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Stories and Analogies in Cognitive Behaviour Therapy: A Clinical Review

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Abstract. The transfer of knowledge occurs most effectively through the stories – the narratives – that we tell others and ourselves about our experiences. Cognitive behaviour therapists may incorporate stories, metaphors and analogies within their daily practice, when assessing suitability for treatment, challenging unhelpful styles of thinking, and addressing maintaining behaviours. The collaborative development of stories can enhance rapport, enable clients to gain a new perspective upon their problems, increase personal impact and clarity of meaning, and reinforce clients' motivation to effect therapeutic change. This paper discusses the use of the story, anecdote, metaphor, analogy, and quotation within cognitive behaviour therapy (CBT). The contribution of other psychotherapies to these forms of therapeutic communication is outlined. Practical examples of stories and analogies that illustrate the main principles of CBT and its application to the treatment of common mental disorders are described. The benefits and limitations of employing individualized analogies and stories within the therapy session are highlighted.

Keywords: Story, metaphor, analogy, quote, cognitive behaviour therapy, communication.

Introduction

A man in bed one night is woken by a loud noise downstairs. He believes it must be a burglar. How will he feel? What will he do? A conviction that he is being burgled might lead to fear and an urge for the man to hide, or alternatively anger and perhaps an attempt to confront the intruder. Now consider the same situation, but this time the man remembers that he has a cat and has left the kitchen window open. How will he then feel and behave? Assuming that it is the cat may result in little distress, so that he goes downstairs to close the window. This example shows how our thoughts, feelings and actions are closely interconnected (Blenkiron, 2000a). It also demonstrates that the problem is not so much the events in our lives, but the way we interpret them. Many cognitive behaviour therapists will have used metaphors, stories, images and analogies – like this one – in their clinical practice. Such tales can clarify an important message, and bring new perspectives to bear upon distressing situations.

The basic principle of telling therapeutic stories in the context of cognitive behaviour therapy (CBT) is similar to when relating them in other situations, such as to a friend at a party (Burns, 2001). A good story is one that is coherent, aesthetically pleasing, and works for the individual to whom it is told (Launer, 2003). Inventing and developing stories is a helpful

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skill for cognitive behaviour therapists and their clients to learn. Anecdotes may come from a variety of sources: from colleagues in clinical supervision, educational workshops, written material, the therapist's imagination, or be spontaneously volunteered by a client. The client's own narrative is becoming a popular method of promoting self-discovery: a recent review (Aronson, 2000) of 206 tales written by sufferers with mental and physical health problems has revealed a striking increase in the publication of such accounts during the past 20 years.

Burns (2001) emphasizes the particular importance of the therapist creating their own stories, and developing stories collaboratively with clients. For example, a man with an overly perfectionist but negative view of his achievements was asked by his therapist to come up with a personal anecdote that described his difficulties. He recalled receiving the result of a college exam by post. When he saw it was a grade "D" he immediately threw the letter to the ground, muttering to himself "D for Dunce, D for Dismal failure". It was only later, when re-examining the letter, that he saw that he had actually passed the exam, and that the "D" stood for distinction. From this personal narrative he concluded: "I'm always jumping to conclusions".

Martin, Cummings and Hallberg (1992) found that the use of stories and analogies in CBT increases personal impact, memorability for key issues and improves clinical outcome. Stories may be introduced at any stage of therapy: when assessing suitability (Safran and Segal, 1996), putting together a formulation, developing an understanding of maintaining factors, or trying to effect change. Popular self-help books such as *Mind over mood* (Greenberger and Padesky, 1995) make frequent use of case vignettes and scenarios to help illustrate problems – and their potential solutions – more clearly to readers.

Aims and method

The purpose of this article is: 1) to illustrate the general principles of CBT, using stories, analogies and metaphors, and 2) describe the application of these forms of narrative to specific mental disorders. The emphasis is upon practical examples of stories, and analogies that may be used by cognitive behaviour therapists and other professionals when they are seeing clients with mental health problems. It is a selective account based on the following information sources:

- a PubMed literature search performed in May 2003 using the key words story, analogy, anecdote, metaphor *and* psychotherapy *or* cognitive behaviour therapy
- the Roundtable Debate on Analogies, Stories and Metaphors held during the 2001 Annual Meeting of the British Association for Behavioural and Cognitive Psychotherapies in Glasgow
- a personalized collection of stories and analogies recounted by professionals during training and supervision sessions over a 5-year period (see acknowledgements)
- clinical CBT experience including client feedback

