

DIAGNOSIS AND METAPHOR

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ABSTRACT Human beings rely on metaphor as a primary cognitive device for interpreting the world around them. Metaphors figure especially strongly in discourse around health, illness, and medicine. It is not just that patients use metaphors to describe their personal experience of being unwell, or that medical professionals employ metaphor to convey a diagnosis, describe a treatment, or explain the function of an organ to their patients. Metaphor, it is argued, lies at the heart of the process of diagnosis. Moreover, diagnosticians employ competing metaphors in the early stages of diagnosis to speculate on alternative ways of viewing a puzzling set of symptoms. Diagnosis is often defined as a process of ordering and classifying, while metaphor is a device for playing with classifications. The medical systems of different cultures depend on different sets of fundamental metaphors. Modern Western biomedicine is organized around a series of basic metaphors: the body as machine, the body as the site of battle, and the body as a communication system. Traditional Chinese medicine, on the other hand, uses images of flow and blockage, balance and imbalance, and works by analogy with five elements: wood, fire, earth, metal, and water. Psychologists are sometimes able to detect from a patient's own use of metaphor, or inability to use or recognize metaphor, clues to a diagnosis of psychosis or autism. With conditions such as anorexia nervosa, therapists may actually work to modify the dysfunctional metaphors by which patients depict themselves, with the purpose of establishing positive metaphors for envisaging recovery.

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MEDICAL PROFESSIONALS ARE THOROUGHLY familiar with the way in which patients employ vivid metaphors to describe their personal experience of illness: “a dark cloud hangs over me,” “the nausea comes in waves,” “it feels as if there is an elephant sitting on my chest,” and doctors are generally well equipped to interpret the significance of these metaphors for the purpose of diagnosis.¹ In the words of psychologists William Banks and Suzanne Thompson (1996), “People are incorrigible users of metaphors in thinking about sickness and health and the workings of the body” (99). Moreover, patients usually bring with them additional metaphors to describe not just their experience of symptoms, but their lay interpretation of what those symptoms might add up to. However, as Banks and Thompson observe, these metaphors are often scientifically seriously inadequate, for instance depicting the cardiovascular system in terms of an “ebb and flow” tidal motion of the blood, rather than circulation, or mistaking pulse rate for an indication of blood pressure (101).

Most doctors and nurses will be aware that they, too, use an extensive range of metaphors to convey a diagnosis, describe a treatment, or explain the function of an organ to their patients: “your blood pressure is so high, you’re a geyser ready to blow,” “your treatment isn’t going to be a sprint, it will be more of a marathon,” or “the kidneys are the body’s rubbish collectors: they are also an efficient recycling centre. They filter metabolic waste products . . . whilst retaining proteins that the body can reuse” (Karl 2014, 32). Some studies indicate a degree of mismatch, however, between the metaphors used by patients and by doctors in consultations (Skelton, Wearn, and Hobbs 2002). Medical professionals probably rely most systematically on metaphor in their communications with patients when administering the McGill Pain Questionnaire, which invites patients to describe the quality and intensity of their pain in terms of metaphors selected from a long list, including “pricking, tugging, scalding, rasping, freezing” (Melzack 1975).

In certain conditions, patients’ free use of metaphors about their experiences may actually facilitate diagnosis. For example, a person’s tendency to generate metaphors indiscriminately and to interpret metaphors literally, whether they have uttered them themselves or are responding to metaphors addressed to them by others, may well point to a diagnosis of psychosis (Rhodes and Jakes 2004). An individual’s difficulty in processing metaphors heard from others may assist the diagnosis of a disorder on the autism spectrum (Rundblad and Dagmar 2010). Researchers working with people experiencing major seizures have tentatively concluded that the specific metaphors patients use to describe their experiences may be a quite strong indicator of whether their seizure is of an epileptic or a non-epileptic type—a distinction which it is not otherwise always easy to make (Plug, Sharrack and Reuber 2011). And other practitioners have reported that a patient’s capacity to employ metaphors in speech indicated that a previous diagnosis of “central nervous system disease” was incorrect (Voth and Bradshaw 1978). The tendency of people suffering from anorexia nervosa to see themselves in terms of gross animal metaphors—“pig,” “elephant”—is well known, and this is a topic I shall deal with in detail later.

