most narratively promising. Finally, these data were arranged chronologically to help locate the patient’s life histories (Mandelbaum, 1986).

Searching the life histories for plots. Various types of plots, such as comedy, tragedy, or melodrama, are widely recognized. Originally, our goal was to identify the underlying plot that tied together the subjects’ narratives. Further approaches to identifying narrative plots involved looking at the points in which the slope of the story changes (i.e., things get better or things get worse over time [Gergen & Gergen, 1983]). Indeed, classic plots can be characterized as a sequence of narrative slopes; for example, in melodrama, things get better, then worse, then better, then worse, and so on.

Another approach to plot analysis is to identify the core narrative (Mischler, 1986), which is one way to represent the structural essence or plot of each story. For example, Helfrich et al. (1994) related one patient’s story that, in essence, was: When I was young I had a bright future. But, bipolar illness has ruined my life and would likely undermine any attempts I could make to better my life in the future.

Consequently, we began the analysis expecting to find such underlying core narratives in the subjects’ life histories. However, the interview data did not conform to this kind of emplotment. We found that the subjects sometimes did not tell stories, such as the following one a subject related about how she came to be hospitalized:

I had woken up a week ago yesterday and...tried to get into hospital because I knew that I was going to cut my wrists again...I’ve done it three times before...and there wasn’t beds available, or I was too much of a risk...so I said, “Well, I’ll just cut myself,” so I gave myself two really good cuts...I went to the hospital to get stitched up, and I told them, “I did this”...so they found a hospital for me to get in, and that’s how I ended up here.

But, more commonly, patients responded to interview questions (e.g., How do you handle it when you run into difficulties?) with nonnarrative descriptive information and lists of traits (e.g., “I seek support from my friends”).

Although clear plot structure with a beginning, middle, and end was not evident in these interviews, the interview data suggested that the subjects were attempting to say something more than the facts. It appeared that they were relating something about the meaning of their lives and about how they evaluated their own lives. After consulting with a colleague whose background was in literary analysis, we searched the interview data again for another narrative feature—metaphor. Although nar-
rative theorists have, by and large, focused on plot as the essential element of narrative data (Barthes, 1975; Propp, 1968), our data suggest that plot is only one of the key qualities that makes discourse a powerful story.

Metaphor. Analyzing the data with a focus on metaphor first required that we gain an understanding of what we were looking for. Following is a brief overview of the working concepts of metaphor that guided our thinking in continuing the analysis.

Ganzer (1993) described metaphor as “an essential component of any narrative or story,” noting that metaphor “underlies, is threaded through, and creates meaning in personal narratives” (p. 1). Metaphor is an imagistic, literary device used to explain something new by using a familiar object or phenomenon to stand in the place of the less understood event or situation (Ortony, 1979). Unlike simile and analogy in which one object or event is thought to be like another in some respect, metaphor and the event it is trying to explain essentially become one and the same.

The value of metaphor is that it enables both narrator and listener to understand complex and detailed ideas in a succinct, parsimonious fashion. It enables, in fact demands, both listener and narrator to be actively engaged in a process of interpretation and sense making. It facilitates and encourages the interpretative process by making connections between the known and the unfamiliar.

Metaphors provide a way of seeing a phenomenon that would not otherwise be apparent. For example, to speak of a person as “battling a disease” immediately serves up an entire way of seeing an illness. The metaphor effectively personifies disease as an antagonist and the victim of the disease as a protagonist, with the two locked in combat. Physicians, nurses, and therapists become allies, or co-combatants, warring against the disease. Drugs and therapy are weapons aimed, or targeted, at the disease with the goal of destroying or defeating it.

We all understand that there are important literal differences between having a disease and going into a military battle. Nonetheless, the power of the metaphor is that, in the superimposition of the warring metaphor on the diseased state, the whole situation is recast into a new way of viewing it.

