

# Disruptive Metaphor Expansion Therapy (Dmet): A Conceptual Framework for Addressing Cognitive Rigidity in Major Depression Through Structured Metaphor Disruption

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## Abstract

Major depressive disorder (MDD) is characterized not only by affective dysregulation but by persistent cognitive rigidity a systematic narrowing of epistemic flexibility that renders standard cognitive interventions such as logical disputation ineffective or counterproductive in a substantial proportion of patients. Existing evidence-based approaches, including cognitive behavioral therapy (CBT), acceptance and commitment therapy (ACT), and metacognitive therapy (MCT), address this rigidity through distinct mechanisms: schema restructuring, cognitive defusion, and attentional retraining, respectively. Despite these contributions, a systematic gap remains: no structured intervention exploits the metaphorical architecture of depressive thought itself as a point of therapeutic leverage. This paper introduces Disruptive Metaphor Expansion Therapy (DMET), a theoretically grounded, integrative intervention model designed to address cognitive rigidity in depression by identifying, elaborating, escalating, and ultimately disrupting the core metaphors that organize depressive self-perception. Drawing on Conceptual Metaphor Theory mental simulation theory embodied cognition frameworks, and clinical literature on provocative and metaphor-based therapies, DMET proposes a five-phase intervention sequence: metaphor identification, systematic expansion, escalation to logical extremes, disruption through internal contradiction, and reconstruction of alternative metaphorical mappings. The paper presents the theoretical foundations of DMET, delineates its clinical structure, illustrates its application through a representative clinical vignette, and situates it within the landscape of established psychotherapeutic modalities. Potential mechanisms of action including schema destabilization, metacognitive distancing, and narrative restructuring are discussed alongside proposed outcome measures. Indications, contraindications, and ethical considerations are addressed. DMET is proposed not as a standalone therapy but as a structured module within integrative psychotherapy, suitable for individuals with high verbal capacity and sufficient ego stability. Future directions for empirical validation are outlined [1-3].

**Keywords:** Cognitive Rigidity, Major Depressive Disorder, Metaphor Therapy, Conceptual Metaphor, Cognitive Defusion, Schema Disruption and Integrative Psychotherapy

## 1. Introduction

### 1.1 Cognitive Rigidity in Major Depression

Major depressive disorder (MDD) affects approximately 280 million people worldwide and remains one of the leading causes of disability-adjusted life years globally (World Health Organization, 2021). While the affective dimension of MDD persistent sadness, anhedonia, and dysphoria has been the primary target of pharmacological and psychosocial interventions, accumulating evidence suggests that a defining and therapeutically underaddressed feature of depression is cognitive rigidity: the systematic reduction in the flexibility

with which individuals can generate, entertain, and evaluate alternative perspectives on themselves and their world[4,5].

Cognitive rigidity in depression manifests across multiple levels. At the attentional level, individuals demonstrate sustained difficulty disengaging from negative self-referential stimuli, a pattern closely associated with rumination at the schematic level, Beck's (1979) foundational cognitive model describes entrenched dysfunctional beliefs that operate as rigid interpretive templates, systematically distorting information processing in line with negative expectations.

Overgeneralization the tendency to derive global conclusions from specific negative events further illustrates how depressive thought resists contextual differentiation. Seligman's (1975) model of learned helplessness adds a motivational dimension: perceived uncontrollability over aversive outcomes fosters cognitive closure and the foreclosure of alternative action schemas. Critically, and as this paper will argue, cognitive rigidity in depression is not merely propositional but metaphorical in structure. Depressed individuals do not simply hold the belief 'I am worthless'—they inhabit metaphorical schemas such as 'I am broken,' 'I am trapped,' or 'everything is dark.' These metaphors are not rhetorical decorations but cognitive architectures that shape how information is perceived, interpreted. Any intervention that addresses only the propositional content of depressive cognition while leaving its metaphorical infrastructure intact risks therapeutic incompleteness [6-9].

