Guided Imagery in Religion, Spirituality, and Faith

The soul never thinks without an image.
Attributed to Aristotle

Guided imagery is a therapeutic practice method that uses imagery associated with auditory, visual, and kinesthetic systems to guide people to increased well-being. Often this approach is employed to help people discover their untapped inner resources, which can be harnessed for healing purposes (Ford Sori, Piercy, & Tubbs, 1998). Imagery operates on numerous levels. While many conceive of imagery as being solely visual, all senses can be involved in creating an image, and thus imagery may be auditory, kinesthetic, visual, or even involve taste and smell.

Spiritual imagery may employ all types of images. It is concerned with universal, global dimensions and often includes religious experience, connection with the absolute, a sense of wonder, or a search for growth, meaning, actualization, and connection. Often the goal of guided imagery is to help people discover methods to improve their spiritual coping and to enhance their relationship with the divine or other sacred figure. Many cultures have spiritual images of gods and sages who are associated with qualities of compassion, emotional sustenance, wisdom, and hope. Theistic clients with a secure attachment with God and a collaborative spiritual coping style are encouraged to employ sensory imagery to perceive their God image as an empathetic, supportive listener who is prepared to partner with them. In addition, clients are coached to ask God for help in dealing with problems and stressors. Such intervention is often comforting, healing, and supportive.
for those undergoing stressful circumstances such as illness or loss. Guided imagery can be a potent experience that helps clients connect to their own sense of spirituality and their sacred life. Thus, the sacred triad of spirituality, religion, and faith are all useful and may be incorporated into this treatment method.

This chapter addresses the many forms of guided imagery that may be useful for a variety of physical and emotional problems, including those involving the sacred life of the client.

**HISTORY OF GUIDED IMAGERY**

The concept that the imagination has healing capacities is ancient. Shamans commonly used aspects of guided imagery in the service of healing their patients. With a rich lineage stretching back thousands of years and across diverse cultural groups, the practice of enlightenment or awakening healing through the use of inner guidance is essential to many religious and spiritual traditions. Typically, healers and shamans were thought to cross over to the spirit realm to converse with the gods who influence health and illness. Healers entered an altered state of consciousness to envision how healing could occur. Some very early practices were founded in ayurvedic meditation, which has four thousand years of history. Ayurveda is translated as life (ayu) science (veda). This ancient tradition holds that we must regulate our way of life and accept the influence of our body on the self, not only the influence of mind or intelligence. In fact, Hindu sages developed a wide variety of imagery techniques as a part of yogic practice. Such techniques direct attention and energy to various parts of mind and body (Battino, 2011).

Tibetan Buddhism’s Abhidharma is another ancient tradition influencing the recent holistic health movement and guided imagery. Tibetan medicine used the image of a healing power as an important way to improve the patient’s chances of recovery. In this tradition, focused concentration on particular colors, sounds, deities, and images is prescribed for specific conditions, to influence healing. Receptive Tibetan meditation, including petitioning the Medicine Buddha for assistance, is similar to the concept of the inner-adviser intervention of guided imagery today (Rossman, 2000).
Parallel traditions influencing holistic health and the practice of guided imagery include the 4,000-year-old practice of ancient Chinese medicine. This tradition is a system of medicine based on the philosophical concept of balance. Some hallmarks include the forces of yin and yang, Qi or Chi, Jing, bodily fluids, the five elements, emotions, and spirits. Yin and yang are complementary opposites, unseen (the hidden, feminine) and seen (the manifest, masculine). Such forces transact within a greater whole as part of a dynamic, ever-moving system. Everything has both yin and yang aspects just as light cannot exist without darkness. Qi is life energy, life force, or energy flow and is the fundamental undergirding theory in traditional Chinese medicine. Qi translates literally as breath, air, or gas. Bodily fluids including blood and Jing are also purported to be responsible for our heritage, comparable to DNA. The five elements—wood, fire, earth, metal, and water—involves a system of interactions and relationships between phenomena in our world. Parts of traditional Chinese medicine include the emotions and the spirit. Powerful imagery is inherent in the constructs of yin and yang, qi (chi), and the five elements, in definitions of emotions, and in the spiritual realm. Imagery and visualization are employed in practices such as chi gong and tai chi (Rossman, 2000).

In ancient Greece, Hippocrates, the father of medicine, employed many forms of imagery for healing purposes (Utay, 2006). Aristotle and Hippocrates held that the inspired imagination freed spirits in the brain who stirred the heart and body. Thus, in the Western world the first acknowledgment of the transactive and dynamic functioning of mind, body, and brain was born. As the Western world developed, imagery became part of healing within various subcultures. In Judaism, practitioners employed a method of peaceful, concentrated awareness known as the practice of kavanah, focusing on images in the kabbalistic tradition of healing.

In A.D. 200 Galen, who had a prodigious influence on Western medicine for the next millennium, purported that the imagination was cardinal in predicting pathogenesis and health. Much later, in the fifteenth century, Paracelsus stated that “the spirit is the master, the imagination the tool, and the body the plastic material” (Rossman, 2000, p. 211).

Fleeing religious dogma in the seventeenth century, philosopher René Descartes defined the body as a machine, independent of mind. As
a result, the contribution of the mind and psyche in health and illness was not addressed until the eighteenth century (Rossman, 2000). In the newer field of psychotherapy, guided imagery has been used for over one hundred years. French neurologist Jean-Martin Charcot influenced his student Sigmund Freud when he hypnotized patients who were suffering from dissociative conversion symptoms. Later, Freud focused on interpreting patients’ daydreams and dreams, noting that imagery represented the internal reality of patients, whether or not it related to their actual history (Utay, 2006). As early as 1920, Ernst Kretschmer and Robert Desoille began working with patients’ daydreams. Kretschmer developed a therapy that encouraged patients to think in the form of a movie, while Desoille named his approach “guided daydreams” (Rossman, 2000). Similarly, analyst Carl Jung practiced an intervention he named “active imagination” as a way to increase insight into the client’s unconscious mind. He advised patients to focus their attention on their symptoms and relate the images that entered their minds. In Italy, psychiatrist Roberto Assagioli developed psychosynthesis, a spiritually based psychology. He believed that in addition to repressed drives, the unconscious also held much creativity, altruism, and inspiration, which could be harnessed as a source of healing. Assagioli (1971) employed imagery and meditation extensively. Other contemporaries interested in imagery included Hanscarl Leuner and Wolfgang Luthe who named their practice “autogenic training” (Rossman, 2000).

Jacob Moreno (1980), father of psychodrama, used the externalization of internal imagery as he developed techniques using auxiliary egos and enactments. In 1954 Luener further developed psychodramatic interventions and used experimentally induced catathymic imagery in what he called “symboldrama psychotherapy” or “guided affective imagery” (Rossman, 2000). In 1965, William Swartley introduced symbol projection as a diagnostic tool. Perhaps the greatest impact on the field of modern psychotherapy derived from Joseph Wolpe’s (1969) behavioral interventions. Today, many of his classic interventions continue to be used, including systematic desensitization, aversive imagery methods, symbolic modeling, implosive therapy, flooding, and exposure therapy (Wolpe, 1969; Wolpe & Lazarus, 1966). All these methods involve aspects of guided imagery.

In the late 1960s, psychologists began exploring the promising field of biofeedback. The significance and impact of the mind on the physical
body was recognized. Using biofeedback, patients could be taught to achieve previously unimaginable outcomes, including slowing the heart rate, reducing blood pressure, lowering or raising body temperature, and clearing asthma-debilitated lungs. In 1964, R. R. Holt published “Imagery: The Return of the Ostracized” in the *American Psychologist*. Soon other investigators, including Jerome Singer, Arnold Lazarus, Akhter Ahsen, and Joseph Shorr, began publishing literature on imagery and mind/body medicine. Anees Sheikh became the first editor of the *Journal of Mental Imagery* (Utay, 2006). National and international conferences on the use of imagery in health and wellness soon followed.

By the 1970s, the military made inroads into the fields of medicine and psychotherapy. Carl Simonton, chief of radiation therapy at Travis Air Force Base, along with psychotherapist Stephanie Matthews-Simonton, developed a regimen known as the Simonton method. It employed guided imagery to assist cancer patients. Patients pictured their white blood cells aggressively attacking their cancer cells. Simonton’s investigations found that the more vivid and aggressive the images used and the more personalized the imagery to the patient, the better the outcome. Simonton noted that comprehension of the patient’s personal images coupled with some understanding of the particular medical condition created an opportunity for designing the most powerful imagery interventions and achieved the strongest results (Wolpe, 1969). Some of the earliest findings came from authors Jeanne Achterberg and Frank Lawlis, who published measures such as the Image CA Rating Scale as well as particular imagery interventions for chronic pain, diabetes, spinal injuries, and cancer. This research gave way to a plethora of studies on the placebo effect (Utay, 2006). Later, Martin Rossman and neuroscientist David Bressler developed clinical training from research at the University of California–Los Angeles pain control unit. In 1989 they founded the Academy for Guided Imagery to provide health care practitioners with in-depth training. A self-help movement soon grew.

**CONCEPTUAL MODELS AND THEORY**

The explanatory theory undergirding guided imagery stems from a number of sources. One primary body of knowledge relates to holistic medicine. The holistic health movement, which is now widely accepted
in the medical and psychological fields, endorses the concept of attending to the whole of a person’s life as defined by that individual. Holistic health puts unique emphasis on positive wellness, environmental concerns, self-responsibility, and practices such as meditation, fitness, nourishment, vitality, and spirituality as domains of interacting influence in the lives of individuals (Chopra, 1990). Previous explanatory models of health and wellness centered on separating psyche from soma, mind from body, and the psychological from the social and medical influences in an individual’s life. Today, explanatory models of wellness increasingly emphasize the totality of the individual living and interacting with significant others and community, and how the individual is influenced by transactive forces of body, mind, spirit, culture, and world (Kolcaba, 2003). Related bodies of knowledge include the natural healing processes within mind, brain, and body connections.

While the exact science of self-healing continues to be under investigation, these explanatory models tell us that informational paths and sensations are unique to each individual. Thus, the practitioner needs to discern with the client which systems of imagery and which images in particular are most powerful, and then to engage those systems with culturally and individually defined imagery. The more closely guided imagery matches clients’ unique experience of operating in their world, the more likely its symbols are to affect outcome.

