

2011

# David Grove's Metaphors for Healing

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## Recommended Citation

Pincus, David, and Anees A. Sheikh. (2011). "David Grove's Metaphors for Healing." *Imagination, Cognition and Personality* 30(3), 259-287. doi: 10.2190/IC.30.3.d

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## **Comments**

This is a pre-copy-editing, author-produced PDF of an article accepted for publication in *Imagination, Cognition and Personality*, volume 30, issue 3, in 2010 following peer review. The definitive publisher-authenticated version is available online at [DOI:10.2190/IC.30.3.d](https://doi.org/10.2190/IC.30.3.d).

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Running head: DAVID GROVE'S METAPHOR THERAPY

David Grove's Metaphor Therapy

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Keywords: Metaphor, Psychotherapy, David Grove, Clean Language, Guided Imagery

Abstract

Within the ever-expanding list of approaches to psychotherapy, there is a tendency to overlook deep imagery approaches. The current paper reports on one such metaphor-based therapy developed by David Grove (Grove & Panzer, 1989). The approach is analyzed within the context of mainstream contemporary psychotherapy in general, the state of empirical understanding of common processes to psychotherapy, and in relation to other deep imagery-based approaches to therapy. Next, a step-by-step description of the techniques used within metaphor therapy are presented, along with a case example demonstrating the use of these techniques on a case involving pain symptoms. Finally, it is argued that deep imagery approaches in general, and Grove's approach in particular, may provide a means for greater theoretical integration within integrative health-care.

## Introduction

Innovation in psychotherapy typically involves an ever-expanding list of approaches, including those that focus on the therapeutic use of imagery. Indeed, there are at a minimum more than 400 well-known approaches within contemporary psychotherapy (Garfield, 1995), each of which is purported to be effective in treating the same clinical conditions. Despite attempts at theoretical integration (e.g., Pincus, 2009), this expansion is likely to persist. As Frank and Frank (1991) have noted, schools of psychotherapy may diminish in influence, but once a following of sufficient magnitude has been reached, the followers of an approach rarely, if ever, disband, even when empirical reasons to do so are compelling.

The result of this process is an overwhelming array of options for possible treatments for any given condition, a lack of clarity with respect to the overlaps and distinctions among different treatments, and an ongoing split between science and practice in psychotherapy. Furthermore, interventions shown to be ineffective through empirical study continue to be practiced due to the breadth of their following within the therapeutic communities, while approaches with great therapeutic potential may be overlooked by psychotherapy researchers and thus remain untested. Due to the effort to be cautious, both in terms of science and patient care, many therapeutic “gems” potentially will be overlooked within this process of ongoing theoretical expansion and jockeying for position.

Deep transformational approaches to guided imagery are particularly susceptible to becoming such overlooked gems. There are several reasons why this is so, including the lack of inclusion of courses in guided imagery in psychotherapy training programs, and the lack of strong and centralized professional organizations to support research and practice in imagery-based psychotherapies.

However, the pervasive reason that imagery approaches tend to be overlooked rests in the paradox that all approaches to therapy are in fact imagery approaches, whether or not they are labeled as such. All psychotherapies seek to modify people's outlooks and perspectives; and outlooks and perspectives are grounded in and filtered through the imagination (Bartlett, 1932; McClelland, & Rumelhart, 1985). This is the reason that one may find imagery techniques that have been used in the vast array of therapeutic approaches, spanning from the deeply analytical and intuitively derived work of Jung (1960) to the empirically derived procedures of the early behavioral work of Wolpe (1969). Ironically, the ubiquity of imagery within psychotherapy leaves it with little infrastructure for research and development. Imagery approaches are unable to align themselves within a single therapeutic school or tradition, and yet the demonstrated effectiveness of each of the major schools and traditions in psychotherapy likely rests heavily upon their ability to modify the imagery of clients.

This anonymous ubiquity of imagery-based procedures extends well beyond the development of modern approaches to psychotherapy. It may also be seen throughout the long and broad history of healing traditions in general, spanning more than 20,000 years and across all cultural traditions (Achterberg, 1985). Indeed, prior to the mistaken split of mind from body that came with Cartesian dualism in western traditions, imagery was central to approaches aimed at physical healing (Sheikh, Kunzendorf, & Sheikh, 2002). Since this split, clinicians have maintained a certain blindness to the impacts of imagery-based approaches to biopsychosocial healing, even within psychosomatic medicine, and even when the empirical outcomes have been robust and consistent. For example, the research is overwhelming that even the most superficial imagery procedures, such as a session or two of guided relaxation, can improve the course of pain and healing for an array of illnesses (for a review, see Pincus & Sheikh, 2009). Yet, such

research is rarely taken as an impetus to empirically investigate the effects of more sophisticated and individually tailored imagery interventions. In the rare cases that more sophisticated approaches are investigated, they tend to come under the label of “hypnosis,” rather than imagery, despite the evidence demonstrating that imagery, as opposed to suggestion, is the mechanism for therapeutic outcomes in such interventions (McMahon & Sheikh, 1986; Pincus & Sheikh, 2009; Spanos, et al., 1993).

The aim of the current paper is to report on one of these “gem” approaches to deep and transformational imagery therapy: Metaphor therapy and Clean Language as developed by David Grove (Grove, 1989). The primary goal of this report is to make the approach more accessible for clinicians. As such, the focus will be upon explaining the way in which the approach is carried out, along with case examples to demonstrate the procedures. In addition, some theoretical and empirical analysis will be presented to provide researchers with some starting points to build upon should they wish to carry out some empirical investigations on the process or clinical outcomes of the approach. Finally, this approach will be discussed within the context of imagination. Ultimately, clean language may be combined easily with the myriad other approaches to therapy; it may be useful in alleviating symptoms across the spectrum of mind-body conditions; and it will enable altered states of consciousness to emerge (i.e., trance) without ever using hypnosis (i.e., suggestion).

### Background and General Theory

Grove’s metaphor techniques have been revised a number of times over the years, under the rubric of “metaphor therapy,” “clean language” (Grove & Panzer, 1989), and most recently as “emergent knowledge” (Wilson, 2008). On a practical level, each of these revisions to the approach share the common grounding assumption that the flows of phenomenological

experience are contained within epistemological metaphors. In other words, information about people's private, subjective, and personally meaningful experiences may be efficiently represented as metaphors within the creative imagination. For example, one may experience a particular feeling of sadness as a waterfall flowing from the chest, up through the neck and out of the eyes. A different experience of sadness within the same individual may be efficiently represented by a small hollow ball in the pit of one's stomach, while an experience of great joy may be contained within rainbows flowing out of the top of one's head. The main point is that metaphors are information containers.

Numerous image therapy approaches work with symbolic content to facilitate experiential information processing toward the goal of healing (for a review, see Pincus & Sheikh, 2009). However, Grove's approach is distinctive in the priority that is placed upon ensuring that the metaphors that are processed within therapy are deeply epistemological, hubs in the meaning making systems of the client. The approach involves simple rules for the therapist to ensure that the therapist does not taint the client's metaphors with his or her own information, diminishing their epistemological nature. These simple rules for interviewing within the approach are referred to as *clean language*. The use of clean language procedures to ensure elicitation of the pure (uncontaminated and unfiltered) experience of clients is the primary, the most unique, and the most elegant feature of the approach.