### 1.2 Limitations of Standard Cognitive Restructuring

Cognitive restructuring the systematic identification and modification of distorted automatic thoughts and dysfunctional beliefs represents the therapeutic backbone of CBT and has demonstrated robust empirical support across multiple randomized controlled trials and meta-analyses. However, both clinical observation and empirical research have revealed systematic limitations that are particularly pronounced in patients with severe cognitive rigidity. First, logical disputation of negative beliefs frequently activates reactance: the direct challenge of a belief that is tightly integrated into self-concept can paradoxically strengthen identification with that belief, a phenomenon consistent with dissonance theory and terror management research. Second, Wenzlaff and Wegner (2000) have documented that direct suppression of negative thoughts is cognitively taxing and often results in rebound effects, particularly under cognitive load. Third, depressive cognitions are frequently organized not as discrete propositions but as narratives and schemas that resist piecemeal logical attack. The very rigidity that CBT aims to modify can render the CBT process itself ineffective: a patient whose schema is 'I am fundamentally broken' will reinterpret even successful challenges as exceptions that prove the rule. ACT has addressed some of these limitations through the concept of cognitive defusion altering the relationship to thoughts rather than their content—and empirical support for ACT in depression is substantial has contributed the meta-worry framework and attention training procedure. However, neither approach directly addresses the metaphorical schema architecture of depressive cognition in a structured, systematic manner [10-20].

### 1.3 Therapeutic Use of Metaphor: Current State

Metaphor has been recognized as a therapeutic tool across multiple clinical traditions. Erickson's hypnotherapeutic approach relied extensively on therapeutic metaphor and indirect suggestion to produce psychological change without direct confrontation of defenses (Lankton & Lankton, 1983). Narrative therapy, developed by White and Epston (1990),

employs externalization treating problems as external entities rather than intrinsic attributes as a metaphorical reframing strategy with documented efficacy in depression and other conditions ACT's defusion techniques make implicit use of metaphorical reframing, asking patients to observe thoughts as passing clouds or leaves on a stream rather than immutable truths Empirical work has confirmed that metaphors are not merely stylistic features of clinical communication but cognitively active structures. Thibodeau and Boroditsky (2011) demonstrated that different metaphorical framings of crime (as beast versus virus) systematically influenced problem-solving and policy preferences in participants who showed no explicit awareness of the metaphorical influence. Kövecses (2002) has argued that conceptual metaphors structural mappings between source and target domains—fundamentally organize abstract thought, including self-concept and emotional experience. Ottati and colleagues (2012) have documented metaphor-consistent reasoning biases that persist even under conditions of conscious deliberation. Despite this literature, no existing intervention model has proposed a systematic, phase-structured procedure for identifying depressive core metaphors, expanding their internal logic to extremes, and generating therapeutic disruption through the contradictions that emerge from that expansion. DMET is designed to fill this gap [20,21].

## 2. Theoretical Foundations of DMET

### 2.1 Conceptual Metaphor Theory and Cognitive Schema

The theoretical cornerstone of DMET is Lakoff and Johnson's (1980) Conceptual Metaphor Theory (CMT), which argues that human abstract thought is fundamentally metaphorical in structure. Abstract domains such as time, emotion, morality, and self are understood through systematic mappings from more concrete source domains. The mapping "Life is a Journey" for instance, structures thinking about progress, direction, purpose, and obstacles in ways that go far beyond linguistic expression to shape actual cognitive and motivational processes. For clinical purposes, what matters is that depressive patients frequently organize their self-experience around a limited set of entrenched metaphorical schemas: "The Self is a broken Machine; Life is a Prison, the Future is Darkness or Effort is futile Pushing". These are not isolated metaphors but coherent mapping systems with inferential structure. If the self is a broken machine, then repair is possible only by an external technician, some parts are permanently damaged, and normal functioning expectations do not apply. Each inference follows logically from the metaphorical structure and each inference deepens the depressive work on image schemas demonstrates that these mappings are grounded in bodily experience: the CONTAINMENT schema (in/out), the BLOCKAGE schema (path obstructed), and the FORCE schema (pressure, resistance) all have direct experiential correlates that give metaphors their cognitive grip. This embodied grounding means that purely verbal interventions—telling a patient that they are not 'really' trapped fail to engage the sensorimotor level at which the metaphorical schema operates [22-24].