Some have thought that self-healing relates to the placebo effect. The exact mechanism of the placebo effect compared to positive treatment outcome is yet to be tested in controlled trials. A good portion of the outcome typically involves nonspecific effects, which can be both psychological and physical. Moreover, treatment expectations can influence outcome in the subject under study. Questions remain. For example, how much do expectations of outcome in study subjects influence other factors, such as motivation, diligence, and cooperation, which in turn influence outcome? To date, studies have not found a significant relationship between placebo response and suggestibility to hypnosis in research subjects (Evans, 1985). However, investigations note that the conviction of the therapist concerning the potency of a drug is related to hopefulness and expectancy in the patient, which in turn are related to anxiety reduction. Such indirect relationships appear to be powerful mediators in therapeutic effectiveness (Evans, 1985).
Further, a positive placebo effect occurs more frequently in subjects with higher rates of free-floating anxiety and with greater expectations of improvement by subjects, doctors, and staff. Research on optimism, outlook, motivation, hope, positive coping, faith, hardy personality, and conditioning consistently show that subjects with greater levels of such dimensions fare better (Kobasa, 1979; Land & Hudson, 2004). In addition, these very dimensions can be independent of the effect of a placebo. Results seem to indicate that placebo effects occur more frequently when symptoms vary and are remittent, and primarily affect the reaction to distress. Moreover, there is some evidence that endogenous opioids within the body mediate placebo analgesia. Other clinical data indicate that a stronger placebo effect is present when the placebo is administered after a period of effective drug treatment rather than before (Grevert & Goldstein, 1985). Such research appears to show that the use of guided imagery involves more than a placebo effect.

Guided imagery is heavily influenced by the field of behavior therapy, particularly the landmark findings of Joseph Wolpe on reciprocal inhibition and systematic desensitization. In an effort to treat war veterans suffering from anxiety and “battle fatigue” (now called post-traumatic stress disorder), Wolpe designed experiments demonstrating the concept of reciprocal inhibition: that is, it is extremely difficult for a subject to hold two contradictory states, such as anxiety and relaxation, simultaneously. Systematic desensitization is based on the principle of gradual exposure to a fear-provoking state while being in a condition of extreme relaxation. Wolpe’s method used a protocol of guided imagery. First, he and the patient listed and ranked negative situations involving anxiety and fear, from least fearful to most fearful. Using imagery, Wolpe guided his patients into a deeply relaxed condition. Then beginning with the last ranked situation, he exposed the subject to anxiety-related imagery for a period of time, then used relaxing imagery to guide the client back to the relaxed state. Over time, Wolpe exposed the client gradually and sequentially to unpleasantness until uncomfortable reactions were eliminated (Jaeger, Echiverri, Zoellner, Post, & Feeny, 2009).

Such exposure therapy also relates to the behavioral concept of classical conditioning and the psychotherapeutic method known as flooding. In this treatment method, the therapist uses imagery to guide the
client into a relaxed state, and then gradually exposes the client to a fear-related situation in vivo until the fear response is extinguished.

Similarly, Arnold Lazarus, founder of multimodal therapy and cognitive-behavioral therapy, linked behavioral concepts of exposure, graded task assignment, rank ordering, and scaling to cognitive elements of thinking, belief, and imagining. His investigation confirmed that using the imaginal system of the client in the process of becoming relaxed greatly enhanced outcome. Moreover, imagining being relaxed while being exposed to a flooding condition improved recovery (Lazarus, 1997).

Theoretical contributions from other schools of psychotherapy are countless. For example, Jungian therapists use archetypal imagery in their work with clients. Other psychoanalytic traditions, such as object relations theory, draw on attachment imagery and internalized object imagery to assist with conflict resolution. Gestalt therapists use dream imagery to assist with completing unresolved issues, or in the Gestalt parlance, completing the Gestalt (Perls, 1974). People tend to have a need to complete or resolve unfinished business. Some religious traditions have formal rituals for doing so, such as rites of confession and baptism in which one is washed clean of residual wrongdoings. Unresolved psychological issues typically involve both figure and ground, that is, the issue itself and the context in which it is embedded. At times it is difficult to separate the two or determine which one is more centrally identifiable as the problem; thus, it is advantageous to engage the situation as a whole. As the maxim states, "The whole is greater than the sum of its parts" (Wertheimer, 2000). Classic Gestalt interventions include working with an image of another individual or a part of the self in the empty chair exercise (see chapter 6). Here, the client may slip into what Winnicott (1989) terms potential space, the time and space between reality and play where we permit ourselves to entertain material that we might otherwise edit out, while staying connected to a trusting other. When operating within this "as if" time, clients may act as if they are in other times and spaces, or are using another person's patterns of behavior or personas as they engage an issue with the empty chair or parts of themselves. Operating somewhere between a fully wakeful, alert, conscious state and the space of play and imagination, the client is freed to access information that might be sanctioned or
resisted in the fully alert state. Thus, the therapist works with the memory of an emotion or situation in the client’s life. Using relaxation exercises ahead of the encounter is often useful. In essence, work with the empty chair helps the client change and rework memories and feelings about historical events and current situations. Typically, the end state involves resolution and relief.

In addition, many aspects of expressive arts theory and therapy use imagery. Art therapy, music therapy, dance and movement therapy, poetry and writing therapy, psychodrama, and drama therapy all involve aspects of work with images (Malchiodi, 2005). Common among these approaches is engaging the client in potential space between reality and fantasy, as it is often here that imagination and creative aspects of the self work to heal.

THE NEUROSCIENCE OF GUIDED IMAGERY

In treatment, guided imagery is one regulatory activity that helps mediate affective states by engaging the right brain and the dual circuitry of the brain, and encouraging neurogenesis, the growth of neural networks, connecting right-brain subliminal experiences with left-brain meaning and speech systems (Siegel, 2012). Using guided imagery, the clinician guides the client to enhance neurobiological regulation. Moreover, the clinician becomes a psychobiological regulator, a container of negative affective states. Employed correctly, the practice of guided imagery and psychotherapy essentially rewires the brain. Internal working models are worked through in the therapeutic alliance and transference. In right-brain to right-brain synchrony between clinician and client, previous negative experiences and ongoing therapeutic ones are contextualized in time and space. Empathy and emotional holding by the clinician affect the growth of mirror neurons, and new brain synapses are formed as new meanings are placed on old emotional experiences. The clinician acts in contingent ways, being affectively attuned and responding to the client’s varied emotional needs (Siegel, 2012). Over time, a secure base is established, and meditation and guided imagery become powerful tools in affect regulation.
What is the contribution of neuroscience to our understanding of guided imagery? Can meditation and guided imagery strengthen brain circuits? How does the process work? In a study of focused attention meditation that employs the Tibetan Buddhist tradition of guided imagery, University of Wisconsin psychologist Richard Davidson compared attentional abilities in novice meditators with expert meditators. Participants in both groups were instructed to focus on a fixed dot on a screen during fMRI scans of their brains. During the scan, investigators used distracting sounds to interrupt meditation and challenge attentional abilities. Results showed that the more experience the meditator had, the less neural response there was to a distracting stimulus. In other studies of fMRIs, changes in parietal lobe scans have been noted from baseline to follow-up; in fact, the lobes are activated during focused meditation (Davidson, 2010).

Neuroscientists studying contemplation assert that making a habit of meditation can strengthen the brain circuits that are responsible for maintaining concentration and generating empathy. One recent study by Davidson found that novice meditators using compassion meditation stimulated their limbic system, the seat of emotional networks. Moreover, expert meditators with over ten thousand hours of practice demonstrated significantly greater activation of their limbic system. Such findings imply that these meditators changed their brain structure on an enduring level, to be more empathic. Studies by this investigative team also revealed that committed meditators experience sustained changes in baseline brain functioning even outside the meditative experience (Lutz, Brefczynski-Lewis, Johnstone, & Davidson, 2008). In addition, earlier investigations by Davidson and colleagues (2003) found that sustained practice of meditation strengthens the immune system.

How does this process work? University of Pennsylvania researchers Newburg, D’Aquili, and Rause (2001) studied brain scans of experienced meditators and demonstrated that the prefrontal cortex (which houses attentional capacities in the brain) lit up during meditation, while the superior parietal lobe (which is responsible for orientation of time and space) went dark. Such experiences may account for feelings of transcendence during meditation. In particular the amygdala, which
is part of the right temporal lobe, controls and mediates virtually all higher-order emotional functioning. It can discern and express emotional nuances such as love, affection, empathy, compassion, friendliness, distrust, dislike, and hate. Within the limbic system, the amygdala performs surveillance functions with the rich set of neural networks that connect it to other structures of the brain. Using these connections, the amygdala monitors sensory stimuli throughout the brain and searches for stimuli that represent the need to respond with action. In fact, the amygdala analyzes the significance of a stimulus and directs our mind to pay attention by assigning emotional value to it. The ability of the amygdala to trigger the autonomic arousal activity is central to the generation of human emotion. When the amygdala activates the hypothalamus, autonomic activity is influenced.

Another part of the limbic system, the hippocampus, plays an important role in attentional activity (Schore, 2012). Acting in a complementary way with the amygdala, these two parts of the brain focus the mind’s attention on sensory input to generate and link emotions to images, memory, and learning. The hippocampus, the filing cabinet and diplomat of the brain, acts with the amygdala and exerts a regulatory effect on the hypothalamus. Both the hippocampus and the hypothalamus can block sensory input to various areas of the brain, particularly the neocortical areas. The hippocampus, in particular, acts by regulating arousal reactions generated by the autonomic nervous system in order to avoid extreme arousal states and maintain equilibrium. While not generating emotion, the hippocampus’s regulatory effects on other key parts of the brain have great influence on the individual’s state of mind. Thus, the limbic system, the emotional brain, is quite likely to be important in creating daily perceptions and is central to meditative and spiritual experiences. Practiced meditators are essentially directing their limbic system by focusing attention on sensory input such as breathing.

