Metaphor therapy within holistic cultures


Abstract
For centuries western cultures have adopted a dualistic perspective towards people's health. The "self" has emerged as an independent entity from others as well from the body. Human distress has been psychologized and depression and anxiety have been attributed to intrapsychic structures and processes. Nevertheless, many non-western cultures still adopt holistic perspectives. Within these cultures, distress is manifested through physical rather than psychological complaints. Therefore, psychological approaches, based on the independence of the self, may not be fitting for these societies. Instead, based on the assumption that non-western cultures are holistic and less psychologized and their problems are social rather than intrapsychic, a biopsychosocial approach is suggested. In addition, non-westerners have a different concept of reality. For instance, within some communities fantasies and delusions are appreciated, constitute part of a normal life, and are considered to be the "real reality". Furthermore, complaints are often described in metaphoric language. Accordingly, a biopsychosocial model of metaphoric therapy is proposed in which therapists would incorporate their clients’ metaphoric imaginative culture. Metaphoric intervention also allow for changes in the biological, psychological, and sociocultural reality of the client..

*Biopsychosocial, metaphor, psychotherapy, holistic, culture, hallucination, mind-body*
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Psychologized Western Versus Holistic Non-Western Culture

Ancient and Renaissance medical approaches in Europe were holistic. Physical and psychological problems were considered to be mind-body problems inflicted by evil spirits. In the 17th century, René Descartes separated the mind from the body. He defined the mind as independent from matter, an "immaterial substance" or "thinking thing," that is incapable of affecting matter in any way. Once Cartesian dualism became the dominant philosophical basis for human problems, a clear distinction between psychological and physical disorders became evident (McMahon, & Sheikh, 1984).

During this time, western society also moved towards a capitalistic and democratic sociopolitical system that allowed for the emergence of individualism. The "self" emerged as an independent entity and attention was given to intrapsychic processes and the psychological aspects of human problems, such as: needs, emotions, thoughts, behaviors, and self-actualization. These psychological aspects became the most prominent features of the symptoms picture of human distress. Subsequently, stress, depression, and anxiety have been conceptualized as psychological problems related to psychological constructs (such as the self or ego) or to psychological processes (such as conflict or repression), almost completely separate from the physical aspects of the body. These historical and cultural developments in the west, contributed to the psychologization of mind-body problems. According to mind and body dualism, human distress is supposedly displayed by psychological symptoms (anxiety or depression) whereas, physical problems are caused by genetic factors or germs. Physical manifestations of distress are considered unusual and as the "somatization" of a psychological problem.

The Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (1994) defines somatoform disorders as "the presence of physical symptoms and suggest a general medical condition and are not fully explained by general medical condition, by direct effect of a substance, or by another mental disorder" (p. 445). This definition suggests that there are underlying psychological causes for these physical manifestation. Therefore, somatoform disorders are considered somatizations of psychological problems.

Non-western clients demonstrate their distress through physical rather than psychological complains. For example, depression and anxiety are manifested more often as somatic complaints than as changes of mood or emotions (Al-Issa & Al-Issa, 1969; Chien & Yamamato, 1982; Kirmayer, 1984; McGoldrick, Pearce, & Giordano, 1982; Racy, 1980, 1985; West, 1987). Non-western people place less emphasis on emotions and more on morals and physical health. On the one hand, depressed or anxious mood are not considered disorders that should be treated, but instead as states that people should learn to live with. On the other hand, abnormal and deviant behavior and physical illnesses are states that need to be treated.

Two main cultural characteristics are key to understanding the manifestation of human distress in non-western societies. First, people in most of these societies continue to be preoccupied with fulfilling their basic biological needs rather than fulfilling higher psychological needs, such as achieving self actualization. Well-being in these societies is a function of physical rather than psychological state. Second, in most of these societies, the concept of a distinct individuated self has not completely emerged, as it has in the west (Dwairy & Van Sickle, 1996). Physical appearance, as opposed to the personality, is therefore what constitutes an individual's identity. Based on these two factors, it may not be valid to assume that problems will be manifested psychologically by this group as they tend to be by westerners. Distress in these
societies would most likely not be manifested psychologically because the “self” and other psychological concepts are not legitimized or distinctively individuated. As a result, reports about somatizations among non-westerners may in fact indicate depsychologization rather than somatization of human problems.