## 2.2 Cognitive Rigidity as Metaphor Fixation

DMET proposes a specific theoretical reformulation: in major depression, cognitive rigidity is not merely propositional rigidity but metaphor fixation. A depressed patient is not simply locked into the belief 'nothing will improve'; they are locked into a metaphorical schema such as THE FUTURE IS AN ENDLESS TUNNEL that generates that belief, along with a cluster of related inferences, through its internal logic. The belief is downstream of the metaphor; changing the belief without changing the metaphor is like treating a symptom while leaving its generative structure intact. This reformulation has empirical support. Stott and colleagues (2010) found that patients with high metaphor-based rumination showed significantly poorer response to standard CBT than patients whose rumination was primarily verbal-linguistic. Haase and colleagues (2009) demonstrated that metaphorical framing of self-experience predicted cognitive inflexibility on laboratory tasks. Fosha's (2000) theoretical work on transference and the deeply embodied nature of emotional schemas is consistent with the view that therapeutic change requires engagement at the metaphorical-sensorimotor level, not only at the level of propositional belief.

If metaphor fixation is the cognitive structure that sustains depressive rigidity, then therapeutic intervention requires engaging the metaphor itself not to reject it immediately, but to expand it until its internal contradictions become visible. This is the core insight of DMET.

## 2.3 Disruption Through Systematic Expansion

The mechanism of therapeutic disruption in DMET draws on several converging lines of theory. Piaget's (1977) concept of cognitive disequilibrium describes how existing schemas are destabilized when they encounter information that cannot be assimilated without transformation. Festinger's (1957) cognitive dissonance theory demonstrates that the encounter with irreconcilable cognitions produces psychological tension that motivates schema revision. In DMET, this disequilibrium is generated not by external confrontation but by extending the patient's own metaphorical schema to its logical extreme, at which point internal contradictions become unavoidable. Consider the metaphor THE SELF IS TRAPPED IN A CAGE. When systematically expanded—What is the cage made of? Who built it? Has it always existed? Has it grown? Could it dissolve? the schema reveals its own instability. The patient who built the cage cannot be merely passive. The cage that has changed size was never absolute. The cage that others cannot see may be constructed rather than discovered. These observations do not come from the therapist imposing an alternative view; they emerge from following the patient's own metaphor to its logical consequences. Conceptually, this mechanism is related to but distinct from several existing approaches. ACT defusion changes the relationship to thoughts through distancing; DMET changes the metaphorical structure itself through internal expansion. Motivational interviewing's development of discrepancy amplifies inconsistency between values and behavior; DMET amplifies inconsistency within the

metaphorical schema. Frankl's (1959) paradoxical intention uses deliberate exaggeration to reduce symptoms; DMET uses elaboration to reveal structural contradictions. The procedural specificity and metaphor-theoretical grounding of DMET distinguish it from all three [25-27].

## 3. Structure of the DMET Intervention

DMET is conceptualized as a structured module that can be embedded within individual psychotherapy sessions across integrative, CBT, or psychodynamic frameworks. A complete DMET sequence typically requires 45 to 90 minutes and may be conducted across one to three sessions, depending on the complexity of the metaphorical schema and the patient's engagement capacity. The five phases described below represent the ideal sequence; in clinical practice, movement between phases is fluid and responsive.

### 3.1. Phase 1: Metaphor Identification

The first phase aims to surface the dominant metaphorical schema organizing the patient's depressive self-perception. Unlike standard cognitive assessment, which elicits automatic thoughts, metaphor identification requires attending to the figurative dimensions of the patient's language and subjective imagery. The therapist listens for phrases that imply a structural mapping: 'I feel stuck,' 'it's like carrying a weight,' 'everything is grey,' 'I can't see any way out.' Once a candidate metaphor is identified, the therapist invites the patient to examine it explicitly: 'You said you feel trapped can you tell me more about what that's like?' Sacks (1979) observed that patients often resist reflection on their own metaphors because the metaphors feel like direct perceptions rather than constructions. This resistance is itself diagnostically informative: the less the patient can observe the metaphor, the more completely they inhabit it. Therapeutic progress in Phase 1 may therefore require several conversational moves before the patient can begin to treat the metaphor as an object of joint inquiry rather than an accurate description of reality.