In guided imagery, sight, sound, taste, and touch enter into the hypothalamus and travel to the prefrontal cortex and the amygdala. By concentrating, the engaged meditator is essentially down-regulating the parasympathetic nervous system as heart rate and respiration slows. External messages presented within the guided imagery enter through the hypothalamus and travel to both the prefrontal cortex and amygdala. The hippocampus and hypothalamus regulate messages, which
pass through neural networks to the left brain, where new meaning may be placed upon them. Over time, neural networks connect and link images to emotions and implicit memories. Thus, both left and right hemispheres are involved, and the dual limbic-system circuitry is activated. The lateral tegmental circuitry, responsible for inhibitory and energy-conserving functions, is engaged as negative emotions are contained. It is probable that with positive stimuli from guided imagery, the ventral tegmental circuitry up-regulates positive emotions.

Whether or not we are aware of it, all human thoughts first emerge as images in the early sensory and movement cortices of the brain. That is, the lower brain cannot distinguish between what is really happening and what is being imagined. Thus, the upper centers of the brain, the cerebral cortex where thinking and imaging occurs, communicate with the lower centers of the brain, which centrally controls all physiology (Rossman, 2000). Moreover, we now know from research into psycho-neuroimmunology that mental images can be translated into significant immune responses (Davidson et al., 2003). In addition, many other systems of the body have important effects on healing, including digestive, endocrine, respiratory, circulatory, and endocrine systems. While we artificially separate them, all these major control systems of the body have been shown to be affected by imagery (Rossman, 2000).

Templates for attachment patterns are laid down in the right brain with associated feelings about self, other, and the world (Siegel, 2012). Such patterns may relate to internalized images of God, as God imagery is associated with parental attachment. In fact, findings indicate that the parents’ God imagery influences parenting style, which in turn influences the child’s God imagery (Birky & Ball, 1987; Herthel & Donahue, 2001). In an unsafe world, the child remains in negative affective states, with little or no help to shift out of these states. High arousal states are disorganizing and result in individuals experiencing greater difficulty in coping with stress. The developing cognitive schema suggests that interaction with others will be negative or deregulated. For a disorganized-disoriented child, the caregiver is both a refuge and a source of danger; hence, there is no coherent way of staying attached. The child does not internalize the safety of the parental figure. Abused children have a propensity to use behavioral symptoms to modulate and regulate
affect. Such children are predisposed to PTSD and may manifest difficulty with affect regulation. Thus, the body is coping with hyperarousal and there are few coping resources available. Dissociation may result and at times such children develop images of internal protectors in response to painful encounters (Siegel, 2012). Hyperarousal may alert the child to potentially dangerous encounters or figures. Dissociation may function to control the amount of pain entering the conscious mind. For example, one client stated of his imagery that during abusive incidents involving his drunken father, a big friendly dog carried him away from being beaten and brought him to safety on a chest of drawers in the corner of his bedroom. Thus, the brain prepares the individual for living within their environmental circumstances.

WHO IS HELPED? RESEARCH FINDINGS

Guided imagery has been used increasingly by health care providers and psychotherapists with impressive results. It has been effective with children, adults, and the aged, with women and men, and across various physical illnesses, including cancer, diabetes, and stroke. With a substantial foundation of research, guided imagery has proved effective in a number of problematic conditions: reducing pain levels, quelling anxiety, increasing affect regulation in PTSD and anxiety-related disorders, stemming eating disorders and borderline personality disorder, assisting with bereavement recovery, and curtailing depression (Avants & Margolin, 1995; Weber, 1996). Much of the treatment literature on guided imagery focuses on physical states such as increasing well-being in cancer survivors, increasing pain control, reducing hypertension, and stimulating the immune system (Eremin et al., 2009).

Especially with support from brain research, guided imagery is considered an evidence-based practice intervention of the highest order and is a part of treatment protocol for many mental and physical difficulties. Guided imagery has a prodigious foundation in the study of psychoneuroimmunology. A broad base of scientific investigations repeated over time reveals the consistent efficacy of guided imagery in reducing both psychological and physical discomfort.

Guided imagery has been successful with improving outcome in rehabilitation for those who have visual, auditory, and motor impairments. One example is an investigation of strength loss in immobilized
athletes in need of wrist rehabilitation. Physically immobilized experimental subjects who were treated with guided imagery showed no significant change from normal functioning in wrist flexion and extension compared with control subjects receiving treatment as usual, who showed impaired flexion and extension (Newsome, Knight, & Balnave, 2003).

Particularly in cancer research, guided imagery has been effective in increasing both health and quality of life. In one randomized controlled trial of oncology patients, subjects receiving relaxation training and peaceful imagery as an intervention had fewer psychological symptoms of mood disturbance, a higher sense of control, and higher self-rated quality of life. These subjects also had enhanced lymphokine-activated killer cytotoxicity, more activated T cells, and reduced blood levels of tumor necrosis factor. In other words, experimental subjects receiving treatment with guided imagery were healthier than controls receiving the usual arm of treatment (Eremin et al., 2009).

Such results are replicated across many studies of physical illness. Another randomized controlled investigation used relaxation training and guided imagery for eighty women with locally advanced breast cancers. Patients underwent chemotherapy, hormone therapy, radiotherapy, and surgery. Those in the experimental groups were taught relaxation training and guided imagery, and kept diaries of imagery vividness and frequency of relaxation exercises. Between-group differences were significant. The experimental group had higher numbers of activated and mature T cells after chemotherapy and radiotherapy. Both guided therapy and relaxation training altered anticancer defenses during and after multimodal therapy (Eremin et al., 2009).

Other research demonstrates that people in similar physical conditions as those noted in the study by Ermine and colleagues (2009) use guided imagery on their own. Many people are attracted to guided imagery as a way to control cancer-related anxiety and pain. One study analyzed excerpts from African American and Caucasian women’s breast cancer narratives (Moore & Spiegel, 2000). The results were interesting. Breast cancer survivors employed guided imagery as a method for reconnecting to themselves, to give coherence and meaning to their experiences with breast cancer, and as a method for stemming pain. Cancer pain escalates the disruption between the body and the mind that is
inherently an aspect of illness. Guided imagery can be one response to this problem, as a method to reconnect mind and body in an effort to increase the survivors’ sense of control and alleviate their distress. This finding has been replicated in other investigations of cancer and quality of life (Burns, 2001).

Pain research has significantly documented the efficacy of guided imagery. In a randomized controlled trial, fifty-five women were monitored daily for pain due to fibromyalgia. One experimental group received guided instruction for pleasant imagery to distract from the pain experience. A second experimental group received relaxation training and attentional imagery upon the workings of the internal pain control system, while the control group received treatment as usual. Amitriptyline and placebos were randomly assigned to subjects. Significant differences were found between groups over a four-week period. Only the pleasant-imagery experimental group had significantly reduced pain levels twenty-eight days after the course of treatment (Fors, Sexton, & Gostestam, 2002).

Similarly, guided imagery has been employed in the psychophysiological stress response and wound healing in surgical patients undergoing cholecystectomy. A randomized procedure assigned twenty-four subjects to either relaxation with guided imagery or quiet time. Three indexes of recovery were measured: state anxiety, urinary cortisol levels, and wound inflammatory responses. An analysis of variance for repeated measures revealed that the experimental group receiving relaxation with guided imagery demonstrated significantly less state anxiety and lower cortisol levels one day after surgery, and less surgical wound erythema than the control group. Stress-relieving outcomes were closely associated with healing (Holden-Lund, 1988). Other studies of colorectal-surgery patients had similar results.

In additional studies of guided imagery and physical illness, stroke survivors receiving both occupational therapy and guided imagery demonstrated significantly more improvement in motor recovery than control subjects, who did not undergo guided imagery (Page, Levine, Sisto, & Johnston, 2001). Similar results have been found with knee-surgery rehabilitation (Cupal & Brewer, 2001).

Some studies examine the effectiveness of guided imagery in both psychological and physiological aspects of predictable life events such
as childbirth. For example, in a convenience sample of sixty primapara women, a pretest-posttest experimental design was employed to ascertain effects of relaxation with guided imagery. Readings of anxiety, depression, and self-esteem were documented during the first four weeks of the postpartum period. Findings reveal that the experimental group had less anxiety and depression and greater self-esteem than the control group. Positive correlations were noted between anxiety and depression and negative correlations between self-esteem and anxiety and depression (Rees, 1995).

In a similar randomized controlled longitudinal study of stress in second trimester African American women, relaxation and guided imagery CDs were played to fifty-nine women over twelve weeks. The Perceived Stress Scale (Cohen, Kamarck, & Mermelstein, 1983) and the State-Trait Anxiety Inventory (Spielberger, 2010) were administered and corticotrophin-releasing hormone blood levels were collected at three times. State anxiety decreased significantly over time in the experimental group but increased over time in the control group receiving usual care. Self-reported stress scores also decreased for experimental subjects, but no significant difference was found in cortisol blood levels between groups (Jallo, Bourguignon, Taylor, Ruiz, & Geohler, 2009). Such findings are important in light of higher risk of premature deliveries among African American women.

Studies of psychological interventions typically use a combination of multiple techniques such as meditation, imagery, and relaxation or hypnosis (Eremin et al., 2009; Kabat-Zinn et al., 1998). For example, investigations have found that when imagery was added to music or relaxation, intervention appeared to result in greater immune response than music or relaxation alone (Gregerson, Ingram, & Amirir, 1996). In this study, a mixed-method approach prevented analyzing the contribution of each type of intervention to the outcome; it is important to note that the impact of a combined approach has been found to be greater than single approaches alone as documented in previous research findings.

Guided imagery has been found to be effective across wide-ranging age groups. In a randomized controlled trial of children with abdominal pain, current pain was reduced 67 percent following the use of guided imagery, compared to control subjects (Gregerson et al., 1996). In adult
psychiatric settings, guided imagery has also been used effectively. In a study of thirty-nine subjects in a general psychiatric inpatient unit, guided imagery was used as a treatment for reducing anxiety. Using the State-Trait Anxiety Inventory, subjects were given a combination of progressive muscle relaxation exercises, guided imagery, music, and meditative breathing pre- and posttreatment. Significant changes were noted posttreatment, with males reporting greater change than females (Weber, 1996).

