Utilization of Guided Imagery within the Four Phases of Adlerian Therapy

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Abstract

Every prospective counselor faces many challenges during the development of his career. He tends to struggle with professional insecurities while exploring various techniques and therapy styles to find an effective combination. The purpose of this paper is to explore the use of Guided Imagery within the four phases of Adlerian therapy to provide professional guidance. Guided Imagery and Adlerian therapy will be examined and defined as separate entities. The paper will also integrate the two and identify specific Guided Imagery techniques for counselors to employ during each of the Adlerian therapy phases. The pronoun, “he,” is used within this paper as a gender-neutral term to refer to men and women.
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Guided Imagery

The earliest therapists in history were considered to be spiritual leaders. They are religious members that spread the healing words of the gods. To the early population, mental and physical illnesses were allegedly works of the higher power or magical doings. Shamans were known to use spiritual visualization to heal the ill (Hart, 2008). The Shamans would take the sick through an imaginary journey to find the evil entity and destroy it. The next assemblies of therapists were philosophers. They explored concepts to explain reality and to reveal the mind’s perception. Plato, a Greek philosopher and artist, believed our behaviors and beliefs stemmed from the collective unconscious. Two other prominent Greek philosophers of that time, Aristotle and Hippocrates, identified mental images as potent articles that have direct impact on the heart and body (Moon, 2009).

As founders of psychology continued to present significant findings on mental illnesses, linking the mind and the physical body, professional institutions began to propagate throughout the world. Franz Alexander, one of the founding fathers of Psychosomatics, had a holistic view of human health. He promoted the idea that human behavior is driven by the unconscious. He also assumed that in order for one to have a healthy body, he must have a healthy mind (Eckardt, 2001). The interconnection between the health of the mind and body has been well-documented and studied. Since the early development of the human society, from cultural and spiritual customs to innovative therapeutic and medical practices, the use of imagery has been a successful approach in achieving recovery (Miller & Utay, 2006).

What is Guided Imagery? Guided Imagery has many definitions but is difficult to describe and verbally identify. The Merriam-Webster Dictionary (2012), defines it as,

“Any of various techniques (in a series of verbal suggestions) used to guide another person or oneself in imagining sensations and especially in visualizing an
image in the mind to bring about a desired physical response (as a reduction in stress, anxiety, or pain).”

The Oxford Dictionary (2012) simply defines it as a “method of relaxation which concentrates the mind on positive images in an attempt to reduce pain, stress, etc.”

In essence it is, “Seeing with the mind’s eyes.” But it is a process that has to be experienced to fully be appreciated (Farah, 1988). Guided Imagery is a research-based tool that allows the participant to look at things in a different way. It encourages positive effects and provides a safe outlet for expressing emotions. Guided Imagery activates more than just visual components. It uses other parts of the sensory system including smell, sound, taste and feel to alter thoughts, emotions and behavior. Guided Imagery generates activities from the brain to the body. It links thought process with the body’s natural responses. The effects it has on the mind and body have not been fully acknowledged but it is undeniable there are notable advantages to using imagery (Hall et al., 2006). Guided Imagery contributes positively to any individual’s existence. It can impact all facets of the person’s professional, social and personal life. The active imagination is a powerful resource to utilize (Wadeson, 1995).

Illustrations and visual arts have been known to provoke intense feelings. The audience of a scary movie spends over an hour being frightened and terrified by the monster on the screen. If image and sound can instigate such powerful negative emotions, it can also instigate powerful positive emotions (Rubin, 1999). Imagine the feeling that rushes through a child when he wakes up on Christmas Eve. By visualizing the child’s face, pleasant feelings quickly transfer to the viewer. There is a sense of nostalgia and excitement that translates emotionally and physically. Guided Imagery utilizes all of one’s senses to evoke thoughts and feelings related to one’s
personal perspective. It leads the mind to mimic familiar sights, smells, sounds, tastes and feelings that the participant has experienced in past events (Hart, 2008).