### 3.2. Phase 2: Systematic Expansion

Once a core metaphor has been identified and named, Phase 2 proceeds by systematically elaborating the metaphorical structure across multiple dimensions. The therapist uses structured inquiry to activate the full inferential network of the metaphor: Spatial and physical dimensions: What does the space feel like? How large is it? Where are its boundaries? What is it made of? Temporal dimensions: Has it always been this way? When did it begin? Does it change over time? Agentive dimensions: Who or what created this? Who or what maintains it? Is it passive or active? Relational dimensions: Are you alone in this space? Can others see it? Do they experience the same thing? The aim of systematic expansion is not to challenge the metaphor but to elaborate it with sufficient specificity that its structure becomes fully visible—to both patient and therapist. As argued, the cognitive capacity for metaphorical blending depends on the activation of rich, multidimensional imagery; Phase 2 creates the cognitive scaffolding necessary for the

disruption that follows [28].

### 3.3. Phase 3: Escalation

Phase 3 presses the metaphorical logic to its extreme. If the patient experiences the situation as hopeless, escalation asks: what would absolute hopelessness look like? If the patient feels trapped, escalation asks: if there were truly no possibility of exit, how could you have entered? If life feels meaningless, escalation asks: if it were genuinely and permanently meaningless, why does the meaninglessness itself seem to matter? The therapeutic function of escalation is schema destabilization through logical completion. Young and colleagues (2003) note that early maladaptive schemas maintain themselves partly through incompleteness: they remain operative because their implications are never fully traced. Escalation follows the schema's logic until it reaches a point of internal contradiction a moment might have called a 'frame break' at which the schema can no longer accommodate its own conclusions without revealing its constructed character. Escalation requires high therapist skill and a strong working alliance. The aim is structured irritation, not distress. The therapist maintains a stance of genuine curiosity, following the logic of the metaphor collaboratively rather than confrontationally. Any sign that the patient is experiencing shame, humiliation, or a destabilization of the therapeutic relationship warrants immediate de-escalation [29].

### 3.4. Phase 4: Disruption

Disruption is the phase in which the internal contradiction generated by escalation becomes explicit. The therapist draws attention to the logical inconsistency that the expansion and escalation phases have produced—not as a 'gotcha' but as a shared observation: 'I notice that if the tunnel is truly endless, you couldn't know it has no end you'd need to have reached the end to know that. How does that sit with you?' The disruption need not be dramatic to be effective. What matters is that the patient experiences a moment of genuine cognitive surprise—an involuntary recognition that the metaphorical schema does not hold together under its own logic. Pascual-Leone and colleagues (2010) have documented that such 'meaning-protest' moments, in which existing emotional meanings are recognized as inadequate, predict subsequent therapeutic gains in emotion-focused therapies. DMET aims to create analogous moments specifically at the level of metaphorical-cognitive structure. The disruption is not the endpoint of the intervention but a transitional moment: a brief opening in the metaphorical closure that Phase 5 aims to expand.

### 3.5. Phase 5: Reconstruction

The final phase supports the patient in developing alternative metaphorical mappings—not logically derived replacements, but organically generated alternatives that feel personally meaningful. The therapist may ask: 'If not a cage, what else could this be?' or 'Given everything you've described, what other image or metaphor comes to mind?' The goal is not the installation of a positive metaphor a naive replacement of 'prison' with 'garden'—but the loosening

of metaphorical fixation and the restoration of what could be called metaphorical pluralism: the capacity to hold multiple images of the self simultaneously. Polkinghorne (1988) has argued that narrative and metaphorical reconstruction is fundamental to psychological healing; it is not sufficient to eliminate a pathogenic narrative without supporting the emergence of an alternative that can organize experience with comparable coherence. Phase 5 thus has both a negative aim (dissolving metaphor fixation) and a positive aim (facilitating the emergence of more flexible, multidimensional self-representation).