Story telling in the psychotherapies

Cognitive behavioural therapists can learn from the use of metaphor and analogy within other schools of psychotherapy. Our beliefs are linked to their spiritual and cultural origins, highlighting the importance of mythology, fables and proverbs handed down the generations (Jung, 1942). Sigmund Freud compared an individual's adult personality to an archaeological

site, with each layer of civilization and growth being based upon and retaining some features of the one it has replaced (Bateman and Holmes, 1995). The same metaphor can be applied to the development of ideas by successive schools of psychotherapy. The focus of modern interpretative therapies is no longer upon a client's conflicts and frustration of wishes but upon translation of their experience into "coherent stories or narratives that make sense and act as guides for future action" (Elliot and Shapiro, 1992). The acquisition of insight in psychodynamic therapy is most easily expressed figuratively: as stories interweave, "the light dawns", "the ice breaks", and "the penny drops".

Narrative and solution-focused therapies make advanced use of the extended metaphor and story. In the conversational model of psychotherapy (Hobson, 1985), the *what* (content) is of less importance than the *how* (manner of discovering and mutually exploring a feeling language). Using metaphor, Hobson emphasized that "learning how to engage in a personal conversation is the heart of psychotherapy". He also described development of the metaphor from non-verbal behaviour, such as a client's hand clutching the chest ("a broken heart") and the client mixing metaphor with pun ("it breaks my heart to be in a grave marriage").

However, the use of metaphor in CBT differs from its application in other psychotherapies. In psychodynamic and some family therapies, there is an assumption that therapist and clients will automatically have a shared understanding. In CBT, the meaning of the metaphor or anecdote is made more explicit, and is usually deconstructed to ensure that the required point has been made.

Tools for communication

Table 1 defines the range of basic tools that may be used to enhance communication by narrative (Allen, 1984). Stories and analogies serve a variety of important clinical uses for practising psychotherapists (Table 2). They help to increase the likelihood of an individual remembering important information, by representing an easily accessible, portable way of retaining the one-hour therapy session in a client's head. Metaphors and proverbs use language efficiently by saying a lot in a few words: for example, "no man is an island". A developed metaphor has three components: topic, vehicle, and ground (Richards, 1936). In the example "my mind is playing tricks on me", the topic is what is referred to literally (the way this person's mind works) and the vehicle is the literal term being used metaphorically (playing tricks). The ground is the enhanced meaning arising from combining the two terms (self deception). A useful metaphor operates within the shared understanding that two parties bring (as at the intersection of a Venn diagram). It allows a person to use a concept that they already understand to help with one that they do not.

The use of quotations relevant to CBT (Table 3) can further convey and reinforce key messages (Nezu, Nezu, Friedman, Faddis and Houts, 1998). Humour, when used selectively, often improves rapport between client and therapist and allows emotional ventilation during a discussion of distressing underlying issues. Analogy can also be effectively combined with humour for the purpose of professional development: a recent paper in this journal presented a new condition – Cognitive Therapy Training Stress Disorder – designed to inspire clinical confidence in an amusing way (Burns, 2002). The cognitive model itself was used to describe common fears of incompetence amongst therapy trainees ("I don't know what's schemata with me").

Table 1. Tools for communicating in psychotherapy

Clinical tool	Definition (Oxford English Dictionary)	Examples
Story	Tale of imaginary or past events and experiences that deserve narration	Noise at night (burglar) scenario; Frankel's survival plan story
Anecdote	Very short story dealing with a single entertaining incident	Vampires and garlic; Unnoticed by passing friend tale
Analogy	Reference to a parallel case that is alike in certain respects	Lovell's factory model for PTSD; Budgeting analogy for chronic fatigue
Simile	Comparison of one thing with another as an illustration	As brave as a lion; Therapy is like holding a mirror up to see oneself more clearly
Metaphor	Application of a name or phrase to something that it does not literally apply to	A glaring error; The journey of life; Insurance metaphor for OCD
Quote	A passage cited or repeated, especially to confirm a view	Think first, then do (Albert Schweitzer, 1875–1965)
Joke	Thing said or done to cause laughter	"How many therapists does it take to change a light bulb?" "Only one, but the light bulb must really want to change".
Sense of humour	An ability to say or perceive what causes amusement	"I told you so!" (grave stone epitaph of Samuel Church, self-proclaimed 18th century hypochondriac)
Proverb	Short pithy saying stating a general truth or giving advice	A bird in the hand is worth two in the bush
Image	Mental representation or picture	Is the glass of water half empty or half full?
Music	Art of expressing or causing emotion by a melodious combination of notes	Many uses, e.g. to inspire hope