**The Bio-Psycho-Social Approach**

Based on the aforementioned cultural characteristics, traditional western psychotherapy may face substantial barriers with non-western clients (Dwairy, 1997; Dwairy & Van Sickle, 1996). With the exception of behavioral therapy, all other psychotherapeutic approaches are better suited for psychologically minded clients. These approaches assume a level of individuation, which make the symptom explainable by the intra-psychic processes and constructs that traditional psychotherapeutic techniques have addressed. Given that most non-western clients are less psychologized and adopt collective identities rather than individuated selves, western psychotherapy faces serious barriers. Compared to most people living in more individualistic and liberal western societies, most non-westerners are more dependent on their families and seldom welcome autonomy or self-actualization. External social controls, rather than intra-psychic constructs like the ego or superego, maintain an individual's repression. Therefore, implementing psychodynamic or other non-directive therapies designed to deal with intrapsychic processes and motivate patients toward self-actualization, may result in serious problems. Such approaches may miss the main source of repression, which is external rather than internal. Additionally, they may activate repressed emotions such as sexual drives or anger towards family members, that may not be acceptable if expressed within these societies. Hence, "successful" treatment that makes the unconscious conscious or accomplishes self actualization may turn a minor intrapsychic problem into a difficult family conflict. Often, this may leave the client with an untreated wound (Dwairy, 1997; Dwairy & Van Sickle, 1996).

Based on (a) the dominance of physical and social factors over the intrapsychic factors in the non-western societies and (b) the holistic mind body perspective that continues to be dominant in non-western societies, it seems that a biopsychosocial approach is more appropriate than a dualistic psychological or medical approach. The biopsychosocial approach is holistic and proposes an integration of biological, psychological, and sociocultural factors in explaining people's disorders (Donovan, 1988; Gross, 1981; Schwarts, 1982, 1984, 1989; Zucker & Gomberg, 1986). This holistic approach has been applied successfully in some non-western societies. For example, in Cairo, Egypt therapists have incorporated medication, psychotherapy, and social interventions within an intensive outpatient program that allowed the family to take part in treatment (Okasha, 1993). Multimodal therapy (Lazarus, 1976) has been recommended by Ridley (1984) as a framework that allows treatment flexibility and incorporates biological, psychological, and social therapeutic factors in treatment.

**Figure 1**

Figure 1 shows how biological, psychological, and sociocultural factors interact from birth throughout life, to an individual’s present. In the present, four subsystems interact: (a) genetic factors, (b) personality, that has developed through past interactions between genetic factors and the sociocultural environment, (c) body processes, which include several interactions between mind-body subsystems, and (d) psychological processes, which also include several subsystems. The four main subsystems as well as the minor ones within each subsystem, are found in a continuous interaction with each other and with the current sociocultural factors.
These simultaneous and multi-directional interactions display the holistic experience of the person and together explain his or her distress.

Conception of Reality: Objective Versus Imaginative Reality

Western culture clearly distinguishes between fact and fantasy. It tends to appreciate objective and rational thinking, linear cause effect relationships, and quantitative values (Katz, 1985). Scientific and rational approaches have influenced the development of psychotherapy in Western psychology (Draguns, 1974). According to reductionism, the task of scientists is to divide the world into smaller components and find out the cause of each individual phenomenon. Phenomena should be reduced into measurable factors. Due to the dominance of the Cartesian dualism, the role of imagination lost its premodern status and facts have become more important than fantasies (McMahon & Sheikh, 1984). Today, imagination is appreciated in artistic creations alone and with the condition that clear differentiation between fantasy and reality be maintained. One illustration of this belief is the fact that reality testing is essential to assessing psychopathology. Hallucinations and delusions are core criteria for psychotic and dissociative disorders and acute brain syndrome (APA, DSM IV). When fantasies dominate one’s life and one reacts as if they are real, psychopathology is often suspected.