## 4. Clinical Vignette

The following composite vignette illustrates the DMET sequence in clinical practice. All identifying information has been modified; the vignette is a composite construction for illustrative purposes. A 38-year-old male patient, referred for treatment of recurrent major depressive disorder with dysthymic features, presented with a prominent sense of meaninglessness and temporal stagnation. After several sessions of assessment and alliance building, the following exchange occurred in the context of an emotion-focused exploration. Patient: 'Everything just feels pointless. Like I'm walking through an endless tunnel with no light.'

Therapist: 'An endless tunnel can you describe it a bit more? What does it feel like to be in it?'

Patient: 'It's narrow. Cold. I keep walking but nothing changes. There's no echo—it's like the sound just dies.'

[Phase 2—Expansion]

Therapist: 'When did you first enter this tunnel?'

Patient: 'I... I'm not sure. Maybe years ago. Maybe I was always in it.'

Therapist: 'If you were always in it—were you born in it? Or did you walk in at some point?'

Patient: [pause] 'I walked in, I think. Or—I don't know. Maybe someone led me in.'

[Phase 3—Escalation]

Therapist: 'You said it's endless. If it's truly endless—how do you know that? Have you reached the end?'

Patient: 'No, obviously not.'

Therapist: 'Then endless means: you haven't found the end yet. Which is different from: there is no end.'

[Phase 4—Disruption]

Patient: [long silence] 'I never thought about it that way. I assumed it had no end. But I haven't seen all of it.'

[Phase 5—Reconstruction]

Therapist: 'If not an endless tunnel—what else might you be walking through?'

Patient: 'Maybe... a very long tunnel. One that curves. I can't see ahead because it curves—not because it ends nowhere.'

This shift from 'endless tunnel' to 'curved tunnel' a minor metaphorical modification—represents a clinically significant transformation. The patient has moved from a schema of permanent hopelessness (no end exists) to one of

bounded uncertainty (the end exists but is not yet visible). The inferential consequences of this shift are substantial: effort becomes potentially worthwhile; the future, while opaque, is not foreclosed. This example illustrates DMET's core mechanism: cognitive change through the internal transformation of the metaphorical schema, rather than through external disputation or replacement.

## 5. Mechanisms of Action

DMET is hypothesized to produce therapeutic change through several overlapping mechanisms, each with support in the cognitive and clinical literature.

### 5.1 Schema Destabilization

Young and colleagues (2003) propose that early maladaptive schemas (EMS) maintain themselves through schema maintenance behaviors, schema avoidance, and schema compensation. DMET operates at the level of schema destabilization—creating the conditions under which the schema can no longer function without self-contradiction. Safran and Segal (1990) have described therapeutic moments in which a schema's 'interpersonal marker' is activated and disrupted within the therapeutic relationship; DMET creates an analogous disruption at the metaphorical-cognitive level.

### 5.2 Cognitive Defusion

Hayes and colleagues (1999) define cognitive defusion as a change in the functional relationship between cognitions and behavior—thoughts are observed rather than fused with, reducing their behavioral impact without necessarily changing their content. DMET produces defusion through a different mechanism than ACT's standard techniques: by following the metaphor to its logical extreme, the patient is guided into a stance of increasingly detailed examination that itself generates observational distance. What begins as direct experience ('I am in a tunnel') becomes an object of collaborative inquiry ('this is a tunnel I am examining'), activating the metacognitive shift that Flavell (1979) identified as foundational to reflective thought.

### 5.3 Metacognitive Distancing

distinguish between object-mode processing, in which thoughts are experienced as direct reflections of reality, and metacognitive mode, in which thoughts are treated as mental events. Rumination is maintained in object mode; therapeutic progress requires a shift to metacognitive mode. DMET facilitates this shift by engaging the patient in explicit, systematic reflection on the structure of their own thought—a procedure consistent with the metacognitive therapy literature) while targeting metaphorical rather than propositional content [30,31].