Table 2. Uses for stories and metaphors in CBT

1. Clarify meaning: make therapy more understandable
2. Gain a new view or insight (metaperspective) from which individuals can reflect upon their problems
3. Make abstract concepts more concrete e.g. to look for the skeleton in the cupboard
4. Assess suitability for CBT: positive response topresentation of examples of CBT rationale indicates more favourable prognosis (Safran & Segal, 1996).
5. Provide initial distance to allow sensitive topics to be discussed e.g. "if I'm hurt I want to wear it on my sleeve"
6. Increase rapport between client and therapist e.g. using humour
7. Increase impact or force of a message e.g. the storm raging within me: ("Metaphors are principally a way of being vehement") (Rose, 2003)
8. Increase motivation for therapeutic change (e.g. by accessing emotions as well as thoughts)
9. Teach particular skills e.g. challenge unhelpful thinking styles, devise behavioural experiments
10. Encourage specific outcomes e.g. learn factual knowledge, set concrete goals, modify behaviour

Table 3. Quotations relevant to CBT practice

Quote	Source	CBT principle
People are disturbed not by events, but by the view they take of them	Epictetus, stoic philosopher, 55–135 AD	Essence of cognitive therapy: it is not what actually happens, but how it is interpreted that causes mental distress
We don't see things as they are, we things as we are	Anais Nin, writer, 1903–1977	
Our life is what our thoughts make it	Marcus Aurelius, emperor, 161–180 AD	
History is not what you thought. It is what you can remember	W. C. Sellar, 1896–1951	Personal meaning of past events affects here and now
It isn't that they can't see the solution. It is that they can't see the problem	G. K. Chesterton, 1874–1936	Importance of problem definition to guide therapy
However much thou art read in theory, if thou hast no practice, thou are ignorant	Sa'di, 1258	Practical focus, setting of behavioural targets
Give people a fish, they eat for a day: teach people to fish, they eat for a lifetime	Anonymous	Collaborative, self-help approach
Awaken the mind without fixing it anywhere	Zen Buddhist saying, c. 6th century AD	Promotion of openness to a new perspective
Afterthought makes the first resolve a liar	Sophocles, Greek playwright, c. 496–406 BC	Weighing up evidence rather than jumping to conclusions
The only thing we have to fear is fear itself	Franklin D. Roosevelt, 1882–1945	Exposure therapy for anxiety disorders
We must travel in the direction of our fear	John Berryman, 1914–72	
Don't trust me, test me	Aaron T. Beck, 1976	Invitation to challenge beliefs in reality via behavioural experiments
All the world is full of suffering . . . it is also full of overcoming it	Helen Keller, 1880–1968	Instilling motivation to effect life changes
"It is not possible to hold the day. It is possible to lose it."	Sundial inscription, 1695	

Basic principles of CBT

Cognitive behaviour therapy is a talking treatment that aims to change the way a person feels by altering how they think and behave in everyday situations (Beck, 1976). Cognitive approaches work by enabling clients to first recognize unhelpful ways of thinking, and the effect this has upon their mood ("Is the glass of water half full or half empty?"). Next they are encouraged to look more objectively at the evidence for and against these beliefs, rather like a jury in a court of law. For example, someone who is depressed may be asked to consider the situation when

a close friend passes by, appearing to ignore him or her. Common interpretations of this are a feeling of rejection, or negative thoughts such as "Nobody likes me". Clients within the therapy session can be presented with this scenario, then encouraged to offer other plausible reasons for this friend's actions: they were in a hurry for an appointment, not wearing spectacles, or simply did not notice them. By coming up with alternative, less threatening explanations for distressing situations ("how would I advise a friend in my situation?"), clients can begin to feel better.

