THE TRANSFORMATIVE POWER OF METAPHOR IN THERAPY
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The Transformative Power of Metaphor in Therapy

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This volume represents a compilation of moments in time in the lives of the individuals mentioned here, as they and I worked together to understand where they had been, who they were, and who and where they wished to be.

It is, as much, the story of my journey to that point in time where our travels met. My journey there has been both circuitous and purposeful, a tapestry of interwoven textures and colors of varied shades and depths.

My undergraduate education focused on social welfare. Although initially most interested in working with individuals, I quickly became disillusioned with the politics and bureaucracy that seemed to be an integral part of both a state agency and judicial system. This was the era of efforts to pass the Equal Rights Amendment, when judges and legislators and even civil servants could with impunity eject women out of their offices and chambers for having been so bold as to wear a pants suit.

Community organization suited both my then-temperament and my need for some visible product of my hours of work and effort. Not surprisingly, my disillusion increased in direct proportion to my encounters with unethical bureaucrats and self-serving politicians. My solution was law school.

I was fortunate to find my niche practicing immigration law and, in the later years during which I practiced, AIDS law. It fulfilled my need to work directly with people, to use the languages that I had studied, to learn about other cultures and other ways of being. In an effort to build a better foundation for the cases for which I was responsible, and to alleviate my sense that my world and/or I were becoming tunnel-visioned, I returned to graduate school to pursue a master's in public health degree.

The excitement of that experience propelled me to apply for admission to a PhD program in epidemiology. Here, I felt, I could integrate all of my interests and my desire to work directly with communities. I moved on to assume a faculty position at Case Western Reserve University, where I am now. As part
of my PhD program, I had learned to design studies, to analyze quantitative data. I thought that would be the end of my formal education.

I was wrong. I needed more. It is an old saying that “the more you know, the more you don’t know.” Several years after I had assumed a faculty position, it became clear to me that I lacked both a theoretical foundation for examining the cultural context of illness risk and prevention and the skills for analyzing interview data (qualitative analysis). Because of the benefits offered to faculty and the caliber of our university, I was fortunate to be able to pursue a PhD in medical anthropology to acquire these skills.

Throughout these years, I continued to work with the same populations with which I had worked as an attorney—individuals who were poverty-stricken, non-English speakers, folks suffering from terminal diseases such as cancer and AIDS, individuals plagued with frightening hallucinations resulting from their mental illness, men and women who had been tortured in their countries of origin by the military or the opposition or both. As an attorney, I represented many of those who were immigrants in deportation (now called removal) hearings, arguing against their removal from the United States. For those who were dying, I prepared living wills and powers of attorney.

As a faculty member, I continue to work with these same communities, but in a very different way. I am privileged to be welcomed into their communities and homes, to hear from them what they need for better health.

It is through my work as a researcher with these very same marginalized communities that I came to realize a need to work with individuals and communities on yet a deeper level and expand further my understanding of their world as seen through their lenses. I returned to graduate school yet again, to complete a master’s degree in social work.

My field work afforded me the opportunity to continue to work with these same communities and individuals, in yet another dimension. Although numerous experiences in the context of my work as an attorney and a researcher provided fertile material for this volume, it was ultimately these field work experiences that provided the impetus to compose this volume, and those experiences continue as well to shape the direction of my research and my interactions with these communities.

I have had remarkable good fortune in my journey. I have studied and worked with amazingly brilliant people and have had the benefit of their experience. Still others have afforded me the privilege of their trust and have shared with me the most intimate of emotions and experiences as they struggled to make sense of their lives and the world around them. From each and every one of them, I have learned more about them, our intersecting realities, and myself. It is my hope that this volume provides you also with the opportunity to view their world and yours through yet another lens.
This book would never have been possible without the privilege of witnessing my clients in their journeys toward finding themselves. The individuals mentioned in this book represent clients with real problems and issues that they were addressing, although names, places, ages, and occupations have been changed or left ambiguous in order to protect their privacy. My co-participation in their journey has enabled me to learn a great deal about myself, about them, and about how to serve better as a witness and a guide in the therapeutic process.

Several people graciously reviewed preliminary drafts of some or all of these chapters and provided me with their insights. Foremost among them are Jerry Willing, LMSW, LMFT; Richard Romaniuk, PhD, LISW; and Victor Groza, PhD. Zane Jennings, MSW, LISW, deserves special thanks both for his careful reading and critique of these chapters and for his insights into my own process in working with metaphor. Both Zane Jennings and Kathi Overmeier-Gant are much appreciated for their openness and flexibility in the supervision that they provided to me during my field training in social work and my use of metaphors with clients in that context. A few clients also reviewed and commented on portions of this text, and although they wish to remain unnamed, they are also deserving of recognition. Sylvia Rimm, PhD, and Pierre Lehu provided me with the initial encouragement to move forward with the writing of this volume. Finally, I dedicate this book to Gussie Zand and Ruth Fogelman, who, through their own stories and storytelling, taught me the value of metaphor.
Introduction:

Peeking Through the Window: Why Use Metaphor?

Why, you might ask, is metaphor relevant to therapy and counseling?

As a skilled therapist, you know the need to have multiple approaches in your work with clients. What works for one client may not work for the next. You also know the difficulty of measuring change and growth; sometimes your client may “feel” that something is different from what it was when they first consulted with you, but may not be able to identify what that difference is.