Many practitioners will have come across books and articles by doctors and nurse educators that encourage them to find or create explanatory metaphors that will connect effectively with the individual patient (Beitz 2013; Mosely 2007). “Metaphor operates lavishly in health and medicine, but it operates, at the same time, somewhat undercover; such is the way of metaphor,” writes Judy Z. Segal (2008, 115). Medicine, of course, is far from unique in this respect. It is widely acknowledged that metaphor is, alongside narrative, “a primary cognitive instrument” (Mink 1978, 131) by which human beings interpret the world around them, and “conceptual metaphors” play a major role in the theory and practice of every discipline (Hanne 1999). (For an overview of contemporary theories around metaphor, see Gibbs 2008). Metaphors are particularly useful for communicating complex ideas (“atoms are miniature solar systems”); for suggesting a fresh perspective (“the improvised jazz theory of the innovative organization”); for conveying a strong emotion (“a rollercoaster experience”); for confronting a challenging situation (“stepping stones to cross the river”); or for attempting to persuade someone of something (“my client has been framed”). Modern metaphor theory emphasizes that the source of most metaphor is to be found in the fact that even our most abstract concepts have their source in our bodily experience (Yu 2008). It should hardly be surprising, therefore, that metaphor figures so strongly in discourse around health, illness, and medicine (Hanne 2011).

A metaphor typically invites the addressee to view a topic from one domain through the lens of another domain. So, for instance, a depressed person may refer to his or her state of mind in terms that normally apply to the weather: “a dark cloud.” (Note, too, that the concept of “depression” itself involves a metaphor relating to the body being “kept low” or “pressed down.”) Often the metaphor provides a concrete image for an abstract concept, and this is especially useful when speaker and addressee occupy different domains or have access to different domains of knowledge, such as the patient’s experience of “illness” and the doctor’s knowledge of “disease” (Boyd 2000). Metaphors exchanged between patient and doctor will sometimes hint at a sense of mystery associated either with the patient’s experience of illness or the doctor’s explanation for it. According to Laurence J. Kirmayer (1996), metaphor can “clarify the tensions between the essential irrationality of illness experience and the biomedical presumption of rationality” (323).

That doctors and patients need metaphors to communicate with each other is broadly recognized. What is less well understood, and what this article argues, is that diagnosis itself is a fundamentally metaphorical process. Metaphors figure strongly at every point in the medical procedures and in the cognitive and linguistic moves by which doctors arrive at a diagnosis and communicate about that diagnosis with other medical professionals. This argument may meet some resistance from medical professionals. People trained in medical science, who seek to practice evidence-based medicine, tend to assume that they are immune to the need to think in metaphorical terms. However, professor of anesthesiology at Stanford University Audrey Shafer

(1995) has observed that “Metaphors enhance understanding by transforming the inchoate to the tangible, to the graspable” (1336). For diagnosticians, this statement must surely echo the mental processes they go through every day.

METAPHORS FOR DIAGNOSIS

A first indication that practitioners are likely to employ metaphor in the process of diagnosis is to be found in the fact that diagnosticians regularly employ striking metaphors to describe their own methods. While many doctors speak of themselves as “problem-solvers” or as “working out puzzles,” some use a more vivid metaphor, likening themselves to “detectives,” thereby picking up on the parallel between the ways in which members of the two professions collect and analyze evidence (Skelton, Wearn and Hobbs 2002; Taylor 2015). Probably the first doctor to make this analogy was Arthur Conan Doyle, who trained in medicine at Edinburgh University and who modelled the character of Sherlock Holmes, with his acute powers of observation and his capacity to interpret the data he collected by means of a brilliant imaginative leap, on his professor of medicine, Joseph Bell. Doctors since Conan Doyle have willingly adopted that analogy, so that we find doctor-writers such as Lawrence K. Altman publishing an article with the title “The Doctor’s World: A Correspondent Recalls His Days as a Medical Sleuth” (2001) and U.S. television’s Dr. Mehmet Oz (2012) bringing together a panel of “disease detectives” to discuss new ways of diagnosing and treating key diseases. The doctor-as-detective metaphor has been reinforced in the public mind by innumerable literary, cinematic, and television works of fact and fiction over the years, exemplified most vividly by journalist Berton Roueché’s *The Medical Detectives* (1980) and the American television drama *House, M.D.* (2004–2012). In fact, the producers of *House* admitted that the program “started as a team of doctors, trying to diagnose the undiagnosable. What we were trying to do, quite cynically, was to do a kind of cop show in a medical setting” (Weaver 2015).