Once these epistemological metaphors have been engaged within the procedure, the goal is rather straightforward: The therapist aims to facilitate their movement in imagination through time or space. When images that previously have been static are facilitated toward movement, they naturally resume a process of evolving. The basic idea is that particularly painful or traumatic experiences, those that cause distressing symptoms and functional impairments, are

incomplete, misplaced, or stuck in mnemonic time and space. Traumatic experiences provide the clearest example of the ongoing avoidance and reexperiencing of a traumatic event that is somehow incomplete. Traumatic memories may be incomplete in several ways. For example they may be lacking in important information pertaining to the client's sense of self or world meaning. They may be misplaced (e.g., triggered by some relatively benign event beyond the original trauma). Or they may be stuck in time, as in the case of flashbacks. In a circular manner, it is the incomplete nature of such experience that keeps them stuck, and it is their stuckness that keeps them incomplete. Beyond trauma, such experiential *stuckness* may be regarded as a common feature of most illnesses, psychiatric and otherwise (e.g., depression, anxiety, irritable bowel syndrome, and various pain disorders).

Grove's approach aims to facilitate the movement of epistemological metaphors in imaginary time and space, as an efficient means to *unstick* the experiential information contained within these metaphors. Hypothetically, this allows for deep and efficient healing to occur. The objective of clean language is for these metaphors to re-animate themselves, of their own accord, without contamination from the intentions of either the therapist or the client. To emphasize this point, the approach is best understood as being *metaphor centered*, rather than most therapies which are *client centered* (Owen, 1989).

Whereas most modern psychotherapies are built around facilitating experiential change through the common factor of empathy (Orlinsky & Howard, 1995) and a deep understanding of the client's subjective experience, Grove's approach goes further by facilitating change in these experiences in a more direct manner, leaving even the client's understanding of his or her own experience out of the process. The client's insights or intentions may be incidental to the process. A client may wish for a particular experience to go away, to become a different

experience, or the client may not even remember important information about an experience. Grove's approach aims to engage the experiences themselves in a relatively direct manner, again without the client's direct influence. As such, Grove's approach hypothetically provides a more direct and efficient means of facilitating experiential change, circumventing common limitations related to a client's use of defense mechanisms, ambivalent motives, or depth of insight.

### Theoretical Analysis

A full scientifically grounded explanation of the approach is beyond the present scope and may be found elsewhere (see Pincus & Sheikh, 2009). Nevertheless, it is useful to point out that each of the major approaches to psychotherapy share the notion that psychotheapeutic healing arises from the reanimation of rigid, static, and highly repetitive experiences underlying neurotic symptoms (e.g., depression, anxiety, and somatization; see Pincus, 2009). Once these repetitive, frozen, or unconscious experiences are re-engaged within the client's conscious awareness, they may be brought back into contact with the client's broader flows of experiential information. In this manner, what was once unknown, isolated, and stuck may become familiar, reconnected, and adaptive. Ultimately, this common process allows for negative experiences to become re-integrated within the broader self-system and to evolve and adapt along with that system.

More specifically, modern psychodynamic therapies aim to identify, examine, and resolve *repetitive relational conflicts*, dysfunctional strategies for relating to self and others that evolve during childhood and remain stuck due to self-perpetuating flows of information (e.g., *This person has hurt me, which is my fault, and so I must try even harder to please him or her*). Modern cognitive-behavioral therapists similarly focus upon identifying and modifying rigid and static belief systems that are fused to the entire self-system of the client (e.g., *I shouldn't have*

*this experience and so I am no good*) by reconnecting such beliefs to novel sources of information from within the client (e.g., rational thinking, problem solving, or coping skills training) or within the immediate environment (e.g., mindfulness skills training and experientially grounded exposure therapies; Hayes, Follette, & Linehan, 2004).

Finally, contemporary approaches to experiential therapy are grounded in highly sophisticated empirical studies aimed at understanding the processing of emotions within therapy sessions (Pascual-Leone & Greenberg, 2007). The general conclusion has been that pathological feelings are highly repetitive within sessions and tend to involve a lack of agency on the part of the client, such as a sense of helplessness or shame. Furthermore, the process of working through such feelings tends to involve the identification of additional information that allows the client to experience the repetitive feeling from a new perspective or within a new context, wherein the feeling may lead to some novel and relatively adaptive outcome. For example, shame about being mistreated by an important attachment figure may be worked through, as one is able to identify coexisting feelings of anger, allowing the client to connect simple child-like attributions of self-blame to more nuanced and flexible adult attributions of cause, to unstick the repetitive nature of the shame experience, and to build a sense of positive agency and competence that will reanimate the development of interpersonal coping strategies.

In relation to these other contemporary approaches to therapy, Grove's approach may be understood to be similar in its potential for increasing a client's level of mindfulness and congruence. Mindfulness in psychotherapy may be defined as an open and accepting stance toward one's immediate experience (Hayes et al., 2004). This simple concept has been promoted recently with enormous enthusiasm within the various psychotherapeutic communities (Baer, 2003). Unfortunately, these communities have overlooked the equivalence between mindfulness

and the concept of congruence, which was greeted with similar enthusiasm when introduced by Rogers (1957) several decades earlier, who defined it as being: “freely and deeply himself, with his actual experience accurately represented by his awareness of himself. It is the opposite of presenting a facade, either knowingly or unknowingly” (p. 829). Rogers (1957) further describes the centrality of experiential acceptance in mental health and psychotherapy as well under the rubric of *unconditional positive regard*. When one dissects the craft of Grove’s approach, it becomes apparent that the cultivation and reanimation of epistemological metaphors represents an extremely efficient manner of increasing a client’s experiential awareness and acceptance, the common process underlying both mindfulness and congruence.

Grove treats epistemological metaphors connected to the client’s symptoms as containers holding bits of information that have become fragmented from one another and from the adult ego state, like living experiential shrapnel left after some traumatic bomb has gone off. The approach identifies these experiential fragments by location, giving them structure, and animating them so that they may continue their migration in experiential time and space. Like pieces of a bomb, the foreign parts move out of the self, while the pieces of the experience that belong to the client are allowed to sort themselves out as well, finding their useful forms and locations within a more coherent self structure. In this manner, congruence takes on structural meaning, integrity in a literal sense.

Grove (1989) drew upon concepts from general systems theory in the earlier development of his metaphor approach and more contemporary systems concepts such as *emergence* in later accounts of how the transformation of metaphors may be healing to the individual (Wilson, 2008). Within contemporary systems theory (i.e., nonlinear dynamical systems), emergence is defined as the bottom up development of ordered patterns through sufficiently complex and

distributed information exchanges among constituent parts (Guastello, Koopmans, & Pincus, 2009). Further, emergence is a facet of the broader theory of *self-organization*, in which the bottom up emergence of order evolves over time, as emergent order exerts top down constraints which impact subsequent the subsequent collective dynamics of constituent parts of a system over time. Theoretical grounding of various approaches to healing, such as Grove's, in self-organization may allow potentially for deeper and more parsimonious models and methods to study disease, health, and resilience (Pincus, Ortega, & Metten, 2010)

On a practical and clinical level, conceptualizing psychotherapies under the rubric of self-organization allows for a deeper understanding of the common etiological process of experiences being stuck, rigid, frozen, repetitive and so on, as well as the common focus upon healing as a process of development involving a balance of integrity and flexibility in one's flows of biopsychosocial information (Rossi, 1997; Pincus & Sheikh, 2009). Experiences necessarily involve flows of information over time within and among biological (e.g., hypothalamic pituitary adrenal axis), psychological (e.g., self-relations), and social systems (e.g., interpersonal relations). Self-organization among such flows may be thought to occur over time and also across the space or topological organization of these interacting systemic components.