**Identifying Effects of Guided Imagery**

The practice of Guided Imagery is a combination of hypnotic induction and meditation. It blends verbal implication, breathing techniques and visualization to place the subject into a trance. The practice permits the therapist and client to accomplish a number of objectives in therapy (Leuner, 1969). But before tailoring the technique to craft and achieve goals, the effects of Guided Imagery have to be identified. There are vast numbers of ways Guided Imagery is used in treatment but it is mainly used by professional helpers to cope with mental and physical ailments. How does Guided Imagery contribute to improving the harmful mental and physical distress an individual exhibits?

For the mind, Guided Imagery improves mood by managing stress, anxiety and depression (Eller, 1999). It reduces the intensity of negative emotions the individual experiences during hectic and chaotic times, removing the main distraction inhibiting him from logically planning and problem-solving. When the emotions are appeased, the individual can use rational thinking to deal with the situation at hand (Miller & Utay, 2006).

For the body, it directly affects the function of the autonomic nervous system, which is identified by the American Heritage Science Dictionary (2012) as,

“the part of the vertebrate nervous system that regulates involuntary activity in the body by transmitting motor impulses to cardiac muscle, smooth muscle, and the glands. The muscular activity of the heart and of the circulatory, digestive, respiratory, and urogenital systems is controlled by the autonomic nervous
The system,” The system controls our heart rate, blood pressure, respiratory rate, and body temperature.”

The Autonomic Nervous System controls organ function. It regulates and maintains normal body functions. In certain events it operates involuntarily. The levels of body functioning changes when emotions such as stress, fear and sexual excitement occurs. The individual will instantly notice changes in their heart rate, blood pressure, respiratory rate and body temperature. Changes in these levels are also indicators of physical illness (Farr, 2002).

**Effects on the mind.** The brain has two hemispheres. It is divided to separate and control a human being’s rational and emotional side. The left side handles “logical” operations while the right side administers “creative” tasks. Lateralization of brain functioning refers to the motors and sensations on one side of the body being managed by the opposite side of the brain. All the tasks the left side of the body performs are directed by the right half of the brain and the tasks that the right side of the body performs are directed by the left half of the brain. The two hemispheres communicate to take in and process human experiences (Cassel, 1991).

Strong and overwhelming emotions tend to have a detrimental effect on one’s execution of daily functions. If the emotions are not well-managed it creates many hurdles. Although it is unrealistic to set a goal of eliminating all unwanted feelings, Guided Imagery provides a means to lessen the impact the emotions have on daily performance (Naparstek, 1994). Not all powerful emotions are negative. Many would classify anger, sadness, grief, etc. as being adverse, but these emotions can appear during good times and happy events. Major transitions during moving, college, weddings and job changes can trigger these emotions. That does not mean these changes are bad. Feelings and emotions are natural responses. Its intensity varies
due to numerous factors. Instead of containing the emotions, the individual should find a safe outlet to explore and express them.

Stress does not only affect an individual’s mental well-being, it also directly contributes to the progression of disease and damaging physical illnesses (Kaufman, 2007). It is conventional for people to fixate on unconstructive thoughts and feelings. The mind is cluttered and scattered during stressful times. Guided Imagery is a constructive distraction that allows the individual to detach and redirect the stress (Battino, 2000). Mental imagery is influential in the sense that the brain responds to imaginary experiences similar to the way it processes real-life experiences (Cummings & Ulak, 1997). An individual’s cognition is organized as memories. New images, imaginary or actual, can create new memories to be stored in the brain. These new memories have the ability to change personal perception. Guided Imagery can create new memories that prompt modification of thoughts, feelings and behavior. Habitual practice of hypnotic and meditative techniques allows the brain to become more powerful and focused. It improves self-control and increases receptiveness. Having a high capacity of self-control and self-realization strengthens coping and emotion regulation skills (Naparstek, 1994).

