

## Chapter 10

### Communicating nuanced results in language consultancy: The case of cancer and the Violence metaphor

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#### 1. Introduction

'She lost her brave fight.' If anyone mutters those words after my death, wherever I am, I will curse them. (Kate Granger, a consultant geriatrician with advanced cancer<sup>1</sup> writing in *The Guardian*, 25 April 2014, <https://bit.ly/2GPuKkO>)

In this chapter, we discuss challenges and rewards we experienced, as part of a larger team<sup>2</sup>, in communicating a nuanced linguistic view of expressions such as 'fight' in relation to cancer when consulting for research users (e.g. charities and hospices) and media outlets (e.g. national newspapers). All our consultancy work is based on a large-scale corpus-based research project investigating metaphors in the context of cancer and the end of life (Semino et al. 2018). As will become clear later in this chapter, we hold a broad view of consultancy as any activity that comes about, whether paid or not, as a result of an invitation to share our expertise or findings with those who can use them in their own professional practice. This definition includes, in our case, invited talks and presentations to patient and professional groups, training delivered at hospices, responses to media enquiries, and new research initiated or commissioned by these same research users.

Metaphor – talking, and potentially thinking, about one thing in terms of another, where the two things are different, but a similarity can be perceived between them (Semino 2008) – is frequent in everyday language, and is particularly useful when articulating ideas or experiences that are abstract, complex, diffuse, sensitive and subjective. Illness, particularly serious illness such as cancer, is one such experience. Studies of metaphor and cancer have shown how it can be used to facilitate expressions of emotion, the integration of new experiences into one's life, and the management of one's identity, among other things (Gibbs and Franks 2002; Appleton and Flynn 2014; Semino et al. 2018).

However, discussions of metaphor and cancer, in research, healthcare and the media, often report, engage in, or are influenced by debates about the appropriateness of different metaphors, and particularly of what has been called the 'Military metaphor', in which cancer is an enemy to be fought (e.g., Sontag 1979; Miller 2010). In our opening quote, Kate Granger exemplifies this metaphor ('She lost her brave fight') and lays the ground for her critique of it in the rest of her *Guardian* article. In brief, this metaphor has been criticised for some aspects of the framing it imposes on experiences of cancer: the sick person and illness are opponents, and not getting better or dying is 'losing the fight', which, as Kate Granger suggests, may then be perceived as a personal failing (e.g. Sontag 1979; Miller 2010; Hurley 2014). Policy documents in the UK, such as the 2007 *National Health Service Cancer Reform Strategy* (2007) and the *Cancer Strategy for England* (2015–20) have avoided references to 'battles' or 'wars' as a result of such critiques. In contrast, a minority of academic and personal contributions to this debate have suggested that this kind of metaphor can be meaningful and motivating, because of a professional interest in war

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<sup>1</sup> Kate Granger died on 23 July 2016

<sup>2</sup> The project team also included Jane Demmen, Andrew Hardie, Veronika Koller, Sheila Payne and Paul Rayson, all at Lancaster University, UK.

(Reisfield and Wilson 2004), for example, or because of a preference for a 'heroic' narrative of illness and death to be shared with family members (Bennett 2013).

An implicit assumption that seems to underlie much of this debate is that there is a single Military metaphor, involving a well-defined group of expressions and a set of fixed and predictable implications. This assumption reflects what Hamilton and Chou (2014, 7) call a 'non-linguistic understanding of language' involving 'the identification of stable lexical meanings that are understood to reflect the world' (see also Reddy's 1993 'Conduit' metaphor for communication and Niedzielski and Preston's (2010) comment on prescriptivism in folk views of language). This view contrasts with how we as linguists understand meaning in communication, and more specifically, with our group's findings in relation to what we called 'Violence' metaphors in communication about cancer (Semino et al. 2018; see also <http://wp.lancs.ac.uk/melc/>). Our research showed that Violence metaphors had a range of functions which depended on the exact words that expressed the metaphor (e.g., 'time-bomb vs. 'fighter'), who used them (e.g., a patient with reference to themselves vs. a doctor in reference to a patient), when and how (e.g., to describe fear and uncertainty around potential recurrence vs. to support one another online). Successfully communicating this kind of nuance was our first challenge in our consulting work with research users who sometimes expected our research to confirm their negative evaluation of Violence metaphors, or the media, who preferred clear-cut messages.