Akin to these findings, in an investigation of unresolved grief reactions, investigators employed a three-phase treatment that included cognitive restructuring for the decision to re-grieve; guided imagery for reliving, revising, and revisiting scenes of the loss; and future-oriented identity construction. Aggregated outcomes of over one hundred subjects revealed that in the intervention of reliving or reimagining guided imagery changed the subjects’ views of reality concerning the bereavement and was thus the essential component of bereavement recovery (Melges & DeMaso, 1980).

Guided imagery has also been studied in healthy adults. In a randomized controlled investigation of twenty-eight healthy adults, investigators screened the experimental and control groups for depression, fatigue, and total mood disturbance as well as cortisol blood levels measuring stress. The experimental subjects were administered the Bonny Method of Guided Imagery and Music (Wheeler, Wagner, Summer, & Madsen, 2012). Subjects in both the experimental and wait-list control conditions were administered the Profile of Mood States (Pollock, Cho, Reker, & Volavka, 1979), and 15 cc's of blood was taken from each subject before and after the thirteen-week intervention and again at a six-week follow-up. A split-plot factorial and post hoc analysis revealed that after six biweekly sessions, those in the experimental group had significant decreases between pre- and postsession depression, fatigue, and total mood disturbance, and had significant decreases in cortisol level at follow-up. Moreover, pretest to posttest measures documented decrease in cortisol that was significantly related to decline in mood disturbance (McKinney, Antoni, Kumar, Tims, & McCabe, 1997). These significant findings are compelling evidence for the efficacy of the Bonny Method of Guided Imagery and Music.
Thus, a substantial number of randomized controlled trials demonstrate that guided imagery either alone or in combination with other expressive forms of treatment, such as music intervention, is an efficacious treatment method that can be used across settings, ethnic/racial groups, and age groups. Those in health care settings as well as mental health settings can benefit from this intervention. Guided imagery appears to be effective with people in need of pain control, with those in need of physical rehabilitation, and with people recovering from various forms of cancer surgery. The use of guided imagery has also been found to be effective with people who are anxious because of expectable life events such as childbirth, and with those suffering from mood disorders. Mind, brain, and body are involved as levels of cortisol, a stress hormone, are reduced after a course of guided imagery. This method of intervention has been demonstrated to be a successful and economical way to increase physical and mental well-being across diverse patient groups.

METHODS AND INTERVENTIONS

Defining distinctions in types of imagery is crucial for the clinician who wants to use guided imagery. Someone whose primary representation system is kinesthetic (having to do with physical sensations) or auditory may experience difficulty using imagery that relies solely on visualization. Consequently, therapeutic directives that involve only visual imagery may be less effective in reducing discomfort and increasing healing (Battino, 2011). Guided imagery includes a range of techniques encompassing simple visualization and direct imagery-based interventions, the use of metaphor and storytelling, and meditation and prayer (Utay, 2006). Images may be receptive or active. Those that appear spontaneously in our minds are receptive images; they are received in the moment rather than being created. Dreams are an example of receptive images. Active imagery involves conscious and deliberate efforts to create and construct an image. It is volitional and is created for a specific purpose. It is the active images that clinicians use in guided imagery to increase client well-being.

Use of religious, faith-based, and spiritual imagery in the application of guided imagery has been well studied across various cultures.
Integrating aspects of the sacred life of the client is not new to guided imagery, as the origin of meditative techniques is seated within most religious traditions. Some methods include the Buddhist practice of mindfulness meditation and the practice of compassion, Christian meditative and contemplative prayer practices, Hindu meditation, Islamic Sufism, Native American healing spirit ceremonies, and Judaic practices of transcendent prayer experience such as in kabbalah. Mindfulness meditation has been especially popular recently among clinicians and research investigators alike for its capacities to increase affect regulation. It has been incorporated into several data-supported therapies, including relaxation therapy and Dialectical Behavioral Therapy.

Many types of images can be employed to assist clients in remediating psychological and physiological distress. Among them is the concept of an internal protector or the third-person perspective. The watching part of the mind appears to be universally felt, especially under hypnosis, meditation, and guided imagery. Usually the function of an internal guide or benevolent watching presence relates to the individual's seeking integration and coherence (Siegel, 2012). Developmentally, under normal conditions the presence of an internal guide may relate to an internalized parental figure who, early in life, provided safety and security under stress. Children often describe a watching presence such as a pretend friend or an image of a protector, including animals or mythical figures such as Robin Hood (Badenoch, 2008). These images are usually sensed after explicit memory develops at around three to four years, although at times people may recall a presence from very early in life as an implicit memory.

Most referents of imagery involve some form of the sacred and are general and generic. Commonly used images include healing lights or energy forces; healing touch; the presence of healing warmth or coolness; a healing guide, wise person, guardian, presence, deity, or guru; and a healing totem or power animal possessing curative or restorative capacities. Likewise, the imagery of a pilgrimage or journey to some specified curative location has been helpful to some groups. So too is the imagery of ingestion of a healing substance. By and large, sacred images are culturally based. For example, while Christians may use the image of God the father, Jesus, the Virgin Mary, the communion of
saints, the in-dwelling Holy Spirit, or the guardian angel, Native Americans and First Nations people may be responsive to imagery of power animals (Pelletier, 2000). Children may have images that include animals, and popular benevolent superheroes such as Harry Potter or similar enemies of the dangerous or bad other.

Images may be realistic or symbolic. A realistic image might involve the actual science of a particular complaint such as T cells, which could be visualized as destroying cancer cells. These concrete images are often biologically correct and can be powerful in illness recovery (Battino, 2011). A symbolic image likely represents something personally and culturally meaningful to the individual being treated. Such an image could be represented as an angel, radiant light, or holy water. Images that are culturally based often carry greater significance and force than those that are less well known to a client. Importantly, personal symbols may be used as images. Often personal symbols embody the deeper levels of the mind-brain-body experience and incorporate somatic, verbal, preverbal, conscious, subliminal, and unconscious levels. The power of a personally chosen symbol is accessible and lies within the individual’s unique history and set of circumstances. No one experiences such symbols in exactly the same manner; therefore, it is up to the clinician to help the client discover what type of imagery is most useful and powerful. Examples of personal symbols might include a patron saint or the scent of grandmother’s house, which fosters feelings of relaxation, safety, and well-being.

Process imagery involves the mechanics of how imagery is employed. It involves the steps or process that implements the activity. The client is an active participant in determining how images are called up. They may be created through music, odors or fragrances, tactile experiences, or simply sensing a presence. Moreover, images may be physiological, that is, sensed at the cellular level. Most images are metaphoric; that is, they use symbols for what is happening physically or psychologically. Such psychological images are created and employed to change the way clients think, feel, or conceptualize themselves and their identity in the experience of their world. Feeling-state imagery centers on helping clients alter their affective state or mood, such as desperation associated with chronic pain. Energetic imagery involves the physics of
our electromagnetic field. End-state imagery highlights a positive outlook on life and realistic short-term goals within an image, such as relaxed muscles. Often specific visualization is employed to define end-state imagery. Athletes frequently use imagery to achieve a specific athletic skill such as kicking a football through, rather than to, the uprights. Similarly, if a client felt depleted after medical regimens, end-state imagery might include using the tide’s energy to swim strongly with the current, arriving at shore feeling invigorated. This image can encourage going with life’s flow as opposed to fighting or resisting certain stressful conditions. Psychologically, end-state imagery is the necessary image the client has of the self in the healed state. The power of such imagery is substantial and is not to be underestimated. In engaging end-state imagery, the end state must be realistic and realizable for the client. Inability to visualize a positive end state suggests a significant psychological burden. Clinically, in such circumstances the goal is to identify and remove the hindrance or blockage, so that the positive end state can be imagined, then engaged. Religious and spiritual material is particularly relevant to this treatment method.

Engagement, Assessment, and Treatment Planning

As in any other method of psychotherapy, rapport building skills are indispensable in establishing trust and confidence in the therapeutic encounter. Being welcoming, genuine, transparent, and accepting of the client is essential in helping clients feel safe enough to relax and use guided-imagery treatment methods. Joining procedures assist in this process and can include making small talk at the beginning of session, finding commonalities with clients, tracking what is said, and summarizing what is disclosed. Providing undivided attention to clients in their situation is central. As the encounter progresses the clinician is wise to be alerted to the client’s posturing, the pace of breathing, and the pace of discourse. Note nonverbal communication such as how the body is seated, and the direction of gaze behavior as interaction unfolds. As Bucci (1997) remarks in her theory of multiple codes, reading body language is an immensely important method of gathering information about the client. As a part of this process, be aware of how the client affects you and how your own body feels sitting with the client. In the
initial phases, mirroring the pacing of language and breathing of the client is helpful. Note client word choice, mannerisms, and style of language including colloquialisms used during discourse. By using some of the client’s word choices in reflective listening and summarizing you will help establish feelings of comfort and safety. Accurate tracking and reflection of the client's experiences, thoughts, associated core feelings, and behavior choices initiates the process of building a relationship. Thus, close listening and empathetic attunement is essential.

As the session progresses use your voice tone and mannerisms to produce a calming presence. Practice making your voice gentle, your eyes soft, your posture open, and convey an accepting manner through gesturing such as nodding. Allow for silences and reflective thought. Use encouraging words and phrases such as “Yes, I see.” In information gathering form open-ended questions gently such as saying, “I wonder how that was for you” and “I'd like to hear more about that,” rather than adopting an interrogatory style of questioning. Unconditional positive regard is elemental. The significance of establishing rapport prior to using guiding imagery cannot be overemphasized.

Assessment is an integral part of engaging clients and thus is part of the initial process of establishing rapport. As you gather information, note which representational systems seem to be most dominant for the client, as such information can be quite useful in choosing imagery in the treatment phase. Most people have a primary representational system that they favor in their speech, including the use of visual, auditory, or kinesthetic language (Battino, 2011). Both in establishing rapport and working with imagery, it is clinically useful to become cognizant of the words a client chooses and which representational system is involved in speech patterns. For example, phrases and words such as seeing eye-to-eye, viewing, perceiving, foggy, blurred, clear, and focus are all signs of a visual representational system, and use of such phrases may indicate preference for visual imagery. Expressions such as tone, feedback, say, scream, rings a bell, sounds like, sound an alarm, and strike a note are more auditory oriented, while handle, build, grasp, pulled, pushed, shaped, go around, step-by-step, wiped out, and concrete are kinesthetically oriented. Matching these dimensional patterns in reflective statements to the client helps you speak the same language and establish rapport. Importantly, such patterns may indicate the type of imagery a
client relies upon. As the interview progresses, reflect on the client’s observable behaviors and beliefs about the self in their world. It is important to get an understanding of clients’ end-state imagery of themselves.