Metaphor gives you another tool to use with clients. It is a way that both you and they can assess where they are, where they want to go with their therapy, and the distance that they travel in their therapeutic quest. And, as your clients gain insights from your use of metaphor with them, they can begin to understand the transformative power of metaphor and how it can help them in their journey even after they have left counseling. You can derive immense satisfaction at knowing that the lessons the client learned in counseling with you will continue to be useful to them.

The *American Heritage Dictionary of the English Language* (2000, p. 1104) defines the word *metaphor* as a “figure of speech in which a word or phrase that ordinarily designates one thing is used to designate another, thus making an implicit comparison” and “one thing conceived as representing another, a symbol.” As an example, a river that winds its way through valleys and mountains and terminates at the ocean can be analogized to the course of one’s life and the many difficulties and obstacles that one may encounter prior to attaining happiness, nirvana, or entry into God’s Kingdom, depending upon one’s beliefs.

Some metaphors can also be thought of as parables, short stories that teach a moral principle. Metaphors bear many similarities to parables and stories. All are ancient traditions that encourage creativity, connection with
others, and the nurturance of dreams that may have not yet been spoken. Aesop’s fables, for instance, are actually short stories that contain a moral lesson for the listener.

Many faith traditions impart their wisdom through the use of stories, parables, and metaphors. The Talmud, which dates back more than 2500 years, is a compendium of Jewish law and life that has been referred to as “an encyclopedia of Jewish life” (Bleefeld & Shook, 1998, p. 2). That portion of the Talmud known as the Aggadah contains parables, stories, and sermons that explain the law.

Christianity similarly relies on stories, parables, and metaphors. Much of Jesus’s teachings were communicated through parable and metaphor (Stein, 1994), as illustrated by the following:

I am the vine, you are the branches. Those who abide in me and I in them bear much fruit, because apart from me you can do nothing (John 15:5).
I am the bread that came down from heaven (John 6:41).
I am the bread that came down from heaven. If anyone eats of this bread, he will live forever. This bread is my flesh, which I will give for the life of the world (John 6:51).¹

It has been said that Jesus’s use of parables was effective as a teaching tool because he “used parables to present situations familiar to the rural poor” (Herzog, 1994, p. 27).

The metaphors referred to in this text have been derived from experience common to a wide range of individuals, and all are intended to stimulate thinking. Some may assist the client to identify and acknowledge different aspects of his or her personality. Others may be more suited to the task of examining relationships and interpersonal dynamics or of setting goals.

In the context of counseling, it is the client who fashions the story from the metaphor and who ultimately determines what, if any, lesson is to be learned from the story told. The use of metaphor rests on the assumption that, because illusions can never be destroyed directly (Kierkegaard, 1950), the best way to encourage and support change and growth is through story and parable (cf. Denning, 2005). Like the sugar that helps the medicine go down, the use of metaphor helps clients tolerate the unpleasantness that they may experience on their journeys to self-knowledge. A safe space is created in which the client can develop his or her own identity, sometimes embedded in story, using the metaphor as a basis. The metaphor creates the opportunity for the client as artist with palette in hand to paint a picture of himself or herself at

¹Christians who believe in the Real Presence of Christ in the Eucharist, such as Catholics and Orthodox, consider John 6 to have a literal, not only a metaphorical, meaning.
a point in time or, as the writer, director, and producer of a play, to determine the beginning, middle, and hoped-for end of their drama. Maguire’s observation regarding the importance of storytelling for children is equally relevant to the use of metaphor with adults:

Storytelling gives children more scope for working out their dreamlike perceptions of life, for symbolically confronting its myriad opportunities and difficulties. It equips them with tools—images and words—that they can use to test their intuition and powers of judgment; and it safely and gently introduces topics that can later be discussed openly outside of the privileged world of storytelling (Maguire, 1985, p. 20).

Because the use of metaphor in counseling often leads to the client’s formulation of a story, some readers may assume that the use of metaphor is narrative therapy by another name. Although metaphor can be used in conjunction with narrative therapy, these approaches are distinct. Like narrative therapy, the use of metaphor permits the client to externalize whatever may be thought of as “the problem” and to construct a story about part or all of his or her life. In the context of narrative therapy, the client may utilize metaphors to describe his or her problem or life; these metaphors originate with the client. In contrast, the use of metaphor as it is described in this text involves the counselor’s identification of an object and an invitation to the client to utilize that object in describing his or her current situation or life.

This approach is advantageous in several respects. First, although the therapist may propose a particular metaphor to the client, whether and how the client chooses to use the metaphor remains entirely within the client’s control. This encourages the therapist to work with the client from a position of neutrality. Second, the therapist’s offer of new language in the form of metaphor serves as an indirect invitation to the client of change:

Speaking isn’t neutral or passive. Every time we speak, we bring forth reality. . . . What is important for psychotherapists is that change, whether it is change of belief, relationship, feeling, or self-concept, involves a change in language (Freedman & Combs, 1996, p. 29).

By offering metaphor, we give the client permission, opportunity, and a vehicle for potential change.