A second metaphor, not quite so widely used but equally illuminating, depicts the diagnostician as “out fishing.” Miriam Lacasse (2008) distinguishes between two main types of diagnostic fishing. The first is “with a net” (“trawling for data,” one might say), where the doctor orders a barrage of tests and scans, thereby scooping up a large, slithering mass of data that subsequently must be sorted meticulously if a limited number of potential diagnoses are to be identified. The other type of diagnostic fishing is with a “line,” meaning that, from the beginning, the doctor formulates one (or a few) diagnostic hypotheses, poses specific questions to the patient, and orders a small range of tests (all of which serve as “hooks”) with the aim of confirming or eliminating each hypothesis. As Lacasse points out, the experienced diagnostician will usually fish with a line and a limited number of hooks. Shafer (1995) underlines the value of metaphor in making sense of challenging situations: “Metaphors can be considered tools for understanding, categorizing and working

with new experiences. . . . Furthermore, metaphoric thinking enhances pattern recognition” (1333). And as we know, the recognition of patterns is the most fundamental technique of medical diagnosis (Baerheim 2001).

METAPHOR IN ABDUCTIVE REASONING

A key feature of the diagnostic process in difficult cases, whether viewed as “sleuthing” or “line fishing,” is the imaginative leap whereby the diagnostician “transforms apparently random symptoms” into a tentative hypothesis (Conrad 2011, ix). This phase of diagnosis involves what 19th-century philosopher C. S. Peirce called “abductive reasoning,” and Umberto Eco (1988) refers to more specifically as “undercoded abduction,” since there is not sufficient data for the doctor/detective to be certain that the interpretation is correct and “the explanation is only *entertained*, waiting on further tests” (206). As Anders Baerheim suggested in his influential 2001 article “The Diagnostic Process in General Practice,” abductive, or speculative, reasoning is required in the early stages to point the diagnostician in a general direction, with deductive logic required subsequently to determine which tests should be carried out and how they should be interpreted. Peirce (1901) argued that “the mode of suggestion by which, in abduction the facts suggest the hypothesis is by *resemblance*” (303). Such “perceptual judgments” he admitted, occur by “a process which I am utterly unable to control and consequently unable to criticize” (1902/3, 303). It is Peirce’s use of the term “resemblance” that immediately suggests the presence of metaphor in the imaginative process by which the practitioner works from scattered evidence to a hypothetical diagnosis, since metaphor is precisely concerned with proposing a resemblance between domains that are conventionally thought of as distinct from each other. The role of intuitive (abductive) thinking in scientific discovery has been highlighted by commentators such as W. Brian Arthur, who writes: “Non-scientists tend to think that science works by deduction. But actually science works mainly by metaphor” (qtd. Waldrop 1992, 327).

Metaphor is a figure of speech involving the use of analogy, whereby a word or phrase ordinarily used in one domain is applied to another. When Shakespeare coined the phrase “All the world’s a stage,” he was not making a statement that was literally true, but rather inviting his audience to ask in what respects it might be appropriate to think of human life as if it were a series of theatrical performances. Indeed he goes on to suggest some of the ways in which that might be illuminating: “All the world’s a stage, / And all the men and women merely players; / They have their exits and their entrances, / And one man in his time plays many parts” (*As You Like It*, 2.7.139–43). This metaphor is an invitation to the audience to view the world through the lens offered by its knowledge of “the stage.” Yet any metaphor is likely only to capture certain features of the topic under discussion. As Segal (2008) has commented: “Metaphors highlight some things and hide others and render some things obvious and others unthinkable” (130). Note, for instance, how

each of the following modern metaphors invites us to view how we live in a quite different way from the theater-centered manner suggested by Shakespeare: “Life is like a walk in the rain: you can shelter or just get wet”; “Life is like a tea cup—to be filled to the brim and enjoyed with friends”; “Life is like a road. It has bumps, cracks and obstacles, but in the end, it gets you somewhere” (Smith 2015). While none of these metaphors has quite the evocative power of Shakespeare’s, each gives us the opportunity to view our lives in a somewhat different light.

Abductive reasoning in diagnosis employs just this kind of speculative linking across domains. While the layperson may well think that diagnosis involves simply identifying which of several objectively real diagnostic boxes the symptoms belong in and unequivocally placing them there, medical practitioners and researchers on diagnosis emphasize the vastness of the gap between symptoms and diagnosis and point to the fact that, initially at least, several strongly contrasting diagnoses may be possible. As Annemarie Jutel (2011) has argued eloquently, diagnosis is not an act of nature, a way of being, rather it is a way of seeing. Metaphor, too, is a way of seeing, sometimes described as a “way of seeing *as*” (Camp 2008, 2). At its most productive, it allows us to see a topic afresh, from a new perspective. That, indeed, is what a good diagnosis does in relation to a puzzling set of symptoms. From the patient’s perspective, the diagnosis and the metaphors employed to explain that diagnosis should clarify the patient’s story of symptoms and help to render his or her world comprehensible. Nevertheless, as many medical practitioners (and patients and families of patients) will acknowledge, the “fit” between diagnosis and specific case will often be imperfect, so that the diagnosis may turn out to be both “an aid and a curse” (Foster-Galasso 2005).

