

Effectiveness of Metaphorical-Allegorical Training Strategy in the Psychotherapy

Abbas Khorshidi¹, Alireza Ahmadian*², Neda Esmaeeli Far², Mohammad Hatami², Hamidreza Hassan Abadi²

1. Islamic Azad University, Islamshahr Branch, Islamshahr, Iran

2. Kharazmi University, Tehran, Iran

* Corresponding author's Email: std_ahmadian@tmu.ac.ir

ABSTRACT: The present study aimed to examine the effectiveness of schema therapy based on conjunctive metaphorical-allegorical narrative training in the treatment of dysthymia disorder. A total of 40 patients suffering from dysthymic disorder, were recruited through the administration of structured DSM-IV (SCID), and using purposive sampling and subsequent to being qualified in accordance with therapeutic conditions, they underwent the treatment process. The study employed a pretest, post-test, follow-up design and the patients in the study received a five-month, twenty-session schema therapy based on conjunctive metaphorical-allegorical narrative training. Beck Depression Inventory (BDI-II) and Young Schema Questionnaire Long Form (YSQ-LF) were the research tools. Two-factor variance analysis with repeated measurement was employed to analyze the data. Recovery percentage was also applied to measure the clinical significance. Results: the data analysis revealed that schema therapy based on conjunctive metaphorical-allegorical narrative training led to significant reductions in symptoms and healing the early schemas. Moreover, there was no lessening of effectiveness with recovery rates in the follow-up study, two month after the treatment. The large positive treatment effects found in the schema therapy based on conjunctive metaphorical-allegorical narrative training suggest that this treatment is more successful in replacing maladaptive schemas with more healthy schemas, alleviating the severe symptoms of dysthymia, reduction of suffering a relapse in dysthymic patients and achieving clinically significant and relevant improvement as compared to Schema Focused Therapy or SFT.

Keywords: Metaphorical-Allegorical Education, Dysthymic, Maladaptive Schema

ORIGINAL ARTICLE

INTRODUCTION

Dysthymia remains one of the most prevalent health disorders (Barlow, 2001; Lopez, 2006) According to the DSM's definition of dysthymia, it is a serious state of chronic depression in which a person's moods are regularly low and is particularly prevalent with a point prevalence of about 5% to 6%. (Klein, Shankman, Rose S, 2006) Different forms of talk-therapy, such as Beck cognitive therapy, interpersonal psychotherapy (Klerman et al., 1984), Problem-and solution-focused therapies (Valice, 1995) have been researched to be not sufficiently effective in treating the disorder (Gonzales et al., 1985; Fenel et al., 1982; Harpine et al., 1992; Alpert et al., 2004; Demelo et al, 2005; Malouff et al., 2007). Investigators Young, Weinberger and Beck (2001), tested the effectiveness of cognitive-behavioral therapy in the treatment of dysthymia and concluded that recovery was achieved in 20% of the patients receiving CBT. However, around 30% of those who recovered experienced a relapse into another episode of depression, most commonly in the 1st year following recovery; moreover, a considerable number of patients in these studies didn't attribute the effectiveness of the treatment. substantial numbers of dysthymic patients tend to suffer from higher co-occurrence in personality abnormalities (Peper et al, 1995; Riso et al, 1996), and early maladaptive schemas

among patients with dysthymia are more common as compared to major depressive disorder.

Maladaptive schemas, according to Young et al., (2003) are defined as and relate mainly to the lack of basic emotional needs met in childhood and a lack of appropriate relationships, bonds, and behaviors of important others involved in the life of a growing child, making them emotionally and psychologically vulnerable to common co-occurring conditions of dysthymia including failed and troubled major depression, anxiety disorders, personality disorders, somatoform disorders, substance abuse and drug addiction (Young, 1999). Avoidant, compensatory and surrendering to the schema modes or coping styles that block access to the vulnerable modes are our behavioral responses to the schemas in hopes of making things better, but in fact they very often wind up reinforcing the schema (Young, 2003). Thimm (2010) asserted that people may permanently live within maladaptive schemas which are a pattern of established (from childhood) unstable reactions to any given situation in life. Young et al (2003), Wishman (2008) and Dobson (2010), stated that the basic assumptions of current cognitive-behavioral therapies are not in agreement with typical characteristics of dysthymia.

Cognitive-behavioral therapy adopts a top-down approach in healing schemas and vulnerable modes, starting with for example hopelessness, then fundamental components and finally schemas (Leahy, 2003). Whereas, schema therapy employs a bottom-up approach, following the process inversely and logically, and starting with the deepest level of schema (Young, 2003). This change of approach can positively affect the patients' response to the therapy (Dobson, 2010).

Overall, according to what was mentioned above, it can be concluded that current cognitive-behavioral therapies have resulted in limited rate of success and substantial reversion level; furthermore, determining the deeper levels and casual layers as an intervening variable can help reduce and treat the psychological symptoms of dysthymia disorder (Murphy et al., 2012).