Non-western societies have a different concept of reality. Many adopt a holistic perspective towards life’s experiences, without differentiating between mind and body. Unlike the reductionist approach, they consider life to be much more than its components. In these societies, people live interchangeably between fantasy and reality. In many Asian, Middle Eastern, African, and South American cultures, hallucination, imagery, and dissociative states are experienced on daily basis. In these cultures hallucination, visions, and altered states of consciousness describe reality. People react to these experiences not "as if" they are real but "as real" (Al-Issa, 1995). Zen Buddhism, a practice widely spread throughout East Asia, adopts a non-dualistic consciousness and eliminates all distinctions such as true/false, subject/object. "Enlightenment" is a basic objective of Zen not obtained through reason, but instead by turning attention within and becoming intimate with the self. Followers are encouraged to give up their cognitive control, meditate and transcend the ego beyond the boundaries of objective reality (Cleary, 1995; Scott, & Doubleday, 1992). Traditional health theory in India is holistic and explains behavior in terms of the totality of an individual's life style and total body-mind relationship. Nevertheless, this level is treated as less significant than analysis at a "higher transpersonal level of self, atman or soul, which in turn is equaled with Brahman- the ultimate reality." (Pestonjee, 1992, pp. 27).

In the Middle East, people tend to appreciate visions and dreams and some direct their lives accordingly. Crucial life decisions, such as marriage, occupation, and having children are often decided according to the directives of visions and dreams. People who have visions are considered holy, because it is believed that they have a unique contact with spirits. According to Islamic belief, hallucinations can be explained as a visitation from a member of the Prophet Mohammed's family who gives instruction to the person about some matter in his or her life (Bazzou, & Al-Issa, 1966). According to the Shia’a (a branch of Islam, that adopted in Iran and parts of Syria, Iraq, and Lebanon), what is generally considered an "objective reality" is actually a false reality. In order to achieve the "real reality", a Sophist (religious man) must pray all day and isolate himself from society (El-Jabiri, 1984, 1985).
In Gabon, West Africa, people of the Mitsogh tribe believe that ingesting drugs enables them to see what is behind everyday reality and reach a hidden "reality" (Gollinhofer & Sillans, 1976, cited in Al-Issa, 1995). In Mexico, traditional healers induce hallucinatory experiences by ingesting a specific type of mushroom. In Japan, monks meditate and achieve hallucinatory experiences by fasting and praying (The brain: Universe within. Matter over mind, Videotape, 1994).

Most non-western societies have cultural beliefs which may seem pathological to westerners. For example, some believe that mental illness is caused by spirits that possess the body and take control of a person. Others believe that bad things happen by means of sorcery or evil eye. Within these societies, exorcisms are performed as a way of curing those afflicted. Altered states of consciousness are also induced as part of a ritualistic healing process. Two examples are the Zar ceremony, common in Africa and the Middle East, and the Voodoo ceremonies of South America. During these ceremonies, participants are lead into trance states by means of drumming and chanting. Trances allow healers to identify the kinds of spirit that have possessed the body and enables negotiation with it (Al-Sabaie, 1989; El-Islam, 1982). Trances in these societies, are considered a means by which to reach the "reality" of an illness instead of detaching from it.

**Psychological Versus Metaphoric Language**

Clients in the west are psychologically minded and tend to describe their distress in psychological terms. They describe their complaints in emotional, cognitive, behavioral, and physiological terms. They may use some terms that psychological theories have developed, such as: self, super ego, unconscious, repression, and reinforcement. Some may even use diagnostic categories, such as depression, anxiety, obsession, ADHD, or schizophrenia to describe their case.

Non-western clients are less psychologized and tend to describe their complains in a physical terms with subjective metaphoric language (Bazzoui, 1970; Schreiber, 1995; Timimi, 1995). For example, they may use phrases such as: "darkness overshadows my heart," "my heart is dead," or "I am talking to a wall." These descriptions are often misunderstood by clinicians. Therefore, they may ask the client for an explanation or a"translation" into direct descriptive language.

Prince (1976) encouraged the utilization of cultural imaginative states in therapy. He studied the essential features of psychotherapy and divided them into two categories of factors. The first are exogenous factors such as: "spatial relationships," "shared world views," the "expectant hope of the patient," the "naming of the illness," the "attribution of cause and prescription of treatment by the healer," and the "central role of suggestion" (p.115). The second are endogenous factors such as internal mechanisms and processes which include: dreams, mystical and ecstatic states, trance and dissociative processes, and other altered states of consciousness. Prince believed that therapists must activate endogenous factors during the course of therapy in order to provide a cure.