Locating metaphors in subjects’ life histories. We returned to the subjects’ life histories, asking whether and how they exhibited the use of metaphors. We specifically looked for deep metaphors (Schön, 1979), that is, consistent, recurring images that the subjects used to give coherence to and aid in the interpretation of the events of their lives.

It is important to note how we came to locate metaphors in the subjects’ stories. Deep metaphors are ordinarily implicit in how events or facts are related and in the use of language that evokes the imagery of the metaphor. For example, although a patient may not directly state that he or she sees the situation of illness as being in a battle with the disease, he or she may instead use such images as fighting against the disease. Consequently, as Schön (1979) argued, to find a deep metaphor, one must interpret the story or “give it a reading” (p. 267).

To locate the deep metaphors in the subjects’ life stories, we gave each a careful reading, looking for what was implicit as well as explicit. In part, this reading involved locating surface metaphors that may index a deep metaphor. For example, reference to fighting disease is a surface metaphor that potentially indexes a deep metaphor of illness as a battle. However, the process of arriving at the deep metaphor is not always straightforward (Sternberg, Tourangeau, & Nigro, 1979). The presence of one or more surface metaphors is not sufficient evidence that a deep metaphor inheres in a patient’s life story.

We used the following criteria in our analysis. First, the surface metaphors should recur in a subject’s life story; that is, a subject should index the deep metaphor on more than one occasion. Additionally, there is greater confidence in the deep metaphor if the subject uses different surface metaphors to index the same deep metaphor.

For example, if a subject refers both to fighting disease and to being victorious, then there is greater confidence in the deep metaphor of the diseased state as a battle.

Second, the descriptions, details, and stories related by the subject should fit the metaphor. When persons use a particular deep metaphor, they will selectively emphasize some aspects of their lives and ignore others. Thus, what is emphasized and what is left out can be indicative of a deep metaphor.

Third, the metaphors should effectively sum up the subject’s life; that is, the events that are related by the subjects needed to cohere to the sense of meaning that the metaphor lent to the facts that were being told. We found it helpful to view these metaphors as analogous to music melodies that unify and aid in interpreting the overall piece. If there were too many “sour notes,” it brought the metaphor into question; that is, if much of what the subject related simply did not fit in with the way the metaphor would frame the life story, then we considered it as evidence against a particular deep metaphor.

Fourth, because metaphor involves both a sender (the narrator) and one or more receivers (i.e., listeners or readers), a basic test is that of agreement. In clinical settings, therapists can readily test their interpretations by determining whether patients agree with what the thera-
pist has interpreted to be the underlying metaphor. However, because the interviews we analyzed were not conducted with an intention to locate metaphors, these checks were not present. Instead, we chose to compare our separate readings of the life histories. If we agreed on the underlying metaphor, then we concluded that the interpretation was dependable. If we disagreed (which was infrequent) we discussed our alternative readings until we could reach a mutual interpretation.

Over time, we were able to refine our interpretive process. After we identified a type of deep metaphor (two types are discussed in this article), it became relatively easy to reach parallel readings of the subjects’ life histories. In the end, we found that the life histories existed on a continuum. On one end were those in which deep metaphors were clearly present, on the other were those in which it was more difficult to locate and agree on a working metaphor.

Results

Two Deep Metaphors in the Life History Interviews

Despite its challenges, locating the deep metaphors in the subjects’ stories was the simplest step in the data analysis. Deciding how to present these deep metaphors was a much more daunting task. On one hand, we wanted to be faithful to the subjects’ tellings in the interview and to rely, when possible, on what they said to point out the metaphor to the reader. On the other hand, we have already noted that deep metaphors were not always readily apparent and required a reading on our part. Thus, it became clear that we needed to present these life histories in such a way as to lead the readers of this article to our reading of the life histories, while at the same time giving enough evidence from the subjects’ stories to show how we arrived at the particular interpretation. We note this process because it bears on the dependability of the findings we present and it parallels the challenges that therapists will face in rendering either oral or written accounts of patient life histories.