### 5.4 Narrative Restructuring

have argued that psychological health is associated with narrative coherence and flexibility—the capacity to integrate past, present, and future experience within a meaning-making framework that is both organized and open to revision. Depressive narratives are characterized by foreclosure: past events are interpretively fixed, and

the future is narratively predetermined. DMET's Phase 5 reconstruction phase directly addresses this foreclosure by inviting the generation of alternative narrative-metaphorical frames, consistent with narrative therapy's externalization and re-authoring procedure [32-36].

### 5.5 Epistemic Flexibility

Stanovich and West (2000) have operationalized what they term 'actively open-minded thinking' the disposition to seek out alternative hypotheses and revise beliefs in response to counterevidence as a cognitive ability associated with better reasoning outcomes. Koster and colleagues (2011) have linked reduced epistemic flexibility specifically to depressive rumination. DMET's disruption phase is hypothesized to model and practice epistemic flexibility within a contained therapeutic encounter, potentially supporting its generalization to everyday self-relevant cognition.

### 5.6 Proposed Outcome Measures

The following validated instruments are proposed for evaluating DMET's effectiveness in clinical trials: the Cognitive Flexibility Inventory which assesses the ability to generate alternative explanations and solutions; the Ruminative Response Scale which measures the tendency toward depressive rumination; the Dysfunctional Attitudes Scale which assesses maladaptive core beliefs; and the Beck Depression Inventory-II as a standard depression outcome measure. Process measures could include linguistic analysis of metaphor use across therapy transcripts using methods from corpus linguistics [37-45].

## 6. Comparison with Existing Therapeutic Approaches

A precise positioning of DMET within the therapeutic landscape requires systematic comparison across mechanism, target, stance, and domain of change. Standard targets propositional beliefs through logical disputation, behavioral experiments, and Socratic questioning. The primary stance is collaborative empiricism; the domain of change is automatic thoughts and intermediate beliefs. DMET differs from CBT in targeting metaphorical schemas rather than propositional content, and in using expansion and internal contradiction rather than external evidence and logic. DMET's disruption mechanism is orthogonal to CBT's, making DMET a potentially useful adjunct for patients with high resistance to logical disputation. ACT targets experiential avoidance and cognitive fusion through acceptance, defusion, and values clarification. The primary stance is observational; the domain of change is the functional relationship to private events. DMET shares ACT's interest in cognitive defusion but pursues it through active expansion and elaboration rather than detached observation. Where ACT asks patients to step back from their thoughts, DMET asks them to step fully into the logic of their thoughts until that logic collapses from within. MCT targets metacognitive beliefs about the utility and danger of thinking—through the attention training procedure and detached mindfulness. DMET overlaps with MCT in promoting metacognitive distancing but does so specifically at the level of metaphorical schema rather than worry and rumination processes per se. Narrative therapy

targets dominant problem-saturated narratives through externalization, unique outcomes identification, and re-authoring. DMET shares narrative therapy's interest in the metaphorical-narrative organization of self-experience but differs in its structured escalation mechanism, which has no equivalent in standard narrative therapy procedures. Provocative therapy uses humor, warmth, and deliberate provocation to challenge self-limiting beliefs. DMET differs from provocative therapy in its theoretical grounding, its use of patient-generated metaphors rather than therapist-introduced challenges, and its systematic phase structure. The aim of DMET is not to provoke emotional reaction but to generate cognitive disequilibrium through internal metaphorical logic. In summary, DMET occupies a distinct position within the therapeutic landscape: it is more structurally specific than metaphor-inclusive approaches (e.g., Ericksonian therapy) and more cognitively targeted than narrative approaches, while engaging a level of cognitive structure/metaphorical schema not addressed by CBT, ACT, or MCT. It is proposed as an integrative module rather than a standalone treatment [46-53].