During the assessment phase note the congruence of thought, feeling, and behavior in the client’s presentation as dissonance may indicate problem areas that require treatment. Then begin to ascertain the primary problem area and events that led up to this problem. Ascertain a sense of those persons and events that were involved in problem creation and maintenance. Begin to determine the client’s perception of the availability of choices in their world. Inquire about their physical and emotional perceptions of symptomatology and its evolution over the course of time. Obtain the extent of hopefulness regarding change and whether the client feels as if they play a part in the change process or if they are resigned to their state of affairs. Typically, individuals seek help because they feel at a loss on how to move forward with unresolved issues. Our function is to help such clients have more than one reaction to or interpretation of a stimulus such as anxiety or pain. Develop an understanding of the client’s mood during the session. Inquire what the client is able to live with and what they cannot tolerate as this latter information will probably need to be addressed in treatment. Address information on their goals and what they hope will happen in therapy.

When considering the use of guided imagery in the treatment planning phase recall scientific findings concerning efficacy and who is helped through this method. Guided imagery has been found to be particularly useful in treating anxiety disorders including fears and phobias, somatic complaints, PTSD, and trauma. Because of the frequency of co-occurring disorders, inquire and note the presence of substance abuse and dependency, as well as problems with depression, loss, grief, anniversary bereavements, and associated problems with affect regulation. Should physical health problems prevail, recall that guided imagery can be effective in pain and associated anxiety. In particular, imagery work should be a part of the treatment plan when assistance is needed with physical rehabilitation and stroke recovery, and in diminishing recurring pain, including headaches, backaches, and skeletal problems. It is further useful in increasing well-being and managing the vicissitudes of treatment and recovery from cancer and coronary disease.
After obtaining explicit information on the problem area, begin the assessment of the sacred life of the client. This part of the assessment is crucial, as sacred imagery can be extraordinarily useful and powerful in recovery. Clients who never think about spiritual issues in their daily life may become deeply aware of them as they encounter illness in themselves or others. Commence by interweaving questions rather than using a direct checklist approach to gathering information. Here, you are looking for areas of potential coping as well as how the problematic condition relates to the sacred life of the client, in the broadest terms. (See chapter 2 for a lengthier discussion of this.) The clinician is wise to assess how the sacred triad of spirituality, religion, and faith are associated with perceptions of physical and mental well-being and whether the client is open to examining how health beliefs relate to their sacred life. Keep in mind the following areas of assessment. Obtain an understanding of the client’s belief system or philosophical stance in life. Is the client more spiritually based, faith-based, religiously devout, or all three? Is there a hierarchy of preference or dominance within the sacred domains? The domain of preference may be useful in planning guided imagery intervention. To what extent is the sacred triad integrated with quotidian life activities? Whether or not the sacred triad is balanced, it is important to understand how spirituality, religion, or faith is integrated into the client’s life. Is one or more of these sacred domains problematic to the healing process? How do spirituality, religion, and faith relate to the client’s worldview and view of themselves as a healthy and whole individual; specifically, what is their end-state imagery? How do these perceptions relate to experiences with primary caregivers, family, loved ones, life themes, and belief systems? All this information will help to shape a sacred-sensitive treatment plan.

Close listening is required to assess how the client’s language use is associated with these sacred domains. Is wellness or illness associated with any or all domains of the sacred triad? Is any aspect of the client’s sacred life associated with benevolent or malevolent forces or imagery? For example, does the client say my guardian angel, the saints, the blessed mother, the loving and enduring Father, God, Jesus, my protector or, conversely, the devil, the evil one, Satan, demons, or the dark side? Note this imagery, as it could be quite important for later use. Then assess whether the client has available imagery that may be either useful or a
hindrance to treatment. For theistic clients, what is their God imagery? If the client is a believer, is God imagery associated with positive forces or is God punishing the client? Does their God play a role in their suffering? Does the client believe in a higher power, an ultimate being, a life force, or something bigger than the individual?

Some children are taught at a very impressionable age that we are all sinners. If these teachings are internalized, the child's self-esteem and attachment to benevolent spiritual figures can be at risk. The client may miss that sense of connectedness that is larger than the self and more enduring. In fact, the client may feel a sense of unworthiness, or fear God's retribution. Conversely, a positive faith system and spirituality can provide motivation, emotional sustenance, hope, and clarity of purpose. Also inquire more specifically about sacred images, including those drawn from nature. If these are present, ask about methods for accessing the benevolent force, including various types of prayer or meditation. Does the client use contemplative or centering prayer, prayers of intercession, glorification, or pleading? Does the client use ambulatory prayer, mindfulness meditation, or yoga? When is it used and under what circumstances? How regular is the client's practice? If the client believes in God, it is helpful to understand whether the relationship is collaborative or deferred. In other words, does the client see God as a figure with whom to collaborate in resolving problems, or as a figure on whom to completely place or defer problems? The answer to this question will provide direction for use of guided imagery with the godhead. Further, question clients about their relationship with God: Has it been damaged or lost? Is their encounter with the figure less frequent in recent times? In general it is important to ascertain whether the sacred life of the client is protective and contributes to well-being or whether the client holds beliefs that are persecutory, impersonal, and unrelated to healing.

When using this therapeutic method, it is vital to understand what clients have done to cope with their problem. Has the client engaged in rituals associated with spirituality, religion, or faith? What elements are involved with her or his sacred rituals, and what imagery surfaces with them? Gathering this information may help identify the most beneficial type of imagery for use in treatment. For example, does the client light candles? Such imagery alludes to a healing light. Is holy water used?
Such imagery alludes to the potential of healing water as imagery that can eradicate the problem. Does the client touch a Bible, Koran, prayer book, or other religious item such as a crucifix or beads? Such items are associated with a preference for kinesthetic imagery. In these circumstances, a physical object or presence could be useful in lessening problematic states such as pain or anxiety. Answers to these questions may be helpful in planning not only the type of treatment that might be most effective but the dosage or frequency of the intervention.

Inquire whether clients believe in a sacred self, as this belief may assist with imagery of healing. If clients sense an in-dwelling spirit, ascertain whether the imagery is benevolent or malevolent. In addition, inquire whether clients feel they are being punished or tested in some way because of their physical or mental symptoms. For clients who are not believers, ask what they do not believe in, and what values they do hold. For example, clients may not believe in an all-powerful God for any number of reasons, including family upbringing or a damaging religious experience. However, they may believe in the spiritual power of love, the majesty of the natural world, or the undeniable resilience of the human spirit. Hence, imagery associated with these beliefs can be useful in the healing process. Subsequently, the client may be helped to determine which values are strongest and the type of healing imagery they bring forth. Such may include visual images of healing hands or parental holding, or safe or beautiful places; auditory images of favored music or a song for healing; or kinesthetic images such as a healing breeze, a warm presence, or a cleansing waterfall. Spend some time getting enough of a description of a safe and healing image so that it can be used in treatment.

By the end of the first session, the clinician should have established a beginning connection with the client and have an idea of the major concerns and the kinds of symptoms he or she is experiencing that initiated seeking help. Moreover, the therapist should have a sense of the client’s end-state imagery. In addition, you should have a beginning understanding of the client’s capacity for using imagery and the kind of imagery that would most profit the healing process. Over the next encounter with the client refine the type of imagery that is best used and learn to guide the client to a relaxed state.
The Middle Phase

In the middle phase of treatment, the clinician and client concentrate on forming a more concise list of problematic areas on which to work. Brainstorming is highly useful in this process. Encourage clients not to edit themselves but to simply list specific concerns they experience. If the client is vague or general about the complaint, encourage exploration of greater depth until several specific scenarios are listed. Then have the client rank them from least severe to most problematic.

The next phase of treatment is guiding the client toward the relaxed state. You can use either a published script or a unique and idiosyncratic one. For published scripts, I refer the reader to Battino (2011, pp. 135–147). The problem with many published scripts is that they are too specific in their imagery; thus, they are limited. For example, when describing a safe place, what is safe for one person may not feel safe for another. Each client has imagery that is best for him or her; hence, I encourage the clinician to co-construct the imagery with the help of the client. The language for imagery should be open, vague, and permissive. Specifically incorporate the client’s own words, phrases, and images into the delivery; in doing so, we speak the client’s language. Some clinicians write out the script ahead of time, while others practice spontaneously.

Begin by helping the client find a comfortable position. Truisms and the Yes Set type of questions offer a series of questions whose obvious answer is yes. These types of questions help connect the client to the present, the environment, and the bodily senses. Then the client will continue to relate to you in an accepting and affirmative manner (Battino, 2011). Examples might include, “Today’s the sixteenth, right? It’s clearing outside now, isn’t it?” As you guide the client to a relaxed state, instruct the client to either close the eyes or fix the eyes on one point. Coach the client to pay attention to her or his breathing. Use a gentle and calm voice to say helpful comments such as “As you attend to your breathing, you become more comfortable. Soon your breathing will slow down while you relax even more [pause]. And as you relax, you become even calmer and your breathing softens.” Use of transitional words such as and, as, and while works to connect and link thoughts. Pauses help the client do internal work and search for internal meaning, or interpretation of a word or phrase. Often it is helpful to use unspecified verbs, as the listener fills in the specification according to their
internal meaning. Some examples include learn, understand, feel, change, wonder, and fix. For example, you might say, “Now you may be wonder-
ing about the changes you are already feeling in your body . . . you are
aware of the change beginning . . . the body just knows how to do that.”
Words such as notice, realize, find, aware, and understand presuppose
the rest of the outcome. Adverbs and adjectives also presuppose the rest
of the sentence: you might say, “Thankfully, you’ve already learned how
to relax yourself deeply. Fortunately, your thoughts and feelings are all
yours alone.” Affirmative phrases help build confidence and are ambigu-
ous enough to have many referents. Phrases such as yes, that’s right, and
indeed add emphasis and encouragement (Battino, 2011).