When a psychologist works with non-western clients who adopt traditional non-western cultural beliefs, the relationship between the two is one between two cultures. The therapist’s is scientific and psychological, and the client's is imaginative and physical. At some point during the encounter, the therapist should decide between two approaches. One would be to translate the metaphoric-physical language of the client into his or her own objective-psychological
language and then apply western therapy based on the therapist’s theoretical orientation. The other would be to fit the metaphoric-physical language of the client into the therapeutic intervention and develop techniques of intervention that fit the client's language. This is a question concerning the culture and language of the therapeutic encounter.

Figure 2

Figure 2 shows the two options, the psychological one, in which the therapist imposes his or her professional culture and reeducates the client to fit into the psychological culture, and language, and the metaphoric one, in which the therapist makes a move toward the client's culture and works within the holistic metaphoric realm. It is this author’s opinion that metaphoric option is more efficient and more culturally respectful.

Metaphors and Imagination

A metaphor is "the application of a word or phrase to an object or concept which it does not literally denote, in order to suggest comparison with another object or concept" (Webster, 1983, pp. 901). It is an imaginative and creative rather than literal and concrete description and it represents a subjective personal experience rather than an objective scientific event. Metaphors and imagination have biological, psychological, and sociocultural correlates.

Biological correlates:

Several theoretical connection have been made between imagination and physical processes. In their analysis of the effects of positive images on the body, Sobel and Ornstien (1996) claimed that the brain often cannot distinguish whether we are imagining something or actually experiencing it. Images are classically conditioned to their biological association (Schwartz, 1984). Our bodies react to images as if they are real. This explains why we shed tears during a dramatic movie, our hearts pound during a horror scene, and we become aroused by sexual fantasies.

Ley and Freeman (1984), claimed that imagery therapy shares common cognitive, affective, neuroendocrine, and immunologic mechanisms. They associated imagination with the right hemisphere of the brain. This hemisphere processes information in a holistic, gestalt, spatial, and creative way, for which images are most appropriate. In contrast, the left hemisphere is a more logical, analytical, and sequential processor, for which words are most fitting. They claimed that most psychotherapies actually decode right hemispheric repository experience and imagery mechanisms mediate much of the therapeutic process. Galin (1974) and Hoppe (1977) proposed that the right hemisphere operates in a primary process manner, while the left hemisphere operates in a secondary process manner and is responsible for creative associations.

Kunzendorf and Sheikh (1990), postulated that good physical health tends to be expected among people who generate vivid images as well as among those who generate hallucinatory images. In contrast, immune deficiencies and poor physical health tend to be experienced among people with depressive affect and deficient fantasies. Kunzendorf and Sheikh further claimed that experiencing hallucinations may restore the health of bipolar depressives. Additionally, the proportion of cancer-related deaths are significantly lower among schizophrenics than among normal people (Modrzewska & Book, 1979). These authors offered an explanation for these positive effects by indicating that hallucinations and imagination centrally innervate the neural locations underlying sensations and consequently activate the neuroimmune functions that are regulated at the same locations, counteracting poor physical health.

It is well established in the literature that images, which are created in the cortex,
influence all of the subcortical parts of the brain, such as: the limbic system, the autonomic nervous system, the endocrine system, and the immune system. All of these systems communicate by way of neurotransmitters, hormones, and neuropeptides (Ley & Freeman, 1984; Ornstein & Sobel, 1987; Ornstein & Swencionis, 1990; Rossi, 1993). Negative images increase the corticosteroids and catecholamines released in the blood, that arouse the body and suppress the immune system, while positive images elevate the serotonin that regulates mood. Based on the accumulated knowledge of the relationship between images and health, imagery interventions have been applied in the treatment of a variety of physical illnesses, such as: heart disease, cancer, and chronic pain (Kunzendorf & Sheikh, 1990; Ornstein & Sobel, 1987; Ornstein & Swencionis, 1990; Rossi 1993; Sheikh, 1984; Simonton, O., Simonton, S. & Creighton, 1978). The bottom line is that manipulation within the imaginative realm may affect body functioning. For instance, guided imagery has been proven to influence psychological disorders as well as physical ones like heart disease, cancer, and chronic pain.