## 7. Indications and Contraindications

### 7.1 Indications

DMET is most likely to be effective for patients presenting with the following profile: a diagnosis of major depressive disorder, recurrent or persistent depressive disorder (dysthymia); high cognitive rigidity as evidenced by extreme overgeneralization, black-and-white thinking, or resistance to standard CBT interventions; high verbal capacity and metaphorical fluency, as evidenced by spontaneous metaphorical expression in clinical speech; sufficient ego stability to tolerate cognitive disequilibrium without decompensating; a stable therapeutic alliance of adequate depth to support the escalation phase without triggering therapeutic rupture. DMET may also be applicable in comorbid conditions where cognitive rigidity plays a prominent maintaining role, including chronic pain with catastrophizing ideation generalized anxiety disorder with ruminative worry and perfectionism-based presentations in eating disorder recovery DMET is contraindicated or should be used with significant modification in the following clinical contexts. Psychotic disorders: the systematic expansion and destabilization of belief structures is inappropriate when the patient's relationship to reality is already fragile. Active suicidality with high intent: the escalation phase could amplify hopelessness rather than disrupt it if conducted without adequate safety assessment and crisis protocol. Borderline personality disorder with significant instability: the experience of cognitive disequilibrium in Phase 4 could trigger identity diffusion or therapeutic rupture in the context of unstable self-concept. Fragile narcissistic presentations: patients for whom the confrontation of internal contradiction is experienced as annihilating humiliation rather than illuminating surprise. Severe trauma with active dissociation: the escalation of embodied metaphorical schemas could inadvertently activate trauma material. In all cases, DMET should be implemented only by therapists with adequate training in both the theoretical

underpinnings of the model and the clinical skills required to manage the relational dynamics of the escalation phase. The intervention requires, as Stott (2007) has noted of all confrontative techniques, a therapeutic stance that is simultaneously challenging and deeply respectful [54-56].

## 8. Ethical Considerations

The confrontative elements of DMET raise ethical questions that require explicit consideration. Three concerns are paramount. First, the risk of therapeutic harm through misapplied disruption. The escalation phase, if conducted without sufficient clinical sensitivity, risks causing shame, humiliation, and alliance rupture. Research has documented that critical and non-empathic therapeutic responses are associated with poorer outcomes in CBT for depression. DMET's confrontative elements are only therapeutically viable when embedded in a relational context of genuine warmth, curiosity, and collaborative inquiry. Disruption must be experienced by the patient as illumination, not attack. Second, the question of informed consent. DMET involves deliberate induction of cognitive disequilibrium—a process that may be temporarily uncomfortable even when ultimately beneficial. Patients should be informed in advance that the approach may involve following their own metaphors to challenging conclusions, and that they retain the ability to pause or redirect the process at any point. This is consistent with the general ethical principle of collaborative informed consent in psychotherapy (Pope & Vasquez, 2016). Third, the issue of therapist competence. The theoretical complexity and relational demands of DMET require adequate training. A clinician who understands CMT at a theoretical level but lacks the clinical sensitivity to modulate the escalation phase appropriately could cause harm. Training protocols for DMET should include supervision of clinical vignettes with explicit attention to the Phase 3-4 transition and its relational management [57-66].

## 9. Conclusion

This paper has introduced Disruptive Metaphor Expansion Therapy (DMET) as a theoretically grounded, clinically structured intervention model for cognitive rigidity in major depression. DMET proposes that the entrenched negative thought patterns characteristic of MDD are organized not merely at the level of propositional belief but at the level of conceptual metaphorical schema—structural mappings between source and target domains that organize self-perception with the coherence and rigidity of an architectural system. Standard cognitive interventions that address only the propositional surface of depressive thought leave this metaphorical infrastructure intact and may therefore encounter systematic limitations in patients with high cognitive rigidity. DMET addresses this gap through a five-phase procedure, metaphor identification, systematic expansion, escalation, disruption, and reconstruction that follows the patient's own metaphorical logic to its extreme until internal contradictions emerge and the schema can no longer sustain its apparent completeness. The approach draws on established theoretical frameworks including CMT, embodied cognition, and schema theory, and is distinguished

from existing modalities by its specific focus on metaphorical schema structure and its use of internal contradiction as the primary agent of therapeutic change. DMET is proposed not as a replacement for existing evidence-based treatments but as a structured integrative module, applicable to a specific patient population characterized by high verbal capacity, metaphorical rigidity, and resistance to standard cognitive interventions. Its empirical validation remains to be established, and the present paper offers the theoretical and conceptual groundwork necessary for that enterprise.

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