Individuals then need to test out unhelpful beliefs and new perspectives in reality using specific behavioural experiments. For example, a socially anxious person may attend a party and attempt to converse with a stranger to challenge the belief that they will be ignored. Someone with panic disorder may practise over-breathing in session with their therapist to evaluate their fear of passing out. Stories and metaphors can facilitate this guided discovery by enabling the individual to attend to information outside their current focus in order to arrive at a new, generalized perspective. However, significant resistance to trying out such behavioural tasks for the first time is common. Creative therapists may make use of memorable images in order to reinforce a client's determination to (in the words of one sports shoe advertisement) "Just Do It". For example, in the film "Indiana Jones and the Last Crusade", the hero has to cross over a deep ravine via an invisible bridge. It is terrifying, but the bridge becomes visible as soon as he has the courage to step out. The central message that "you will only know if you test it out" may also be conveyed by use of the following vampire story. In Transylvania there exists a tribe of people who believe in vampires. For 300 years they have lived in fear of being bitten. In order to protect themselves from this, they have worn cloves of garlic around their necks at night. During that time, not one person has ever been bitten by a vampire, and so this life-preserving ritual continues. How could they test out the garlic's magical protective power for certain?

The collaborative philosophy adopted in CBT may itself be summarized as a story. In a typical clinical encounter the individual relates their story (presenting problems). The therapist develops and structures this information using their professional knowledge. A new story that makes sense and works for both parties is then jointly retold. The emphasis is on promoting self-help: the therapist is like a football coach – who can advise, guide and encourage, but can not play in the match itself. Those who are referred for CBT will need to weigh up the costs as well as the benefits of therapeutic change: "there is no gain without pain". They should also be prepared to adopt an active approach to their problems: completion of assessment forms, thought diaries, and regular homework tasks between sessions requires a high degree of motivation and hard work: "you only get out of life what you put in".

Christine Padesky's road to recovery analogy (Greenberger and Padesky, 1995) likens the collaborative treatment path to a journey in which the therapist (who has the map) and the client (carrying the baggage) need to:

- Establish the reasons for travelling (motivation, problem definition)
- Decide upon a destination (target setting)
- Set off down the chosen path (action)
- Stop off along the way to refuel (consolidation)

When encouragement is needed to practise the skills involved in CBT, a comparison may be drawn with the experience of a first driving lesson. "Remember how you struggled to perform basic tasks, like changing gears, that you can now do automatically?" Those who complete

mutually agreed "homework" tasks between therapy sessions are significantly more likely to benefit from CBT (Hawton, Salkovskis, Kirk and Clark, 1989). Clients who cite a lack of time as the main reason for not carrying out homework may benefit from a comparison with other aspects of their life. "Do you have anything in your weekly routine that you do regularly, such as have a bath or watch a favourite television programme?" Asking the individual to consider how it is that they are able to make time for these activities allows them to consider the issues of prioritization and self-motivation more clearly.

For those who argue that the cognitive-behavioural approach described above is too simplistic for addressing complex human problems, a medical analogy is useful. When comparing a varicose vein operation with a heart bypass, one is undoubtedly much more complicated than the other. Yet in both operations the surgeon uses only two basic techniques: cutting and stitching.

Specific disorders

Depression

Trying to function with depression is for many individuals like carrying a 100-pound weight around. Those affected often see their low mood as a sign of weakness and may express guilt when asking for help (Hawton et al., 1989). A discussion about coping with depression can include use of the car analogy. Human beings are akin to machines, needing fuel and regular servicing in order to work properly. What is the best course of action to take when a person's car develops a major problem? Give up and stop using it altogether, blame the vehicle, punish it for a few more weeks on the road till it breaks down totally, or take it in to the garage (cf. therapy) to be repaired? Individuals with depression who minimize progress or fail to acknowledge even small achievements may be encouraged to compare their approach to recovering from having a broken leg. Would you be able to run 200 yards? Should an athlete recovering from an injury expect to run a marathon straight off? Or would you be pleased if you managed just two steps?

The vicious cycle of negative thinking in depression, like seeing the world through dark tinted spectacles, may be explained via a "bad hair day" metaphor (Blenkiron, 2000b). A morning that has started badly can appear to be filled with one problem after another as the day progresses. In this self-fulfilling prophecy, biased and selective focusing on what is going wrong allows negative automatic thoughts to fuel the fire of frustration. An individual's performance at home or work is then reduced, reinforcing their low mood. Other unhelpful thinking styles (cognitive processing errors) that are common in depression may be illustrated in session using brief anecdotes. One woman thought that her partner had forgotten her birthday and spent the day seething, only to discover he had arranged a surprise romantic evening meal (jumping to conclusions). The tears of the man in the wheelchair must be about his physical disability (mind reading). One minor mishap may be extrapolated as applying to all other situations, like a drop of ink that discolours the whole beaker of water (over-generalization). We sense a deliberate snub when a preoccupied friend forgets to telephone (personalization).