On the one hand, Young model of schema therapy as a tailored therapeutic strategy can exert more beneficial and positive effect as compared to other forms of therapies. (Reese et al, 2007; Cuijpers et al, 2010; Holzelet al., 2011). On the other hand, through integrating the metaphorical-allegorical narrative training with cognitive-behavioral therapies, the patients can achieve a more distinct perceptual appearance of therapeutic applications and implications, better called as therapeutic conceptualization. In terms of theoretical verbalization, Some patients try to grasp the subjective and technical concepts of the therapist, however, they have no clear perception and recollection of these vaguely-stated matters and therefore, no appreciable and therapeutic effect can be observed. The use of symbolic and figurative language (allegory and metaphor) creates a more effective process of receiving, retaining, processing, management and retrieval of the information and enables the therapist to transfer the imbalance information of two different linguistic variations from a more subjective system of psychological perception to a more objective one. Therefore, a lexicon of objective terms can provide us with a more vivid and clear description of propositional concepts. In terms of the propositional language of the classical therapies, it's worth mentioning that the effectiveness of cognitive-behavioral therapy is supported by to the many previous studies that have found higher effectiveness of this therapy as compared to other non-selective therapies and at least equal effectiveness to pharmacological therapies. (Dobson, 1988). However, regardless of the comparison with other therapeutic approaches and in general, the propositional language of Beck classical cognitive-behavioral therapy has always been subjected to criticism and even to the best of its therapeutic benefit and application can't

appreciate and justify the subtle differences and sharp focus which is required in different levels of processing the rational, irrational and emotional beliefs during the therapeutic process (Kopp,1993). Classical schema therapy with its established and conventional techniques in mental imaging is also open to the same criticism owing to the lack of adopting effective strategy and initiating positive move toward facilitation and leveraging the abstract, complex and clinical concepts across the patients' cognitive levels. Therefore, through adding a more visual language to the classical schema therapies' conversational context and highlighting the visual elements of the language, the therapist is equipped to maximize the therapy's full potential for cognitive and emotional levels of the patients and enhance the clinical utility and broader conceptual decoding (Kopp, 2005; Burns, 2007). Cognitive linguists emphasize that metaphors and allegories serve to facilitate the understanding of one conceptual domain, typically an abstract one, through expressions that relate to another and linking to a more familiar conceptual domain, typically a more concrete one.

Emphasizing the heavy usage of propositional language in a psychotherapeutic session may be largely responsible for reaching a dead end in grasping and framing the conceptual understanding during the therapeutic process. Hence, the psychotherapists are obliged to avoid such conceptual dead ends through the usage of symbolic language, e.g. a line of poetry, proverb, allegory, parables, anecdotes, analogies, fables, and metaphors which are designed as a form of indirect, imaginative, and implied communication with clients and serve as non-threatening means to help clients discuss problems and consider possible solutions. metaphors are effective, subtle, and potent tools for communicating the data from our research laboratories, acquiring deeper meaning and moving from unintengible conceptualization toward more understandable concepts (Gibbs, 1990; 1994; Burns, 2007; blenkiron 2010). According to Burns (2007), rules governing the therapies which deal with fundamental psychological levels are of considerable difficulty in the absence of apt allegories and metaphors that enrich the therapeutic language of clinical intervention, bridge the gap between the psychotherapists' and patients' cognitive levels and aptly describe the therapy's concepts (McCurry et al.,1992).

Hypotheses: Schema therapy based on conjunctive metaphorical-allegorical narrative training is more effective in reducing the symptoms of dysthymia as compared to classical schema therapy.

MATERIALS AND METHODS

According to Kazdin (1998), the present research adopts a comparison, process and conclusion-based method. Empirically-supported therapies are becoming increasingly commonplace. Moreover, clinical psychologists and psychotherapists are expected to design and conduct their research in way that points to defensible conclusions. (Derubeis et al., 1998).

The population included the individuals suffering from dysthymic disorder who attended the counseling and mental health centers located in the east of Tehran, out of which a sample of 40 patients was selected using purposive sampling, these participants aged 20- 55 with at least qualification of secondary school diploma, and not having received psychological therapy or psychiatric treatment for the last four months. The patients who scored higher on BR and were diagnosed with severe personality disorder (borderline personality disorder, schizophrenia and paranoia), or psychotic disorders were not sampled, to fulfill this criterion, MCMI-III was administered. Dysthymia has a high degree of simultaneity with other disorders. To eliminate this problem we recruited patients who received definite and original diagnosis of dysthymia Riso et al. (2012) had done so to correct the problem of simultaneity. The sample of 40 patients was subsequently assigned to experimental and control group.