Begin to give suggestions, implications, and presuppositions in your
directives. Some communications bypass the conscious mind, yet they
are heard by the listener. Contingent suggestions infer causality, such
as in the comment “And the more you attend and pay attention to your
breathing . . . the more relaxed you become.” Psychological implications
direct clients’ associative processes when they are unable to do it on
their own. Moreover, presuppositions cannot be ignored and are out of
awareness. They create the expectation for change.

Giving open-ended suggestions emphasizes choice and often opens
the door to change: “You don’t need to know how the pain is ebbing
away . . . within your mind, you can safely drift off . . . to your special
place.” In addition, using the language of time presupposes that what is
wanted already occurred: “As you change, and understanding all that
you’ve learned, you’ve already begun your healing process, even while
you continue to progress more and more.” This phrase suggests that
what is needed has already happened and that it just needs to be discov-
ered. Use of nongrammatical language can help the client relax: “That’s
just the way the body heals itself, just how it is.” This phrase suggests a
truism that can be quite convincing. In addition, tag questions and dou-
ble negatives assist process and flow and serve to confuse the listener
out of a conscious process: “And now you are there . . . there in your
special place, are you not?” Similarly, apposition of opposites and oxy-
morons can be interspersed with similar results: “Learning to unlearn
can feel good, how quickly time can slow down . . . and soon you are at
your safe haven . . . how fast you can slow down and escalate the melting
away of that discomfort . . . now.” Not knowing and not doing, overloading and repetition of phrases can be powerful suggestions: “You don’t even have to bother to listen . . . listen to me as your mind just does that by itself . . . now the achievement for you is to know that we don’t even know all our capacities, and you have to discover them in whatever slow way you wish . . . and when the occasion [of whatever] arises, your unconscious will simply supply that knowledge” (Erikson, Rossi, & Rossi, 1976).

The illusion of choice offers the possibility of change that is outside the usual range of conscious choice and behavior (Battino, 2011). Here, we are aiming for win-win behavior, as in the question “Just how soon will that healing light begin its work?” Or “Those old sensations of anxiety will safely, easily change to just a teeny blink of a flutter in how many minutes . . . and now it just . . . melts away . . . and gone.” In this situation, it is the very essence of relaxation that is responsible for the healing. This approach is much more process based than content based, in that you are not presenting an anxious image or painful image to the client while in a relaxed state. It is the relaxation and trance-like state itself that is healing.

Nominalization of a noun and phonological ambiguity (words that sound similar) can be therapeutic and can be used with punctuation ambiguity to confuse reality and imply suggestion and change (Battino, 2011). Consider the comments “And now your healing music . . . you can hear your harp music, touches your heart, and you . . . can take that . . . turn around your life . . . and . . . feel joy.” Many ideas happen in this phrase, including the imagery of music touching the heart, the similarity in sound of the words harp and heart. The phrase “take that turn around your life” has double meaning, and the phrase “feel joy” implies a result and a suggestion.

**Process versus Content Approaches: Enrique**

All these relaxation approaches are process-oriented; while the primary goal is to induce relaxation, treatment often occurs simultaneously. In effect, the process of creating relaxation and suggestions of a safe place can have the effect of reducing anxiety or pain. Some approaches work with each level of content specifically, while others use both content
and process work. Such is the case with hierarchical desensitization. Here, after constructing the list of fears and ranking them from least to greatest, guide the client into a relaxed state using the imagery of choice. Beginning with the least-feared situation, instruct the client to imagine the situation until anxiety and fear is present and to raise a finger when it occurs. Noting how long the client can tolerate the fear, guide the client back to the safe haven where the client may dwell until completely relaxed again. Signaling to the clinician with a finger, the client is again exposed to the stimulus. This process is repeated until no anxiety is present with the particular feared situation. Subsequently, the process is repeated over several sessions until all phobias are resolved in the list of hierarchies. This approach is useful for many states of fear, as the following case demonstrates.

Enrique was a gay man of Dominican descent in his late twenties. In the psychosocial history, Enrique revealed that he had a year-long, emotionally intense dating experience with a partner, Craig, who insisted on being with Enrique as much as possible. This was Enrique’s first serious relationship, and while at the beginning he was flattered with the attention, after a few months he began to feel smothered and manipulated. When Enrique left town on a family vacation, Craig gave him cards to open every day so that Enrique would remember him. Craig texted Enrique incessantly. Enrique ended the relationship after enduring several angry acting-out episodes by Craig, who felt rejected or affronted by Enrique. On several occasions Craig became physically and emotionally volatile while intoxicated. These situations occurred both in private and public settings. Following the break-up, Craig began to stalk Enrique, showing up at his apartment in the early hours of the morning, pounding on the door of his apartment, threatening to break it down, and demanding entry. He pursued Enrique around town and harassed him in public places, often becoming physically aggressive. Much hostile gossip appeared on Internet sites. Craig’s behavior alienated Enrique’s other friends to the point that all were anxious and watchful for Craig’s appearance. Several friends did not want to risk going out publicly with Enrique and dropped from his friendship circle. Enrique began to have episodes of intense anxiety, which interfered with his sleep and work productivity. He suffered from associated depression and began to isolate himself.
Enrique sought therapy. His social history revealed normal developmental milestones, supportive friendships and family members, and integration of his gay identity in the coming-out process. Although raised Roman Catholic, Enrique did not participate in mass, but believed in God and called himself a spiritual person. Enrique’s current symptomatology was clearly related to his past relationship with Craig. We decided on a course of guided imagery for the problems with anxiety and sleeplessness. We made a list of feared situations, and Enrique ranked all ten of them, from least to greatest. At the bottom of the hierarchy was seeing a hostile Internet posting, followed by getting a hostile text message from his ex-partner. His greatest fear was a public encounter, where Craig became hostile and physically aggressive with Enrique. Enrique was guided into relaxation with the safe-place exercise. His imagery was a guiding light that appeared and helped him calm down. He described the light as a shaft of sunshine that glowed and encompassed him in warmth and safety. Using guided imagery of the light’s presence, I guided him into a relaxed state, then described the shaft of light visually and kinesthetically. I suggested that Enrique dwell in its glow and warmth and let the light encompass him. I encouraged him to note the growing sense of relaxation and security he experienced in its presence. As I presented visual and kinesthetic descriptions of the light, I instructed him to dwell in the image for approximately one or two minutes. I then presented the least fearful stimuli until Enrique indicated a clear indication of anxiety and discomfort. I then guided him back to his safe haven, using the imagery of the guiding light. The process was repeated until the first fear was negligible. Enrique did extremely well with mastering his anxiety. Repeating this process, we worked on the next few feared situations. Within two to three sessions, Enrique’s anxiety was sufficiently under control that he did not need to work through the entire hierarchy. His depression remitted. Enrique had subsequent contact with the ex-partner in public but did not respond anxiously and was able to chat briefly and casually with him. Contact with former friends resumed, and subsequent postings on the Internet did not cause his anxiety to rise. Our attention turned to discussions of what Enrique was looking for in a relationship and recognizing red flags in dating situations.
Many aspects of this case are important to note. Using a neurobiological lens, it is likely that Enrique's fear response resulted in fight-or-flight behavior, extreme anxiety, and increased cortisol flooding into his system. Both visual and tactile imagery of the trauma may have remained in the amygdala, as the hippocampus is often overwhelmed in such circumstances and cannot sort and process information in usual ways. Unable to call forth words associated with these traumatic experiences, it is probable that Broca’s area and Wernicke’s area, Enrique’s speech centers, were not functioning at optimal levels; thus, information processing between right and left hemispheres may have been reduced. In addition, when memories are stored in the amygdala and hippocampus, areas in the upper brain, including the neocortex, are limited in processing trauma information; thus, like many others exposed to trauma, Enrique may have experienced fear states as being held in his body. Because mutually contradictory information cannot be simultaneously experienced, the use of relaxing visual and tactile spiritual imagery helped Enrique engage the limbic system and memories at appropriate therapeutic levels of tolerance, thus providing a sense of safety and control. Both the use of spiritual imagery and subsequent verbal reflection with an empathic clinician helped Enrique put abstract meaning on right-mode information processing. Thus, mind, brain, and body were activated and connected within the treatment process.

Did this intervention use the sacred triad? Although Enrique had been raised in the Roman Catholic tradition, neither he nor his family were practicing. In his social history, Enrique had stated that his life values such as love, charity, kindness, and forgiveness were influenced by his family as well as by those values taught within Roman Catholicism. While his imagery of a guiding light certainly could allude to the guiding light of God, Jesus of Nazareth being “the light of the world,” or a heavenly light, Enrique did not define the guiding light specifically. Yet the light imagery offered safety, healing, condolences, and comfort. In the reflection phase, Enrique revealed that his guiding light imagery held more spiritual significance than religious. Most importantly, his imagery was soothing and helpful in his healing process. Thus, this intervention included aspects important to Enrique’s sacred world, particularly his spirituality.
Consulting the Inner Adviser

At times people edit and censor themselves in their conscious mind to the point where solutions to problems seem out of reach. Under these circumstances, it is helpful to search internally for solutions. Dialogue with the internal self, the ego ideal, or a significant attachment figure has been found to be quite useful in accessing previously unavailable internal information (Rossman, 2000). Such experiences are the symbolic representation of internal wisdom and understanding garnered from a number of philosophical, religious, and psychological precepts. The construct of the inner adviser is ancient. Many Native American and First Nation peoples conceive of healers or shamans who help individuals connect with their inner advisers to obtain guidance and direction at the crossroads of life. Conversing with the inner adviser may help make subliminal, intuitive information available to the conscious mind for examination and decision making. How is guided imagery helpful in accessing this information? The functioning and ability of the right hemisphere of the brain is quite constructive in perceiving subliminal information, subtle cues, connections, and so-called intuitions because such information often operates outside of awareness. As such, this information may be less vulnerable to editing and defensive reasoning. Through relaxation methods coupled with internal dialogue, clients consult their inner advisers to learn about the nature of their problems. The adviser may also assist in providing comfort, support, peace, inner calm, and compassion where little existed previously. Subsequently, the mind is clear enough to envision possible solutions to problems. Finally, inner advisers can help clients access, comprehend, and weigh inner resources and can supply direct resolution of symptoms (Rossman, 2000).