The second challenge, related to the first, was to do with how to respond to requests, for example from some patient groups and charities, to translate our findings into a 'dos and don'ts' format, i.e., lists of good/positive metaphors to be used vs. bad/negative metaphors to be banned. Such requests also rely on the idea that words and metaphors have fixed meanings, which leads to the conclusion that communication problems can be caused or fixed by choosing the wrong or right words. This view tends to influence communication skills training and communication guidelines in healthcare and beyond (cf. Sarangi 2005; Skelton 2008). For example, the *A to Z of NHS Health Writing* (2019 <https://bit.ly/2MSPdpy>) consists of an alphabetical list of words to use and avoid (and their 'correct' spellings). In the context of cancer, the 2017 *Writing About Cancer Guidelines* of the Cancer Institute of New South Wales, urge people to 'Avoid battle language', while acknowledging that some people may find it motivating (2019; <https://bit.ly/2Z93O5G>). More generally, some requests we received assume that we, as linguists, take a word-level prescriptive approach to language use, which contrasts both with our professional commitment to a descriptive approach to research and with our view of meanings as fluid, emergent and context-dependent (see also Niedzielski and Preston 2010 on prescriptivism in Folk Linguistics).

In what follows, we provide an overview of the research project and results which underpinned our consultancy work, before discussing the nature of the consultancies and associated challenges.

## **2. Project overview**

The consultancy work we reflect on here was based on the 'Metaphor in End-of-Life Care project' (MELC), funded by the UK's Economic and Social Research Council at Lancaster University (2012-2014, ESRC grant number: ES/J007927/1). The project originally set out to investigate metaphors used for views and experiences of end-of-life care by healthcare professionals, patients and unpaid family carers, and the implications of those metaphors. Manual and corpus-aided analyses were combined to identify relevant uses of metaphor in a 1.5-million-word corpus of interviews with and online forum posts by people with advanced cancer, family carers looking after someone with advanced cancer, and healthcare professionals (see Demmen et al. 2015).

The project was cross-disciplinary and involved research users as advisors from the start. The team consisted of linguists, a computer scientist and an end-of-life care specialist, and was assisted during the preparation of the bid and throughout the work by the Lancaster University Research Partner forum, a group of about a dozen local people with experience of cancer (either as patients or carers), who were originally funded by Cancer Experiences Collaborative at Lancaster University. The end-of-life care specialist and advisors were instrumental in shaping the design of the project to begin with, and then directing its focus once the project was under way and began to generate interest from the healthcare sector and media. In particular, while the original focus was end-of-life care, we found that the cancer-related aspects of our work attracted most attention. This led us to expand the project's focus, which culminated in our book *Metaphor, Cancer and the End of Life* (Semino et al. 2018). As such, although the original project was conceived of as a research project rather than consultancy, it already had elements of consultancy as it involved collaboration and interactions with different stakeholders, and was shaped to cater to their interests and needs. One could say that it was based on a consultative model of research (Sarangi 2005). Other consultancy work, as we will discuss below, emerged more post hoc in the course of the project and after its completion.

### 3. Key findings

We found that all three groups represented in our data used a wide range of different metaphors to describe experiences of having cancer or of caring for someone who does, whether as a family carer or as a healthcare professional. People used the following types of metaphors:

- Restraint ('I feel like a prisoner with all the rules about don't eat this don't do that')
- Animal ('I am so sorry to hear that the beast is back')
- Openness ('from then on we were open we talked about it')
- Sports and Games ('caring for somebody with a terminal illness is more of a marathon rather than a sprint')
- Religion and the Supernatural ('I just feel like a sitting duck waiting for the green eyed monster to come up and swallow me whole')
- Obstacle ('add the dispensary [sic] pharmacist to the GP's receptionists and you've got the two big blockers to me getting what I need')
- Wholeness ('you realise you are only half a person')
- Machine ('I'm not really happy about being back on the treadmill of treatment')