I used each of the 10 metaphors described in this volume with clients over a period of years during my supervised training in social work. (I mention here, again, my appreciation of the openness of my field advisors, Zane Jennings and Kathi Overmeier-Gant, to these ideas.) All of the clients described in
this text had diagnoses of serious and persistent mental illnesses, including schizophrenia, bipolar disorder, major depression, and dysthymia. Some of these clients had been diagnosed with co-occurring substance use disorders, borderline personality disorder, and/or chronic physical conditions, such as diabetes, fibromyalgia, and irritable bowel syndrome. Clients ranged in age from 18 to their mid-70s and included men and women, those with insurance and those without, those who self-identified as white and those who self-identified as other than white, English speakers and non-English speakers, churchgoers and atheists, individuals of various sexual and gender identities and sexual orientations, those with employment and those without, folks with significant sources of emotional and/or financial support and those without either.

The use of metaphor in counseling has not, to the best of my knowledge, been tested empirically in a scientifically designed study. Nevertheless, it appears to be beneficial for some, both on an individual basis and in group work. Clients and students have come back years after their contact with me had ended to ask that I remind them of a particular metaphor and how it can be used, finding that it once again has the power to reveal to them hidden dimensions of their lives.

REFERENCES


SUGGESTIONS FOR FURTHER READING


How do we know who we are? Our ideas about how we know ourselves derive from the work of William James, a nineteenth-century American psychologist. James distinguished between the I-self, which is the active observer and knower of experience, and the Me-self, or what is known about the self (James, 1892/1968). The I-self has also been referred to as the phenomenal self, and the Me-self as one's self-concept (Harter, 1988). Because the I-self is so difficult to perceive and assess, most research has focused on the development of the Me-self.

The term **self-concept** refers to individuals’ knowledge of themselves, which can be thought of as the cognitive component of the self. This is to be distinguished from the concept of **self-esteem**, or what individuals feel about themselves; that is the affective component of the self. The development of self-concept and self-esteem and the use of metaphor in working with individuals around these issues will be the focus of this chapter.

It is believed that our sense of ourselves results from our evaluation of the feedback that we receive from others (Cooley, 1902) and that we integrate the values and expectations of others in society into our sense of ourselves (Mead, 1934). This occurs through the cognitive processing of information that we receive. Individuals process information by organizing it into **schemas**, which are essentially frameworks that they use to understand the world around them and their own experiences; by adapting to new information through assimilating it into existing schemas or accommodating it through the modification of existing schemas or the construction of new ones; and by attempting to maintain cognitive balance, known as **equilibration** (Singer & Revenson, 1996). The concept of equilibration is similar to the biological concept of homeostasis, that is, maintaining a steady state. One’s ability to know oneself depends on
the maturation process of the brain and nervous system, which is genetically determined; one's experiences in the physical world; and interactions with other individuals (Markus & Nurius, 1986). Increasingly complex understandings of the self become possible with increasingly advanced cognitive development (Labouvie-Vief, Chiodo, Goguen, Diehl, & Orwoll, 1995).

Researchers have suggested that one's self-concept is stable and is very resistant to change once it has been formed. The stability of the self-concept has been explained as the result of a need to reduce ambiguity as quickly as possible (cognitive urgency) and to maintain cognitive closure (cognitive permanence) (Kruglanski & Webster, 1996). Information that is consistent with the existing schema may be more easily recognized and accepted, while information that is inconsistent is more likely to be ignored (Stangor & Ruble, 1989). Individuals who have developed a poor self-concept may consequently disregard all information that conflicts with their already-existing negative self-concept. For instance, individuals who think of themselves as failures because of the consistent negative feedback that they have received from others throughout their lives may be unable to perceive their own successes. Similarly, individuals with an unrealistically inflated self-concept may be reluctant or unwilling to hear that improvement may be possible and may react defensively to such suggestions.

As indicated, self-esteem can be thought of as the individual's feelings toward himself or herself, and as his or her self-evaluation along a negative-positive continuum. It is the evaluation that the I-self makes of the Me-self on a bad-good continuum. Individuals who have high self-esteem are those who are able to realistically evaluate themselves, accept and respect themselves, and decide that they have self-worth (Berk, 1991).

Self-esteem is believed to be “the most important requirement for effective behavior” (Coopersmith, 1967, p. 218). High self-esteem has been found to be associated with both good physical and good mental health (Antonucci and Jackson, 1983; Harter, 1988). Research has found that high self-esteem protects individuals from feelings of anxiety (Greenberg et al., 1992; Greenberg, Pyszczynski, Solomon, Pinel, Simon, & Jordan, 1993; Pyszczynski, Greenberg, Solomon, Arndt, & Schimel, 2004) and motivates individuals to engage in behaviors that are self-protective and beneficial (Greenwald, 1988).

During childhood, individuals develop an assessment of themselves in disparate tasks, such as sports, making friends, or academic performance. During middle childhood, between the ages of 6 and 12, these disparate assessments are integrated into a synthesized self-assessment, or global self-esteem. Individuals' self-esteem is enlarged as they acquire new skills and participate in new experiences, which are then used as the basis for further self-assessments. To a great degree, individuals derive their self-esteem from the value that others attribute to them (Cooley, 1902), particularly from those
who are significant figures in their lives, such as parents and other family members (Demo, Small, & Savin-Williams, 1987; Rosenberg, 1979; Ross & Broh, 2000; Schwalbe & Staples, 1991). Self-esteem can be thought of ultimately as the extent to which an individual’s self-concept is consistent with his or her idealized self, in other words, with the way he or she would like to be (Atchley, 1982).

Many individuals with mental illness have both a poor self-concept and poor self-esteem, which then have an impact on their behavior. An examination of how mentally ill individuals are often perceived by others and the nature of the feedback that they receive from others is important to understanding why this might be the case.