Within ones consciousness, such flows of information may be represented as metaphoric images, also possessing temporal and spatial features, such as location, size, and shape. As such, some information contained in a metaphor may become stuck in time, leading to disintegration of that information from other broader flows of information evolving over time within the individual. Isolation of that information will be expected to lead to rigid and unhealthy dynamics, just as stagnant isolated pond water tends to become warm, eutrophic, and putrid over time. On the contrary, Grove's approach to metaphor therapy may be thought to identify these

pockets of stagnant information and facilitate their reanimation through the use of clean language. Utilizing self-organizing momentums (referred to elsewhere for example as natural healing mechanisms) of information flow, these metaphors may be assisted in developing over time, becoming defused from the client's self-system, or reconnecting to broader flows of information. The result is enhanced flexibility of the self system or improved systemic integrity respectively.

### Techniques

In review, Grove defines metaphors as containers of information. In particular, certain emotion-laden metaphors pertaining to the body are considered to be foreign objects. The information pertaining to these metaphors is stored in the body, outside of episodic or other mental memory systems. Their foreignness to the rest of the bodymind is what is believed to create their negative emotional power. Finally, the metaphors used within the approach are referred to as "epistemological" because they come directly from a client's experience and are believed to be involved in a person's meaning-making systems (Grove, 1989).

The first step in the process is to ask questions that will elicit such a foreign, body-related, emotion-laden, and epistemological metaphor. As a container, the metaphor, containing emotional or mental information, can then be moved outside of the patient's body, where it belongs. For example, butterflies in the stomach or a knot in the shoulder is not "you," nor is it your body. Instead these are thoughts and feelings pertaining to some situation. They are foreign sensations. When situations overwhelm the mental and emotional processing capabilities of the individual, for example in cases of trauma and particularly childhood trauma, such information may be mistakenly stored in an unprocessed manner within the individual's body. These experiences come in, but they usually do not leave. Putting this information into a

metaphor during treatment allows one to trap the butterflies or to isolate the knot. Then the metaphor can be removed from the body, placed back into the content of the traumatic memory or, if necessary, with another metaphor that can do something with them. For example, butterflies will do well in a field, and a knot can be unwound with hands.

To elicit the first metaphor, one asks questions that allow the somatic experience of the patient to take on the form of a metaphoric container, something that can be drawn. In response to the patient's description of the pain, the clinician asks the following questions (Grove, 1989):

- 1) "And what would you like to have happen?" A patient may respond: "I want it to stop." This simple question deepens the immersion of the patient into the experience and begins to activate the sense of foreignness of the experience. Next the clinician asks: 2) "And when you have [body sensation or feeling], how do you know you have..?" This question establishes the epistemological and phenomenological basis of the experience. For example, the question "And when you have pain, how do you know you have pain?" will bring a response such as: "I can feel my shoulder *tightening*." "Tightening" is a key word here; it is subjective and meaningful to the patient. Next the clinician establishes the location in the body with: 3) "Where do you have the pain?" and "Whereabouts is pain?" Grove generally asks these types of "where" questions three times or so to be sure that the exact location is determined. A patient may be even more specific than "shoulder" in identifying tightening and may specify that the pain originates in the shoulder blade and then reaches up over the top of the shoulder. Next, the clinician asks: 4) "And does *it* have a size or a shape?" The word "it" is carefully selected as an aspect of clean language that establishes the metaphor as a separate entity from the patient. Separating the metaphor in this manner allows it to be engaged without also engaging the ego state of the patient. A patient could respond, for example: "It is a big square knot, like the kind one uses to tie down a tent."

Even if the metaphor seems clear from the patient's natural language, there always are details that can make the container more robust. This robustness maybe maximized by engaging the image directly through the use of clean language.

These are the four basic questions that are repeated in eliciting metaphors. A number of follow-up questions are advised as well, such as: "And is it on the inside or the outside?" "And what's it like?" "And what kind..?" "And is there anything else about..?" (Grove, 1989). These questions serve to elicit a clearer metaphoric container. Other questions may be asked as well, and the clinician's style of interviewing is slow, nonreactive, yet attuned. The aim of all questions, scripted or improvised, is to objectify the bodily experience within a metaphoric container, to separate the metaphor from the patient through the clean use of pronouns like "it," and to give the metaphor a specific location in the body.

This initial eliciting process is focused upon locating an appropriate metaphor in the space of the bodymind, an area of the body that is represented in the imagination. In the second phase, one considers the location of the metaphor in time. Grove's rationale assumes that the relevant metaphor will exist within the patient's memory just before some trauma. His cases typically involved trauma such as child sexual abuse. However, the approach could be applied to trauma with higher physiological loadings as well, such as bodily injuries, or to harmful psychological experiences that would not be defined technically as "traumatic." For the sake of clarity, the term "trauma" will be used to represent any such aversive experience that was the precursor to some nonadaptive and repetitive set of symptoms.

The first metaphor for any set of symptoms will exist at a time just before some traumatic event, at  $t-1$ , with  $t$  representing the exact point of the trauma. Grove (1989) suggests that the replay of symptoms contained within the metaphor has the function of blocking the patient from

reexperiencing the trauma at time =  $t$ . Consequently, symptoms tend to be reexperienced in a rigid and recurring manner over time. If cues from within or without the patient are moving the memory systems toward some aspect of the trauma, the pain will reemerge and detour that memory process to protect the patient. The end-result is avoidance, which increases the traumatic impact and leads to more avoidance over time.

The result in the patient's bodymind is a fractured set of metaphors, typically more than one, which needs to be put back together, reintegrated, and then moved forward in time, and also outside of the body. Moving the metaphor to time =  $t$  allows the experience to mature along with the rest of the patient, to resolve the trauma. Essentially one is identifying the metaphor, which is usually fragmented, and creating a process through which it can be reassembled within the neighboring ego-systems of the patient. Grove suggests that one can tell when the metaphor is moving forward towards time =  $t$  because things seem to go from bad to worse within the patient's account. Similarly, the patient's language will become more active and intense; for instance, a knot may be "tightening," "pulling," or "burning."

Once the metaphor is created, its location in the body established, and is at  $t-1$ , the guide begins to engage the metaphor in a clean dialogue. Being metaphor- rather than client-centered, the therapist interacts directly with the metaphor, using rules of clean language to avoid activating other aspects of the experience or the ego of the patient. Through clean communication the metaphor may be prompted to unravel, to unpack some of its information, and to move toward time- $t$ . Using the knot as an example, one can ask: "And what would a knot like to have happen?" "And what would a knot like to do?" "And as that happens, what happens next?" Follow-up questions to move the metaphor toward time- $t$  include: "And how long will that take?" "And what happens after that happens?" (Grove, 1989).

The clinician's goal is to locate the experience of the patient and to never contaminate it. Contamination can occur not only through the clinician's specific agenda or by expressing a reaction. It is thought to occur also through any language that elicits the perspective of either clinician or patient. The objective is to engage the experience and the metaphor, not the patient. Once you locate the experience within the body, you attempt to establish that experience as separate from the body. You begin to relate with it as separate. Then you draw out a metaphor by asking about size, shape, location, and so on. Finally, you begin to unravel the metaphor, to relate to it by asking what its purpose is, what it would like to do, and so on. These questions help to create a more coherent and goal-oriented state within the metaphor. Finally, questions are asked to facilitate movement in time toward *t*.

Because all of the information within us (thoughts, feelings, bodily-states, and the rest) has the potential to be contained within metaphor, one must be extremely careful not to enact these other metaphors when a patient's primary epistemological metaphor is engaged during treatment. As with all images, metaphors naturally mix and merge when they come into contact with one another. Therefore, clean language allows for a pure treatment of the patient's own epistemology. The situation is akin to the surgical removal of a foreign object, which demands a perfectly sterile environment in order to avoid contamination of the patient's body. The approach digs rather deep, and so one needs to be sure to remove the true metaphoric information package, not to tug at another metaphor that comes from the patient or from the clinician.