Beck's cognitive theory of depression (Beck, 1976) recognizes three basic layers of unhelpful thinking. Automatic negative thoughts lie on the outside, dysfunctional rules and assumptions in the middle, and core beliefs about the self, world and others at the centre. Therapy involves peeling back this metaphorical onion of distress. Alternatively, a fountain of

Table 4. Analogies for unhelpful beliefs

Example	Description	Key message
Reference library	If what you say is true rather than a belief, it must be written down somewhere (e.g. in a library, the 10 commandments, or scientific thesis). Show me the place!	Beliefs are not facts
Parents	Where do your rules and beliefs come from? Do you accept everything your parents believe in, such as their political views?	Parents as a source of core beliefs
Pink elephant	If I said you were a pink elephant, would you believe me? If I told you this every day of your life for 30 years, would you then believe yourself to be one? Although you might *believe* it, would this make it definitely true?	Past experience and emotional reasoning ("I feel it, therefore it must be true")
Newspaper readers	Consider the likely reaction if readers of the *Times* and *Daily Mirror* were asked to swap newspapers for the rest of their lives	Changing core beliefs is difficult
Hermit crab	The hermit crab must exchange its shell as it grows, leaving it vulnerable for a while till a new shell that fits is found	Change carries risks as well as benefits
Old clothing	Changing beliefs is like discarding old worn out clothing: comforting to wear but out of date, unattractive and no longer useful	Attraction of familiarity
Letterbox	A standard size letterbox can not accept packages of a different shape unless its opening is modified to receive them	Need to collect, not filter out, positive evidence supporting a new belief
Heart versus head	"I understand my thoughts are illogical, but I still don't feel any better". If you have told yourself the same message for years, it is unsurprising that you will need to hear the new idea many times in order to feel better	Cognitive change precedes emotional relief

beliefs may be visualized with a column, spray and droplets representing the three components. These images illustrate the principle that automatic negative thoughts (such as "it is going to go wrong") are the most accessible and easiest to modify in therapy, whilst core beliefs (for example "I am a failure") are usually much more difficult to access and change quickly. When identifying negative thoughts, it is often helpful to encourage the client to slow down their account of a distressing situation as in a slow motion action replay of a television sports programme, or frame by frame as in a cine film. Core beliefs may then be reached by the use of repeated specific questioning (e.g. "if that were true, what would it say about you?") until a point of no change in response is heard from the client. This downward arrow technique (inference chaining) is a powerful method for eliciting an emotional reaction (Beck, 1995). It may be compared to the behaviour of a small child who repeatedly asks his parents "Why?" until a response of "because I say so!" is received. Table 4 contains further examples illustrating how analogies may be used to challenge and modify unhelpful beliefs as therapy progresses.

Anxiety

For anxious individuals, the avoidance of feared situations, thoughts and feelings leads to a short-term gain but a long-term maintenance and worsening of their problems (Hale, 1997). Coping by avoidance, the use of safety behaviours or seeking reassurance leads to negative reinforcement of unhelpful responses (Warwick, 1998). Those affected need to understand this basic principle because it underlies the rationale for exposure treatment and goal setting in a range of anxiety disorders (Hale, 1997; Hawton et al., 1989), including phobias, panic, obsessive-compulsive disorder, post-traumatic stress disorder and health anxiety. From the client's perspective, those actions bringing only temporary symptom relief may be compared to scratching to relieve an itchy rash, failing to pay off a credit card debt, digging with a spade to get out of a hole, or giving in to the school bully's demands.

The following quotation summarizes the graded exposure approach: "she feared she'd die if she tried . . . but when she tried, her fears they died". Climbing 10 flights of stairs may appear daunting, but one flight is likely to be seen as achievable. After engagement, individuals begin to gain confidence during exposure, and may change cognitive perspective so that a sprint up the remaining stairs is common. However, repeated practice is needed on the top flight (relapse prevention) in order to prevent their slipping upon a metaphorical banana skin and falling downstairs again.