Anxiety is a mood response that can occur without having a trigger present. It is exhibited in forms of fear and phobia. Most people have experienced test and performance or stranger and social anxieties (Cwynar & Tusek, 2000). An individual struggling with anxiety before giving a speech in front of his colleagues can employ Guided Imagery to reduce his uneasy thoughts and feelings. He can use his mind to generate relaxing imagery by tapping into his stored memory. He could pick a place he found to be calming and soothing in the past to stimulate the same feeling. The visualization of calming elements settles anxious feelings. The process reduces the uncomfortable sensation related to anxiety (Kaufman, 2007). The vision
transports the individual to another setting, a place that provides him with more control over his mind and body.

Progressive muscle relaxation is also a Guided Imagery technique that reduces tension in the mind and body to heighten relaxation. It follows a series of directives that tenses and relaxes major muscle groups (Shames, 1996). The exercise is usually paired with deep breathing to reduce anxiety.

Low mood, negative self-esteem and loss of satisfaction directly tie to depression. General feelings of sadness are universal. People go through ups and downs but it is how they cope with the sadness that makes a difference. One can manage his sadness with self-destructive behavior or he can apply productive practices to handle the emotion. A depressed individual usually suffers from negative thinking. Positive thinking has to become dominant to reverse his cognitive processing. Relaxation induced by Guided Imagery increases the production and the release of neurotransmitters known as endorphins. Endorphins work with chemicals in the brain, epinephrine, serotonin and dopamine, to increase one’s energy and mood. High levels of epinephrine are experienced in instances such as a runner’s high. Physically, the individual is taxed, yet he receives a second boost of energy that takes him to the finish line. An increase in levels of serotonin means an increase in mood. This chemical contributes to peasant and pleasurable feelings. Dopamine is known for regulating sleeping patterns. Adequate sleep directly enhances energy and mood (Barchas et al., 1982).

A study performed by Taiwanese students integrated Guided Imagery and music. They used a five step procedure to effectively reduce their subjects’ depression. Through a qualitative research format, the students successfully led their subjects through:

1. Becoming more aware of the origins of distress.
2. Enhancing self-awareness,

3. Becoming aware of family relationships and using it as inspiration in creating change.

The insight the subjects discovered contributed positively to lessening their depression (Crawford et al., 2010).

**Effects on the body.** Endorphins are also a natural form of tranquilizers that lower cholesterol, high blood pressure and blood sugar levels (Farah, 1988). Individuals with elevated levels of cholesterol, blood pressure and blood sugar suffer from various physical problems. Some of the problems relate to the presence of pain and soreness. These individuals also have a weak immune system making it challenging for them to heal or recover. The process of Guided Imagery can alleviate the pain and boost their immune system. The chemicals associated with endorphins, epinephrine, serotonin and dopamine, are found to have the capability of reducing pain. They can also stimulate the immune system to activate and function at a higher capacity (Barchas et al., 1982).

The brain is a computer system. The body generates messages to the brain and the brain generates responses according to the information it receives. But only one message can be sent through the spinal pathway to the brain at one time (Cassel, 1991). When the pathway is preoccupied, other messages are not able to go through and get registered in the brain, preventing certain responses from occurring. When an individual uses Guided Imagery it blocks messages from other parts of the body. For example, conjuring up images that support healing and pain management can preoccupy the brain to decrease adverse physical responses controlled by the autonomic nervous system. Instant discomfort comes from any changes in the heart rate, blood pressure, respiratory rate, and body temperature. If the brain is too busy processing the imaginary images, the body is not able to make drastic changes. The autonomic nervous system
can continue to send messages to the brain but it may have difficulties receiving instructions when the participant is in the process of visualization.