Many individuals diagnosed with mental illness cease, in the minds of those who encounter them, to be individuals with a disease and become, instead, the disease and all that their label signifies. As an example, an individual with a diagnosis of schizophrenia may cease to be viewed by others as an individual with schizophrenia and becomes, instead, a schizophrenic, disaffirmed and diminished in importance.

As a result of this “mark,” or stigma (Jones, Farina, Hastorf, Markus, Millar, & Scott, 1984), others may set the individual apart, may cease their “normal” conversations with him or her, and begin to isolate and marginalize him or her because of this mark (Laing, 1960, 1961; Launer, 1999). The “marked” individual may, as a consequence, experience feelings of rejection, loneliness, and depression (World Health Organization, 2001) and may redefine himself or herself in such a manner as to conform with the definition that is inherent in others’ treatment of them or segregate himself or herself even further (Goffman, 1963; Scheff, 1984). One woman, diagnosed with bipolar disorder, wrote:

Mental illness interacts with the way you define yourself from the instant it enters your life. There was a whole seventeen and a half years of living before this horrible episode descended upon me. Seventeen and a half years of wondering why I never felt quite right anywhere. Not in my home, not in my schools, not in my cliques, not with my boyfriends. Did this mental illness thing explain everything that ever happened to me? (Simon, 2002, p. 27)

Individuals may then behave in a way that they believe is consistent with others’ treatment and expectations of them (Becker, 1963; Kitsuse, 1962; Link, Struening, Cullen, Shrout, & Dohrenwend, 1989; Scheff, 1984). They may act “crazy” or respond to situations in a manner that dooms them to further failure and/or rejection, perhaps even while unaware that they are doing so.

This is not to say that the development of and reliance on a diagnosis is ill- advised. Many benefits may come from the identification of an illness that is rooted in biology, including increased access to needed services, a broader
array of beneficial therapeutic interventions, and the mobilization of family and community members to provide increased support (Carrey, 2007). However, all too often, the individual may adopt this “sick” identity as his or her own, together with the negative and threatening characteristics often attributed to such diagnoses: volatility, instability, incompetence, irresponsibility, violence, unpredictability. Not surprisingly, by the time individuals come into counseling, they have often assumed identities of failure and may be unable to point to any positive qualities that they may have. Other negative consequences may result, as well: an avoidance of help-seeking, nonadherence to prescribed medications, and the persistence of depressive symptoms (Chesney & Smith, 1999; Dinos, Stevens, Serfaty, Weich, & King, 2001; Goffman, 1963; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Link, Struening, Rahav, Phelan, & Nuttbrock, 1997; Roberts, 2005).

As seen, however, this self-identity as a sick person does not exist in a vacuum. Individuals do not conjure up such an image of themselves from nothing, but rather derive it as the result of interactions with those in their environment (Goffman, 1963; Scheff, 1984). First, the story that a client’s family members tell about him or her cannot exist without support from the larger environment. Imbalances in the family dynamic, whether premised on age, sex, sexual orientation, color, earning power, or other factors, are supported by power imbalances in the larger culture (Reiss, 1985). Second, the story that clients then tell about themselves is directly a function of the story told about them by others and the story told to them about themselves by others. However unknowingly, they have co-constructed their own stories with individuals within and outside of their families. As one scholar noted, “[T]he story of my life is always embedded in the story of those communities from which I derive my identity . . . The possession of an historical identity and the possession of a social identity coincide. . . .” (MacIntyre, 1981, p. 221).

Some individuals may possess additional characteristics, such as their skin color or their sexual orientation, that “mark” them even further. In such instances, the intensity of their stigmatization and resulting marginalization may be compounded (Capitanio & Herek, 1999; Herek, 1999; Herek & Capitanio, 1999; Reidpath & Chan, 2005).

**THE ALPHABET SOUP**

Many times individuals who come into counseling are asked to relate their experiences and explain why they have chosen to seek counseling at that particular time. It is not uncommon for individuals with a chronic mental illness to report that they have sought help because of current or repeated difficulties
at work or at home, or as a condition of probation. Frequently, their recitation of their experiences is devoid of any emotion or insight because it is a script that they have formulated, repeatedly verbalized, and perhaps even repeatedly acted out many times before. Their completion of formal intake forms may provide the professional with important information for insurance or program purposes, but it often fails to expand the client's self-evaluation skills.

I have used the metaphor of the alphabet soup as a mechanism to learn about both the client's life experiences and the client's self-concept and level of self-esteem. The client and I visualize together what it might feel like to be served a big bowl of alphabet soup. Most frequently, the client will describe the feeling of warmth that comes with the soup, not only of physical warmth, but also of emotional warmth, a sense of being cared for. Then I ask the client to imagine that every letter of the alphabet in that wonderful, warm soup signifies a positive quality that he or she has and invite the client to share a listing of these positive qualities with me.

To do this, I ask the client to list on a separate line of a sheet of notebook paper each letter of the alphabet and to choose a word for each letter that the client believes is a description of who he or she is. We then talk about each quality, what that quality signifies, how the client has used it in the past, and the meaning that the client ascribes to his or her use of it. Each experience that the client relates in conjunction with a particular adjective provides me with insight into significant events in the client's life, the client's strategies for responding to various situations, the client's perceptions of the significance of these events and the effectiveness of his or her responses to them, and the client's evaluation of himself or herself as an actor in relation to others.