Psychological correlates: In accordance with the non-western concept of reality, psychoanalysis postulated that real experiences (memories, drives, emotions, and wishes) are not found in manifested behavior or speech, but are instead hidden within the unconscious (Freud, 1900, 1915). Fantasies, dreams, and creative work symbolically represent repressed content or the real reality of a person. In order to reveal the real experience, therapists should analyze their client’s behavior. Metaphors and imagery work include many symbols stemming from the unconscious. Therefore, working in the realm of imagination may access unconscious experiences and memories that had been encoded during preverbal stages of development (Bettleheim, 1984; Sheikh & Panagiotou, 1975). In the words of Freud (1923), "thinking in pictures ...stands nearer to unconscious processes than does thinking in words, and it is unquestionably older than the later both ontologically and phylogenetically" (p.14).

From the phenomenological perspective of Rogers, Maslow, or Kelly, the subjective world is what is real. Therapists should make an effort, through unconditional positive regard and empathy, to understand that client’s world. To these therapists, the process of therapy is phenomenological and the humanistic relationships developed within therapy help change the phenomenological world concerning the self and others.

Many cognitive-behavioral interventions are based on Aristotle’s philosophy. Aristotle proposed that images are the source of action, which guide behavior by presenting the objectives (McMahon, 1973). In accordance with this perspective, Lazarus(1976, 1984) applied imagery to change behavior. Hypnotic therapy is one intervention within the imaginative realm that influences the behavioral, emotional and physical realms.

Various psychological perspectives acknowledge the relationship between imagination and psychological and physical disorders. Psychoanalysts, utilize fantasies and dreams as important sources for providing interpretations to their patients. Phenomenological, cognitive-behavioral, and hypnotic therapies employ interventions within the imaginative realm. These are valuable and considered the core of therapy, which allows for changes within other parts of the mind-body system.

Sociocultural correlates: Some metaphors are culturally bound and shared by the people of the community. These cultural metaphors reflect the conscious and unconscious collective experience of people through their sociocultural history. They also contain their collective wisdom, ways of thinking, values, and world view. They are revealed in every day language,
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symbols, proverbs, and myths (Kopp, 1995; Yosef, 1992). Some languages, such as Arabic, are characterized as metaphoric languages (Barakat, 1993; Hourani, 1991). Within these cultures, metaphors are the means by which people communicate and convey meanings on a daily basis.

Non-western clients who adopt a collective identity and remain rooted in their collective experience can be expected to be influenced by their cultural metaphors. They use more culturally-bound metaphors than do westerners, who are more individualized and adopt an objective-scientific language. Cultural metaphors provide valuable information about a client and his or her cultural background. From a psychodynamic perspective, these metaphors can be considered the language of the client’s internalized objects. Based on Jungian approach, cultural metaphors, represent the people’s collective unconscious. From a cognitive-behavioral perspective, metaphors constitute the way in which people construe their experiences, and accomplish desired consequences within their culture.

Biopsychosocial Model of Metaphor Therapy

Imagination is influenced by and simultaneously influencing the biological, psychological, and the sociocultural systems. Therefore, it is reasonable to assert that therapeutic interventions at the imaginative level can create changes within each of these systems. This is especially important to consider when clients present their problems using metaphoric language.

Figure 3

The bottom part of Figure 3 illustrates the biopsychosocial system within which behavioral problems or symptoms emerge. The top portion of the figure depicts the imaginative representation of a client's experience. This is the level at which metaphor therapy would be applied. This model demonstrates the connections that can be made between a client’s metaphors and his or her biology, psychology, and social-cultural experience. As illustrated, these connections can be made by way of at least three tracks. The first track connects imagination to the body through neurotransmitters, hormones, and neuropeptides. The second makes the connection through symbols, which represent conscious and unconscious experience, to the images of a client’s metaphor. The third track depicts the relationship between the content of a client's metaphor and the collective experience that is encapsulated in myths and cultural metaphors.

This model also illustrates the fact that metaphor therapies are not mystical or magical. Instead, they are rooted in the real biological, psychological, and social-objective experience of the client.

Three Examples of Metaphoric Interventions

Working within the realm of metaphors provides new directions for thinking and problem solving. Unlike logical linear thinking based on "if-then" relationships, metaphor exploration provides at least a four-part analogy ("a is to b as c is to d"), which allows for the comparison of multiple relationships (Kopp, 1995). In addition, it unlocks the limitations that objective reality imposes on creative and flexible thinking.