The following are some clean language rules of thumb. Do not use the word "I." "I" brings the patient into the here and now, away from *t* or *t-1*. "I" also injects you, the clinician, into the situation. Similarly, do not use the pronoun "you," even in response to the patient using

the word “I,” once you have the metaphor. “You” goes to the adult part of the patient. Since metaphors exist at  $t-1$ , the metaphor may not exist within the adult patient in your office. You want to communicate with the metaphor, not with the patient, nor with the patient’s current ego state. You are trying to establish a relationship with the metaphor, not with the here-and-now patient. Finally, you should use the subjective and passive tone in all questions asked. You are nondirective and open in this manner because neither you nor the patient knows what information is wrapped up in the metaphor. Therefore patients need to be able to say “no” or “yes,” or nothing to any question posed. Resistance is the metaphor saying, “Don’t ask that question, it is not relevant” (Grove, 1989). Any question that is not open-ended imposes upon the metaphor from the clinician’s metaphors; it forces the metaphor to lose its epistemological, meaning-making role within the patient’s consciousness.

Finally, clean language involves identification of epistemological metaphors “owned” by earlier selves, and the process involves discovering the owner of the metaphor. Remember, the approach is information centered, not patient centered; so you talk to the knot, for example, not to the patient who has the knot. Then, the knot will let you know what else is happening and who else is involved. You are encouraging the metaphor to grow toward the level of the adult, in mnemonic time, but you must engage it first. Because the metaphor typically belongs to earlier selves within the individual, Grove instructs clinicians to speak very slowly, gently, and simply when engaging metaphors. The younger you suspect the owner of the metaphor to be the slower and cleaner your language should be (Grove, 1989).

One practical advantage of the use of clean language and of working with metaphors is that one can do deep symbolic work without activating the defenses in the patient or even gaining access to a high degree of their detailed traumatic memories. Working with metaphors

provides a sort of analgesic protection around the traumatic experiences, and the work is largely content free because one is working with implicit memory contained within the metaphors.

In his training videos, Grove (1989) shares another insight concerning work through metaphors: Somatic metaphors do not work in isolation. The metaphor exists within the memory of the adult; thus, the adult or observing ego of the patient is involved. On the other hand, the metaphor is treated like a separate entity, a container of information within the patient that resembles a foreign invader or a disease process. This distinction between the patient and the metaphor is what is maintained through the use of clean language. Finally, there is a context to the episodic memory at  $t-1$ , the time in the patient's memory just before the traumatic experience, when the metaphor and its symptoms become activated in meaning making. The context contains the various aspects of the memory, such as: other people, location, and different features of the location.

To review, there are three aspects involved at  $t-1$ : a) the metaphor, b) the patient, and c) the memory context. One can infer which aspects patients are describing by the language they use. If you hear a somatic or feeling word, then you know you are hearing an experience within the patient, thus a metaphor. If patients use personal pronouns such as "I," "he," or "she," then they are describing themselves. If they describe things outside of themselves with pronouns such as "it" or "he" (i.e., "He is chasing"), then you can infer that the focus is upon context.

The response of the clinician depends upon which aspect is in focus at the time. If a feeling word is used, then the clinician responds with the metaphor responses, such as establishing a location and growing the metaphor toward time  $t$  by asking what it wants or what happens next. If patients describe themselves or their bodies within the process (i.e., "I want to hide"), then you respond to the body using clean language (i.e., "And you want to hide"). A

variant on focus on the body of patients occurs if they describe just a body part (i.e., “a shoulder won’t move”). Following the principles of clean language, the clinician then responds directly to that body part (i.e., “And when *a* shoulder won’t move, what does *a* shoulder want to do?”).

The pronouns are important. The clinician uses a personal pronoun like “you” only when patients describe their whole selves as being in the memory. The difference can be quite subtle. For example, “I’m feeling hot” is clearly a feeling inside the person, so the response that targets the feeling is, “And when you’re feeling hot, whereabouts is hot?” If the patient says, “I’m hot,” then the better response could be, “And when you are hot, what happens next?” If the patient describes the context, “It’s getting hot outside,” then the clinician’s response goes to context: “And when it’s hot outside, what happens next?” As a final rule, the clinician should respond to the last phrase of the patient which takes priority over prior information. For example, if the patient describes a first episode of pain and says: “It starts to hurt, up in my shoulder, and I remember it is spring and the birds are chirping outside of my window,” then the clinician responds to the birds: “And when birds are chirping outside of a window, what happens next?”

Sometimes patients will supply numerous experiences, metaphors, but very little ego-related content or context. If this is the case, the clinician can explore integrations among various metaphors. The clinician can simply ask the patient if the various metaphors that have been collected thus far will go together in various combinations. Grove (1989) uses the example of a patient who feels a whirlpool of confusion in the head and a rock in the stomach. A clinician could ask for example, “And can a whirlpool go to a rock? And what would a whirlpool do with a rock, if a whirlpool goes to a rock?” In his example, the whirlpool cleaned the rock, leading to a decrease in the negative experience associated with the rock. Remember, metaphors and their associated symptoms are viewed as unsuccessful internal attempts at

healing. Therefore they can be used as medicine, all the while maintaining clean language in order not to impose purpose or meaning upon them during the dialogue process. Whirlpools go to rocks and either does something, or they do not. The patient and the therapist need not become involved directly.

Ultimately, the clinician will need to shift the focus of questions in order to follow the patient's lead. Furthermore, if patients respond with "I don't know," then the clinician may simply query another source within the memory. For example, the clinician may ask in an open-ended manner, "And when you don't know, what happens next?" or "And when you don't know, how can you tell that you don't know?" If the patient responds, "I feel foggy," then the clinician can query the experience of being "foggy" with, "And whereabouts is foggy?" Likewise, the clinician could go outside of the patient to engage context with: "And what keeps you from knowing?"

The clinician simply works within this mapping in time and internal space to collect the distinctive metaphors and to work towards allowing them to become more integrated. Integration occurs by moving the information within the metaphors around within time and information-space – among the domains of patient, somatic experience, and context. Metaphors in particular are grown forward in mnemonic time, and grown outward from within the body toward the surrounding context where they are assumed to originally belong. The clinician facilitates such movement by following the rules of questioning described thus far, by using clean language.

Within the patient, pain is believed to be exacerbated by what Grove (1989) refers to as an "enmeshment." An enmeshment is a fusion that may occur among information pertaining to the body, the metaphor, or the context of an experience. The term "enmeshment" can be

considered to be equivalent to a conflict, to a rigid flow of biopsychosocial information, or to a tangle or knot within biopsychosocial space. Such a knot restricts the flows of information therein.

In technical terms (see Pincus & Sheikh, 2009), the topological surface describing such a constriction would be described as a fixed point attractor surrounded by a repellor, a modified saddle attractor (Guastello, 2002). A common example in nature would be a whirlpool or tornado. At the center, where the metaphor is located, one would find a deep hole that sucks information in. Thus, the metaphor and the pain associated with it are re-experienced repeatedly in a rigid manner, moving around quickly toward a center. Once this action is triggered sufficiently, it is nearly impossible to break free of symptoms on one's own. Around the hole, one would find strong repelling forces, comprised of the patient's ego-state and the surrounding context in memory. These areas would serve to deflect information, which would tend to be blown away or to disintegrate. The process is both rigid and chaotic at the same time, as information is fused near the center of the metaphor and fragmented in the surrounding biopsychosocial areas.