Consequently, in presenting the life history narratives, we sought to show both how we saw subjects making sense of their life stories and what it was in the telling of their own stories that led us to that particular interpretation. Thus, whenever possible, we presented as data the language, imagery, and symbolism of the responses that cued us to the existence of a deep metaphor. We have changed the names and identifying details of these subjects to protect confidentiality and have done so with care so as not to alter the direction or substance of their stories.

We chose to illustrate how the subjects used metaphors by highlighting life histories that exemplify two deep metaphors that we found most often in the life histories. These metaphors are momentum in time and entrapment. The following life stories demonstrate ways in which metaphors of momentum or entrapment might appear in a patient’s life story.

Metaphors of Momentum

A number of the subjects used surface metaphors such as speed, inertia, impetus, acceleration, and deceleration to characterize their lives. They related images such as getting one’s life going again, life slowing down, life passing one by, life grinding to a halt, or life going nowhere when they were summing up or evaluating the events of their lives. The subjects who used the metaphor of momentum consistently characterized their struggles, motives, life junctures, and life events in imagistic terms and phrases having to do with the progression and direction of their lives.

Alex. Typifying the theme of momentum, Alex describes the events in his life as alternately “racing,” “slowing,” and “holding me back.” In relating his life, he consistently uses images of forward movement to characterize events. He described how after starting out well enough, his life began to decelerate in recent years. After graduating college, he practiced for several years as a reasonably successful architect before joining his father in business. However, the business was soon bought by a large corporation, and Alex stayed on as a manager. His increasing dissatisfaction with his job resulted in his resignation a few years later. He sustained a back injury around the same time, which curtailed his avid tennis playing, and he interprets these two events as dramatically impeding the progression of his life.

Because he had quit his job with no other prospects, Alex spent the next few months unsuccessfully trying to arrange other business opportunities. He evaluates the failure to close one particular business deal just as it was about to be signed in terms of its deleterious impact on the momentum of his life: “After that [deal], I tried moving forward on some other opportunities…but my heart wasn’t in it.” Weeks turned into months, and still no jobs turned up. Alex commented, “I was working real hard but getting nowhere, stuck, my mind, my body was racing tremendously…but that seemed to work against me. I couldn’t move. I was stuck. I’d stay in the house [instead of looking for a job], with a thousand thoughts in my mind that I wanted to do but couldn’t do them.” Medications that had originally been prescribed for his
back injury exacerbated his lack of momentum as he began to take larger and larger doses. "Eventually," he said, "everything just seemed to wind down." With no job, no prospects, and declining health, Alex interprets his life as having come to a halt: "I couldn't continue with my life the way it was...I made a very serious and determined suicide attempt."

At the time of the interview, Alex was about to return home after spending several weeks in the hospital. He believed that he was ready to go home because he felt that the hospital program was "holding [him] back." Throughout the interview, Alex interprets his experience with mental illness as a struggle to regain the momentum in a life that had wound down and nearly stopped. For Alex, momentum serves as an evaluative framework within which he appraises himself and the events of his life. He interprets his choices and actions, events, and others' actions in terms of how each affect the forward movement of his life. His sense of efficacy, feeling of enjoyment in life, and the importance he attributes to life events are contexted in the deep metaphor of being able to move forward. His main concerns are to find opportunities to move forward.

Megan. Megan, a gifted musician who always dreamt of being a concert cellist, stated, "I was really on fire...it was like nothing could stop me." Instead, she has had a variety of other jobs (typesetter, music critic, editorial assistant). At the time of the interview, she was in the hospital for the third time in as many years and living on disability income. On a typical day she "winds up on the couch crying." Megan describes her life as one that stutters along, continuously broken into by a series of interruptions, both large and small. She yearns for a stretch of time in which she can plan and finish the things she started: "without getting interrupted, you know, by my own head." The rhythm of Megan's life had become a staccato. Over the course of her life and in the course of each day there has been interruptions, false starts, digressions, and no persistent forward movement. Her days are a series of interruptions with thoughts that could not be gotten straight, panic attacks that grip her in the middle of a store, and so on: "My thoughts would go around and around and around and repeat themselves, and I couldn't follow through...on even the simplest things." She said that she "pushes" and "forces" forward but finds herself halted by "her own head." Thoughts intrude and then go around and around without getting anywhere.