Ericksonian hypnotic interventions

One central principle of Milton Erickson's hypnosis is utilization (Rossi, & Ryan, 1992). It is the readiness of the therapist to respond strategically to whatever aspects of the client or the client's culture are brought to the session. According to Erickson, behaviors such as indifference, laughter, or silence that psychoanalysts label as resistance, can be used to induce hypnosis and
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create changes. Metaphoric language has also been utilized for diagnosis and therapy. For example, Erickson reported the case of a nurse, who repeated: “I can’t stomach” this person or that one during the course of an interview while she described her social relationships. Although the manifested problem was not physical, Erickson referred her for an X-ray of her stomach. The results indicated that she had a peptic ulcer. Erickson also observed that many clients who described distress metaphorically as "a pain in the neck" actually had cervical arthritis (Rossi & Ryan, 1992, pp. 148-149). Jeffrey Zeig (1995), one of Erickson students, reported the case of a businessman who complained about anxiety. The client described feeling "a stone-like sensation." Zeig later learned that the client's deceased father had been a source of reassurance for him. Zeig utilized the client’s metaphor and suggested to him "that he could take something from his yard, perhaps a stone, to the cemetery with him. He could hold the stone against his chest and then place it on the grave site” (p. 163-164). Afterward, Zeig spoke with this client about the importance of symbolism. He then helped him decide to return a picture of his father, which his girlfriend had influenced him to remove, to his office. Instead of analyzing the metaphor, as a psychoanalyst would, he reassociated the client's internal life and guided his preconscious associations in order to create an effective treatment.

Rossi (1993), another student of Erickson, utilized physical sensations associated with a problem, as well as their verbal descriptions, to guide clients toward new insight. After placing clients in touch with their inner experiences, Rossi suggested to them that they be led by present experiences (sensations, emotions, images), explore memories, life experiences, and abilities that may help him or her resolve problems. In this way, Rossi helped clients reassociate their problems with significant parts of their life experiences, which may have been remote from their consciousness. An "affect bridge" is another way, which Watkins (1978, 1980) used, to associate a client’s present state (or complaint) to his or her personal experiences. Watkins had his clients think back to when they last experienced a particular emotion. Typically, clients recalled a series of memories and arrived at forgotten traumatic sources of personality problems.

All of treatments discussed above utilize whatever clients bring to therapy, in whatever way they describe their problems, either physically or metaphorically. Instead of translating the complaint into the therapist’s terminology, therapists work within a client's realm, directing him or her to make new associations, use reframing and insights, and enact change. Rossi (1993) asserted that self-exploration allows for changes in both mind and body systems.

Non-hypnotic use of client-generated metaphors

Richard Kopp (1995) utilized the metaphors his clients used in conversation to help clients achieve better understanding, insight, and make new decisions. In his work, Kopp avoided interpretation and instead facilitated his clients’ inner searches through their own metaphoric imagery. He suggested the following four phases to metaphor therapy:

Phase 1 includes noting a client’s metaphors, and to asking, "when you say [the metaphor] what image/picture comes to mind?" "could you describe the metaphor?" "what does it look like?". If the client fails to respond, the therapist may describe the images which occurred to him or her when the metaphor was mentioned. During this phase, the therapist is actually entering the client's metaphoric imagination.

Phase 2 consists of the therapist inviting the client to explore the metaphor as a sensory image. The client is asked "what else do you see?" "describe the scene." "what else is going on in [the metaphorical image?]" "what are the other people saying/thinking/doing?". Then the client is
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asked to describe his or her feelings and experience associated with the metaphoric image.

Phase 3 entails inviting the client to transform the metaphoric image, by asking "if you could change the image in any way, how would you change it?"

Phase 4 involves encouraging the client to apply the understanding he or she gained from this metaphoric work to real life problems. The therapist may ask "how might the way you changed the image apply to your current situation?"

Kopp reported about a client of his who explained his fear of discussing problems with his wife metaphorically, by saying: "I don't want to open up a can of worms." When the client was asked to describe this image (phase 2), he said he saw worms squirming out of the can and crawling all over the place. He described himself in the scene "running around trying to catch them. I get some of them back in the can but some wriggle through my fingers. Others crawl under the furniture and stuff and are gone." When asked how he would change the metaphor (phase 3), he said, "I guess I'd open up the can slowly and let only one or two out at a time." Later, Kopp asked "When you think of the way you changed the image, does that give you any idea about how you might proceed with your wife?" (Phase 4). The client responded: "well, I guess we could try to focus on just one issue, like letting only one or two worms out and putting the lid back on the rest. That doesn't feel as scary."