Like those who pay attention to rumours and gossip, anxious individuals gather pieces of information from friends and the tabloids and combine them into plausible but sensational and false scenarios. In panic disorder (Clark, 1996) and health anxiety (Warwick, 1998), individuals tend to misinterpret their normal physiological reactions to stress, such as palpitations and sweating, as evidence of serious illness or catastrophe ("I am having a heart attack"). Education about the nature of this healthy anxiety reaction may be enhanced using a practical "fight or flight" anecdote. Upon being charged upon by a bull in a field, our natural fear leads to a speeding up of the heart and breathing rate, a tensing of muscles, and a heightening of the senses. This survival response, present since prehistoric times, improves performance: we can quickly look for a way out of the field and run if necessary. Similarly, if we were not fearful of common dangers, we would not look before crossing a busy road. If we were not anxious about examinations, we would never study. Yet for many stresses in modern life, there is no need to run, so normal physiological body changes need to be dispersed in some other way. Hence the goal of treatment is not to get rid of all anxiety, only to manage it successfully, by losing one's fear of it so as to allow the feelings to pass.

Anxiety is often maintained in those with panic disorder and health anxiety by a selective attention to normal body changes – in the same way that anyone who has just bought a car or moved house will tend to notice other similar cars or houses for sale around the same time. Hypervigilence (actively looking for evidence of danger) is analogous to that of the overly sensitive radar on a ship sailing through Arctic waters. The radar constantly scans the sea for icebergs so that the captain can steer a safe course. However, it detects even very small icebergs, causing the ship to precede very slowly, blind to the safe waters ahead that could allow the individual to get on with life.

Obsessive compulsive disorder

Clients with obsessive-compulsive disorder (OCD) take personal responsibility for controlling their thoughts and try hard to exclude upsetting ideas such as "my family will die" from

their minds (Salkovskis, Forrester, Richards and Morrison, 1998). Since it is very difficult to resist such thinking, their anxious ruminations increase further. Being asked *not* to think about a pink elephant (or similar image) in session usually results in the client immediately picturing the elephant in their mind (Salkovskis and Warwick, 1985). This exercise helps to demonstrate the futility and paradoxical effect of thought suppression, allowing clients to begin to treat such ideas as mere thoughts, and relax in their presence. In long standing OCD, underlying obsessional fears may become less prominent, with the associated compulsions such as checking or cleaning becoming a habit. This over-learned behaviour may be likened to approaching a traffic light on red and then automatically stopping without thinking.

Cognitive theories of OCD (Salkovskis and Warwick, 1985) emphasize that sufferers often set impossible criteria for personal control and avoidance of risk, and grossly overestimate the likelihood of something serious happening. The insurance metaphor asks clients to consider whether the insurance policy on their home covers all eventualities (acts of God and terrorism are invariably excluded). The therapist can then ask the client whether they would be prepared to pay £10 million for a policy that guarantees cover for all eventualities. This analogy can be used to demonstrate both the high personal cost of OCD rituals in terms of daily restrictions (Blenkiron, 2001), and the impossibility of guarding against all risks in life.

Perfectionism

Perfectionism has been defined as the inability to accept even a minor flaw in oneself or others (Hamacheck, 1978). Those with perfectionist traits are more vulnerable to depression because they equate self-worth with performance. Beck (1976) related the case of a depressed man who did the kitchen wallpapering, but who thought he had failed because one of the flower patterns on one strip of wallpaper was slightly out of line with another. However, when his wife asked what he would have said if his neighbour had done the work, he replied "pretty good job". Such double standards ("one rule for me, another for everyone else") were then effectively addressed in therapy.

Perfectionists may be asked to suggest occupations for which consistently high standards are essential (for example, being a proof reader or bomb disposal expert) and compare these with the majority of jobs where it is not important to get things precisely right. Ideals may be usefully regarded as like the stars in the sky: good to look up to as a guide, but impossible to reach in practice.