The first major interruption in Megan's life came as she was just out of college and in her first job when she moved to a new town to live with a cult. She notes how this halted her momentum toward becoming a concert cellist explaining that it "took 3 years out." Nonetheless, she continued moving forward, leaving the cult, and returning home. Since that time, her illness and subsequent hospitalizations have interrupted her attempts to keep a job.

The cello playing lurched on in a similar fashion: "I kept trying to return to playing the cello [because] that's what I really love doing. I would go through phases of doing that...I couldn't keep it up." She pushes haltingly forward, but it requires extreme effort. All the interruptions have had the cumulative effect of slowing the forward momentum of her life. Megan explained that she could not complete an activity "unless there is this huge impelling force behind it." Every time she tries something, even as simple as going to the store, she is halted and cannot finish.

Megan's use of imagery emphasizes how important and difficult keeping going has become for her. For example, cello playing (once her passionate interest) now is characterized as yet another aspect of her life that she cannot keep going, that does not reach a successful conclusion. Rather, it stops and starts, with no real progression. Megan has to constantly provide new energy to move her life forward. Even with all her efforts, life falters on: stop, start, stop, start.

Neil. When Neil realized that in pursuing law school he had really been living out his parents' dreams, he frames this choice of a wrong path in terms of the way it affected the momentum of his life. In doing so, this son of a wealthy family found himself in a life that was "going nowhere." He examined how his life has become shattered with incidents that sabotaged his efforts "to get ahead." For most of the 2 years he spent at an Ivy League school, he had been doing substantial daily doses of cocaine, at his parents' expense. His scholastic work suffered: "I couldn't finish anything I started, I couldn't go on with my life."

When his increasing drug abuse made his continuing school impossible, he started working for his father, "managing the office." He laughed as he went on to explain that he really was not doing anything productive there. Most mornings he would generally sit in the office and do nothing. Then in the afternoon he would go to the racetrack and spend the evening out with his girlfriend. Getting the next fix of cocaine was as much as he planned. Neil describes this period as an inability to get his life going; instead, he was "living for the moment."

What Neil really wants to do is study graphic design. Unfortunately, by the time he realized this, he also discov-
erred that his heavy drug use not only effectively sabotaged
the possibility of going to law school, but meant that he
is further away from his goals in art. Eventually, he real-
ized, “I was just wasting time... I hadn’t gotten anywhere
in the last year and a half.” He describes it as being
unable “to get on with life.” It was at this point that he
agreed to seek help for his addiction.

Neil shows us a picture of how, having gotten on the
wrong pathway, he halted his momentum with drug abuse
and ended up wasting time while going nowhere. He
began to overcome the inertia that his life had achieved
when he entered treatment. At the time of the interview,
Neil had 2 weeks until discharge from the hospital, and he
was just then able to look toward the future. He plans to
take a few art classes at school. When talking about his
future plans, Neil said, “I want to go slow, as long as I
never have to have...

Metaphors of Entrapment

The metaphor of entrapment illustrates a substantively
different way in which patients may organize and inter-
pret their life stories. When the subjects described their
lives, they referred to being severely restricted or confined
by life circumstances and of wishing to escape or find a
way out. They described themselves as both unable to tol-
erate and unable to escape their life circumstances. What
these life histories have in common is a conflict between
the subjects’ desires and reality; that is, a conflict between
the story they would like to be telling and the events of
their lives as they were currently unfolding.