Metaphor scholars in many fields have emphasized the value of trying out several different metaphors for a given topic, to test the validity of each. So George Annas (1995), for instance, has highlighted the way in which metaphors for health-care policy in the United States derived from the marketplace (patients as consumers, medical care as a business, medical practitioners replaced by health-care corporations) have generated inequities (and iniquities) in the provision of health care. These, he suggests, might be corrected with the substitution of metaphors derived from ecology, where the key terms would be “community,” “limited resources,” “quality of life,” “renewable,” and “responsibility for future generations” (Annas 1995, 746). It is just this kind of weighing up of competing metaphors and their attached hypotheses that the diagnostician is constantly involved in.

A number of scholars of metaphor have drawn attention to the danger of getting locked into considering a topic through the lens of an inadequate metaphor. For example, Shafer (1995) warns that “A narrow metaphor . . . can constrain understanding of an abstraction by reducing and circumscribing it” (15), and Annas suggests this is what happened with the metaphor of the marketplace in health care. Much the same may be said of an inadequate diagnosis: it, too, can be dangerous.

METAPHOR IN CLASSIFICATION

Diagnosis, it is often stated, is largely a process for classifying, or categorizing health conditions. Yet, as Mildred Blaxter wrote nearly 40 years ago and many commentators have reiterated since (Jutel 2011, xiv), the business of categorizing the disease observed in any individual patient cannot be separated from the business of constructing the categories. Charles E. Rosenberg (2002) has highlighted the way in which the construction of increasingly technical, specialized diagnostic categories has taken over as a central concern of Western medicine over the last 150 years. According to Segal (2008), this has led to the widespread adoption of the notion that “diagnosis is health” (117), a misleading metaphor which causes us to assume, among other things, that early diagnosis is necessarily beneficial, whereas in a number of conditions that is not the case.

Diagnostic categories in biomedicine are constantly proliferating and under revision, often in quite radical ways. The *International Classification of Diseases (ICD)* published by the World Health Organization and the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association are regularly revised—the *ICD* is currently in its 10th edition and the *DSM* in its fifth edition. Revisions of the *ICD* have introduced numerous newly identified diseases and groups of diseases, such as chronic fatigue syndrome and the various autoimmune disorders, and, especially, redrawn boundaries between conditions. Revisions of the *DSM* have removed certain conditions, notably homosexuality, from the list of psychiatric disorders, but added numerous others, including some which many practitioners regard as part of normal growing up, such as “disruptive mood dysregulation disorder” (Frances 2012). There has been acute concern among some psychiatrists about the increasing tendency for their profession to treat the naturally occurring sadness that stems from misfortunes in a person’s life as “depressive disorder” requiring medication (Horwitz and Wakefield 2007). There is, in fact, heated debate among professionals about the validity of whole new categories of the *DSM*, with Thomas Insel (2013), director of the National Institute of Mental Health, declaring that *DSM-5* is “at best a dictionary creating a set of labels and defining each.” Indeed, it has long been suggested that the concept of “mental illness” is itself no more than a metaphor, which draws on an analogy with physical illness (Sarbin 1969).

A fundamental issue about the construction of any system of disease classification and the assigning of a diagnosis to an individual patient’s condition is, as Jutel (2011) points out, that they may be undertaken on the basis of several quite different principles and interests: “treatment, prognosis, medical education and communication, [and] research” (26). It has been suggested that the classification offered in the *DSM-5* is based almost entirely on symptoms rather than, say, causal explanation or treatment (Conner 2004). The *DSM* has been roundly criticized, moreover, for reflecting the specific interests of the American medical insurance and pharmaceutical industries (Corbett 2013).

Diagnosis, as I have said, is often defined as a process of ordering and classifying. In the words of Jutel (2011) again: “Effective classification recognizes difference as well as similarity. By classifying, we are putting items together that have more in common with one another than they do with things that we have decided belong in another category” (15). Metaphor involves a process of reordering and reclassifying, of playing with categories and a striking metaphor allows us to see a familiar topic in a new light (Black 1979). Donald Schön (1979), nearly 30 years ago, highlighted the extent to which such metaphors may be “generative,” in the sense that they may open up the opportunity for a new way of looking at, and so dealing with, a topic. Erich Goode (1969) wrote that “by devising a linguistic category with specific connotations, one is designing the armaments for a battle; by having it accepted and used, one has scored a major victory” (15). Some of the most striking examples of generative metaphors are to be found in the history of medical research. One of the stimuli for William Harvey’s revolutionary suggestion that Galen’s theory that blood ebbed and flowed through the body might be replaced by the notion that the blood circulates was his knowledge of the way in which the Ptolemaic system of an earth-centered cosmos had been displaced by the Copernican theory that the earth revolved around the sun. Diagnosis in relation to a presenting illness, whose nature is not immediately obvious, may equally involve a metaphorical leap.