Post-traumatic stress disorder

The "factory" model (Lovell and Richards, 1997) provides clients with a rationale for using exposure therapy to treat post-traumatic stress disorder (PTSD). Like a factory, the mind processes raw material (life events) by moving the "box" of information along a conveyor belt (thinking) to a store (the memory). Energy is normally released at the time as smoke (emotional reactions). However, when a traumatic event occurs, such as a serious accident or assault, the mind receives a large amount of disturbing information, and a large box is placed on the conveyor belt. The factory worker (client) presses the emergency stop button (avoidance and escape from thinking about the event) and the box falls off the conveyor belt. The worker is startled by this (hyperarousal) and replaces the box of traumatic material back on the conveyor belt (cf. intrusive thoughts and flashbacks), before once again pressing the emergency stop

button. Breaking this vicious cycle involves graded processing of the information (exposure therapy). During therapy, the contents of the box eventually pass to the end of the conveyor belt, letting off smoke (upsetting feelings) once and for all, and reaching a suitable "storeroom" in the client's memory.

Physical health problems

Chronic fatigue, chronic pain, fibromyalgia, irritable bowel and somatization are examples of the labels applied to individuals with unexplained "functional" somatic problems. Frustration and emotional distress are common reactions in those who present with physical symptoms, are fully investigated by doctors and are then told that no abnormality has been found (Fischoff and Wessely, 2003). This situation is analogous to the experience of taking one's car to the garage and repeatedly being told that nothing wrong has been found. Mechanics, like doctors, may find no abnormality with the structure of the car (there is no disease present). However, there is a problem with the functioning (fine tuning) of the car, as with the human body. Providing an explanation based on functioning, such as scalp muscle tension as a cause for headache, or inactivity leading to reduced muscle power in chronic fatigue, has been shown to help legitimize an individual's problems and encourage self-management (Salmon, Peters and Stanley, 1999).

In chronic fatigue syndrome, a common maintaining factor is the pattern of alternating prolonged rest on "bad" days followed by overly ambitious catch-up activity when "good" days occur. Such a "boom and bust" pattern represents an attempt by individuals to counter guilt and low self-esteem, but (as when investing upon the stock market) merely increases the risk of further setbacks (Sharpe, Chalder, Palmer and Wessely, 1997). A "sensible budgeting" analogy likens this behaviour to reckless spending upon receiving a salary on payday leading to debts (relapse) by the end of the week. Clients need to learn to break this vicious cycle by evening out their energy expenditure (activity and goals) over all seven days of the week, not just one or two. Their energy saving by doing less on "good" days is money invested wisely in the bank, which they can then "spend" in regular amounts each day.

Individuals who are trying to come to terms with a diagnosis of life threatening illness or disability may receive inspiration from hearing the story of the psychologist Frankel (Covey, 1995). He was a German of Jewish descent, detained by Nazi officials during World War Two in a concentration camp. He witnessed many of his friends and relatives dying in the gas chamber, and noted that they became mentally empty even before their death. Frankel reasoned that although he did not have any control over whether or not he died, he could control his state of mind in the present. So he began to plan in detail every day what he was going to do with his life and how he could make most use of it. He did survive, and went on to write eloquently about his experiences and the usefulness of this approach. Similarly, feelings of hopelessness and uncertainty following a diagnosis of cancer may be addressed in therapy (Moorey, Greer and Watson, 1994): "If you were to live 20 years, what would be your goals? Well, since you don't know how long you will actually live with this illness, is it not even more important that you try to achieve them now, starting in the next week?"

The issue of individualization

Many of the stories and analogies described above are standardized examples widely used by CBT practitioners. However, it is often the client who comes up with good analogies

in session, which the therapist can encourage the client to amplify and develop into their own personalized story. For example, a health professional with social phobia compared her distorted self-perspective ("others see me as a shaking red-faced fool") to her experience of individuals with anorexia nervosa, looking in the mirror and seeing themselves as grossly overweight. Metaphors may also be usefully modified when working with particular clients. A man with obsessive-compulsive disorder expressed frustration at his steady but slow rate of progress. Recalling the client's hobby of mountaineering, his therapist introduced the following analogy: "Consider climbing Mount Everest, and reaching base camp at around 19,000 feet altitude. Although it can feel like your journey has not yet begun, have you not already made impressive achievements?" In another case a woman with low self esteem, working in the legal profession, was invited to engage in reverse role play by metaphorically "entering the dock to present the case for the defence" (of her positive attributes) under the therapist's "cross examination".