Randy. The recent events of Randy’s life have en-
snared him. He came to Boston from Maine where he
had excelled in his undergraduate classes and successfully
worked as a systems analyst for a local computer corpo-
ration: “I was part of the research and development depart-
ment,” explained Randy, “so I could always investigate
what I wanted, and they always used whatever I investi-
gated.” His success both as an undergraduate and in cor-
porate work followed on a pattern of excelling at math
from childhood.

When he went to graduate school as a doctoral stu-
dent, everything changed, and he gradually found himself
boxed in a new reality not to his liking. “The pressures
were considerably higher than I was used to,” said Randy,
“I was now in a class with people who were as bright as I
was; competition was tough.” He went on to describe
the work at graduate school: “I don’t want to say it’s less cre-
ative, but that’s what it is, it’s more routine.” Circum-
stances not only closed in on him, but soon demanded
more than he could successfully do: “To a person like
myself, who was always used to succeeding at everything,
I felt very bad when I wasn’t... doing as well as I needed
to.” Dismayed, Randy watched his performance slide,
amplified by a sense that he was trapped in classes he
would rather not be in: “classes almost dictacted for me, I
didn’t have a choice in them, I didn’t feel like I chose it,
it was chosen for me.”

As the year progressed, Randy’s sense of entrapment
and powerlessness grew: “Well, I was having problems
completing problem sets, more than usual... I was really
having problems motivating myself to work on them... and
not working on them meant not completing them
and not completing them meant, you know, things were
going down hill, so that was right before the suicide
attempt.” He concluded, “I felt very trapped into my
PhD program.”

Randy’s entrapment is largely the choice of the
wrong graduate program. Spurred on by past success and
encouragement by others, he chose a doctoral program
that prepares students to be career mathematicians. Randy
would rather use his talents to be a high school teacher.
Now, Randy begins to contemplate a choice that would
take him out of the trap and seek an alternative doctoral
program.

Anna Marie. “You know it’s like putting your hand
or your elbow and your whole arm gets stuck in flypaper
and you’re trying to get out,” said Anna Marie, “you
know, that’s just what I feel like.” Her image of being
stuck in flypaper is a powerful metaphor for a life in
which she feels encaised by the wishes and expectations of
others and to which she is bound by her desire to be a
good wife and mother.

Anna Marie has had a sense of being trapped for a
number of years, but the feeling has escalated since she
moved from New Orleans to Boston with her husband
and children 3 years previous. She was born and raised in
New Orleans and married her high school sweetheart
when he returned from Vietnam. She explained how from
the beginning of their marriage, her husband controlled
her actions, citing employment as one example. She was
pregnant with their third child when her husband an-
nounced, “It’s time to quit [work].” Less than 12 months
after their fourth child was born, Anna Marie had “a ner-
vous breakdown.” Having quit work at her husband’s
insistence, she returned to work at his direction: “When
I started getting sick, my husband thought it would be
nice if I got a job again, so I went back [to work].”

In similar fashion, she reluctantly relocated to Bos-
ton because “it was best for the children.” Now, she
longs for the good life in New Orleans. She misses her
friends and family and finds it difficult to join in previous activities such as bowling and playing the organ at church. She described a world that begins to close in around her as she spends more and more time in the house. Panic attacks, which began in association with the move to Boston, now occur daily and imprison her in the home: “I was holding all my emotion in, and it finally caught up with me... I’d be scared to death to go out of the house.” Her anxiety attacks worsened as her dependence on her husband grew. Fearful of the panic attacks, Anna Marie asks her husband to accompany her to church activities, but he says, “I’m not going out, and you’re not going up to the church.” Similarly, Anna Marie explained, “I’ve been asking my husband to go bowling... everything I say he says, ‘No,’ so there it goes. I just sacrifice then, I give it up.” Both her panic attacks and her husband have fenced her in a life she no longer controls.