The Structured Clinical Interview for DSM-IV Axis 1 Disorders: Clinical Version (SCID-CV), which was developed by Spitzer, Gibbon, Williams (quoted from, Segal) in 1983 was specially designed as an adaptation of the SCID that is intended to introduce the benefits of structured interviewing into clinical and research setting, the SCID-CV covers those DSM-IV diagnoses most commonly seen by clinicians and includes the full diagnostic criteria for these disorders with corresponding interview questions. SCID-CV will assist in making standardized and accurate diagnoses that incorporate DSM-IV by a systematic probe for symptoms that might otherwise be overlooked. This interview incorporates the benefits of structured interviewing and makes more accurate and reliable diagnoses. SCID-CV helps not to resort to the lengthier and more complex process used principally in research studies and dispose of other diagnostic categories which are not related to the study (Bakhtiyari et al, 2000). The SCID-CV is divided into six self-contained modules covering: module A: mood episode, module B: psychotic symptoms, module C: psychotic disorders, module D: mood disorders, module E: substance use disorders, module F: anxiety and other disorder, also included in module F are disorders without diagnostic criteria such as agoraphobia, social phobia, specific phobia, etc. The

SCID-CV may be administered to either psychiatric or general medical patients. It is most appropriate for adults (18 years and over), but with slight modification, may be used with adolescents. This instrument can't be carried out with patients who suffer from serious cognitive disorders or exhibit severe and distressing symptoms of psychotic disorders and having acquired at least 8 years of education is required for full understanding (Mohammadkhani, 2005). Tran and Hagg (2002), (quoted from Tran et al., 2004) have reported the results indicate moderate to good reliability among formulations constructed by teams of independent clinician in the .60 based on a weighted kappa. A Persian version of this interview was administered on 229 individuals by Sharifi et al (2005) and a result of kappa coefficient was over .60. In order to assess the validity of the instrument, Bakhtiyari (2008), (quoted from Mohammad) asked a panel of judges to formally rate the validity, which was rated as having satisfactory and acceptable validity to be used in clinical setting. The test was also shown to have a high one-week test-retest reliability (Pearson $r = 0.95$).

The BDI-II, The development of the BDI was an important event in psychiatry and psychology; it represented a shift in health care professionals' view of depression from a Freudian, psychodynamic perspective, to one guided by the patient's own thoughts or cognitions. A 1996 revision of the BDI developed in response to the American Psychiatric Association's publication of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, which changed many of the diagnostic criteria for Major Depressive Disorder. All but three of the items were reworded; only the items dealing with feelings of being punished, thoughts about suicide, and interest in sex remained the same. Finally, participants were asked to rate how they have been feeling for the past two weeks, as opposed to the past week as in the original BDI. Beck's Depression Inventory (sometimes referred as Beck Depression Scale) can be used for both adults and adolescents 13 years of age and older. Beck Depression Test is a standard measure of depression used mainly in research and for the evaluation of effectiveness of depression therapies and treatments. It is not meant to serve as an instrument of diagnosis, but rather to identify the presence and severity of symptoms consistent with the criteria of the DSM-IV. Each of the inventory items corresponds to a specific category of depressive symptom and/or attitude according to DSM-IV. The statements are rank ordered and weighted. Like the BDI, the BDI-II also contains 21 questions, each answer being scored on a scale value of 0 to and has a set of at least four possible answer choices, ranging in

intensity and then the total score is compared to a key to determine the depression's severity. The cutoffs used, differ from the original: 0–13: minimal depression; 14–19: mild depression; 20–28: moderate depression; and 29–63: severe depression. Higher total scores indicate more severe depressive symptoms. The test was also shown to have a high one-week test-retest reliability (Pearson $r=0.93$), suggesting that it was not overly sensitive to daily variations in mood. The test also has high internal consistency ($\alpha=.91$). The psychometric properties were reported as following in Iran, alpha coefficient=.91, correlation coefficient=.89, one-week test-retest reliability 0.97 (Fata et al, 2005). Aggregate validity coefficient for each item equaled 0.913 with a Cronbach's alpha coefficient of around 0.90, meaning that the items on the inventory are highly correlated with each other. The construct validity based on convergent validity was equal to 0.873. Overall, the Persian translation of the BDI-II version demonstrates good psychometric properties among Iranian population and its results can be trusted for statistical and psychometric analysis. (Mohammadkhani, 2007).

Young Schema Questionnaire-Long Form (YSQ-LF),(Young et al., 1999) which was developed as a method of identifying EMS in clinical practice is a 205-item self-report inventory designed to measure these 16 EMS, the number of items used to measure each schema varies with each sub-scale and ranges from 9 to 18. In order to provide a shorter and more convenient version of the initial schema questionnaire,

the Young Schema Questionnaire-Short Form (YSQ-SF) was developed (Young, 1999). The YSQ-SF is a 75-item self-report inventory designed to measure 15 of the initial 16 EMS. A series of studies represent the first attempts to develop and explore the psychometric properties of the Young Schema Questionnaire. This questionnaire was standardized among a population of 513 students with a Cronbach's alpha coefficient of 0.79 to 0.93. The test was also shown to have high two-week test-retest reliability of 0.67 to 0.84. Face validity and interlude agreement have been checked and turned out to be satisfactory. Overall, many studies lend support for the efficiency of young schema questionnaire in measuring the early maladaptive schemas. (Schmidt Joiner Telch, 1995; Nelson et al., 2004; Walker et al., 2001; Tailure et al., 1999).