It should be no surprise that Aristotle, whose philosophical endeavors depended greatly on his concern to classify and categorize phenomena, also underlined the importance of metaphor: “the greatest thing by far is to have a command of metaphor. This alone cannot be imparted by another; it is the mark of genius, for to make good metaphors implies an eye for resemblances” (*Poetics*, chap. 22). So medical professionals need not be embarrassed by their frequent use of metaphors—as the remarkable number of doctors who have embraced the opportunity for metaphorical creativity by writing poetry associated with their medical practice, including Jack Coulehan and Rafael Campo (United States), Danny Abse (United Kingdom), and Glenn Colquhoun (New Zealand), attests.

METAPHORS IN THE DIAGNOSTIC FRAMEWORK

The categories against which any individual patient’s condition must be mapped are unstable, because they are conceived by human beings in specific historical, scientific, and cultural contexts. In any culture, the framework for diagnostic classification is fundamentally metaphorical. Western biomedicine employs three main metaphors: the biomechanical, the biomilitary, and the bioinformationist (Montgomery 1996). The concept of the body-as-machine evolved, alongside actual innovations in technology, from the 17th-century notion of the “body as clock”; through the 18th century, with its recognition of the heart as a pump and blood vessels as a hydraulic system with valves; to the 19th century, with its notion of the nervous system as a telegraphic network for sending messages and recognition that breathing and

digestion involve processes akin to the working of the internal combustion engine; to the late 20th century, with the idea of the brain as computer. (Resistance by some medical professionals to the notion that their work is highly dependent on metaphor is nicely exemplified by the fact that, after a talk I gave in my local university medical school, I was castigated by a neurologist, who insisted “But the brain *is* a computer!”) The biomilitary metaphors, which have bacterial infections “invading” the body, cancer cells “colonizing” the organism, and the immune system “defending” it, have a rather shorter history, their origins being traced primarily to Louis Pasteur and the emergence of the “germ theory” of infection in the mid-19th century. However, as Abraham Fuks (2009) and others have noted, military metaphors were used in a rather generic way by English physician, Thomas Sydenham, in the mid-17th century. The bioinformationist cluster of metaphors has proliferated more recently still, with the parallel development of computers and understanding of DNA and genetic “codes.” In biomedicine, the three main metaphor clusters operate not just alongside each other, but are interwoven. Each set of metaphors serves to generate research, but also to generate treatments and even diagnostic classifications which may not previously have existed (Hanne 2011). So, for instance, a biomechanical perspective on the workings of the body continues to stimulate research and practice around the possibility of replacing defective parts of the body, from knee joints to hearts. However, as Segal (2008) suggests, it has also contributed to the framing of some new diagnoses: for example, “Erectile dysfunction, insofar as it is a diagnosis at all and not simply a description, is a diagnosis that depends, overall, on the assumption that parts ought to work for the life of the machine” (121).

The biomechanical, the biomilitary, and the bioinformationist metaphors prevalent in modern biomedicine replaced the metaphor of the humors, which dominated Western medical thinking throughout the Middle Ages, the Renaissance, and into the early 19th century. The doctrine of the humors, with its belief in the need to maintain a balance in the human body among four fluids—black bile, yellow bile, phlegm, and blood, associated respectively with the melancholic, the choleric, the sanguine, and the phlegmatic temperaments—depended on a fundamental metaphorical assumption about their relation to the four elements of earth, air, fire, and water. Traditional Chinese medicine uses a similar metaphorical scheme, involving images of flow and blockage, balance and imbalance, where the elements seen as fundamental are five, rather than four: wood, fire, earth, metal, and water (Stibbe 1996). As Laurence Kirmayer (2008) points out, patients from different cultures will actually experience and describe such fundamental sensations as pain in ways that are shaped by different overarching cultural models and metaphors.