Friends from New Orleans visited Anna Marie 2 months previous, heightening her sense of being caught in a situation from which she cannot escape: “Being with them I had the [good] feelings I used to have... And I was trying to tell my husband... how I felt like I wanted to go back... but it would have been the worst thing for my children... So, I had to try to deal with, you know, staying up here alone.” Her anxiety attacks worsened, and two brief hospitalizations followed on the heels of her friends’ visit. Anna Marie’s desire to be a good wife and mother combined with her acquiescence to what seems best for her family has entangled her in a life she no longer controls.

On returning home from the hospital, Anna Marie’s frustration built as she struggled to get out of the web of demands that encircle her: “then I got fed up. I said, ‘Is this gonna be my life?’ and I was getting angry.” Her attempts to find a way out of the flypaper culminated in a threat to leave her family and Boston: “I was getting sick again and I said, ‘I can’t go through this again,’ so I was gonna leave them, I was gonna go to New Orleans by myself, and my husband said, ‘No way, no you’re going in the hospital.” Ironically, her illness becomes a source of temporary escape, and the hospital a refuge. In the hospital, Anna Marie can leave the constricting confines of a house and husband that demand so much from her. The hospital is not New Orleans, but it is a time and space where she can be on her own. In the hospital, she can “get away” and “let go.”

Anna Marie is trapped in that she feels no control and no choice. Panic confines her to her house. The decision to leave New Orleans has locked friendships and having good times in the past. Her values demand continuous sacrifices and ensnare her in a life she otherwise would not choose. She is caught between such desires as being a good wife and mother and wanting to leave her family and return to New Orleans, and with such choices, she is trapped.

Discussion

The aim of this study was to discover narrative features of data gathered with the OPHI. Although our original intention was to locate the ways patients were emploting their life stories, we found ourselves instead focusing on their use of deep metaphors. In retrospect, it is not surprising that metaphor was the narrative feature that emerged in the OPHIs. As Schön (1979) noted, metaphors are a primary vehicle through which persons “describe what is wrong and what needs fixing” (p. 255). The OPHI implicitly, if not explicitly, is an interview that is about what is wrong and what needs fixing in a person’s life.

Although the interview did not explicitly ask the subjects to emplot or otherwise cast their lives in an evaluative framework, metaphors still emerged as central features of what they said about their lives. In fact, narratives have been described as an extended metaphor (Mattingly & Garro, 1994; Ricoeur, 1984). Consequently, we suspect that deep metaphors used by the subjects were not merely invented in the context of the interview. Rather, we believe that these metaphors represent, to a large extent, the subjects’ working versions of their lives. The interview provided an opportunity for the subjects to actively relate these deep metaphors. However, the more important issue is that they likely were already using these metaphors as a way of seeing their own lives and for acting in accordance with that view (Helfrich et al., 1994). For example, Anna Marie acts as if she only has two choices, to stay with things the way they are or leave town. Alex, who had previously been involved in many activities, now spends most of his days doing nothing.

Consequently, the findings from this study strongly suggest that deep metaphors are especially important narrative features. The life histories obtained through the OPHI evoke metaphors that the subjects already use as vehicles for making sense of their own lives. It is no small matter that they are using these metaphors to interpret and, more importantly, to live their lives.

Metaphor and Problem Setting

We are not attaching importance to any specific metaphor but contend that what deep metaphor a person uses matters. From Schön’s (1979) work, we are reminded...
that metaphors play a central role in how we perceive the world—the sense we make of things. The subjects who used metaphors of momentum interpreted their experiences in substantively different ways than those who used metaphors of entrapment. The facts of the life histories took on different meaning, depending on whether they belonged to a life in which momentum is lost or a life of entrapment. Most importantly, however, the metaphors in these life histories “describe what is wrong and what needs fixing” (Schön, 1979, p. 255). In as much as the subjects’ metaphors are ways of naming and framing their problems, the metaphors structure how they will receive efforts to solve their problems.