There are indications that confirm that patients, during pre-operative and post-operative periods, experience less pain and anxiety with a combination of Guided Imagery and medication than patients who only utilized medication (Hart, 2008). As the sensory system gets triggered, the mind starts to believe the information being processed is reality. Even when the perceived event is created from the imagination, the mind can be deceived. The placebo effect is a great example of how powerful the mind is, even when it has been mislead. A group of participants were administered a form of treatment perceived to be a remedy but actually having no benefits. Just the idea of having a remedy improved some of the participants’ physical symptoms (Kiene, & Kienle, 1997). Cancer Guided Imagery is valuable when used with medical treatment to promote recovery. In this process, the cancer patient is encouraged to visually imagine an attack on their cancerous cells. They are also instructed to envision their tumors dwindling in size. The patient’s aggression and feelings of loss of control are redirected towards harming the illness, the cancer cells, instead of towards oneself or others (Eller, 1999).

**Benefits of using Guided Imagery in Therapy**

People seeking therapy struggle with a wide range of different tribulations. They may need someone objective to confide in but also someone to provide guidance and solutions for overcome obstacles. Some common problems clients in therapy may suffer from are: emotional distress, personal growth, relationship issues, lack of coping skills, loss, trauma, abuse, sexual problems and mild to severe mental disorders. The core goal of therapy revolves around self-discovery in addition to alteration of thinking and or behavior. Guided Imagery is an effective, yet playful instrument to use in therapy since it promotes self-reflection, encourages change and
is goal-oriented (Utay & Miller, 2006). It also collaborates well with the here-and-now therapies, such as Cognitive, Behavioral, Cognitive-Behavioral and Adlerian therapy.

**Cognitive therapy.** In the mid-twentieth century, the growing interest and concerns regarding mental illness paved the way for the development of several branches of Psychology. During this time, renowned Psychiatrist Aaron Beck’s interest in depression gave rise to the research of Cognitive Therapy. This therapy focused on helping clients identify and change their dysfunctional behavior (Davison & Neale, 2001). Cognitive therapists believed that humans are born with the potential to be “straight or crooked.” There are predispositions that contribute to one’s thought and behavioral development but one can learn from his mistakes to promote change. Once one can fully acknowledge that his way of thinking is responsible for his emotional problems, he will recognize these behaviors come from a set of irrational beliefs. Through philosophical restructuring, the client is made aware of his ability to change these behaviors (Mullin, 2000). After the misconceptions are challenged, the client will see the value of disputing his self-defeating beliefs. This will prompt him to work hard at counteracting the negative beliefs and behavior.

Personal experiences foster private values and ideals. When one is being repeatedly reinforced by internal and external forces that he must be do well to be liked and loved by others, he will attempt to carry out this conviction in everything he does. His process of thinking and pattern of behavior become a cycle (Thompson, 2003). If he is not able to achieve the approval of others, emotional symptoms may occur. His feelings of rejection and insecurities have to be challenged so his mental health can improve. The process of thinking begins with an activating event that creates a belief with emotional and behavioral consequences. When the therapist
incorporates a disputing intervention to challenge the client’s belief, it creates an effect that produces a new feeling (Mullin, 2000).

Aaron Becks referred to human processing of personal experience in everyday life as cognition. He identified six errors of thinking that were observed while treating his patients. They include: arbitrary inference, selective abstraction, over-generalization, magnification and minimization, personalization, and absolutistic, dichotomous thinking. By providing the client with psycho-education on the different errors of thinking, he can spot which one he uses, how the errors are harmful and he can begin to practice an alternative form of thinking to change his pattern. An individual who draws a conclusion even with a lack of evidence relies on arbitrary inference. An Example is someone believing his teacher dislikes him because he received eighty percent instead of a hundred percent on his research paper. Selective abstraction is when one draws a conclusion from a small detail but ignores other valuable facts, like someone thinking he is not smart enough even though he is academically ranked second in his graduating class. An individual who bases a general experience and creates a rule for all similar future experiences tends to over-generalize. This individual may avoid his daily routine on days he wakes up late because he had one bad experience in the past. Magnification of the negative and minimization of the positive is another extreme way of thinking. Instead of appreciating good deeds from others, one may spend his time thinking about the negatives and ignoring the positives of the experience. An absolutistic or dichotomous thinker is only able to see black or white; he is not able to see the gray areas in between. This individual will categorize each person as either being good or bad (Beck, 1979).