As the imagery procedure unravels the information within the metaphor, the various aspects of memory may become whole again, distinct, and healed. The various aspects of the symptom-related memory are stretched out from one another spatially and also in mnemonic time; the traumatic information becomes whole again and those aspects that fit within the client's adult ego state become reintegrated within his or her sense of the here-and-now. The outermost chaotic areas of the "memory-tornado" are brought into contact with the rigid inner areas at time  $= t$ , returning the system to a state of balance.

In summary, the three phases of Grove's metaphor therapy are the following: First, the "separation" phase involves separation of the metaphor from the person. At this time, the clinician asks questions aimed at identifying, locating, and engaging metaphors within the person. The first question of the patient is: "What do you want to have happen?" with regard to pain. Subsequent questions aim at identifying features of the metaphor, such as location, size, color, shape, what it wants, and what happens next.

Next, the "individuation" phase involves questions that extend the significance of words or phrases of the patient downwards, to greater depth, and towards greater distinction among metaphor/feeling, person/body, and context (information outside of body). Each aspect is queried separately depending upon the nature of the patient's unfolding description. Just like metaphor questions, questions that can develop or deepen the body can pertain to age, clothing, what the person wants, or what happens next. Similar questions may be asked to develop contextual factors.

In the final phase, "maturation," the aim is to work through, unpack, and defuse metaphoric information to promote reintegration and healing. There are two ways in which this may occur. The primary method is to move the three gathered and deepened sources of information forward in time, toward  $t$ . The primary question here is, "And what happens next?" More generally, each of the deepening questions may serve to move the metaphor, body, or context forward in time. Metaphors will tend to move from within the body to the outside context as healing occurs. Expect things to go from bad to worse and then for metaphors to migrate out of the body, back into context.

The alternative process involves a lack of context. In these situations, context dissolves as the metaphors move toward time- $t$ . In these situations, one guides the process of combining

various metaphors, without actually moving through time-*t*. For the sake of clarity, we will refer to this alternate phase as the “combination” phase. The clinician asks, for example, if a “needle” will go to a “balloon” or if a “rock” will go to a “river.” If the answer is “yes,” then the clinician asks what the needle or rock does, and what comes next. Finally, the clinician may wish to query subsequent metaphors that have emerged after such transformations. For example, if a “rope” is woven into a “sweater,” the clinician could ask if a sweater would go to the patient’s body, and the patient could respond that when it goes there it brings warmth and comfort. One never knows which metaphors will go together, what they may become, and what they may do. The process is quite creative in this sense, but at the same time it is highly structured through the rules of clean language.

#### Case Example

The case example that follows involves a woman with recurring pain in her upper back, just under the left shoulder blade. The pain is associated with stiffness in the jaw on the opposite side, which runs down her neck. This pain emerges during times of stress and also at other times in an inexplicable manner. On occasion, the pain has been intense enough to limit her physical activity. Modified excerpts from an imagery session with her are interspersed with explanatory text:

Guide: And now I want you to focus on your body and allow the discomfort you typically feel to emerge. When you can begin to feel the pain, describe it to me in your own words without the use of any medical jargon. Then tell me what you want to have happen with your pain.

The session begins by asking the patient to describe her pain and what she wants to have happen with it over time. Medical jargon can distance a person from the experiential aspects of

their pain, so it is avoided. This gathering of descriptive language can be done prior to the actual imagery session, during an eyes-open interview or at the start of the imagery process. In either case, it is usually best to use a notepad to record the actual language used by the patient, particularly adjectives and adverbs that pertain to any experiences. These descriptive terms will provide useful information about the metaphors that contain the pain-related experiences.

Patient: It starts to feel tight, right here in my jaw, like there's something pulling down on it and then tightening it, so it gets stiff.

The patient is using the pronoun "it" to describe her experience. This conveys the start of a natural separation of the patient from the metaphor. If she had demonstrated greater fusion with the image, such as: "*I'm tightening up,*" then further use of clean language to address the "tightening" rather than the patient herself would be required. However, this patient uses a clean description of a feeling, so the guide's choice of "it" is simple.

Guide: And a jaw is *tight*, and something is pulling *down*, and *tightening*, and in *tightening*, and it gets *stiff*?

Patient: Yes (starts to show facial expressions indicating mild stress and discomfort).

Deep metaphor approaches, particularly Grove's, emphasize the connections between physical and metaphysical space and time. Movement is facilitated within the process across the space of information (e.g., metaphors within the body) and mnemonic time (e.g., memory for events in time). Terms within the patient's verbiage are repeated and emphasized (shown in italics above) in order to facilitate awareness and immersion within those aspects of the imagination. The guide uses the patient's own language and uses those descriptive terms to massage the consciousness, bringing the metaphoric content to the forefront of the patient's awareness.

Guide: And *whereabouts* in a *jaw* is *tight* and *stiff* and *pulling down*, when a *jaw* is *tight* and *pulling down* and *stiff*?

Patient: In the bottom of my jaw, all along the bottom right here (patient brushes along the bottom of her jaw with her index finger).

Here the guide is attempting to identify the location of the metaphor within the body of the patient. The patient has already said it is in “the jaw.” However, the specific location within the jaw and any extensions (i.e. pulling down) into other areas will be identified through this process of deepening the immersion into or “separating” the image. The patient uses the pronoun “my” to describe her jaw. However, the focus will stay with the metaphor, not with the patient, because she did not switch targets to her whole self, as would have been the case if she had instead said something like “I’m stuck” or “I don’t know.” These types of responses would have allowed the guide to respond with the pronoun “you” and to explore these experiences further, with “And when you don’t know, how do you know that you don’t know?” or “And when you are stuck, how do you know you are stuck?” Or the guide could query the patient rather than the experience, with “And when you are stuck, what do you want to have happen?” The first two queries would have led to further epistemological experiences and metaphors within the patient. The third would have led the patient’s memory of herself forward toward time-*t*. Instead, the next question will query the physical aspects of the metaphor in the jaw, beginning with size or shape:

Guide: And when the bottom of a *jaw* is *tight*, and *tightening*, and *pulling down*, and *stiff*, does *stiff* have a *size* or a *shape*?

Now the guide attempts to identify a metaphoric object that will be a container for information pertaining to tightness and pulling down within the patient’s jaw. Several feelings

are described (i.e., “pulling,” “tight” and “stiff”) spontaneously in sequence. Therefore, each is repeated in temporal order, and the next query follows the final experience in the sequence, “stiff.” Sometimes the patient will provide the metaphor spontaneously, and then the guide will engage the metaphor and attempt to move it forward in time by asking what it wants or what happens next. Other times, the patient will require more time to respond, and the guide will need to repeat the request for a size or shape after a long pause. Again if the patient does not know, one can either query the experience of not knowing, or, if the patient is referring to the self, then the self may be asked what it wants to do when it does not know. The dialogue continues with the patient’s identification of a metaphor:

Patient: Yes, it’s like a metal rod...

Guide: A metal rod.

Patient: Yes, a metal rod, and at the end is tied a string that goes down into my back, pulling under my shoulder and it hurts right there (pointing).

The patient has attached a string to the rod, which follows naturally in time with discomfort under the shoulder blade. Since the patient has spontaneously moved forward in time and the two metaphors are connected, the guide will proceed with these queries:

Guide: And a metal rod, and a string, and *tied*. And *pulling* under the shoulder...and

hurts under a shoulder. And is a metal rod light or heavy? Hot or cold? Thick or thin?

At this point in time, the guide is attempting to obtain more information about the rod, for example weight, temperature, and thickness.

Patient: It’s thin but very hard and stiff. It runs along the bottom of my jaw, and it is very cold, freezing cold. It hurts, but the cold kind of makes it feel numb.

Guide: And *thin*, and it's *hard*, and...it's...*stiff*, running on the bottom of a jaw, and...it's...*cold*, *freezing cold*, and it hurts, and it is numb.