However, what we call Violence metaphors were the most frequently used type of metaphor for all three stakeholder groups in our corpus. In our definition, Violence metaphors include not just expressions such as 'war' and 'battle', but also 'attack', 'hit', 'hammer' and many others, which can be used to suggest physical aggression without necessarily having military associations. This accounts for the range of related expressions actually used in our data more adequately than a single and separately identifiable 'Military metaphor'. Journey metaphors were the second most frequent type of metaphor, again for all three stakeholder groups (e.g., 'as much as we have support from family and friends, we go through the cancer journey on our own'). Given the debate we mentioned earlier, the former finding was somewhat surprising. However, a detailed analysis of our data revealed a more complex picture than might be expected.

In our data, Violence metaphors can: (a) be applied to many different aspects of the illness experience, (not just trying to get better, but also experiencing cancer treatment and its side effects, e.g. 'they hit me with radiation'); (b) perform a variety of different functions, e.g. identity construction, emotional disclosure, encouragement of others, etc.; and (c) have different implications for the positioning of the person who is ill, particularly in terms of whether they are presented as empowered or disempowered. In fact, similar findings also

apply to Journey metaphors (Semino et al. 2017), and, to varying extents, other types of metaphors in our data (Semino et al. 2018).

Concerning point (c) in particular, we found plenty of evidence of potentially harmful, or, in our terms, disempowering effects of Violence metaphors, especially when the illness is incurable (e.g. when an online forum contributor whose cancer has spread says: 'I feel such a failure that I am not winning this battle'). A subsequent experimental study confirmed that, other things being equal, people who read a passage describing somebody's cancer as a battle were more likely to imagine that this person would feel guilty if they could not get better than people who read a passage in which cancer was described as a journey (Hendricks et al. 2018). However, things are very often not equal. In our analysis, we also found evidence that Violence metaphors can be empowering, for some people at least some of the time, depending on what expressions are involved and which context they are used in. For example, Violence metaphors can be used to convey a positive sense of self (e.g. 'My Consultants recognised that I was a born fighter'), to express a sense of achievement even in the face of death (e.g. 'OK we didn't win but we made a jolly good fight of it'), to encourage others (e.g. 'Soldier on everybody'), and so on.

Overall, therefore, in our publications and other modes of dissemination we argued that the most important distinction among different metaphors in our data was not to do with what domain of experience they drew from (e.g. Violence versus Journey), but whether they were empowering or disempowering for the people involved, and particularly for patients.

In view of this, from our perspective, the main practical implications of our work, which we emphasised in our consultancies and research user engagements, were as follows:

- a) To communicate sensitively about cancer, especially publicly (for example in healthcare settings, news reports and charity campaigns), speakers and writers in positions of power (be they clinicians, policy writers or campaigners) need to be aware of the (dis)empowering implications of different uses of metaphor, particularly with respect to the positioning of patients.
- b) Violence metaphors can be particularly disempowering and therefore might be best avoided by healthcare professionals, the media, etc. when addressing patients or carers, unless they themselves are using them;
- c) There should otherwise be no blanket ban on some metaphors or promotion of others, especially when it comes to patients' own choices;
- d) Patients should be encouraged and enabled to use the metaphors that work best for them at each individual point in their experience of illness.

While, on the whole, our findings and their potential applications have been well received, some aspects of our message have been easier to convey than others in consultancy activities and interactions with the media. We now describe our experiences in more detail.

#### **4. Engagements and consultancies**

Throughout the duration of MELC (and beyond), the team spoke with a wide variety of organisations and individuals in the areas of end-of-life care, cancer care, and communication about the experiences of cancer and/or the end of life more generally, including:

- Staff in two hospices in the UK: St Joseph's Hospice in London and St John's Hospice in Lancaster;
- Healthcare professionals caring for people with cancer and/or receiving end-of-life care, notably in two NHS hospitals in the North West of England, participants at the TEVA Dialogues in 'Cancer Care' nursing symposium in Manchester, and more broadly via our events and on Twitter;

- National and regional cancer charities, including: Cancer Research UK and Macmillan Cancer Support;
- The National Research Cancer Institute;
- The European Association for Palliative Care;
- Local patient groups, e.g. the Morecambe Bay Prostate Cancer Support Group;
- A group of students at the University of California, Berkeley who were creating an app for children with cancer;
- The media (newspapers, magazines, radio and TV, in the UK and internationally);
- Members of the general public interested in end-of-life care, cancer care and communication about cancer, including individuals who contacted us directly, audiences at public lectures, and followers on our Twitter accounts.