The participant were interviewed based on the structured clinical interview for DSM-IV AXIS I disorders and 40 individuals were selected accordingly. Each week 2 individuals simultaneously entered the base line with regard to the research design. Each 6 subjects participated in the base line for 3 weeks and subsequently underwent the therapy and received 20 sixty-minute weekly, individual sessions. The subjects who were absent for two consecutive sessions were excluded from the research. A two-month follow-up study was also conducted to assess the possible lessening of effectiveness with recovery rates after the completion of treatment.

Table 1. Female and Male Gender in the Present Study

Gender	Number	Percent
Female	23	57.5
Male	17	42.5

RESULTS

In order to analyze the data, both descriptive and inferential statics, including two-factor variance analysis with repeated measurement on the second factor were employed using SPSS software. In repeated measurement, two types of groups (classical schema therapy and schema therapy based on integrative metaphorical-allegorical narrative training) were regarded as inter-subject factor while depression and maladaptive schemas entered the analysis as

within-subject factor. The results of repeated measure for depression, maladaptive schemas, cognitive distortion and difficulty in emotion regulation are reported separately in pretest, post-test and follow-up. In this report, Mauchly's Test of Sphericity was also used to measure the covariance consistency. Moreover, there was a drop-out of 3 subjects whose scores were calculated based on last observation carried forward (LOCF).

Table 2. Results of Tests of Between-subjects Effects for the two forms of therapies

Test	d.f.	F	Level of sig.
form of schema therapy	1	32.34	$p<0.001$
error	37		

The above table demonstrated that these two groups differ significantly. To observe the between-group difference in terms of more effective treatment, we refer to the table 3 which compares the mean distribution.

The table above reveals significant between-group difference and lends support for higher effectiveness of schema therapy based on integrative metaphorical-allegorical narrative training as compared to classical schema therapy.

Table 3. Results of comparison of the mean distribution in classical schema therapy and schema therapy based on integrative metaphorical-allegorical narrative training

Form of Schema Therapy		Mean
Classical Schema Therapy		
	Pretest	25.75
	Post-test	10.75
	Follow-up	12.75
	Total	49.25
Schema Therapy based on Integrative Metaphorical-Allegorical Narrative Training		
	Pretest	25.75
	Post-test	10.75
	Follow-up	12.75
	Total	49.25

Table 4. Results of within-subjects effects for classical schema therapy and schema therapy based on integrative metaphorical-allegorical narrative training

Test	Sum of squares	d.f.	Mean square	F	Level of sig.
Greenhouse-Geisser					
Time	6499.883	1.60	4054.61	1168.05	p<0.001
Time Type of Therapy	114.242	71.26	71.26	20.53	p<0.001
Error	205.895	59.13	3.47	-	-

The above table demonstrates that all the patient have reached recovery over time. Furthermore, the scores of time type of therapy

indicated that change of performance have been significantly different with time.

Table 5. comparison of classical schema therapy group and schema therapy based on integrative metaphorical-allegorical narrative training group in pretest, post-test and follow-up of dysthymic patients' cognitive distortion

Source	Comparisons	S.S	D.F.	Ms	F	Level of Sig
Factor	Time					
	Pretest Posttest	10208.50	1	10208.50	1558.09	p<0.001
	Posttest Follow-Up	22.69	1	22.69	8.01	0.007
	Time Type of Therapy					
	Pretest Post-Test	54.65	1	54.65	8.34	0.006
	Post-Test Follow-Up	59.62	1	59.62	21.06	p<0.001
	Error					
	Pretest Post-Test	242.42	37	6.55	-	-
	Post-Test Follow-Up	104.73	37	2.831	-	-

As observed, there exists significant difference in the performance of all the patients from pretest to post-test and then to follow-up.

DISCUSSION

The present study aimed at investigating whether schema therapy based on integrative metaphorical-allegorical narrative training is more effective as compared to classical schema therapy. Patients suffering from dysthymia exhibit symptoms such as, loss of interest in daily activities, feeling sad or down, hopelessness, lack of energy, fatigue, trouble concentrating, trouble making decisions, self-criticism, excessive anger, decreased productivity, avoiding social activities, feelings of guilt, poor appetite or overeating and sleep problems. Patients may seek the medical care for years and come to conclusion that their disease results from physical disorders like diabetes or thyroid. While the form of therapy that we have employed in this study, cannot be given to individuals with high expectation of rapid recovery or illiterate patients, it has the potential to enrich the therapy process through effective usage of language and its special tools which can occupy dominant and key role in acquiring, processing and retaining the information and accessibility of therapeutic techniques for patients. As time elapses, patients find it difficult to retrieve the information which was exchanged in the therapy sessions that precipitates the relapse and symptom may arise again. Allegory and metaphor can commit the exchanged therapeutic concepts to memory. Regardless of the statistical structure and design of the present research, it can be mentioned that whenever more powerful and striking metaphors and allegories were invoked, the comparative results proved to be statically significant which indicated the high correlation with the usage of allegories and metaphors. Through invoking metaphors and allegories the healthy individual is able to produce a cognitive conservation which can be generalized to other unstated issues which lie ahead. However, the patient's cognitive preservation, slow processing and cognitive disability doesn't let him to easily make useful and valid generalization and shift which are among the potency of metaphors and allegories to other situations and positions.