Patient: The string is thin but very strong, like fishing line. And under the shoulder it is all in a knot. When it pulls on that knot it hurts.

Guide: And a thin, hard, stiff rod runs along the bottom of a jaw...and freezing cold...and numb...and a thin...strong string...a fishing line...goes under a shoulder and pulls on a knot...and a knot hurts...and when a knot hurts...what...happens...next?

The guide is attempting to intensify the clarity and emergence within the spatial, temporal, and experiential aspects of the imagery. The question also engages the metaphor into a clean language interaction with the guide. Then the guide simply asks “What happens next?” This is the process of maturation toward time =  $t$ , when the biopsychosocial “injury” or trauma originally occurred. What will follow is either a shift to the patient’s ego (i.e., “I want to scream”), a shift to the situation or context of the imagery scenario (“It won’t let me scream”), another image will unfold, or the patient will stay with a final experience suggesting that time =  $t$  may have been reached. Within this patient, the rod simply continued to pull upon the knot, which became tighter and tighter, until eventually the rod softened up as it became warmer from the friction of pulling. Over time, the patient reported that it stopped pulling.

One could infer that the information contained in the jaw was attached to a traumatic experience from around the time that the pain symptoms first emerged in the patient’s life. The trauma may have been physical or psychological in nature. Regardless, simply moving the activity of the rod forward in time matured it and allowed it to soften, and its stiffness dissipated out of the patient.

Despite the rod's maturation, however, within this patient the knot remained, and further queries aimed at individuation and maturation of the knot led nowhere. Therefore, the guide used the alternative process of combination to assess where a knot may wish to go. In many cases, one may find numerous metaphors that can be gathered, each related to a subsequent experience in the pain process. One would then query which of these other images, each containing potential for healing, would go to a knot. However in this case, the patient had no other images, just a knot that stayed a knot. The rod and string were gone. For this patient, then, the aim was simply to allow that knot to go wherever it wanted to go by asking: "And where would a knot like to go?" An alternate question could have been to ask the knot what it would like to do or what it would like to have happen. In the case of this patient above, the knot wanted to go into the ocean, along with the string dangling along behind it. Responses to "What happens next?" led the knot into the ocean, where it sank to the bottom, and came to rest in a bed of sand. The subsequent prompt of, "What happens next?" resulted in the image of a fish that came along and ate the knot and string. After a final prompt, the fish defecated the digested knot, and these remains were dispersed through ocean currents. This transformation of the metaphoric knot under the shoulder blade led to immediate relief of the pain episode that was occurring at the outset of the session and to a shift in the experience of subsequent pain episodes, which became more diffuse across the upper back.

This patient continued to experience some discomfort associated with the tightening of the jaw, and the metal rod became cold again on occasion. However, this remaining discomfort was more manageable, and consequently the patient discontinued treatment after two sessions. It is possible that the metal rod was anchored by a more strongly emotionally charged set of episodic developmental memories (i.e., subjectively traumatic memories from childhood), which

she was not yet ready to explore even in a metaphoric format. Nevertheless, a follow-up assessment at 6 months and 1 year indicated that this patient did not have any significant recurrence of the shoulder pain, and she was able to manage her neck-aches and headaches with occasional massage therapy.

It is worthwhile to note that there are many other methods that may be useful in the transformation of metaphoric images associated with pain. Indeed, Grove's own techniques have continued to evolve over the years. As long as one uses clean language to separate and engage with metaphors and one allows these metaphors to mature and transform in imaginary time and space, one may use these approaches creatively. This may be of comfort to clinicians who understandably may find the procedures described above to be quite complex. For example, when patients identify several distinct metaphors associated with the pain process, the guide can simply ask, if each of the metaphors will "go to" any of the others. In this case, one simply is exploring the more nonlinear process of combination from the outset (Grove, 1989). For example, if the patient above had identified a fish, swimming in the stomach and a hail-storm moving down the shoulders in response to the prompt "What happens next?" the guide simply could have asked: "And does a hail storm go to a metal rod? And does a fish go to a knot?" Typically, it is good to query each combination. For example, a rod going to a fish may involve a different process than a fish going to a rod.

It is noteworthy that patients almost always will be able to answer "yes" and "no" in response to queries about what goes to what. Typically the guide does not even need to understand what the metaphors may be representing or what the outcomes will be if one item does go to another. If a particular metaphor does go to another, one has the opportunity for transformation. The guide simply needs to ask, for example, "And when a fish goes to a knot,

what happens when a fish...goes...to a...knot?" In the case above, the patient probably would have said that the fish eats the knot, followed by the prompt, "What happens next?"

In summary, while the techniques are quite detailed and sophisticated, the overall process and goals of these deep metaphoric approaches to treatment are rather simple. First, patients describe their pain experiences in common language and identify what they want to happen. Next, the separation phase involves identifying the location within the body and the physical aspects of the metaphor. As the metaphor emerges, it is engaged by the guide and moved forward in time in the processes of individuation and maturation respectively. These phases are repeated with different metaphors, as movement in space and time continues, by asking what the metaphor (or the ego or context) wants to do next or what happens next. Finally, the patient explores possible transformation through combination, by asking which ones can go together and then what happens next.

#### Comparative Analysis

As a practical matter, it is useful to compare and contrast Grove's metaphor therapy and the numerous other metaphor-based imagery therapies. First, approaches based on Jung's active imagination (Chadorow, 2006) are similar to Grove's work in that each relies upon the notion that consciousness is active, and that the heart of its activity rests within the ongoing flows of metaphors within the imagination. However, the two approaches differ in the origins of healing symbols. Jung believed that the source of renewal and healing in the imagination came primarily from the collective unconscious, in the universal archetypes existing beyond the individual. Grove's metaphor therapy relies upon metaphors generated from the autobiographical, meaning-making experiences of the patient.

Grove's approach is also far more specific and circumscribed in its procedures compared to most approaches based on Jungian theory. This specificity centers upon the use of clean language and is intended to allow clinicians to better engage the deepest aspects of a patient's metaphoric imagery without any interference through engagement of the patient's or the clinician's dominant ego state. The use of clean language to draw out metaphors, purely from within the patient and with no influence from the therapist, is a primary distinction between Grove's work with metaphors and numerous other trance-like approaches to working with imagery, particularly Ahsen's (1973) eidetic imagery approach, Erickson's hypnotherapy (Erickson & Rossi, 1980), and, to a lesser extent, Gendlin's (1996) focusing approach.

Pincus and Sheikh (2009) highlight some of the similarities and differences among deep imagery-based therapies with respect to their relative use of trance. In Gendlin's focusing approach, for example, there is no trance. Clients are fully conscious, present, and awake as they develop metaphoric labels to represent their bodily experiences associated with key symptoms. Eidetic imagery involves traveling back to key developmental memories in the imagination; so the degree of trance will depend upon the client's conscious access to the time in life when the key experience(s) occurred. Finally, Ericksonian hypnotherapy and Grove's metaphor therapy are similar in that clients' levels of consciousness and trance are nearly always shifting as treatment occurs. However, a critical distinction exists. In Ericksonian hypnotherapy, trance is a tool that is used to gain access to the unconscious, while in Grove's metaphor therapy the trance state is an incidental by-product.