Freudian analysis offers a striking example of an area of Western medicine where the entire discourse, both theoretical and clinical, is metaphoric, modelled, it has been suggested, on the notion of “the mind as a steam-engine or an electrical apparatus of some sort” (Carveth 1984, 503). Similarly, the etymology of a great number of terms relating both to anatomy and disease in Western culture reveals a

rich metaphorical foundation. The “fibula” in the lower leg is named (from Latin) as resembling a “clasp” in relation to the brooch-like tibia. The “sartorius muscle,” which runs down the front of the thigh, is named (from the Latin) for the cross-legged position formerly used by tailors. “Devil’s grip” is a viral disease (epidemic pleurodynia) that is accompanied by severe pain in the lower chest. “Coup de sabre” is a skin lesion that resembles a healed wound from a saber.

The key questions in relation to the metaphor schemes for health and disease classification in each culture concern not only how much each facilitates or obstructs research and effective practice, but also whether the metaphors are mistakenly understood, as frequently occurs, to be literal descriptions of reality. Friedrich Nietzsche (1873) highlighted the danger of so doing: “truths are illusions of which we have forgotten that they are illusions, metaphors which have become worn by frequent use and have lost all sensuous vigor” (46–47). For instance, in applying the bioinformationist metaphor in relation to human genetic inheritance, there is a real danger of slipping into the deterministic assumption that an individual’s health prospects may be “read” with certainty from their genetic profile.

METAPHOR IN COMMUNICATION AFTER DIAGNOSIS

David Casarett and others (2010) have noted that “Physicians who provide care to patients with serious illness face daunting challenges of communication. For instance, physicians often need to deliver painful news about a new diagnosis, relapse or worsening prognosis” (255). Casarett and his colleagues found that oncologists who employed plenty of analogies and metaphors in discussions with patients and their families were rated highly by their patients for their communication skills. Clearly, metaphors are required, not only to convey a comprehensible version of complex technical information, but also to assist the patient in dealing with what may be very distressing news and making difficult choices about treatment. In the words of Deanna Hutchings (1998), a clinical resource nurse specializing in end-of-life care: “The creative and judicious use of metaphor provides health care practitioners with many veils—veils that shield the dying from the glare of their prognosis, veils particularly valuable and suited to communicating with our palliative patient population.” She goes on: “Metaphor is mysterious . . . creative . . . invitational . . . safe . . . open to interpretation and multiple meanings . . . respectful of the dying . . . playful” (283). Hutchings emphasizes the importance of listening to patients who “speak metaphorically in reference to their impending death,” observing that common metaphors include “maps, a compass, a boat. A trip, a train ride, a journey” (284). David Southall (2013) suggests that “engaging with patients at the metaphoric level enables them to create new ways of viewing their situation and opens up the possibility of new coping strategies” (304). In the use of metaphor with patients receiving palliative care, the medical professional is likely to be caring also for his or her own emotional state.

There has been much debate about the prevalence of metaphors of fighting and war in the discourse around cancer. Susan Sontag (1978) objected to this imagery because it could lead patients into an inappropriate sense of responsibility for their own disease and of failure if treatment did not go well. Many oncologists declare that they try to avoid the military metaphors, but that they and their patients seem to slip into such imagery anyway: “Even the pacifist and mindful caregiver and the gentlest of patients think about fighting when they are faced with cancer. It is almost instinctive. The real question is, how can we reconcile that instinct to fight, and our words of encouragement, with expressions of healing and acceptance” (709). Other metaphors frequently used between medical professionals and their patients, such as “journey” and “work,” may well be preferable. Advantages they offer include the sense of a shared commitment and the emphasis on continuity rather than a win-or-lose endpoint. Nevertheless, it has been suggested that the metaphor of the journey does not work for all patients. Metaphor scholar Elena Semino (2015), for instance, undertook a study of the use of metaphor in blogs by patients with cancer and found that “For several patients in our data[,] journey metaphors were disempowering. They were used to express feelings of helplessness and frustration, particularly in the face of ‘navigating’ a journey that patients hadn’t chosen to embark on. Another person talked about people with cancer as ‘passengers’ on a journey they couldn’t control.” She concludes: “As with dishes in a restaurant, different people will find different metaphors more or less appealing, but, ideally, each will be able to recognise or discover one or more metaphors that are helpful for them.”