The results offer an initial attempt to model the association of integrative metaphorical-allegorical narrative training with schema therapy. In the present study, the sample is limited to refer dysthymic patients and the current literature on schema therapy and all the studies published so far have limitations, making it difficult to reach a definitive decision on the subject. Therefore, on the basis of the data available, excluding studies with inadequate methods and applying sound

epidemiological methodological principles, resent findings cannot be generalized to the dysthymic population as a whole. Some of the results depend on the therapist's characteristics (the quality of therapeutic implication and approaching the problem, capability of framing the therapeutic problem and showing sensitivity to patient's needs). Therefore, further research should elaborate on the usefulness of metaphors and allegories in future studies through literal, operational and systematic repetitions in large samples of both clinical and non-clinical, different age range with varying psychological symptoms or disorders and with more qualified therapists or more objective scales of assessment.

REFERENCES

- Alpert, J., & Fava, M. (2004). Handbook of chronic depression. Diagnosis and therapeutic management. New York: Maca Pekker.
- Aragones, E., Pinol, J.L., Labad, A., Masdeu, R.M., Pino, M., & Cervera, J. (2004). Prevalence and determinants of depressive disorders in primary care practice in Spain. *International Journal of Psychiatry*, 4: 21-35.
- Bamber, M., & Price, J. (2006). A Schema-focused model of occupational stress. In M. Bamber (Eds). *CBT for occupational stress in health professionals: introduction a schema-focused approach*. London: Routledge.
- Barbaranelli, C., Caprara, G.V., Rabasca, A., & Pastorelli, C. (2003). A questionnaire for measuring the big five late childhoods. *Personality and Individual Differences*, 34: 654-664.
- Barlow, D., Craske, M., Cerny, J.A., & Klosko, J.S. (1989). Behavioral treatment of panic disorder. *Behavior Therapy*, 20: 261-268.
- Barlow, D.H. (2001). *Clinical handbook of psychological disorders*. New York. Guilford press.
- Battino, R. (2002). *Metaphoria: Metaphor and guided metaphor for psychotherapy and healing*. Williston, VT: Crown House.
- Beck, A.T., & Freeman, A. 1990). *Cognitive therapy of personality disorders*. New York: Guilford Press.
- Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press.
- Beck, A.T., Ward, C.H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, 4: 561-571.
- Beck, A.T. (1964). Thinking and depression: II. Theory and therapy. *Archives of General Psychiatry*, 10: 561-571.