**Behavioral therapy.** Behavioral Therapy disregards thoughts and feelings and concentrates on behavior. There is little interest on past experience. There is more of a concern
for the present and future. The therapy process is subjective and the counselor is the expert. The client learns new skills and additional responsive options to gain self-control. The individual is the producer and the product of his environment. The problem in his life can be fixed with the use of behavior therapy or behavior modifications (Sundberg, 2001). Behavior therapy is based on Ivan Pavlov’s approach of Classical Conditioning. Behavior modification uses techniques from B.F Skinner’s, Operant Conditioning (Lovell, 2000).

One of the most influential studies on behavior is Ivan Pavlov’s experiment with canines. In his work, he learned how to control the dogs’ responses to food. He was able to manipulate their salivation responses. Pavlov correlated the sound of a bell to the canines’ sight of food. The process became branded as Condition Reflexes or Classical Conditioning. As long as Pavlov continued to show food to the canines as he rang the bell, the sound of the bell would cause the canine to salivate. But if Pavlov stopped ringing the bell at the sight of food, the dogs’ learned response began to decrease. The ideas of Classical Conditioning led to B. F. Skinner’s development of Operant Conditioning (Domjan, 2003).

Human behavior is motivated by the need for gratification (Cassel, 1991). Skinner said, "The consequences of behavior determine the probability that the behavior will occur again." Consequences can promote or discourage certain behavior. According to Skinner there are four consequences that can occur: positive reinforcement, negative reinforcement, positive punishment and negative punishment. Positive reinforcement is adding pleasant factors to increase a behavior and negative reinforcement is taking away pleasant factors to increase behavior. To use positive reinforcement, a parent may praise a child every time he finishes his vegetable, which will increase his desire to eat them. To use negative reinforcement, another parent may not allow the child to have dessert until his vegetables have been eaten. There is also
positive punishment which is when an adverse outcome is added to decrease behavior. For negative punishment the adverse outcome is removed to decrease the behavior. An example of positive punishment is a parent may put the child in time out for discipline purposes. For negative punishment, a parent may take away the child’s favorite toy when he is being disobedient. The terms are distinguished as positive means to add while negative means to take away. Reinforcement is to increase behavior while punishment is to decrease behavior (Domjan, 2003).

Joseph Wolpe was another Behavioral therapist who created his own process, branching off from Pavlov’s Classical Conditioning. Wolpe used Systematic Desensitization to help his patients overcome their anxiety. Wolpe would gradually introduce an anxiety producing stimuli to his patients to slowly reduce the intense feelings that were associated with the object. He would change the quantity of the stimulus according to his patients’ reaction. If the patients’ anxiety was reduced he would increase the amount and time of exposure. If the patients exhibited more anxiety he would decrease the amount and time (Wolpe, 1973).

Cognitive behavioral therapy. Cognitive and Behavioral therapy were kept separate for a short time. Within a decade, the idea that perception and behavior were intertwined quickly infected the Psychotherapy world. As the connection between cognition and behavior became prevalent in treating abnormal psychology, it gave birth to Cognitive Behavioral therapy (Sundberg, 2001). The system merged the treatment of destructive thoughts and feelings with harmful behavior. The therapy focuses on the directive from the therapist. It uses an assortment of techniques to change one’s language and responses, such as humor, force and vigor to role playing. The therapy is effective because it uses brief interventions to teach coping and problem
solving skills. It is action-oriented to make specific modification and implement long-term changes (Neale & Davison, 2001).

The first professional to integrate emotions and behavior was Albert Ellis. Ellis believed the therapist’s fundamental goal is to change thinking and behavior to remedy the client’s emotion problems. In the mid-1950s, he presented Rational Emotive Behavior therapy to the Psychological community. Ellis’s ABC Model draws in the connection between thoughts and conduct. A represents an antecedent event or activating event. Antecedent events are occurrences that instigate or prompt a particular behavior. B represents belief or behavior and C signifies consequences. Beliefs are manifested by an activating event and those beliefs have emotional and behavioral consequences that individuals learn and adapt. If the individual can identify all three factors, A, B and C, D will transpire. D is dispute. He will be unable to challenge the pattern and generate change (Abrams & Ellis, 2009). Rational Emotive Behavior therapy is intended to be implemented into one’s daily routine indefinitely. It is a self-managing program that keeps the individual conscious and aware of his behavior, thoughts and feelings (Thompson, 2003).