Drawbacks and limitations

Are there any risks associated with the use of stories, analogies and metaphors by CBT practitioners? Whilst they can provide illuminating insights and explanations, there is a danger that the satisfaction derived from their development will be greater than the information imparted. The job of the therapist is not to "think up fanciful analogies with which to ice the cake" (Hobson, 1985), as the use of overly complex or obscure stories can mislead, confuse or be unhelpful (Rose, 2003). Conversely, dissecting a story too much can remove its spontaneity and appeal. This is especially true where humour is involved (never ask someone to explain the punch line of a joke you did not understand).

Whether a metaphor works will depend on its personal meaning for the client. Several of the "stock" metaphors described in this article are extremely culture specific. Some clients might take offence at certain comparisons (e.g. between their health problems and nothing being found wrong with their car). Others may arrive at unhelpful conclusions (e.g. that there is something seriously wrong that requires further medical investigation). The effect of appearing to minimize the distress of suicidal or depressed thinking, by pushing comparisons too far, should be recognized. An unskilled illustration of the cognitive approach (as simply positive thinking) could be misinterpreted by a client as an exhortation to "change your faulty thinking", or even to "pull your socks up" and "snap out of it". Challenges arise when we attempt to integrate a view of the world through stories and allusions with a scientific (evidence based) approach to knowledge (Launer, 2003). Given that a tale may be defined as both a true narrative and a lie (Aronson, 2000), can anecdote be considered as evidence?

Therapists should be aware of the possibility that stories used in session may turn out to be literally true. One client seen by the author was presented with the scenario in the introduction to this article, and then asked to come up with different explanations for hearing a noise whilst in bed at night, only to be woken the following week by a burglar breaking into his house (Blenkiron, 2000a). This incident was subsequently used in therapy to emphasize the importance of the client considering a range of alternatives (rather than one central truth) and then testing them out in order to draw their own conclusions (bad things do sometimes happen). In another example, an individual with apparently unhelpful perfectionist traits turned out to be a former leading bomb disposal expert. The key issue for this client was then to consider the

Table 5. Analogies to promote change

Example	Description	Key message
Frogs	Charles Hardy observed that if the water in which frogs are floating is gradually heated, they take no apparent action and die (Kennedy, 2000)	Unwillingness to adapt in a gradually changing world can be fatal
Office life	How many people on their death bed wish they had spent more time at the office?	Need for balance and prioritizing
Architect	A house is not built by finding some bricks and saying "let's make a start and see how it goes". We use an architect's plan and a picture of how we want it to look	Plan and visualize life's end goals
Open door	"When one door of happiness closes, another opens, but often we look so long at the closed door that we do not see the one which has been opened for us" (Helen Keller)	Focus on new opportunities, not past problems
The miracle	You go to bed one night and awake the next morning. All your problems are solved. What will your life be like? What will you be doing?	"This is not a rehearsal, your life is up and running"
Post mortem party	Imagine you are looking down after your death upon a celebration of your life: what is it that you wish to hear people saying?	Other person perspective of personal goals

circumstances in which behaviours such as perfectionism and checking are useful and when they are not.

Conclusions

Analogies can allow mental health professionals and their clients to integrate new information within their existing beliefs, create new mental models and set important new goals for living (Pennebaker, 2000). Potential areas for further research include comparison of the efficacy of standardized versus personalized metaphors, and the extent to which they enhance both client satisfaction and specific outcome measures. The use of stories and anecdotes is not exclusive to the cognitive-behavioural approach. We may consider all the different psychotherapies to be like raindrops falling on the pond of human emotional distress, producing a series of overlapping concentric circles. At the centre of each circle lie ideas best characterising that school of belief, for example counter transference in psychodynamic therapy, biased thinking in cognitive therapy, or system effects in family therapy (Bloch, 1979). However, the further one travels from each centre, the more the different psychotherapy "waves" overlap and merge. This coalescence emphasizes basic common truths within the talking treatment "pond": the importance of the therapeutic relationship, a desirability for clients to "buy" into a particular model, and the requirement for a change in behaviour or feelings to occur in order for psychotherapy to be deemed successful.

A good story provides a narrative for explaining the client's situation (Greenhalgh and Hurwitz, 1998) and creates a feeling that progress is possible (Table 5). Therapists may therefore make appropriate use of stories, analogies and metaphors in their daily practice, and

listen out for them from within the client's account. Not to do so increases the risk of a clinical encounter ending up focusing on literal meanings or becoming stuck with a single perspective. As a result, the full implications of material may be missed, leaving the therapy session in metaphorical hot water.

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