This approach is less structured than a formal chronological life history, but it is often less threatening to clients. I have also found that because this strategy requires that clients tie their description of events to particular qualities that they own, they are provided with an enhanced opportunity for reflection and the development of an enhanced level of self-awareness. Their identification of positive qualities that they have used successfully can serve as a springboard for the improvement of their self-concept and the enhancement of their self-esteem from whatever level may exist at that time. The following case studies indicate how this metaphor can be used in working with clients.

**USING THE STORY**

Geoffrey (not his actual name), was 40 years old and struggling with the multiple "marks" of schizophrenia and homosexuality at the time of our first encounter. Geoffrey had been diagnosed two years previously with schizophrenia. Prior
to the initial onset of illness symptoms, which included frightening auditory hallucinations, bouts of severe paranoia and anxiety, and a disabling inability to feel anything other than fear, he had been an instructor of adult education for many years and had been in a long-term relationship with his same-sex partner for almost two decades. Geoffrey had ended that relationship following the discovery of his partner's multiple instances of infidelity and his increased risk of exposure to HIV as a consequence of his partner's sexual behavior.

The progressive worsening of Geoffrey's illness resulted in his loss of employment, loss of income and medical insurance, and, ultimately, bankruptcy. Geoffrey had resided in a large urban area for most of his adult life, but, unable to support himself any longer, had moved in with his father and stepmother. They lived in a small, rural Midwestern community, known for its religious fundamentalism and conservative politics and often referred to by urban residents of the state as “dog and gun country.” His father had “taken him in” out of a sense of responsibility to his son, but made clear that his son would not need medications if he were a “real” man and would get better if he would only “pull himself up by his bootstraps.”

After a year with his father, Geoffrey relocated to a subsidized apartment. Although he had been faithfully following a prescribed medication regimen for several months at the time that we had this interaction, he continued to experience auditory hallucinations and bouts of severe paranoia and anxiety.

At this point, Geoffrey felt that his life, in his words, had been “a joke” and that he was a complete and utter failure. Each of the residents in the subsidized apartment building had been diagnosed with a severe mental illness; hence, he said, he was living in a “House of Dysfunction,” providing yet another confirmation of his incompetence. Although he had self-identified as gay from an early age, he now felt that he should seek out Exodus, a group for homosexuals seeking to re-embrace heterosexuality. His schizophrenia, he believed, was a punishment from God for being gay, for this horrible being that he was at his core.

At the time of this initial encounter, Geoffrey had internalized homophobia. The term homophobia has been used to refer to antigay (including gay, lesbian, transgender, transsexual, and intersex) prejudice and discrimination that exists “out there,” in the external world (Russell, 2007). In contrast, “internalized homophobia” is construed as that which resides within individuals. However, neither can exist without the other; one cannot internalize homophobia unless it first exists outside of oneself (Russell, 2007).

A task of primary importance was to help Geoffrey not only tell his story, but tell it in such a way that he could begin to recall the positive aspects of his life and his being, a process that White (2007) has referred to as the
reauthoring of one’s history. I used the metaphor of the alphabet soup with Geoffrey.

Geoffrey compiled a listing of his positive attributes. The use of the alphabet soup metaphor allowed Geoffrey to externalize the discussion and begin to examine his positive qualities without being required to accept ownership of them immediately, which he was unlikely to do in view of the negative identity conclusions that he had drawn from his life experiences and the diminished value placed on him by others. Geoffrey wrote:

Accepting  Nutty
Bleary-eyed  Observant
Compassionate  Perspicacious
Daring  Query
Ebullient  Realistic
Factual  Salubrious
Generous  Teacher
Heartfelt  Unaffected
Imaginative  Valiant
Jaunty  Wakeful
Kind  X-rated
Lasting  Youthful
Malleable  Zippy

I asked Geoffrey to explain how each of these adjectives applied to him and to give me an example of an event or occurrence in his life that reflected each quality that he had listed. We progressed through the words contained in Geoffrey’s listing in an order that he chose, rather than alphabetically. This allowed Geoffrey greater control over the process and his level of vulnerability. As he focused on each adjective, I posed a series of questions to him in a manner designed to facilitate reflection and self-understanding. As an example, when Geoffrey talked about being “imaginative,” I asked him to give me an example of a situation in which he was imaginative and to explain the circumstances that gave rise to that situation. He shared with me that he had been imaginative in how he had communicated ideas to his students so that they could more easily understand and integrate various concepts. I followed this discussion with questions such as:

- Does having been imaginative with your students tell you anything else about yourself?
- Are you ever imaginative now? In the same way or a different way?
- How did you know to do that?
- How did your students respond?
Similarly, when we came to the word *lasting*, Geoffrey described his friendship with a man that dated back to their initial meeting in grade school more than a quarter of a century earlier, and his efforts to maintain the friendship despite the many changes in each of their lives. I followed this disclosure with more “meaning questions” (Freedman & Combs, 1993), designed to understand the meaning and importance of the quality and its manifestation to Geoffrey:

- What does that say about yourself that you have been able to maintain this friendship over such a long period of time?
- Do you do this with all friendships? How do you decide which ones to be this committed to?
- Is this same quality noticeable in other parts of your life? In what way?
- Is there ever a time when it is not good to have this quality? In what situations?