The concept of the inner adviser spans a range of roles. The adviser could function as the idealized self. Moreover, it could be associated with a wise, compassionate, and nurturing parent figure or relative living or dead, an old friend, or a mythic figure. The adviser can be a spiritual figure such as Buddha, Moses, an angel, a patron saint, Jesus, Allah, or God. Under these circumstances, dialogue with an inner adviser, or God image, may resemble prayer. Prayer can help the client focus on the timeless qualities embodied in cross-cultural images of
gods, including wisdom, mercy, consolation, and love. Focused prayer can help heal emotional issues, and can comfort and support. When the inner adviser is a compassionate holy figure, healing may take place in the larger sense of the word. The God figure may be embodied through roles in popular media such as Morgan Freeman, who played God in the film *Bruce Almighty* (2003). Advisers can be represented as animals, such as a wise owl. For some, the inner adviser is a figure of innocence, such as a fawn or deer, unpolluted with worldly matters and thus endowed with clear vision of solutions. Inner advisers can come from literature. One client chose Aslan the lion, from C. S. Lewis’s *The Lion, the Witch, and the Wardrobe* (1950). Others have selected popular media figures such as Yoda or Obi-Wan Kenobi from *Star Wars* (1999). Animal characters such as Mufasa, the wise lion-father in the *Lion King* (1994), have also been chosen. Still others have spoken to a dear pet from childhood, because as one client confided, “He always understood my moods and problems somehow. He just got me.” Advisers can communicate through an inner voice or presence, or they may be represented as a light, an oracle, or a flower. One client chose Glenda, the good witch from *The Wizard of Oz* (1939), who helped resolve her feelings of being lost, anxious, and out of control as was Dorothy. An inner adviser may be a force of nature, such as a gentle wind that communicates nonverbally. Most often the inner adviser embodies spiritual qualities such as wisdom, compassion, and capacity to see ultimate truth within complex situations.

To help the client meet their inner adviser, guide the client to a relaxed state through progressive deep muscle relaxation, the imagery of descending a staircase to the count of twenty, or the safe-place exercise. Next, instruct the client to imagine their inner adviser: a wise, kind figure who knows the client well. The client should try to accept whatever image comes and remain open to it. Taking some time to observe the image and become comfortable with it, the client asks the adviser’s name and permits it to have a voice to answer. Direct the client particularly to notice if the adviser appears to be wise and kind and what it feels like to be in its presence. Once the adviser is acknowledged, instruct the client to ask the adviser if it would be willing to help with the problematic situation, and to let the adviser respond. The client proceeds by asking the adviser questions concerning the client’s situation, taking all
the time he or she needs. Encourage clients to remain open to the process. If the client has further inquiries to make or is uncertain about the meaning of advice, encourage continued conversation until the client feels that he or she has learned as much as possible at that time. Ask the client to imagine taking the advice that has been given: does the client see problems or obstacles with the approach? If so, what are these obstacles? How might they be dealt with in a healthy and constructive way? The client could question the adviser about such concerns. At times, no immediate relief or solution may be evident. If this occurs, the client can ask the adviser about further steps that may need to be taken to solve the problem. Toward the end of the imagery experience, the client can thank the adviser for meeting and ask about meeting again, if needed. Subsequently, the client may say goodbye and be instructed to reenter waking consciousness in the present time: ask the client to count upward from one to ten; when reaching ten, the client is refreshed, awake, and alert, remembering significant aspects of the meeting (Battino, 2011; Rossman, 2000).

Evaluate the experience with the client. What form did the adviser take? What questions were asked of the adviser, and how did the adviser respond, both generally and specifically? Is further dialogue needed? Have the client evaluate the most useful aspects of the conversation. Note any actions that should be taken as a result of this inner conversation, or if something else should occur first. Together, evaluate the safety of the advice and whether there are obstacles to following the advice. Discuss potential constructive ways for the client to deal with the obstacles. Also note which other people in the client’s life might be affected by the adviser’s advice. Then help the client evaluate the risk/benefit ratio among alternatives. If the adviser’s advice involves substantial risk, such as terminating employment, confronting a significant other, or converting to another faith, potential benefits should be weighed carefully. Together, examine how taking action will change the client’s life circumstances.

**Collaborative and Deferred Imagery Exercises for Theistic Clients**

After determining whether clients’ spiritual coping style with their God is collaborative or deferred, guide them into a relaxed state. If the relationship is collaborative, you could counsel clients to initiate sharing
their anxieties and difficulties with their God, visualizing how God listens attentively. Then being aware that God is near and listening carefully to the response, help clients understand that they are not alone in this problem, as God is there to assist, protect, guide, and keep them safe. Allow clients to rest in the presence of their godhead. Have clients imagine God helping them with the problem and ask God to tell them where it is that God can help. Subsequently, counsel clients to inquire about which parts are best turned over to God. Then encourage clients to ask what part is their responsibility. Encourage clients to listen and take comfort in the presence of God, who is compassionate, loving, and available always. Suggest that clients listen to God’s voice and bask in the glow of the godhead, who provides protection, comfort, and acceptance (Tuskensis & Ford Sori, 2006).

When the relationship to the divinity is deferred, guide clients into the relaxed state. Encourage them to approach their God and share intimately all the concerns that are held within. Counsel clients that God understands these concerns. Using all the senses, help clients attune to God’s compassion and love, knowing how much God cares for every conceivable part of them. Suggest that clients listen to God, become one with God, and feel the warmth and love of God’s being. Say that God suggests that they unburden themselves and begin to relinquish all anxieties and worries to God’s care, as God can carry all the burdens and does not want the client to carry them. Use of appropriate sacred texts is helpful here, such as “Come to me, all who labor and are heavy laden, and I will give you rest” (Matthew 11:28, Revised Standard Version). Suggest that God cares for the client deeply and wants to help. Tell clients that they are not alone. Suggest that the client picture handing over each burden to God, each one, placing them in God’s hands, until God has all the burdens and the client can rest in God’s arms, feeling utterly safe and loved. State that God will never leave the client, ever. Now is the time to rest (adapted from Tuskensis & Ford Sori, 2006). Then help clients return to wakefulness in the manner described above.

**God as the Adviser: Suzanne**

Suzanne came for counseling because of mounting problems in her life. As a set designer for musical theater, she had been recently laid off from
work in her early forties. Shortly thereafter, she had an accident on the street, falling off a curb and hurting her foot. Because she experienced significant pain during her recovery, her physician was watching her for onset of complex regional pain disorder, a sympathetic pain condition. Suzanne was frightened by the possibility of this diagnosis and its implications of ongoing pain. She related that her anxiety was debilitating and actually increased her level of physical discomfort. Over the weeks, she had become ever more despondent. On top of everything, Suzanne’s elderly parents were becoming increasingly frail and were considering moving into facilitated care. Suzanne had relied on her parents for emotional support and sustenance and could not conceive of a life without their active advice and guidance. To afford this facility, the parents would have to sell Suzanne’s childhood home. She was tearful as she stated that all of a sudden she felt very old, and that she seemed to cry at the drop of a hat.

In her spiritual assessment, she revealed that she was a practicing Anglican, attending services weekly and singing in the choir, and that she prayed often and had a strong faith. When asked about a positive experience of prayer, she conveyed a situation some years prior when life felt overloaded and out of control. Her father had been hospitalized with a heart attack, and her mother was stricken with a severe bout of arthritis. During this stressful time, she was forced to move from her apartment and broke up with a romantic partner. At her father’s hospital bed, she prayed for her father’s health and for relief from her problems. The hospital chaplain suggested that she place all her burdens on the strong shoulders of God. During the next hospital visit, sensing the presence of God, Suzanne was able to let go of her overwhelming anxiety and get through the immediate crisis. Suzanne’s God imagery revealed a God who was supportive, on whom she could depend.

Our session focused on guided imagery using a deferred approach to spiritual support. In therapy, Suzanne consulted God as her inner adviser several times. Over the next several weeks, Suzanne notably improved. Her anxiety lifted, and her pain gradually decreased. With greater mobility she was able to find work, and with more income and a clearer head she located an in-home caregiver for her parents. Her depression abated as her sacred life expanded. With much dialogue with her God, she began to comprehend her parents’ aging process and
decrease her dependency on them. Suzanne grew through therapy, prayer, and religious involvement with her church. Her relationship to God, her inner adviser, also grew. Over time, she was more able to tolerate her parents’ increased frailty and assume greater responsibility as an adult child of aged parents.

In many ways Suzanne began with God imagery that corresponded to her attachment to her elderly parents. What is different about this case is the manner in which Suzanne’s relationship to her inner adviser matured and compensated for her anxious attachment to her parents. Over time, using the inner-adviser approach, Suzanne was able to contain her anxiety and accept the increased frailty of her parents because her relationship with her inner adviser was an earned secure attachment (Brisch, 2012). In a sense, Suzanne’s relationship with her God evolved into a compensatory experience, one that allowed her to mature into adulthood and become less dependent on her elderly parents for support. Moreover, the use of Suzanne’s sacred triad made this approach especially powerful. All three aspects of the triad—spirituality, religion, and faith—were employed when using guided imagery; thus, she had ample resources on which to draw. In a real sense, we captured the most comprehensive facets of her sacred experience. As Suzanne matured in her faith development, she moved from the synthetic-conventional stage, characterized by conformity to authority and development of a personal identity, to the individuative-reflective stage, characterized by taking personal responsibility for beliefs and feelings. As clients are able to reflect on their beliefs, there is openness to a new complexity of faith (Fowler, 1981). In the end, Suzanne was able to confront her parents’ needs as an adult without becoming anxious and regressing to a childlike relationship to her world. Hence, she could become the caregiver of her parents rather than remain in a childlike role during her adult years. Moreover, her physical pain decreased over time; thus, we worked with the biological, psychological, social, and spiritual aspects of the client’s experience.