These relationships began as research dissemination and research user engagement, but our activities with hospices, healthcare professionals and charities in particular, developed in ways that led to consultancy work. While the nature, breadth and depth of these consultancy activities varied greatly, the fact that these activities happened at all resulted from an approach that was both proactive and reactive. We were proactive, for example, by contacting a local oncologist, inviting representatives from hospices and relevant charities to an end-of-project research user event in London and, more generally, giving the project visibility by writing blog posts for different stakeholder organisations (e.g. the European Association for Palliative Care), and putting out appropriately timed press releases on our findings at key points in the project. That is, we actively wrote and talked beyond our disciplinary audiences (cf. Roberts and Sarangi 2003). Some of the broader public dissemination activities attracted media attention in the UK and beyond, which facilitated the more reactive aspects of our communications approach. The bulk of our consultancies resulted from responding to requests and invitations to share our expertise, or give talks and training workshops, including from the hospices and cancer charities mentioned above, as well as the organisers of local and national events (e.g. the 2017 Lancaster Health Festival and the 2016 TEVA Dialogues in 'Cancer Care' nursing symposium), who came across our work via our dissemination activities amplified by media attention.

Broadly speaking, hospice staff and healthcare professionals involved in cancer care and end-of-life care were interested in gaining a better understanding of the experiences of patients, and in improving their approach to communication with patients and their families, while cancer charities were interested in making their fund-raising messages more effective in ways that were sensitive to the feelings and needs of patients. The extent to which our relationships with these stakeholders were (and still are) reciprocal also varied from case to case. For example, we provided a single two-hour training workshop for St Joseph's Hospice in London, but several training sessions for St John's staff, with whom we are also co-developing new research questions (e.g. on the language used in de-brief sessions after a challenging event, and its implications for a better understanding of staff members' experiences). Similarly, we gave a single invited talk at Cancer Research UK, but had several interactions with Macmillan Cancer Support. We were invited to share the findings of our research and subsequently conducted additional research in response to questions from the charity's communications team, resulting in a tailor-made report concerning the use, in our data, of a group of words and phrases that were being considered for inclusion in Macmillan's own communication with stakeholders. Finally, our initial contact with a local oncologist developed into a collaboration aimed at producing a metaphor-based tool for supporting patients (see below).

This variety in partners, relationships, needs and activities as well as the particular context in which our work was situated (healthcare) meant that, in contrast with prototypical consultancies, we did not necessarily charge for our contributions. Some activities were carried out as part of, and therefore funded by, the project's engagement programme (e.g.

talks at charities); others helped give visibility to the project (e.g. media reports); and yet others were part of long-term and mutually enriching interactions with partners who themselves rely on charitable contributions (e.g. St. John's Hospice in Lancaster). It should be noted, that while we consider our activities to fall under the broad category of consultancy, some of these contributed to initiatives on the part of stakeholder groups that can be seen as forms of advocacy or, potentially, activism. For example, the members of the Lancaster Research Partner Forum and of some patient groups we engaged with directly made use of our findings in their regular activities of support and advocacy for patients. Another initiative for better support for and communication with cancer patients, this time in a French hospital, was launched by a volunteer patient advocate who read about our work online and contacted us directly. Finally, as will become clear below, the media often framed our work in ways that suggested activism. We considered these as welcome, if not necessarily planned, consequences of our other efforts.

In the rest of the chapter, we focus on the main achievements and challenges in our consultancy activities and interactions with the media. While the latter do not fall under the notion of consultancy, media reports on our work are indicative of the kinds of successes and problems in the wider uptake and impact of our work, that are often difficult to evidence in the case of consultancies (cf. McEnery 2018).