Grove suggests that his approach goes a bit further than Ericksonian hypnosis and is more elegant in its use of language to create conditions in which therapeutic change is unavoidable (Grove & Panzer, 1989). Clean language is referred to as the *language of trance*, with trance as

an inevitable outcome that occurs naturally and with no induction. Yet the adult ego state of the client remains outside of the trance, able to communicate freely and consciously with the therapist. In many case examples, Grove may be observed to engage in humorous and lighthearted exchanges with his clients, even as they are working through deep and painful experiences in metaphor. The trance occurs as the client enters a completely self-absorbed state within his or her metaphor encapsulated experiences. Inasmuch as the approach is hyper-nondirective, the therapist is able to remain almost completely unengaged with the process. This is the opposite of an induction-based trance within classical hypnosis, where suggestion by the therapist allows the client's imagery to be directed in various ways. Similarly, the lack of any linguistic reference to client or therapist (i.e., personal pronouns) keeps both the client and the therapist from getting in the way of the raw experiences as they are unfolding within the trance. Grove and Panzer (1989) describe the process as such:

*Clean language encourages and defines the client's internal process. It is couched in the client's sensory channel and terms, allowing the client to explore further and know about his own experience. Questions couched in "normal" language ask the client to comment on his experience. Every time he does that he comes out of a state of self-absorption to perform an intellectual task which interrupts the process we are working to encourage and to facilitate (p. 13)*

Gendlin suggests that there is an inverse relationship between access to therapeutic material and ability to work that material through in a beneficial manner: "When in a hypnotic state, you may access a lot, but you cannot make enduring changes to the more wakeful conscious processes of the individual. If you work with the conscious individual, you can't get at as much, but what you do get you can work with. In focusing, this is why you have the

conscious person and also the body engaged at the same time in communication with one another. Each needs the other” (quoted in Rossi, 1997, p. 160). Grove seems to have bypassed the limitation altogether in the development of clean language. His approach dispenses with the need for the conscious or unconscious distinction. Because the approach is information focused, rather than client focused, there is nearly complete access to the most important therapeutic material, the epistemological metaphors, and neither the client nor the therapist needs to work with anything. Indeed, the therapist typically has little sense of what the information means, and clients may have little more sense themselves. If carried out directly, any sort of insight on the part of the client, or interpretation on the part of the therapist is irrelevant. Change instead is facilitated by directly activating the intrinsic dynamics within the metaphors themselves.

Pincus and Sheikh (2009) highlight a second distinction among these deep metaphoric approaches with respect to their use of suggestion. Ericksonian hypnotherapy, for example, is centered around suggestive techniques, albeit primarily indirect suggestions which are considered to be collaborative (Rossi, 1997). By contrast, Ahsen’s eidetic approach and Gendlin’s focusing aim to be collaborative and so nonsuggestive. For example, Gendlin writes:

I relate to the client’s body only through the client. I don’t elicit things directly from the client’s body without consulting the client. I am like a lawyer, not like a doctor.... A lawyer would not go to court and sue someone in my name without my approval or my knowledge. (in Rossi, 1997, p. 160)

One of the most interesting features of the use of clean language lies in the intensity of its nondirective nature that allows one to move even beyond a collaborative therapeutic relationship with clients or their experiences. Indeed, the therapist facilitates a process of experiential absorption without ever even becoming involved with those experiences whatsoever. By

contrast, eidetic imagery allows the therapist to relate to clients within their imaginations in a traditional imagery guide role with some notable enhancements in precision and depth. In Ericksonian hypnotherapy, the therapist typically is engaged with the client's unconscious, attempting to elicit some healing imagery from the client's "experiential learnings." The innovation and artistry of Erickson's work lay in his ability to leave his own agenda aside and to find images that provided a deep and sensitive fit for the client. One could argue that this moved Erickson's work far into the direction of being "clean," compared with other hypnotic work at that time. However, it is this aspect of the work that is most challenging for Erickson's students to replicate or to teach.

The key paradox in Grove's metaphor work is that the guide is eliciting a metaphor and engaging it without ever actually "relating" with it in any substantive manner. The only things that actually relate are the metaphors among themselves, and even this is not always necessary in situations where metaphors are simply allowed to move to different locations (e.g., outside the body) or points in time (e.g., "And what happens next?"). Because the guide uses clean language, the ego states of neither the client nor the guide are involved in a relational process. The guide is only receptive, there is no "I" that relates to the metaphor. There is no agenda either in process or in content; there are only heuristics that serve to create metaphors and then move them wherever it is that they want to go. Essentially, Grove's approach provides a basis for the guide to become a therapeutic agent of change without actually forming a relationship at all, not with the client, not with the unconscious of the client, and technically not even with the metaphor itself. This may be the most interesting technical aspect of the approach and the one that makes the approach so unique among the vast varieties of psychotherapeutic practices.

In its general goals and rationale, however, metaphor therapy is similar to the other techniques outlined above, particularly to focusing, which is highly formulaic and involves the elicitation of metaphoric experiences nested within the body. The differences lie primarily in approach. Each aims to elicit deep body-nested metaphoric images and to create a context in which they can heal.

One could make the case, however, that Grove's approach is more complete or "teachable" than any of the other approaches inasmuch as clean language provides rule-governed heuristics for what to say in different clinical situations. The process is radically open-ended, while the therapist's job is quite structured. Clean language also provides a means to maintain the depth of the process while not contaminating it, while the other approaches require the therapist to stay balanced within a process of mindful detachment, so as to remain more or less client centered. Alternatively, the clean language used in metaphor therapy makes any imposition by the therapist impossible. While clean language procedures may be difficult to acquire at first, once one is comfortable with the syntax of the approach, it may be used at various times and to varying degrees throughout more traditional therapeutic conversations.

Finally, outside of the deep and comprehensive approaches to experiential therapies, Grove's approach is similar to other symbolic transformation techniques that exist within the guided-imagery literature. In addition to clean language, the basic distinction between these approaches and Grove's lies in their relative depth. For example, Weaver (1973) and Greenleaf (1978) describe the encapsulation of sensory symptoms within metaphors which may then be shifted in size, shapes, colors, smells, or weight. Similarly, Bellissimo and Tunks (1984) describe working to make changes to the emotional aspects of metaphoric imagery.

Indeed, this simple process of engaging metaphors attached to experience is similar to all of the imagery approaches, from Jung's active imagination to Grove's metaphor therapy. The key differences lie in the specific "road-maps" that are used by clinicians to guide and understand the process of transformation. Jungians rely on notions such as renewed balance that arises from contact with metaphoric imagery from the collective unconscious. Ericksonians try to unlock efficient healing potentials within the unique unconscious experiences of each client. While Ahsen, Gendlin and Grove propose that the transformation of metaphors allows for trapped aspects of the patient's ego to be matured and brought back into harmony with the dominant adult ego.

Pincus and Sheikh (2009) suggest that the various systems within the "bodymind" react to overwhelming trauma by creating unresolved conflicts, rigid, and disintegrated flows of biopsychosocial information. The transformation of symbolic images may hypothetically lead to healing inasmuch as it allows the flows of information within the bodymind to become reopened and reconnected. This process is thought to facilitate healing by renewing flexibility and integrity of conflicting bodymind systems. Groves approach is unique in its potential to facilitate this type of healing process in an efficient and elegant manner.

#### Some Later Developments in Grove's Metaphor Therapy

David Grove suddenly died of a heart attack on January 8, 2008, while he was only in his mid-fifties. Until the very end, his exceptionally creative mind was focused on developing innovative approaches to therapy, in collaboration with his long-time partner, Cei Davies Linn. Most of the newer material was never formally written down or recorded, but he had presented some in lectures and workshops (e.g. Grove, 2003), and Linn kept extensive notes or informal recordings of these developments and currently is working on a compilation of them. This

section includes only a few examples of the novel procedures and is based largely on personal communications between Linn and Sheikh (February, March, 2010).