- Beck, A.T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.
- Bernstin, D.P. (2005). *Schema therapy for personality disorders*, *Handbook of personology and psychothology*. New Jersey: John Wiley & Sons.
- Blackburn I.M., & Davidson K.M. (1990). *Cognitive therapy for depression and anxiety*. London: Blackwell Scientific Publications.
- Blackburn. I.M., & Peck D.F. (1995). *Behavioral and Cognitive therapies*. In R. E. Kendell, A. K. Really (Eds), *Companion to psychiatric studies*. Churchill Livingstone UK.
- Blenkiron P. (2010) *Stories and analogies in Cognitive Behavioural Therapy*, Wiley Blackwell.
- Brambilla, F., Catalano, M., Grenazzani, A. R., Facehinetti, F., Pugnetti, L., & Scarone, S. (1987). *Neuroendocrine aspects of dysthymic disorder*. Raven Press, New York.
- Burns, G. W. (2001). *101 healing stories: Using metaphors in therapy*. New York: Wiley.
- Burns, G. W. (2005). *101 healing stories for kids and teens: Using metaphors in therapy*. Hoboken, NJ: Wiley.
- Burns, G. W. (2007). *Healing with stories: Your casebook collection for using therapeutic metaphors* (pp. 12-300). Hoboken, NJ: Wiley.
- Chadwick, P. D. J., & Lowe, C. F. (1990). *Measurement and modification of delusional beliefs*. *Journal of Consulting and Clinical Psychology*, 58, 225-232.
- Clark, D. A., Beck, A. T., & Alford, B. A. (1999). *Scientific foundations of cognitive theory and therapy of depression*. New York: John Wiley Sons, INC.
- Demeyer, I., De Lissnyder, E., Koster, E. H. W., & De Raedt, R. (2012). *Rumination mediates the relationship between impaired cognitive control for emotional information and depressive symptoms: A prospective study in remitted depressed adults*. *Behavior Research and Therapy*, <http://dx.doi.org/10.1016/j.brat.2012.02.012>.
- Disner, S. G., Beevers, C. G., Haigh, E. A. P., & Beck, A. T. (2011). *Neural mechanisms of the cognitive model of depression*. *Nature Reviews Neuroscience*, 12(8), 467-477, <http://dx.doi.org/10.1038/Nrn3027>.
- Duggan, C. F., & Lee, A. S. (1990). *Predict long term outcome in depression?* *British Journal of Psychiatry*, 157, 19-24.
- Martin, R. & Young, J. (2010). *Schema Therapy*. In k. S. Dobson. (Ed). *Handbook of Cognitive Behavioral Therapies*. (p. p. 317-346). London. Guilford press.
- Dura, J. R., Stukenberg, K. W., & Kiecolt-Glaser, J. K. (1990). *Chronic stress and depressive disorders in older adults*. *Journal of Abnormal Psychology*, 99, 284-290.
- Ennett-Levy, J., Richards, D., & Farrand, P. (2010). *Low intensity CBT interventions: A revolution in mental health care*. In: *The Oxford guide to low intensity CBT interventions*. Oxford: Oxford University Press.
- Fairburn, C. G., Jones, R., Peveler, R. C., Hope, R. A., & Doll, H. A. (1991). *Three psychological treatments for bulimia nervosa: A comparative trial*. *Archives of General Psychiatry*, 48, 463-469
- Fekadu, A., & Abebaw, S.J. (2012). *What happens to patients with treatment-resistant depression? A systematic review of medium to long term outcome studies*. *Journal of Affective Disorders*, 11(6): 4-11.
- Ferrara, K.W. (1994). *Therapeutic ways with words*. New York: Oxford University Press.
- Fisher, J., & Corcoran, K. (2007). *Measures for clinical Practice and research*. Oxford: Oxford Press.
- Frank, E., & De Raedt, R. (2007). *Self-esteem reconsidered: Unstable self-esteem outperforms level of self-esteem as vulnerability marker for depression*. *Behavior Research and Therapy*, 57: 1531-1541.
- Gaffan, E.A., Tsaousis, I., & Kemp-Wheeler, S.M. (1995). *Researcher allegiance and meta-analysis: The case of cognitive therapy for depression*. *Journal of Consulting and Clinical Psychology*, 63: 966-980.
- Glucksberg, S. (2003). *The psycholinguistics of metaphor*. *Trends in Cognitive Sciences*, 7(2): 92-96.
- Glucksberg, S., Gildea, P., & Bookin, H.B. (1982). *On understanding nonliteral speech: Can people ignore metaphors*. *Journal of Verbal Learning and Verbal Behavior*, 21: 85-98.
- Gonzales, L.R., Lewinsohn, P.M., & Clark, G.N. (1985). *Longitudinal follow-up of unipolar depressive: an investigation of predictors of relapse*. *Journal of Consulting and Clinical Psychology*, 53: 461-469.
- Gordon, D.E. (1988). *Formal and interpersonal and affective disturbances in adolescents*. In E.D. Nannis & p.a. Cowan (Eds), *Developmental Psychopathology and Its Treatment*, (pp. 51-73). San Francisco: Jossey- Bass.
- Greenberger, D., & Padesky, C.A. (1995). *Mind over Mood: A Cognitive Therapy Treatment Manual for Clients*. New York: Guilford Press.
- Grelsma, C., Das, J., & Emmelkamp, P.M.G. (1993). *Depressed patients Parental representations: Stability across changes in depressed mood and specificity across diagnoses*. *Journal of Affective Disorders*, 27: 173-181.
- Hammond, D.C. (1990). *Handbook of hypnotic suggestions and metaphors*. New York: Norton.