## **5. Achievements and challenges**

Our initial challenge was that, once news about the project had spread, we came under pressure to provide answers or comments before we felt that we had enough evidence, from our perspective as researchers. When we did arrive at findings we could be confident about, our new challenge was how to reconcile those findings with assumptions and expectations of different stakeholder groups who were seeking our expertise in the form of consultancies.

While nuanced recommendations and responses based on our findings were, on the whole, well-received (see below), we had some difficulties in managing some stakeholders' assumptions and expectations about our topic, the relevance of our findings, and our role as linguists, as we indicated earlier. Here we focus on the assumption that Violence metaphors are always bad, and the expectation that, as linguists, we would provide lists of communicative do's and don'ts, i.e., metaphors to use and avoid.

### **5.1 '*Violence metaphors are always bad – and can even kill*'**

The MELC project is, to the best of our knowledge, the largest and most systematic analysis of metaphors for cancer in English. However, as we mentioned earlier, it took place at a point in time where what we call Violence metaphors for cancer had been criticised from a variety of perspectives. In this context, the aspect of our work that has come to be most closely associated with our team is that we provided evidence that Violence metaphors can be harmful for patients, rather than the more complex view we described above. Hospice staff and healthcare professionals in our training sessions understood and welcomed the nuanced view, as it is consistent with their experience of individual variation in communication with patients, and their goal to provide person-centred care. However, they were also consistently interested in our critique of Violence metaphors and this was often due to a concern for the refinement or development of communication guidelines and further trainings. As such guides are notoriously simplistic from a linguistic point of view (Skelton 2008, 2011), this made us wonder to what extent the nuanced view we were putting forward would actually impact the working practices of the healthcare practitioners we were consulting with.

Unfortunately, we have little concrete evidence of the impact our recommendations had in the context of consultancies, but we do have some evidence of how our findings were taken up more broadly in our engagements with the general public, social media users (from

different interest/professional groups) and the media. While we were always careful to put forward the same nuanced view, we have received more unsolicited emails of gratitude (as well as 'Likes' and retweets) for evidencing that Violence metaphors are bad and should be avoided, than for showing that what matters more generally is whether a metaphor has empowering or disempowering consequences in context. Social media users tend to involve us in interactions where Violence metaphors are criticised, and news outlets tend to emphasize our critique of these metaphors, particularly, in their headlines (even when the text of a press report includes our nuanced findings). As evidence of how our message is taken up or, in this case, not, they also attribute to us a prescriptive attitude that we always steered clear of (more on this below):

Cancer should not be called a 'battle' say language experts who fear metaphor makes people feel guilty if their condition gets worse (The Daily Mail, 4<sup>th</sup> November 2014)

Stop saying John McCain will beat cancer because he's a fighter (Washington Examiner, 20<sup>th</sup> July 2017)

Though these headlines are not misrepresentations of our work, they provide a partial view of our findings – one that is consistent with what many people already believe and that appears to rely on the assumption of a single Military metaphor with fixed meanings. A negative consequence of the picture that is being painted is that people who do find Violence metaphors helpful, in some contexts and for particular purposes, may feel alienated, marginalised and potentially censored.

A particularly problematic variant of such reactions is the idea that using Violence metaphors may actually shorten people's lives. This is linked to the belief that attitudes and emotional states affect length of survival – a belief that, to the best of our knowledge, has not been conclusively proven by research (e.g., Nakaya 2014). The headlines below, again from articles reporting on our research, potentially suggest this view:

Mind your language: 'Battling' cancer metaphors can make terminally ill patients worse (The Independent, 3<sup>rd</sup> November 2014)

How Calling Cancer a 'Fight' or 'Battle' Can Harm Patients (TIME magazine, 17<sup>th</sup> December 2014)

In addition to never suggesting such an interpretation, we have always clarified, when directly asked, that we did not research a potential link between metaphor use and prognosis, and that we do not think such a link could in fact be reliably established or refuted, given how many variables would have to be controlled. In spite of this, it has proved difficult to prevent some stakeholders from attributing to us the finding that Violence metaphors shorten people's lives. A blatant case of this is the first edition of the book *You're not human: How Words Kill*, by speech-writer Simon Lancaster (2018). While researching the book, Lancaster had contacted the project's Principal Investigator (Semino) as an expert in communication about cancer, and requested a mini consultation based on MELC's findings. Nonetheless, when the book was published, Lancaster made the following reference to our work:

Elena Semino of Lancaster University has conducted extensive research on cancer metaphors [...]. She discovered that terminally ill patients who feel they are at war with their cancer have lower survival rates than those that don't.