Some of the most vivid metaphors or similes used by oncologists to explain features of both disease and treatment derive from horticulture. For example, Casarett and colleagues (2010) report that one physician explained that a dysplastic cell line is like “weeds in your garden that take over a garden, it chokes everything else out. And so the way to treat it is to use a weed killer, so you get rid of all that bad stuff. And slowly the good stuff comes back.” Another physician, explaining treatment with stem cells, said that “the stem cells are like seeds that we take out of you so we can give you very high doses of chemotherapy that can damage what’s left in you and then we give you back those seeds so that it can grow” (258). Other metaphors, in addition to the overtly militaristic, are those related to sport, driving a car, or to “switching” mechanisms in the body. Clearly, in conveying painful news, it is important for the physician to “get alongside” the patient and communicate empathically. A key to the value of metaphors in this context may be philosopher Ted Cohen’s (1979) observation that metaphors are “an invitation . . . to intimacy” (6).

Commentators on diagnosis, including authors writing in this volume, use a considerable range of metaphors to capture something of the impact of the diagnosis of a serious disease on patients, as do patients themselves talking about what the diagnosis means to them. Jutel (2011) uses an image that stems from the underlying metaphor of the “illness journey”: “Receiving a diagnosis is like being

handed a road map in the middle of a forest. It shows the way—but not necessarily the way out. It indicates what the path ahead is going to look like, where it will lead, the difficulty of the climb, and various potential turnoffs along the way” (i). Jutel quotes Suzanne Fleischman (1999), who wrote: “The utterance of a diagnosis marks a boundary. It serves to divide a life into ‘before’ and ‘after,’ and this division is henceforth superimposed onto every rewrite of the individual’s life story” (10).

After they are diagnosed with a serious condition, many patients employ metaphors that suggest loss of direction, overturning, loss of the map they had relied on. For example, Havi Carel (2008) recalls of her own diagnosis with a rare disease, lymphangioliomyomatosis, which gave her only about 10 years to live: “my life had been turned upside down” (4). People who have had a stroke often use vivid metaphors that suggest they perceive the event as coming at them from outside: “disaster,” “nightmare,” “crash,” “hurricane,” “struck by lightning,” “shot with a firearm”—though, as time passes, they may focus more on the process of recovery, which is often described in terms of “battle” or “war” (Boylstein, Rittman, and Hinojosa 2007). A patient’s sense of identity and of his or her own body alters after diagnosis with a serious disease, and the metaphors the patient uses to express that sense will often be very revealing. Carel (2008) wrote that: “I was locked in my body, trapped by the feeble lungs” (6). Some patients actually feel antagonism towards their bodies. Blogger “Mdg” posted in 2010 that: “Though I am over the shock of hearing I have breast cancer, I just feel so betrayed by my body. This body I have known my whole life. The body that I have worked hard to keep healthy and maintain. This body that gave my son life. This body that my husband loves to hold and touch. I just can’t believe that my body betrayed me and grew cancer.” Like the surprising number of doctors who turn to poetry to convey something of their professional experience, patients, too, often turn to metaphor-laden poetry to communicate their plight (McEntyre 2012).

Fleischman (1999) raises the interesting question of the variation among patients in terms of their conception of their relationship with the disease and the range of formulations available to them to express that conception, noting the different formulations: “I am diabetic, I have diabetes, I suffer from diabetes” (8). Whereas the first of these implies identification with the disease, the second sees it almost as a possession, and the third depicts the disease as something attacking from outside. The question of whether you “own” your disease merges into the deeper question of whether you “own” your body (Segal 2008, 122).

One of the most difficult communication situations for the diagnostician is that of conveying that he or she has no more “tools in the toolbox” or “weapons in the armory” that could save the patient. Medical professionals associated with end-of-life care, especially in the context of hospices, often propose the image of the journey, which emphasizes continuity rather than finality. Many terminally ill patients find it comforting to know that they will have the company of a medical professional at every point on that journey, and the importance of assuring the dying

patient that he or she will be accompanied to the end is communicated beautifully in Abraham Verghese's 2011 TED talk, "A Doctor's Touch."

METAPHORS IN TREATMENT

Medical practitioners in a number of fields refer to their direct or indirect use of metaphor in the treatment of a range of conditions. So, for example, surgeon Grahame Brown of the Royal Orthopedic Hospital in Birmingham, United Kingdom, has declared that, by using an appropriate metaphor, he can dissuade a high proportion of patients who have come to him for joint surgery from going through with it (Hammond 2009). Cognitive behavior therapists have highlighted the potential of employing metaphors in treating conditions as serious and diverse as depression, anxiety disorders, bipolar disorders, and psychosis (Stott et al. 2010). They work especially with the patient's own metaphors to modify how they think about themselves to develop problem-solving strategies.