Arnold Lazarus was a pioneer in integrating other influential factors into Cognitive Behavioral therapy. He constructed the Multimodal therapy. Lazarus added physical sensations, visual images and biological elements to help identify behavior, thinking and feelings. He tied these factors together in the BASIC I.D. model. There are seven dimensions that shape our cognition and behavior. The seven dimensions are comprised of behavior, affective responses, sensations, images, cognitions, interpersonal relationships and a cluster of external forces such as drugs, biological functions, nutrition and exercise. In treatment, the therapist works with the client to list details about each of the seven dimensions. This bridges
and tracks the effects the destructive behavior has on different aspects of the client’s life. The layout provides a comprehensive view (Lazarus & Wolpe, 1966). The inventions are tailored specifically for each client. Lazarus’ model is subjective based. It does acknowledge some external forces, but puts little emphasizes on social impact.

Psychologist Albert Bandura gave recognition to environmental components in understanding and treating his patients. He is mindful of humans being communal and collective. He realizes humans learn through social exchanges but does keep certain personal factors relevant in his theory on human development. Bandura’s Social Learning theory takes note of assessing the beliefs, references, expectations, mental self-perceptions and interpretations (Bandura, 1977). He understands humans are also self-directed to change and be self-efficient. The client has to be active and take action to solve his own problem, but change cannot take place without understanding the underlying dynamics. It is vital to assess the client’s overt and covert behavior, identify the problem and evaluate change.

The Social Learning theory describes the learning as a universal process. As a child and as an adult, people use observation and modeling to sculpt their behavior. They view the responses of people around them and adapt the behavior. There are three types of modeling: Live, Verbal and Symbolic. Live modeling is when the behavior is directly demonstrated in front of the individual. Verbal instruction is a modeling through a set of explanations describing the behavior in detail. The last type of modeling is Symbolic, which revolves around media sources (Bandura, 1977). These are behaviors of characters described in a novel, on television or in a movie. The modeling process has four steps. The individual has to take notice and pay attention to the modeled behavior. He then has to be able to retain the information to practice and reproduce it. Finally, he must also be motivated to reproduce the behavior. The motivation
tends to be associated with a desirable outcome (Domjan, 2003). A child that observes his friend getting a treat for cleaning will imitate the behavior, hoping to receive a treat himself.

**Adlerian Theory**

Adlerian psychotherapy is derivative of Alfred Adler’s experience as a medical physician and his professional involvement with the Vienna Psychoanalytic Society (Ansbacher & Ansbacher, 1956). There are a variety of progressive concepts in Adlerian Theory but the innovation is in the democratic style of the therapy. Therapist-centered counseling dominated psychotherapy in the early twentieth century, but Alfred Adler believed humans are competent, trustworthy, and forward-moving species that have their own unique view of the world.

His process was client-centered and strayed away from the traditional approach of being therapist-centered. The therapist focuses on building social interest with the incorporation of community based activities to steer his client away from focusing on subjective problems. Adler recognizes that personal discrepancies within any of the three life tasks (love, community and occupation) will have a negative impact on an individual’s well-being. The idea is that an increase of social interest and involvement will be more valuable and provide more satisfaction (Corey, 2009). High levels of social interest support psychological stability. The more community oriented the client becomes, the more physically and mentally healthy he will be. Adler also identifies socioeconomic status, gender, age, religious and sexual preference as factors that formulate an individual’s private logic and misconceptions at an early age. Family atmosphere and birth order have a big impact on an individual’s personality development.