When There Is No Inner Adviser

Some clients appear to have no inner adviser. Under these circumstances it is important for clients to understand that working with the internal
imagery is a way of allowing something to happen, rather than forcing it. Several impediments may exist in the imagery of an adviser. The difficulty may relate to the process itself; for example, the client may not be fully relaxed. When such circumstances exist, encourage clients to perform imagery rituals while waiting for their adviser: much as we prepare for the arrival of a guest, they could imagine preparing for a visit of a dear friend in a safe place. Clients might imagine gathering flowers, lighting a campfire, or strewing fragrant herbs on the floor. These images can help relax and prepare them. Alternatively, while in the relaxed state, clients might imagine going to the residence of the adviser. Then suggest that they imagine how the adviser would look. You could ask the gender and age of the adviser, whether the adviser is a spirit, a human, or an animal, where it might live, and how it might move. Discuss what the adviser might tell the client if it were truly wise and cared about the client. Have clients listen for instruction on how they might begin to prepare themselves for change and help. For example, they might note whether rituals could assist in preparing for changes. Some faith traditions include a period of preparation in which the individual takes time for self-examination or rest in a retreat or performs rituals and actions of faith such as lighting a candle. Instead, clients might draw the image of the adviser or write to the adviser. Then suggest that they answer the letter. You might also suggest that clients imagine having a conversation with a very dear friend, living or dead. They might ask the friend to lead them to their adviser, or even to become their adviser. At times I have asked clients to imagine a situation where their friend had the exact same problem as they have. What might the client tell the friend to do? In addition, clients could imagine a historical or mythical figure that fits their idea of a wise and compassionate inner adviser, such as Gandhi, Mother Teresa, or even a fictional character such as Dumbledore (from Harry Potter). Help clients talk with that figure about their situation and allow the figure to respond to them. What guidance or direction is given on the problem? Suggest that clients notice the character traits and qualities of the figure and imagine how being touched by some of these qualities might assist in the healing process.

Another reason for the absence of an inner adviser is protection from hurt or rejection. For example, there may be negative God imagery or God content that the client has internalized. God imagery refers to
Chapter 9  Guided Imagery in Religion, Spirituality, and Faith

clients’ emotional relationship with their deity and can operate outside of awareness, while God content represents what clients have learned consciously about the divine (Moriarty & Hoffman, 2007). For example, clients may have learned that God is merciful but have experienced relationships where clergy, teachers, or parent figures have been punishing and uncharitable. Anyone who teaches the philosophies of life, values, and ethics may be associated with God imagery. Clients may also have been taught that God will punish sinners for misdeeds. Negative God content and associated internalized God imagery can be very damaging and can leave clients hopeless and helpless. In many of these circumstances, the attachment relationship to the divinity is insecure-ambivalent, insecure-avoidant, or disorganized (Noffke & Hall, 2007). If such is the case, do not assume that clients do not want to work on their relationship with God. However, clients may fear an association with an inner adviser. These circumstances require further work to help identify their source and transform the negative God content and imagery, so that a compassionate and appropriate adviser may be found. If the client’s image is unpleasant in any way, encourage the client not to concentrate on the totality of the image but to observe closely the God figure. What does the figure actually look like? What might this God really be trying to communicate? At times close attention to such details reveals a more compassionate godhead or the source of the conflict.

If, however, there is a clear negative, critical, or avoidant voice that emerges in the guise of the inner adviser, the issue should be addressed. In such instances, alert the client that this voice is not truly the inner adviser but most probably a memory of an internalized negative or critical attachment figure. This voice can have a powerful impact on the client, as it influences life by increasing feelings of insecurity and abandonment, dismantling hope, and deprecating self-esteem. In these situations, examine with the client the tonality of the voice and determine its origin. Clues to identity lie in familiar phrases or expressions, accusations, life stances, or belief systems that sound familiar to the client, as they have been heard before. Elicit from the client whether anyone in the client’s life resembled or sounded like this negative voice. Is the voice critical in the same way a clergy member or a grandparent was critical, avoidant, or ignoring? Does the inner adviser’s voice mirror another attachment figure? Is it hostile in the manner of a previous
partner or teacher? Are certain phrases used, such as “Your lifestyle is an abomination,” or “You are undeserving to enter the Kingdom of God,” or, as one client put it, “If your faith were stronger, you wouldn’t be having these problems.”

Under such circumstances, trauma recovery work is necessary. You might ask the client to do a body scan and notice how different places in the body feel in interacting with the negative voice. Starting with the body often helps clients begin to identify feelings and ultimately to communicate them to an empathic other such as the clinician. By working through traumatic events, the client and clinician can discuss these feelings, where they may have come from, and how trauma has affected the client’s perceptions of life, health, and illness (Bedford, 2012). Importantly and ultimately, how has trauma affected the client’s sacred self and world? Often traumatized people feel devoid of spirituality, as a spiritual self encompasses a sense of the future. This time perspective may be lacking especially in traumatized individuals who reexperience past events in present time but have limited capacities to conceive of their future. When language is inaccessible, clients can be encouraged to draw the feelings that come up and then discuss the drawing with the clinician. (See chapter 3 for further details on art therapy and trauma recovery. Other expressive methods to treat trauma found in previous chapters of this book may also be useful.) Processing feelings over time can assist in neutralizing trauma and conflict. In further guided imagery encounters, counsel clients to confront the negative voice, stating that they are interested in positive interactions that may help with healthy living and problem solving, and that criticism, contempt, ridicule, and condemnation will not be tolerated. Subsequently, you might discuss how these intonations differ from the loving guidance and compassion of an inner adviser. Furthermore, you could ask clients what they would like to do with the negative voice. During another guided imagery encounter, the plan can be enacted. Other treatment methods, such as cognitive-behavioral therapy, can also be paired with guided imagery. Using cognitive-behavioral therapy, clients can learn to recognize these negative voices and then use thought stopping to end the conversation with the voice, examine its content for a reality base, and replace the internalized voice or thought with a more compassionate, hopeful, and helpful voice of a true inner adviser. Through this type
of work, the inner adviser and the clinician essentially create for the client an earned secure attachment to a positive figure, one that replaces the old insecure-ambivalent, avoidant, or disorganized attachment. Operating from the secure base, the client can then seek inner guidance for help with problem resolution.

At times, the inner adviser may seem alarming or surprising to the client. The image could represent any emotion that the client has internalized, such as sadness or anger. In nearly all cases there is a reason why the image is present, and thus, the material is useful in problem solving. It may be that the mind of the client produced the image as a result of internal questioning and life experiences. Whatever feelings come up, they are a part of the internal landscape of the client, and discussing such feelings and what caused them is essential to healing. Fear may relate to the need to confront a life situation and associated avoidance or resistance. It is possible that resolution will not occur without confronting these feelings. If fear is present, the client can be supported and encouraged to attempt to deal with the fear or the feared figure in counseling. Or over time, the client may wish to befriend the adviser. A number of other methods can be used to help the client feel more secure in this interaction. The client could observe the adviser while gathering information such as what the image might represent and how best to deal with the fearful qualities of the adviser, such as unpredictability or that which is different in life. What exactly makes the adviser fearsome? Such qualities may directly relate to the client’s fears or problem area. In addition, the client might imagine wearing a protective suit of clothing or being enclosed in a protective force field. You can then ask the client to examine the makeup of these protective items, and in doing so the client can become aware of analogous qualities in the self that are useful in confronting the fear. For example, the force field might be strong yet flexible. Such qualities are often useful in interactions with others. Alternatively, the client could imagine wearing a covering that provides invisibility. In another scenario, the client could imagine carrying a device that transforms frightening situations into amiable ones (Rossman, 2000). Again, observing how the device operates might give direction to the client in future interactions with others. For example, a magic wand might cast warm radiant light on the frightening adviser and help transform it into a friendly being, just as
being warm with others helps create friendly interactions. Other feelings may be examined similarly. For example, if the adviser is seen as sad, what makes the encounter with the adviser sad? Observing the sad image and gathering information from it, describing it, and processing the sad feelings often helps resolve them. In addition, creating another image to help tolerate the sadness or transform it often results in insight and problem solving in future situations. When describing the qualities of the transformative image, clients learn what might be needed in themselves to also transform their lives.

The empty chair experience can also assist with interaction with the adviser. This approach can be engaged either through guided imagery after induction into a relaxed state, or in a wakeful, conscious state. Using the imagery approach, direct the client to imagine addressing questions to the adviser as if the adviser were sitting in a nearby chair. This exercise is especially useful with clients experiencing negative God imagery. Speaking directly to the image of God, clients can tell their God what they are feeling and ask the God figure their questions directly. Then clients imagine taking the role of the God adviser and sitting in the adviser’s seat, and respond to posed questions. Here, it is useful to clarify whether the answering God is more related to God content, that is, what was learned from others about God, or the emotional relationship with God, that is, God imagery, or in the end, another internalized attachment figure. A number of seat switches may be accomplished before the end of the conversation. Through this process, God imagery may be redefined. In the waking alert state, the interaction occurs through the actual switching of seats. The client poses questions to the adviser; then taking the adviser’s chair, the client answers the questions. Subsequently, you and the client discuss the experience, noting feelings that emerged in the unfolding process of the conversation, what was useful or not in the discussion, the effect of the conversation on the client, and what was gained from the interaction, including plans for future change. (For a full discussion of this method, see chapter 6.)

Termination, Evaluation, and Follow-up

Evaluation and termination decisions are made by both client and clinician as improvement is noted. Typically, symptoms have remitted, and
clients have engaged wellness as a lifestyle. Assessment instruments related to presenting symptoms may be used to evaluate client improvement and to guide decisions about termination. Visits might be scheduled less and less often over a period of time, so that the clinician can assess the degree of client stabilization. Most often, as termination approaches, the client has practiced guided imagery at home, using tapes made by the clinician. By the end of treatment, the client leaves therapy with skills in the use of guided imagery. Once terminated, clients may be scheduled for follow-up sessions as needed.

CONCLUSION

Guided imagery is a powerful, research-supported approach that is useful for a wide variety of clients experiencing diverse types of physical and emotional problems. As a sacred-sensitive intervention, guided imagery often makes use of the individual and cultural experiences of the client. At its foundation, guided imagery is based upon the premise of the synchrony of interaction and dynamic influence of mind, brain, and body in the healing process; thus, it is considered to be a holistic health treatment. Human beings are infinitely resourceful in their capacities to access their creative inner forces. Once tapped, these forces can be harnessed in remarkable ways for self-healing and increased well-being.

REFERENCES


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of meditative expertise. PLOS ONE, 3(3), e1897. doi:10.1371/journal.pone.0001897