This dangerously inaccurate statement was only corrected in the electronic version of the book and in subsequent print-runs after the mistake was publicly exposed on social media,

and, crucially, through a negative review on Amazon, signed by the project's Principal Investigator.

Overall, we have come to accept that our critique of Violence metaphors is the main finding associated with our work among many research users and consultancy partners: it has the key advantage that it is clear-cut, and confirms what most people already strongly believe. From our point of view, it is partial but at least not inaccurate. In contrast, the claim that we have shown that Violence metaphors shorten survival is not just false – it is dangerous, because of the pressure and guilt it can impose on patients. We are still learning how to develop ways to counter, or, ideally, prevent, this particular interpretation of our work.

### **5.2 'Tell us what (not) to say, or give us a list of good and bad metaphors'**

As noted above, some of the news headlines reporting our work attribute to our team a prescriptive approach to the use of metaphor in communication about cancer. These headlines reflect a much more general expectation that a linguist can and should put forward a list of dos' and don't's. As we discussed earlier, this expectation also reflects a folk view that words carry singular and invariant meanings across contexts, and that communication problems can be caused and fixed by picking the right or wrong words, as with the guidelines we mentioned. This expectation is at odds with our view of our role as linguistic consultants: based on our findings, and our understanding of language and communication, we aimed to help stakeholders communicate sensitively and effectively by raising their awareness of the framing effects of metaphors in context, particularly in terms of (dis)empowerment of patients, rather than providing static communication guides of 'good' and 'bad' metaphors. In this sense, our challenge was a specific version of the issues described in the literature on (critical) language awareness, in, for example, language teaching and learning (e.g. Carter 2003), branding and consulting (Koller 2018), and so on.

As a research team, we dealt with this expectation to different extents and in different forms in our consultancies and public engagements. Not surprisingly, staff at the cancer charities, have a subtle understanding of the complexity of communication, especially in public and media messaging, while also soliciting our views on the appropriateness of specific choices of words and phrases. In the case of one particular charity, for example, we responded to a request about how expressions such as 'getting [one's] life back' after cancer are used in our data by pointing out the different ways such expressions are used, and the implications of this variation. In training sessions for hospice staff and healthcare professionals, on the other hand, we had to be explicit early on about the fact that we did not aim to provide clear-cut rules on language use, but rather an approach to listening and speaking that was maximally sensitive to the needs and preferences of individual patients.

## **6. Impact**

We have already alluded to the difficulties of evidencing the impact of our consultancies. One cause of this is that contacts at charities, hospices and NHS Hospitals inevitably change roles or move on to other jobs, so that it is very difficult to obtain information about what practices may have been influenced by our work in these organisations (see also McEnergy 2018, 30-31). In spite of these difficulties, our consultancy work has been general well received, and has had some impact on thinking and, potentially, practice in several areas. Healthcare professionals (in the NHS and hospices) and staff at cancer charities reported having reconsidered and refined their communicative practices as a result of our advice on (dis)empowering uses of metaphor. Participant feedback on our training session at St Joseph's Hospice London (2014) emphasized its relevance:

Will help with my area of care, will help me understand and think about what my patients and relatives are actually telling me. Will make me reflect and respond more appropriately.