An advantage to using Adlerian Therapy is its ability to integrate additional theories and techniques. It incorporated parts of the Psychodynamic, Cognitive-Behavioral, Experiential and Systems of Therapy philosophies, but can adapt other concepts to tailor the needs of each client.
There are four stages in Adlerian Therapy that are used as a course of action to provide effective therapy. The stages include: Relationship Building, Information Gathering, Interpretation and Goal Setting, and Re-orientation. The stages direct providers from the initial start to the end of treatment (Carlson et al., 2006).

**Four Phases of Adlerian Therapy**

Certain individuals enter counseling believing the therapists have the ability to resolve all their problems. But the main intent of therapy is to provide strategies that improve problem solving skills. The client’s convictions tend to be so strong they have difficulty recognizing multiple solutions. The therapist can assist by identifying alternative choices the individuals are not yet aware of (Dinkmeyer & Sperry, 2000). The key for therapists in working with clients is to thoroughly understand their own bias and assumptions. A solid therapeutic relationship develops in a safe and protected atmosphere. Therapists that know and are comfortable with their preferred style of operation are more confident when implementing treatment. Clients can hypothetically investigate the consequences of their past behaviors. The four stages of Adlerian psychology enables the therapist to provide clarity by building strong connections with the client to create mutual respect, help the client understand his convictions, develop insight and change harming beliefs and behaviors.

**Forming a relationship.** The most important aspect of any relationship is to develop a strong connection between the individuals involved. In the field of mental health, a majority of the progress depends on the client’s willingness to disclose personal information. Most of these individuals have had negative consequences for conveying this type of information. In the beginning process of therapy, they tend to hesitate and filter personal information. They are probably also experiencing disconnection with different relationships in their life so it is crucial
to provide them with the setting and confidence that is needed for trust to develop. In Adlerian Therapy, the professional must be emphatic and encouraging. Using encouragement to alter the patient’s position into an empowering one is a great direction for professionals to take (Carlson & Watts, 1999). Individuals seeking help need a positive role model to be present for support. Clients must feel equal in the relationship. This will allow mutual trust and respect to grow (Carlson et al., 2006). Once there is confidence in the professional, collaboration will come naturally. Mutual cooperation is the key to achieving a common goal. Progress is limited to the type of relationship the helper and client have.

There are many ways to make the client realize that the therapist is a supportive and understanding individual he can rely on. Attentive listening is a way to show empathy; by being engaging, clients can comfortably communicate thoughts and feelings. Using verbal reflections, the professional can demonstrate good listening skills. Techniques such as mirroring and reframing allow the client to discover their own understanding of their current situation with some direction from the therapist. Verbal and nonverbal cues are very effective in encouraging self-disclosure. Building a strong bond can be challenging. The amount of time it takes to build a relationship varies, but it is a simple task to achieve with dedication.

**Information gathering.** The next stage consists of proper analysis, assessments and the use of several resources to examine the client’s inner mind. Tests, medical and family history contribute to the professional’s understanding of the client (Carlson & Watts, 1999). Each individual has a private logic that helps him cope with his environment. During this stage, the therapist needs to observe and lead the patient in becoming more aware of his psychological processes. Insights are discovered to shed light on issues inhibiting the client from living a
fulfilling life. Digging deep to find the unconscious motivations for particular behaviors can help the client move on to the next stages of counseling.

One technique that is very beneficial in investigating the mind is lifestyle assessment, and its affect on the life tasks. This format explores all aspects of the client’s life (Barnard & Brock, 2009). Not only is family history explored, childhood experiences like early recollections, dreams and final goals will also be examined. Griffith & Powers (1984) defines early recollections as,

“Early recollections are those single incidents from childhood which the individual is able to reconstitute in present experience as mental pictures or as focused sensory memories. They are understood dynamically; that is, the act of re-collecting and re-remembering is a present activity, the historical accuracy of which is irrelevant; therefore, early recollections are understood in Individual Psychology as mirroring presently-held convictions, evaluations, attitudes, and biases.”