- Hays, J. C., Krishnan, K. R. George, L. K., Pieper, C.F., E. P., & Blazer, C.G. (1997). Psychosocial and Physical correlates of chronic depression. *Psychiatry Res*, 72: 149-159.
- Heilemann, M.V., Pieters H.C., Kehoe, P., & Yang, Q. (2011). Schema therapy, motivational interviewing, and collaborative-mapping as treatment for depression among low income, second generation Latinas. *Journal of Behavior Therapy and Experimental Psychiatry*, 42: 473-480.
- Heimberg, R.G. (1990). Cognitive behavior therapy (for social phobia). In A. S. Bellack, & M. Hersen (Eds.), *Comparative handbook of treatments for adult disorders* (pp. 203-218). New York: Wiley.
- Hirschfeld, R.M.B. (1989). Psycho-social predictors of chronicity in depressed patients. *British Journal of Psychiatry*, 148: 648-654.
- Hoffman, R.R., & Kemper, S. (1987). What could reaction-time studies be telling us about metaphor comprehension? *Journal of Metaphor & Symbolic Activity*, 2(3): 149-186.
- Hölzel, A., & Lars, H.M. (2011). Risk factors for chronic depression: A systematic review. *Journal of Affective Disorders*, 129: 1-13.
- Howland, R.H., & Thase, M.E. (1991). Biological studies of dysthymia. *Biol. Psychiatry*, 30: 283-304.
- Howland, R.H. (2004). Psychopharmacology of dysthymia. *Handbook of chronic depression: Diagnosis and therapeutic management* (pp. 159-182). New York: Marcel Dekker.
- Imel, Z.E., Malterer, M.B., McKay, K.M., & Wampold, B.E. (2008). A meta-analysis of psychotherapy and medication in unipolar depression and dysthymia. *Journal of Affective Disorders*, 110: 197-206.
- Ingram, R.E., Hayes, A.Q., & Scott, W. (2000). *Empirically Supported treatment: A critical analysis*. New York: Wiley.
- Ingram, R.E., Miranda, J., & Segal, Z.V. (1998). *Cognitive vulnerability to depression*. New York: Guilford Press.
- Kingdon, D.G., & Turkington, D. (1994). *Cognitive-behavioral therapy of schizophrenia*. New York: Guilford Press.
- Klein D.N., Shankman S.A., & Rose, S. (2006). Ten-year prospective follow-up study of the naturalistic course of dysthymic disorder and double depression. *Am J Psychiatry*, 163:872-880
- Gibbs, R. (1990). Comprehending Figurative Referential Descriptions. *Journal of Experimental Psychology: Learning, Memory and Cognition* 16, 1: 56-66.
- Kopp, R.R. (1995). *Metaphor therapy: Using client-generated metaphors in psychotherapy*. New York: Brunner /Mazel.
- Leader, J.B., Klein, D.N. (1996). Social adjustment in dysthymia double depression and episodic major depression. *Journal of Affective Disorders*, 37: 91-101.
- Leahy, R.L. (2004). *Contemporary cognitive therapy Theory, research, and practice*. New York: the Guilford Press.
- Lopez-Ibor, J.J., Saiz-Ruiz, J., & Iglesias, L.M. (1989). Neuroendocrine challenges in the diagnosis of depressive disorders. *British Journal of Psychiatry (supplement)*, 154: 73-76.
- Maes, M., Vandewoude, M., Maes, L., Schotte, C., & Cosyns, P. (1989). A revised interpretation of the TRW test results in female depressed patients. *Journal of Affective Disorders*, 16, 203-213.
- McCullough, J. P. (1984). Cognitive behavior analysis system of psychotherapy (CBASP): An interactional treatment approach for dysthymic disorder. *Psychiatry*, 47, 234-250.
- McCurry, S.M. & Hayes, S.C. (1992). Clinical and experimental perspectives on metaphorical talk. *Clinical Psychology Review*, 12, 763-785.
- McFarland, B. R., & Klein, D. N. (2005). Mental health service use by Patients with dysthymic disorder: treatment use and dropout in a 7 1/2-year naturalistic follow-up study. *Comparative Psychiatry*, 46, 246-253.
- McGlone, M. S., & Manfredi, D. A. (2001). Topic-vehicle interaction in metaphor comprehension. *Memory and Cognition*, 29, 1209-1219.
- McKeith, I. G., Marshall, E. F., Ferrier, I. N., Armstrong, M. M., & et al. (1987). 5-HT receptor binding in post-mortem brain from patients with attentive disorder. *Journal of Affective Disorders*, 13, 67-74.
- Miller, L. W., Norman, W. H., & Dow, M. C. (1986). Psychosocial characteristics of double depression. *American Journal of Psychiatry*, 143, 1042-1044.
- Mineka, S., Watson, D., & Clark, L. A. (1998). Comorbidity of anxiety and unipolar mood disorders. *Annual Review of Psychology*, 49, 377-412.
- Moori, G., & Garland, A. (2003). *Cognitive therapy for chronic and persistent depression*. New York: John Wiley & Sons, Ltd.
- Murphy, A. J., & Gerard, J. (2012). Prevalence and correlates of the proposed DSM-5 diagnosis of Chronic Depressive Disorder. *Journal of Affective Disorders*, 139, 172-180.
- Ogles, B. M., Lunner, K. M., & Bonesteel, K. (2001). Clinical significance: History, application and current practice. *Clinical Psychological Review*, 21, 421-446.
- Ortony, A., Richard, J., Vondruska, M., Foss, A., & Lawrence, E. J. (1985). Saliency, Similes, and the