As we progressed through Geoffrey’s listing, he was gradually able to see his accomplishments, to take ownership of them, and to redefine himself as something other than a “failure,” a “joke,” or a “schizophrenic.”

A number of the traits that Geoffrey listed reflected not only qualities that he perceived as positive, but also symptoms of Geoffrey’s illness and its current impact. As such, the listing provided clues as to issues that could require attention in the context of our work together. For instance, Geoffrey had indicated that being “malleable” was a positive trait because it reflected flexibility and the ability to deal with even drastic changes in his life, even those over which he had no control. It also, though, reflected a trait that is often associated with schizophrenia: ambivalence or the inability to make a decision. Geoffrey was, indeed, flexible in his dealings with others, but he was also easily led into situations that could be potentially injurious to him, including anonymous sexual encounters.

Geoffrey’s use of this word and his subsequent interpretation of the quality in his life allowed us to identify and explore the differences between situations that demand flexibility, those in which flexibility might be desirable but not required, and those in which flexibility might leave him vulnerable to abuse or betrayal. Geoffrey explained the need to be flexible in his definition of his responsibilities at work in order to contribute as a member of the team. He could be flexible in deciding which restaurant to go to for dinner with his friends. However, “flexibility” in the context of a new romantic-sexual relationship could be dangerous if it meant engaging in intercourse without a condom and thereby possibly exposing himself to HIV transmission.
Geoffrey still periodically struggles with feelings of low self-esteem and self-worth when he is confronted with events beyond his control. On most days, he is able to maintain a more balanced view of himself as a person and of his own accomplishments.

I also used the metaphor of the alphabet soup with Joseph, who initially had a difficult time identifying any positive qualities that he might have. He had met me through my activities with a minority young adult–focused community center, but he ultimately consulted me for counseling after he received a referral from another African American gay man with whom I had worked. Therapy, however, signified weakness. Joseph was deeply fearful that his carefully constructed, seemingly impenetrable veneer of defiance and toughness and his reputation for inflicting immediate retribution in response to any perceived affront would be irreparably diminished if others in the “hood” learned that he was seeing a therapist, leaving him open to possible attack. His fear was, in large part, reality-based; three gay African American men in his community had been murdered at gunpoint during the six months preceding his initial consultation with me.

Despite his fears of the potential consequences if his therapy were to become known, Joseph began to see me because, as he said, he was “tired of feeling depressed.” Joseph gradually and incrementally revealed the details of his life. He was one of four children, each of whom had a different father. His mother left him at a young age to be raised by his grandmother, and moved to a southern state, together with the other three children. His family constellation included, in addition to his grandmother, several male and female cousins, his mother’s adult brother, an aunt, and, eventually, his grandmother’s boyfriend. Although his grandmother had remained married, her husband, Joseph’s grandfather, was rarely present and his whereabouts were usually unknown.

Joseph was raped by his uncle at the age of 9 or 10. Several years later, he was sexually abused by one of his older cousins. He expressed guilt because, unlike the episode with his uncle, he had enjoyed these sexual encounters with his cousin. These sexual activities somehow became known to the other members of his family, and Joseph was soon known as the “fag.” When, as an adolescent, he visited his mother and other siblings down South, she accused him of sexually molesting his younger brother, which he has consistently denied doing. His mother responded to his denial by beating him with a pipe, resulting in injuries severe enough to his arm to require medical attention “for falling.” He returned to live with his grandmother, who, he reported, increasingly insisted that he was “no good” and “all bad.”

It was at this time, in 1999, that Joseph appeared to have suffered his first major depressive episode. The second occurred approximately 5 years later, following the break-up of his first long-term sexual-romantic relationship.
with another man of the same age. According to Joseph’s description, his partner was abusive towards him even during the initial stages of the relationship. However, the combativeness became mutual over time, which Joseph attributed to his own efforts at self-defense against his partner’s blows. Following this break-up, Joseph sought counseling through a publicly-funded program, but soon discontinued his sessions with the psychiatrist and the social worker, believing that the medications that he had been given were ineffective and that the psychiatrist was uninterested.

At the time Joseph consulted with me, he was in his early 20s and had not completed high school. He worked intermittently, often losing jobs because of absences and tardiness. He reported frequently bingeing on alcohol and periodically using marijuana. He continued to reside with his grandmother and her boyfriend, and had intermittent contact with his abusive uncle and cousin at family gatherings. He rarely communicated with his mother and siblings, with the exception of a younger brother who had moved in with one of his aunts who resided locally. His daily routine consisted of sleep until early afternoon, “hanging” with his friends, and drinking into the early hours of the following morning. Although he continued to be sexually impulsive, he reported deriving no pleasure from these anonymous sexual encounters and feeling “even more shitty” after each one. He described his life as purposeless and himself as a “loser” who had failed at everything and would never succeed at anything.

Initial assessment indicated that Joseph was suffering from dysthymia. He had lost interest in writing music, “hanging” with friends, and all other activities that he had previously found pleasurable. He alternated between periods of excessive sleep and insomnia. Although he had once been able to compose lyrics, some of which had been published, he reported that he was no longer “able to write feelings down” and “couldn’t feel.”