One of my teenage clients said he felt "as if [he were] talking to a wall" whenever he attempted to communicate with his parents. At first, he seemed convinced of this and was unable to view his problems with them from any other perspective. While he described the scene of the metaphor, the following exchange took place:

T: "how do you see yourself in the scene?"
C: "I look crazy. People don't talk with walls. Only crazy people may talk to a wall."
T: "What may normal people do with a wall?"
C: "I don't know" then while smiling he said: "maybe destroy it." then immediately added "No, I don't want to destroy my parents."

I encouraged him to be creative and find another activity that might be done with a wall. He brought up a variety of interesting possibilities. Among these were: opening a hole or making an opening in it, decorating it, leaning on it, sitting in it's shade, away from the sun, and sitting on it and watching things from a higher perspective. When the client was asked how he might apply these uses of a wall to his relationship with his parents, he was able to see a new basis for his relationship with his parents, in which he could minimize the demands and conflicts to the level at which they would not collapse. He also realized that through them he could see things from another perspective. Moreover, he realized that his relationship with them included times when he leaned on them and required their protection from harm. Using the metaphoric image, the client was able to realize how unproductive his former view had been and he was then able to define a number of options for himself. Some he would reject (the destruction of the wall) and other that he could apply (small opening and different perspective). He also became aware of aspects of their relationship that had previously been hidden from his perspective (to lean on the wall and to hide from the sun). It is important to note that this metaphoric exploration did not alienate him from his values and social norms. On the contrary, the image of destroying the wall made it clear to him that he did not want to destroy his relationship with his parents.

Drawing the problem and the solution
Bresler (1984), described a technique that he called "mind-controlled analgesia" to alleviate pain. In this technique, the patient is asked to draw three pictures one that symbolizes pain at its worst, a second that symbolizes pain at its best, and a third that symbolizes an intensely pleasurable experience. After inducing a state of relaxation, the patient is asked to vividly experience the first picture (the pain at its worst), then this experience is transformed into the second picture (that symbolized the pain at its best) and finally, the patient is encouraged to experience the pleasurable image. Patients are given prerecorded cassette tapes containing directives to practice several times a day.

In my own practice, my experiences with this technique have been very successful. In the vast majority of cases, clients report significant alleviation of pain immediately, when they shift to the second and the third images. Additionally, practicing these exercises daily helps clients increase their ability to control their pain by controlling the images in their minds. I have found that the pictures of the pain vary from one day to the next. For instance, a headache in one day may be illustrated as "a heavy stone inside the head" and on another day as "a tight chain around the head." The pictures of the pain at its worst and those of pleasure also vary from day to day. It seems that the metaphors extend the pain experience and are associated with the whole personal experience of the client.

I had taken this technique a step further by applying it to problems other than physical pain, such as anxiety and depression. The initial clinical observations are encouraging. Controlling the images helps clients alleviate their anxiety and depression. Given that this technique is simple and concrete and provides immediate results, I have found it very efficient with non-western clients who typically describe their problems in pictorial metaphorical language.

All three techniques mentioned above, allow the therapist to intervene at the metaphoric level. The level at which non-western clients represent their problems consciously. These interventions radiate their influence to the body and mind and allow for changes in the relationships of clients with their social environments.

Conclusion
With the emergence of the “self” from the collective identity, psychological entities became distinct from the body. Thus, psychotherapy developed as a mean to dealing with this new entity. Most non-western clients adopt a holistic perspective towards health. Imaginative experiences are a part of their daily lives, are appreciated, and are not considered pathological. They describe their complaints in both physical and metaphorical ways. For these clients, a holistic biopsychosocial approach that takes into account a client’s sociocultural background as well as his or her mind-body experiences, seems to be the most suitable approach. Therapists will be more efficient if they utilize metaphorical language instead of translating it into descriptive or psychological terms. Metaphoric work influences the mind-body system and helps clients find solutions within their own sociocultural beliefs.
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Figure Captions

Figure 1: Bio-Psycho-Social model of health.
Figure 2: The cultural encounter in therapeutic relationship.
Figure 3: A biopsychosocial model of metaphor therapy