- Asymmetry of Similarity. *Journal of Memory and Language*, 24, 569-94.
- Pepper, C. M., Klain, D. N., Anderson, R. L., Riso, L. P., Quimette, P. C. (1995). Axis II Comorbidity in dysthymia and major depression. *American Journal of Psychiatry*, 152, 239-247.
- Persons, J. B., Davidson, J., & Tompkins, M. A. (2001). Essential components of cognitive-behavior therapy for depression. Washington, DC: American Psychological Association.
- Phillips, W. J., Hine, D. W., & Thorsteinsson, E. B. (2010). Implicit cognition and depression: A meta-analysis. *Clinical Psychology Review*, 30(6), 691-709, <http://dx.doi.org/10.1016/j.cpr.2010.05.002>.
- Piaget, J. (1981). Intelligence and affectivity: Their relationship during child development. Palo Alto, CA: Annual Reviews. Original work published 1954.
- Riso, L. P., Klain, D. N., Ferro, T., Kasch, K. L., Pepper, C. M., Schwartz, J. E., & et al. (1996). Understanding the comorbidity between only-onset dysthymia and unstable personality disorder: A family study. *American Journal of Psychiatry*, 153, 28-33.
- Riso, L. P., Dutoit, P. L., Blandino, J. A., Pena, S., & Dacay, J. S. (2003). Cognitive aspect of chronic depression. *Journal of Abnormal Psychology*, 112, 72-80.
- Riso, L. P., Froman, S. E., Raouf, M., Gable, P., Maddux, R. E., Turini-Santorelli, N., & et al. (2006). The long-term stability of early maladaptive schemas. *Cognitive Therapy and Research*, 30, 515-529.
- Riso, L. P., Klain, D. N., Ferro, T., Kasch, K. L., Pepper, C. M., Schwartz, J. E., & et al. (1996). Understanding the comorbidity between only-onset dysthymia and unstable personality disorders: A family study. *American Journal of Psychiatry*, 153, 28-33.
- Riso, L. P. M., Gable, P., Maddux, R. E., John, C. Markowitz., & et al. (2012). Select comorbid personality disorders and the treatment of chronic depression with nefazodone, targeted psychotherapy, or their combination. *Journal of Affective Disorders*, 117, 174-179.
- Rotter, J. B. (1978). Generalize expectancies for problem-solving and psychotherapy. *Cognitive Therapy and Research*, 2, 1-10.
- Sadock, B. J., Sadock, V. A., & Ruiz, P. (2009). Kaplan & Sadock's Comprehensive Textbook of Psychiatry, 9th Edition. Lippincott Williams & Wilkins.
- Sadock, B. J., & Sadock, V. A. (2007). Kaplan & Sadock's synopsis of psychiatry: Behavioral Sciences/Clinical Psychiatry. New York: Lippincott Williams & Wilkins.
- Salemink, E., Hertel, P., & Mackintosh, B. (2010). Interpretation training influences memory for prior interpretations. *Emotion*, 10(6), 903-907, <http://dx.doi.org/10.1037/a0020232>.
- Sava, F. A. (2009). Maladaptive schemas. Irrational beliefs, and their relationship with the five-factor personality model. *Journal of Cognitive and Behavioral Psychotherapies*, 9, 135-147.
- Shelton, R. C., Davidson, J., Yonkers, K. A., Koran, L., Thase, M. E., Pearlstein, T., & Halbreich, U. (1997). The under treatment of dysthymia. *Journal of Clinical Psychiatry*, 58, 59-65.
- Stein, D. J., Kupfer, D. J., & Schatzberg, A. F. (2006). The American psychiatric publishing textbook of mood disorders. Washington, DC: American Psychological Association.
- Stewart, M. T., & Heredia, R. R. (2002). Comprehending spoken metaphoric reference: A real-time analysis. *Experimental Psychology*, 49, 34-44.
- Stott, M., Salkovskis, L., & Cartwright, H. (2010). Oxford guide to metaphors in CBT: Building cognitive bridges. Oxford: Oxford University Press.
- Lakoff, G., & Johnson, M. (1980). *Metaphors we live by*. Chicago: University of Chicago Press.
- McCurry, S. M., & Hayes, S. C. (1992). Clinical and experimental perspectives on metaphorical talk. *Clinical Psychology Review*, 12, 763-785.
- Murphy, a., Jenifer, Gerard, j., Byrne. , (2012). Prevalence and correlates of the proposed DSM-5 diagnosis of Chronic Depressive Disorder. *Journal of Affective Disorders*, 139, 172-180.
- Teasdale, J. D. (1993). Emotion and two kinds of meaning: Cognitive therapy and applied cognitive science. *Behavior Research and Therapy*, 31(4), 339-345.
- Torpey, D. C., & Klien, D. N. (2008). Chronic depression: Update on classification and treatment. *Current Psychiatry Reports*, 10, 458-464.
- Vittengl, J. R., Clark, L. A., Dunn, T. W., & Jarrett, R. B., (2007). Reducing vs. medications in moderate to severe depression. *Archives of General Psychiatry*, 62, 417-422.
- Warwick, H. M. C., & Salkovskis, P. M. (1989). Hypochondriasis. In J. Scott, M. G. Williams, & A. T. Beck (Eds.), *Cognitive therapy in clinical practice: An illustrative case book* (pp. 50-77). London: Routledge.
- Why brow, P. C., Akiskal, H. S., & McKinney, W. T. (1985). *Mood Disorders: Toward a New Psychobiology*. New York: Plenum Press.
- Williams, J. M. G., Watts, F. N., McLeod, C. R., & Mathews, A. (1988). *Cognitive psychology and emotional disorders*. New York: Wiley
- Wishman, M. A. (2008). *Adopting cognitive therapy for depression*. New York: Guilford Press.

- Young, J. E. (2007). Early maladaptive schemas in chronic depression. In *Chronic Depression* (Ed. p. p41-58). New York: Guilford press.
- Young, J. E., Klasko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York: Guilford press.
- Young, J., Norman, S., & Thomas, J. (1995). Schema Questionnaire. *Journal of Cognitive Therapy and Research*, 19(2), 95- 321.