Joseph’s alphabet soup, which encompassed most of the letters of the alphabet, consisted of the following:

| A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V |
| Adventurous | Brave | Control | Dynamic | Expressive | Friendly | Go-getter | Honest | Intense | Joker | Keyless | Loyal | Meticulous | Nice | Observant | Practical | Quick | Reliable | Sad | Talented | Understanding | Vocal |
Unlike the alphabet soup that Geoffrey had “cooked,” which in many ways appeared to accurately reflect the positive aspects of his personality and his interactions with others, Joseph's listing of his positive qualities suggested that he was unable to distinguish between those that were aspirational or idealized and those that he actually possessed. For instance, although he characterized himself as reliable, he had forgotten numerous scheduled meetings with his record agent, to the point that his agent dropped him from his list of clients. This behavior was not confined to interactions with his agent but also characterized his dealings with his grandmother, his uncle, his instructors at school, and his employers.

I did not raise Joseph's lack of reliability with him directly. If I had done so, he would likely have terminated counseling because of the still tenuous state of our therapeutic relationship and the ensuing feeling of danger and vulnerability. Instead, I repeatedly returned to his self-description with more questions that sought to help Joseph both question his reality and discover his own answers: Can you describe a situation in which you were reliable? What helped you to be reliable then? How important is it for you to be like that? Why? Joseph gradually came to realize that there were situations in which he was reliable and those in which he was not.

Because Joseph already had an image of himself as a “loser,” it was important that this self-realization not become the focus of self-blame and result in a further diminution of Joseph's self-worth. As Joseph came to realize how frequently he had been unreliable, we identified and increasingly emphasized in our work together those circumstances and factors that seemed to encourage and support him in being reliable. This process provoked additional questions for Joseph: How can you bring these factors into your life more often? How can you emphasize them more so that they can help you to be reliable?

Joseph's process of listing his self-perceived positive attributes led to an awareness of the need to develop a realistic self-appraisal that encompassed the strengths that Joseph possessed and the behaviors that required change if he were to succeed in his creative ventures and interpersonal relations. Over time, as we progressively addressed each of the enumerated qualities in the context of actual situations, Joseph came to realize that he had painted an idealized picture of himself and indicated that he may have done this as a mechanism to ward off feelings about his own incompetence. The questions that I had posed to Joseph were critical to the development of this insight; indeed, “every time we ask a question, we’re generating a possible version of a life” (D. Epston, quoted in Cowley & Springen, 1995, p. 74). One day, he exclaimed in amazement and with laughter, “You read me all along!” meaning that I had recognized from the beginning that what he had said about himself with the listing had not been entirely accurate.
Charonda, a 35-year-old African American woman, had been diagnosed with bipolar disorder. When I first met her, she had recently been discharged from the hospital and had entered an intensive outpatient treatment program that utilized cognitive behavioral therapy. I was provided with only Charonda’s diagnosis and details of her hospitalization and medication regimen. Our use of the alphabet soup both afforded Charonda an opportunity for self-reflection and self-assessment and provided me with basic information about her current living situation.

Charonda’s list and accompanying explanations of her qualities reflected not only her perceptions of herself, but also what she believed others thought of her.

<table>
<thead>
<tr>
<th>Quality</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active</td>
<td>I do love to stay active.</td>
</tr>
<tr>
<td>Believer</td>
<td>I believe in the future and my family.</td>
</tr>
<tr>
<td>Caring</td>
<td>I care about everyone.</td>
</tr>
<tr>
<td>Daughter</td>
<td>(Good). All the way there for my mother.</td>
</tr>
<tr>
<td>Enjoy</td>
<td>People say that I’m a joy to be around.</td>
</tr>
<tr>
<td>Friendly</td>
<td>Everyone should be this way.</td>
</tr>
<tr>
<td>Giving</td>
<td>I give to everyone if possible.</td>
</tr>
<tr>
<td>Helpful</td>
<td>Love to give in the time of need.</td>
</tr>
<tr>
<td>Intelligent</td>
<td>Knowledgeable about many things</td>
</tr>
<tr>
<td>Joyful</td>
<td>Always happy to be around</td>
</tr>
<tr>
<td>Kind</td>
<td>Never too mean</td>
</tr>
<tr>
<td>Loving</td>
<td>Love is the best of all. I just about love everything.</td>
</tr>
<tr>
<td>Mother</td>
<td>(Good). 3 great kids, single mother</td>
</tr>
<tr>
<td>Neat</td>
<td>Always cleaning</td>
</tr>
<tr>
<td>Original</td>
<td>I love myself. My mom says I’m deep.</td>
</tr>
<tr>
<td>Pretty</td>
<td>I think I’m pretty.</td>
</tr>
<tr>
<td>Quick</td>
<td>Get the job done quickly</td>
</tr>
<tr>
<td>Respectful</td>
<td>Respect others</td>
</tr>
<tr>
<td>Successful</td>
<td>I’m happy.</td>
</tr>
<tr>
<td>Talk</td>
<td>Love to meet people</td>
</tr>
<tr>
<td>Useful</td>
<td>Have a way to use things in another way</td>
</tr>
<tr>
<td>Vibrant</td>
<td>Always smiling</td>
</tr>
<tr>
<td>Worker</td>
<td>Boss says I’m a good worker.</td>
</tr>
<tr>
<td>X-ray</td>
<td>Kids say I see all things.</td>
</tr>
<tr>
<td>Young-at-heart</td>
<td>35 and still going on, love to walk, play, run, etc.</td>
</tr>
<tr>
<td>Zoo</td>
<td>I love the zoo &amp; the cats &amp; fish.</td>
</tr>
</tbody>
</table>

Charonda reported that this was a difficult exercise for her and that she had to struggle to identify good qualities about herself. Her listing and
explanations give us clues as to what issues might arise during her efforts to heal and to move forward with her life. Consider, for instance, the following:

I care about everyone.