### Clean Space

Later in his career, David Grove devoted considerable attention to questions such as, “Where does our sense of purpose and mission in life come from? What defining moments in our life history obscure our life’s original path? How does the loss of personal direction influence psychological and physical symptoms?” He often addressed those issues innovatively by evoking imagery and discourse in a “clean space.” He found that by simply asking clients, who are stuck, to move from the places where they normally sit in the therapist’s office and to find a space that knows the answer, an amazing shift in the clients’ epistemologies, that dramatically helps to make both experiential and cognitive sense of their lives, can occur.

Clean space is basically an extension of clean language questions: The client first finds a place to be within the office, and next is asked to select a place for the therapist. Quite often the first reply to the therapist’s request for a location is, “I don’t mind,” or “It’s not important.” However, when the therapist moves slowly around the client, it becomes clear that it is very important indeed. Even small movements take on marked significance; for example, the client might say, “It’s not good for you to be there,” or “I need to be able to see in that direction.” The therapist asks clean language questions to develop all emerging angles, such as, “What kind of ‘there’ is that ‘there’ that is not good to be there?” or “What kind of ‘direction’ is that ‘direction’ you need to be able to see?” All angles around the client are explored and new memories, thoughts, and feelings surface.

Grove and Linn often would *reposition the client* several times, encouraging movement from the last position to a new one, until a *sweet spot* was reached, where all the information

intersected, revealing new cognitive and affective congruence. In every position, the therapist asks clean language questions to develop the information coming from that position (e.g., “And what kind of you are you when you are there?” and “What do you know from that space there?” and “Is there anything else you know from there?”) Each position is a vantage point from which to look back and view more details about the information that had emerged from the last position.

### Mission Statement

Grove often successfully began the session with a mission statement by the client, such as, “I want to try to understand what happens to me, so I can get on with life and not affect my kids with my confusion,” “I want to spend more time with my family,” or “I don’t know.” Linn explained that the mission statement can be just a question, a word, a sentence, or several sentences, or it can be communicated by a medium other than words. This is followed by questions by the therapist in clean language to develop information. Subsequently the client is encouraged to put the statement where it belongs with respect to the client, such as, “just out of arm’s reach” or “in the parking lot outside the building.” The next step is to develop the space in-between the client and the mission statement, by asking about the nature of that space. The space might be perceived by the client as “impossible,” “too far away,” “dangerous,” “full of fear,” or even “unknown.” The client might even say that the space belongs to someone else, requiring a trespass to reach the goal. The intervention continues until the landscape shifts toward integrity or oneness with the client.

### Pulling-Back Questions

All the clean language questions discussed so far either deal with the present situation (e.g., “And when you have pain, how do you know you have pain?” “And where do you have

the pain?” “And does it have a size and shape?” “Is there anything else about it?”), or they are “pushing-forward” questions (e.g., “What would you like to have happen?” “And what happens next?” “And what happens after that happens?”). But Grove and Linn also had been actively exploring “pulling-back” questions that resulted in many valuable new ideas and techniques, such as the *pristine noun* and *idyllic time*. The former refers to the condition experienced by the child prior to a traumatic experience, which deeply changed the child’s being. The aim is to regress to discover the child’s pristine being and the environment that supported a pristine sense of being. *Idyllic time* is the period of this experience. The goal is to retrieve the essence of this time, so that it can be incorporated into the client’s newly emerging perspective.

Linn notes that pulling information backwards generally is a harder task. An example of pulling-back questions follows: “And when you are angry like a volcano, *where did you get angry like that angry-like-a-volcano from?*” “My father was always exploding.” “And he was always exploding like what?” “A volcano” (Linn, 2009).

When a pulling-back question elicits a response that “takes the metaphor outside the body, questions pull the information back in time and develop.... Further back in time the information becomes represented by tacit knowledge from which Emergent Knowledge was born” (Linn, 2008, p. 16). Grove seemed fascinated by this development in metaphor therapy. He began to treat the human psyche as a system and believed that a change in one aspect thereof is bound to influence other aspects of the system (Grove & Rawlin, 1989; Grove & Wilson, 2005).

## The Four Quadrants

It seems that the pulling-back questions elicited much new material which significantly influenced metaphor therapy. Subsequently Linn and Grove (Linn, 2008) classified their interventions or, in fact, their entire therapy work along Four Quadrants.

In the first quadrant, the client is in the present, although work in this quadrant may involve reflections on the past or images of the future. Interventions in the second quadrant locate the metaphors in  $t-1$  and mature them into  $t+1$ . Most of the child-within work happens here, and the emerging information is primarily biographical. The third-quadrant interventions involve questions to retrieve information, which follow the client's eye movements or any other repeated movements, such as foot and finger tapping (e.g. "As foot does that, and take all the time foot needs to do that, and what might foot like to do after it does that?"). In the fourth quadrant, the information is pulled back out of the biographical into the ancestral domain, right back to the time just prior to the child's experience of trauma ( $t-2$ ), to data about parents, grandparents, or even great-grandparents ( $t-3$ ), to cultural and ethnic heritage ( $t-4$ ), to circumstances that molded the people ( $t-5$ ), and to the client's religion and view of the universe ( $t-6$ ) (Linn, 2008).

## Concluding Remarks

What will become of the approach? Ideally, the current paper will provide a means for clinicians and researchers to gain access to the approach. Beyond simple access to the approach, it is hoped that clinicians will understand the ways in which the approach is similar to and also distinct from other approaches to psychotherapy. Among the broad, modern schools of therapy, the approach is similar in its ability to facilitate mindfulness and congruence in clients: a broadening of experiential awareness while judgment and evaluation are minimized. Grove's

approach is unique, however, in that it bypasses the client, going directly to experiences contained within symbolic metaphors. In this manner, there is relatively little reliance on insight, motivation, and defenses – the most common barriers to improvement across the psychotherapies.

Grove's approach is similar to other imagery-based approaches to therapy, which also aim to bypass these barriers to positive outcomes. Yet it provides a simple formula for doing so, while at the same time leaving the flexibility for each client's therapy to be completely unique and tailored. Furthermore, the approach has the rather unique ability to allow access to deep information through trance and to bring that information to immediate use during everyday life. Likewise, there is no need for suggestion, hypnotic or otherwise, on the part of the clinician. Overall, the approach may be seen as being as deep and individually tailored as other deep imagery approaches, while being more elegant, efficient and simple to carry out (Pincus & Sheikh, 2009).

Researchers aimed at investigating Grove's approach ideally should ground the approach in some general theory. This would allow for conclusions beyond therapeutic outcomes and may spawn new ideas about how the various approaches to therapy work through common mechanisms. Such mechanisms hypothetically focus on the reconnection of rigid, static, and incomplete information to other flows of information within consciousness. Indeed, the various psychotherapies, from psychodynamic to behavioral, appear to be moving toward the middle with a common focus on phenomenology and the importance of here-and-now experiential flexibility and acceptance (Pincus, 2009). As such, Groves approach is well situated for investigation of its efficacy as a stand-alone treatment approach and also as a mediating process common to most other treatments.

Ideally, subsequent clinical, theoretical, and empirical advancement of Grove's approach, and other gem-like imagery approaches will assist the field of therapy in recognizing the centrality and ubiquity of imagery in psychotherapy. With increased awareness and use of such approaches in the clinical communities and with increased direct investigation within the clinical-research communities, greater infrastructure may emerge to support the development of high-quality approaches to image therapies in healing practices across the disciplines. Such refinement of knowledge in imagery-based therapies may occur within the offices of clinicians, within the labs of health-scientists, within the classrooms of clinical training programs, and within the conferences of professional organizations. On the grandest scale, increasing knowledge into the therapeutic potential of imagery may assist in the understanding of the common processes underlying health across biological, psychological, and social systems, and the unique role that imagery plays as a connecting process among those systems.

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