Our commissioned report and recommendations to a particular cancer charity were described as ‘incredibly useful’, while Cancer Research UK posted a blog on their website following Semino’s talk at their London headquarters in 2015, with a link to a video of the talk. The blog post summarises our nuanced findings, and spells out how our work confirms and potentially informs Cancer Research UK’s work:

So while we’ll be keeping a keen eye on research like Professor Semino’s, and make sure we’re always aware of the wider context, we’ll also keep on making sure that we can raise every pound we can to fund the scientists in labs around the UK, in their quest of discovery, to find new ways to help more people survive. (<https://scienceblog.cancerresearchuk.org/2015/09/28/may-i-take-your-metaphor-how-we-talk-about-cancer/>)

At the time of writing, the video of Semino’s talk has been watched over 3,000 times. Our publications aimed at research users in the *BMJ Supportive & Palliative Care* and the blog of the European Association for Palliative care have received high numbers of downloads, compared with similar publications (the article in *BMJ Supportive and Palliative Care* was the most downloaded in the journal in the year after its appearance online, and the blog was republished in 2015 as the second most read ever, at that point, on the Association’s website). Social media reactions to our activities from healthcare professionals specialising in palliative care similarly suggested a positive reaction to our nuanced findings and their implications for interactions with patients:

heightened alertness to metaphor when talking to patients since today’s session!

am listening in a new way!!

I have learnt from your work that different metaphors suit different people

If we are really to be person-centred we need to pay close attention to the language that people use about themselves, recognising that this language may change over the course of their living with dying experience.

However, we have often found out by chance that our work is being used by charities or healthcare professionals. Because of our approach to online dissemination and the number of media reports, our project may partly demonstrate the ‘non-linear diffusion of impact’ (McEnergy 2018, 40), that is, ideas generated by a particular group of researchers are shared among many people over time without an explicit reference to the source, so that a change may well be achieved, but ‘no direct link between [the researchers] and the change is easy to find’ (McEnergy 2018, 40). The fact that some of our findings provide (further) evidence for previously held beliefs makes this partly anonymous diffusion even more likely.

More concretely, a particularly explicit challenge from a prescriptive perspective eventually led to a major development in our work and its potential impact. Following a discussion of our findings on (dis)empowering metaphors to the Lancaster Research Partners Forum, a member of the group asked: ‘So, how will your work improve things? Will you produce a list of good and bad metaphors?’. We could not satisfactorily address this question on-the-spot (where we emphasised the context- and person-dependence of whether a metaphor is ‘good’ or ‘bad’), but managed to tackle the spirit of the question, consistently with our findings and identities as linguistic consultants, in the form of the ‘Metaphor Menu for People with Cancer’ – a collection of quotes from our data and other sources involving a range of different metaphors for cancer, such as the following from the online forum we analysed:

Plenty of us have been through it and come out the other side so imagine it a bit like a scary fairground ride ... it might be scary in places, but it will eventually stop and you can get off ... be strong, be brave and you'll be ok and we will be here to hold your hand if you need it.

The idea is that, as in a restaurant menu, different people will find different metaphors appropriate at different times, but that hopefully everyone will find something that resonates with them in helpful ways. The Menu was collaboratively developed with an oncologist at Preston Royal Infirmary – Dr Alison Birtle and led to a small pilot study in which it was distributed among patients with prostate cancer, together with some questions concerning its usefulness. Fifteen patients returned the Menu with answers to our questions. The mean score for the usefulness of the Menu on a 5-point scale was 3.2, and the ‘fairground ride’ metaphor above was found to be particularly apt and helpful. Following further fine-tuning, the Menu will be disseminated further.

## **7. Concluding remarks**

In this chapter, we have discussed opportunities and challenges we have encountered in engaging with stakeholders regarding a large-scale project on metaphors for cancer, particularly in the context of consultancies and media reports. We have focused particularly on difficulties caused by differences in assumptions about language and the linguist’s role between our team and different types of stakeholders. While these difficulties have at times caused some degree of frustration, they have also enabled us to gain a better appreciation of the challenges experienced by different stakeholder groups in communication about cancer. For example, prescriptive guidelines about word usage may conflict with our understanding of how communication works, but they may in some cases be the most pragmatic and realistic way to deal with particular problems in communication in specific healthcare settings, or at least be preferable to a total absence of guidelines. More positively, the Metaphor Menu shows that, when a genuine two-way interaction with stakeholders takes place, it is possible to reconcile different assumptions regarding communication about illness.

Overall, the difficulties we have experienced are easily outweighed by the opportunities for learning and the many rewards that flow from consultancies and other activities aimed at ensuring that research makes a positive difference.

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