*All the way there* for my mother.

Everyone *should* be this [Friendly] way.

*Always happy* to be around

Always smiling

While not conclusive, Charonda’s frequent nonuse of “I” in describing her own qualities suggested that she may have difficulty acknowledging herself. In addition, her phrasing suggests that Charonda may view situations in absolute terms (*should, always*) and that there may be boundary issues with others (*everyone, all the way there*).

Charonda and I used the self-descriptions contained in her list as a springboard to discuss the meaning of love and what it meant to Charonda to think of herself and to be thought of by others as “giving,” “caring,” “helpful,” “loving,” and “useful.” We explored the variety of responses that Charonda had received to her efforts at being helpful and loving, and how these responses had affected her life. Gradually, Charonda was able to identify situations in which she had neglected herself in the process of helping others and had felt drained as a result. Charonda’s apparent altruism was actually a “pseudo-altruism,” masking her lack of self-acceptance and providing a mechanism for self-destructiveness (see Seelig & Rosof, 2001).

I have also used this exercise in a group setting with individuals with diagnoses of bipolar disorder and major depression. I find the use of the alphabet soup metaphor particularly helpful when starting a new group because it serves as a relatively nonthreatening invitation to people who do not know each other to share who they are. It also provides an opportunity for me to understand on a preliminary basis how each individual in the group perceives himself or herself, the context of that perception, and how they choose to relate to others who are new to them.

To begin, I provide pencil and paper to the group participants and invite them to list one of their qualities for each letter of the alphabet. I have found it helpful to provide pencils rather than pens to emphasize to participants that they can feel free to change their responses and so that they are less likely to become preoccupied with the neatness or sloppiness of their paper.

After everyone has written down their list of alphabetical qualities, individuals take turns reading their lists out loud. They are each given an opportunity to choose one quality that they mentioned and explain in greater
detail when and how they use it. After each individual has read his or her
list and explained no more than one quality, other members of the group
have the opportunity to comment on the list that has been read, indicating
which of the qualities they have observed and which of the qualities identi-
fi ed by the person about himself or herself may have been helpful to other
members of the group. Many individuals do not have an awareness of how
they manifest their qualities through their interactions with others and how
those interactions impact others. This exchange provides valuable feedback to
group participants.

In other instances, group members may be unable to identify their own
positive traits or may be reluctant to do so. The reading of their incomplete lists
to other members of the group provides an opportunity to consider the observ-
vations of other group members and to decide whether the qualities that they
experience from an individual are to be owned as their own. Marsha and Susan,
both participants in an intensive outpatient program for individuals with bipolar
disorder, completed only portions of their alphabet. Their lists are placed side
by side here to demonstrate both the diversity and the similarity of responses
that can arise in the group context. Contributions from other group participants
to their lists are placed in brackets. “Missing” is indicated in brackets for those
letters for which the individual could not think of a trait or characteristic.

MARSHA
Act politely
Believe in God
Compassionate
Do nice things for others
Empathy for others
Forgiving
G [missing]
Helpful
Include others
J [missing]
Kind
Listen
Minister to others
Nice
[Open]
Pure thoughts
[Quality]
R [missing]
Smile

SUSAN
Assertive
[Believer]
Caring
Daring
[Enjoying]
Fighter
Giving
Humorous
Intelligent
Jokes around
Kind
Loving
Mindful
Nice
Original
Patient
Quiet
Realistic
Silent
Talk
Uphold people
V [missing]
W [missing]

Timely
Unique
Vivacious
Weird

There are significant differences in the listings prepared by Susan and Marsha. Marsha explains herself almost entirely in relation to others: Do nice things for others, Empathy for others, Forgiving, Helpful, Include others, Minister to others, Uphold people. Although Marsha may actually relate to others in this manner, this listing reflects what she does. The listing necessarily prompts the question: Who is Marsha apart from her actions? This suggests issues that, over time, Marsha herself may wish to address and, in fact, may need to address if she is to receive the support that she needs from others in her life to deal effectively with her mental illness.

The use of the alphabet soup metaphor in group is not without its dangers. Sometimes, an individual may want to disclose details of a situation that the group is not ready to hear because of the nature of the issues involved, the focus of the particular group, or the stage of the group’s development. An individual may later regret, be embarrassed by, or be harmed by a very personal disclosure that he or she impulsively makes. Because the use of this metaphor encourages clients to self-disclose, the therapist must be mindful of the nature, depth, and timing of the disclosures that are made in the group context and be prepared to intercede to inhibit or restrain self-disclosures that may be self-harmful in this context.

As an example, disclosure by Geoffrey of his homosexuality to group co-participants residing with him in his “House of Dysfunction” would likely have resulted in ostracism from the group, potential harassment, and even possible violence in view of the extremism of members’ religious beliefs and the homophobia that prevailed in the larger community in which he lived. Accordingly, I will not use the alphabet soup metaphor in a group setting if I have reason to believe or sense at the beginning of the group session that a participant may be prone to naïve and/or self-destructive disclosures or that I might have difficulty modulating the group rhythm and dynamic.

REFERENCES


**SUGGESTIONS FOR FURTHER READING**

**Same-Sex Relationships**


**Schizophrenia**


Sexual Orientation