My particular interest here is with conditions, especially psychiatric and psychosomatic conditions, in which metaphors play a significant role at every stage, from presentation of symptoms to diagnosis to treatment. As indicated earlier, there are a surprising number of cases where the patient's use of, or response to, metaphors may provide some evidence that they have, or do not have, a particular condition, including psychosis and autism. One of the most interesting of these conditions is anorexia nervosa, where the patient's use of a cluster of erroneous/misguided metaphors about her body or her identity is a key feature of the condition itself. Finn Skårderud (2007a) notes that, for all of us, our body functions on certain occasions as "a symbolic tool, as a language to communicate with others and ourselves about matters beyond corporeality" (163). People suffering from anorexia nervosa have a tendency to employ body metaphors to conceptualize emotional, social, or moral phenomena in excessively concrete ways. So, for instance, they see emptiness as standing for alertness, strength, or moral purity. Having a body size above the minimum makes them feel they are taking up more space than they are worth. They experience weight as a burden, contributing to sadness. They value feeling their exposed skeleton as hard to the touch because that indicates reliability or honesty. Shedding weight is seen as discarding waste and blame. Skårderud (2007b) suggests that these metaphors "serve the function of maintaining the cohesion and stability of a tenuous sense of self," and that the patient is, in some sense, trapped by her own metaphors (324). Other psychologists dealing with anorexia nervosa mention additional metaphors used by patients about themselves. For example, Katie Metcalfe (2006) observes that they refer to themselves as one or another large animal—an elephant, a whale, or a pig. Another patient refers to her body as "an overgrown garden," its beauty hidden in a tangle of weeds. For many, imagery from athletics, especially running or racing, dominates their thinking, and the concreteness of this metaphor may be realized in an obsession with actual running, to keep the person's weight down (Liu 2010).

It has been observed that one of the main obstacles to the treatment of patients with anorexia nervosa is the patients' lack of insight into their own condition and the difficulty they have in expressing their feelings in any way other than these concretized metaphors. Some therapists see working with, and on, those metaphors as a key element in treatment of anorexics. Skårderud (2007b), for example, asserts the importance of the therapist's "entering the concrete"—that is, acquiring "an acceptance and understanding of the patients' way of mental functioning"—and then aiming to "de-concretize" and then "re-metaphorize" the patient's thinking (336). Other therapists suggest that metaphors can be used as a shared terminology or context of meaning between counselor and client (Angus and Korman 2002).

Most of the metaphors employed by anorexics, it will be clear, operate between the domain of the body and an abstract social or moral domain. At a certain point, the anorexic may develop one or more metaphors of personification to refer to the condition itself: "Ana, the bitch," "Ana, the thief," "the demon Ana," "a bulimic boa constrictor," or "a parasite," or "an evil elf" (Stott et al. 2010, 198). The personal creativity involved in generating such metaphors is inherently therapeutic. For the patient to reach a point where she acknowledges the existence of the condition and externalizes it in this way is already an achievement. She may come to refer to the plight of being anorexic with a range of scary metaphors: "walking a tightrope," "teetering on the edge," "fighting demons" (Burton 2014). A therapist will encourage the patient to take this process further and to come up with fresh imagery around herself. She may see herself as "lost," as "a jigsaw puzzle," with one or more pieces "missing," or "not fitting." Therapy will involve working on the distress represented by each of these metaphors. The process of recovery is likewise depicted in the form of a range of metaphors: as a "search," a "path," a "battle," a "journey," or a "labyrinth" (Cook 2011; Schaverien 2014). The therapist may introduce fresh metaphors, such as "food as fuel" necessary to keep the car running, but also "food as medicine," which will assist the patient to behave more rationally about eating food (Mathieson and Hoskins 2005).

CONCLUSION

The lessons which may be taken from this study of metaphor and diagnosis are, I hope, reasonably clear. There is no way of avoiding the use of metaphors around health and sickness in general and diagnosis in particular. Communications between doctors and their patients will always be threaded through with metaphors. Patients will often convey their experience of illness to the doctor by means of vivid metaphors, and it is incumbent on the diagnostician not only to attend to the metaphors used by the patient but to respond with metaphors that convey both information and empathy. Metaphor may even, with conditions such as anorexia nervosa, be a significant instrument in the toolbox of the medical professional. Diagnosis in difficult cases may involve an imaginative metaphorical leap being

made by the doctor between the individual patient's symptoms and the domain of disease classification. While a metaphor used creatively in a medical context may open a door into a fresh domain, metaphors used uncritically may lock both diagnostician and patient into an unproductive understanding of the situation. It is crucial for medical professionals and laypeople to become more aware of the significance and effects of the metaphors they use, to critique their own and each other's metaphors, and to acknowledge the value of multiple metaphors, capable of illuminating the many facets of any situation.

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