Metaphors determine what sort of fixing will be required. Until a patient perceives a congruence between the problem and how therapy comes across to him or her, it is unlikely that things will go well. Helfrich and Kielhofner (1994) underscored this point when they illustrated how a patient’s narratives influenced his or her view of and experiences in therapy.

In as much as metaphors set problems, they also imply possible solutions. For a patient who views his or her life problem as one of having lost momentum, the solution must have the metaphorical quality of helping to get things going again. Thus, it would appear that a therapist, having identified and received patient validation of the deep metaphor in the life story, has the option of framing therapy to match that metaphor or seeking to reframe the life story in another metaphor that allows a solution to emerge. For example, as long as Anna Marie perceives that she is trapped in the house by the demands of her husband and children, there is only the solution of escaping the house. But this solution is in direct contradiction to her values and, thus, results in great anguish for her. By metaphorizing her life as a trap, Anna Marie focuses on the things (including her own values and the children she loves) that keep her in a life without enjoyment and that limit her choices. Consequently, that which is cherished and valued is also a source of entrapment. Escape is both the only and a poor solution because it means abandoning things that are good. In this sense, the work of therapy becomes either a rephrasing or a replacement of Anna Marie’s entrapment metaphor.

The most clinically relevant part of how persons narrate their lives is the latent possibilities (or lack thereof) in their metaphors. The nature of the entrapment metaphor suggests that there is no easy or apparent way out of the trap. Hence, Anna Marie’s metaphorical problem is particularly troublesome and recalcitrant. However, not all metaphors make solutions remote or impossible. Rather, metaphors can be a door into finding a good solution to a life in trouble. All lives in progress imply possible outcomes; metaphors appear to be particularly powerful narrative devices for circumscribing possible future moves in a story. For example, the metaphors of momentum related in this article suggest need of solutions. Alex needs to get things going, to pick up the pace. Megan needs to get enough momentum to keep things going despite potential barriers and interruptions. Neil needs to get on the right track, move forward, and maintain a sustainable pace to avoid going backward again. By understanding the metaphors patients use to characterize the trouble in their lives, we may be better able to help them locate choices to solve their problems.

Evaluating the Metaphor

Discovering the deep metaphor in a patient’s life history does not absolve the therapist of the evaluative stance required in the OPHI rating scale. That is, with the scale, the therapist rates relatively narrow and well-defined items in terms of the adaptiveness or maladaptiveness shown in the patient’s life. Finding the deep metaphor requires the therapist to step outside the objective judgment represented in rating and to see the life history from the inside—as the patient sees it. But this is not enough for therapy. The therapist must next step back into an evaluative frame and ask: What is this deep metaphor doing for the patient’s life? For the subjects who saw themselves as trapped, the metaphor was constraining them, robbing them of control. The therapist’s evaluation of the metaphor will depend on such factors as the patients’ success in going on with their lives. For example, if the patient, like Randy, is able to find a way out of the trap, then life can go on. On the other hand, if the patient remains stuck in the trap, like Anna Marie, the therapist may determine the need to reframe the patient’s life in some other metaphor.

Conclusion

Although it is interesting to speculate how metaphors may provide possibilities or impediments to therapy and how therapy might build on the metaphor to help patients improve their lives, future research will be required to explicate such issues. This study has only introduced some ideas and questions about the role of metaphor in patients’ narrative self-understanding, in clinical interviewing, and in therapy. It provides evidence that deep metaphors are present and have importance in life histories obtained with the OPHI. It illustrates a method through which such metaphors can be located, and we have exemplified a way of reporting life histories and their metaphorical content.

There are a number of possibilities for future re-
search. One possibility is to explore how therapists can better elicit patient narratives. Additionally, it would appear useful to catalog types of deep metaphors that occur most commonly in patient life histories. We expect that there are many more deep metaphors than those of momentum and entrapment. It will be important to see how such metaphors influence life outcomes. Finally, as alluded to earlier, researchers will need to examine how metaphors play out in the course of therapy.

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