The experiences that clients choose to share are never random. These memories are significant for a reason. They link to the misconceptions and personal beliefs that the individual has. By closely looking at these early recollections, ethical convictions, personal judgment of the self and others will be revealed (Dinkmeyer & Kopp, 1975). For inexperienced individuals the use of lifestyle assessment may be tedious. It is a time consuming technique but once the professional can memorize the main complements and objectives for completing an assessment, the task will become effortless.

**Interpretation and goal setting.** The information that is revealed during the psychological examination moves forward for interpretation. This is a tricky stage, incorrect
interpretation can easily occur. As a professional, it is imperative to not create any inaccurate labels. Society is sensitive to mental health labels and categories. Once the diagnosis has been given some clients may purposely exhibit particular behaviors to identify with the illness. The professional should always ask the client if his assumptions were correct to minimize any errors (Dreikurs & Mosak, 1973). If the client disagrees, the professional has to have the ability to accept the rebuttal and move forward. It is difficult to keep bias concealed but even harder to keep it outside of therapy. If the therapist cannot separate his opinion from the information he uses to treat the client it would have a negative effect on treatment. The five tasks of life are helpful in recording the client’s current thoughts and feelings. Having the client rate the five tasks of life enables both the therapist and client to have a better perspective on the client’s present condition.

Socratic questioning is a great method to direct the client during session. It lets the professional have more control over the information that is disclosed. Keeping the client on track will help the therapist obtain the necessary information needed for interpretation. In the previous stage, lifestyle assessments were used for psychological investigation. The same information can be used to translate ideals from the client’s private logic into easy to understand concepts (Corsini & Manaster, 1982). When assisting in the discovery of new insights the therapist can begin to educate and help make alterations in behavior.

**Re-orientation.** In the re-orientation stage clients are pressed to change their misconceptions. The professional must treat the individual from inside out. Adlerian psychology focuses on finding the motivation behind the misbehavior (Nystul, 1985). Many of these individuals have lived with these ideals and misconceptions all their lives and may be very
resistant. Once the client successfully reframes their beliefs, they will have the motivation to move towards a constructive path.

The time that clients spend with the therapist is not enough to implement permanent change unless the client makes a conscience effort to practice the new beliefs and utilize it in his everyday routine. People in stressful situations will react in a way that is familiar to them. It is a safe route to take. That route creates a pattern of behavior. The client must understand that there will be discomfort during this time of reprogramming. In time the new behavior will become just as familiar and effortless to use as the old ones. The client will realize that the outcome of positive change is worth the patience required.

By this stage of treatment the individual’s progress depends on his commitment. The insight discovered is the source of motivation for behavioral change but without at home assignments to keep the client on track, the process of recovery slows down. It also lessens the success for improvements after therapy (Moon, 2009). At-home journaling regularly advocates the practice of therapy. Entries can be reflected upon and assessed during therapeutic sessions or confidentially. Recording thoughts and events, then reflecting on them can broaden the individual’s understanding of the self.

It is impossible to change the events that have already taken place, but recapping and exploring the past events will provide the individual with much more insight. Adlerian concepts such as early recollections and dream exploration could also be assigned in forms of writing. Therapists should also create short term goals and long term goals with the client to assign tasks that will move clients close to their new goals. Delegated behavioral tasks will increase the amount of time the client has to rehearse the materials that were discovered in therapy. If the first few stages of Adlerian Counseling were executed appropriately, the final stage of re-
orientation will be manageable. The client will be more willing to change if they can understand the cost-gain factors of their behavior (Carlson & Watts, 1999).

Integration of Guided Imagery Techniques

The therapist has to demonstrate his professionalism in his conduct and execution of therapeutic techniques. Guided Imagery is one of the most utilized techniques for healing. It builds on the connection of the mind and body, enables one to mend internally in an altered state and promotes the “locus of control.” The Locus of control provides a sense of empowerment. The individual realizes he has power and ability to change aspects of his life (Naparstek, 1994). There are many techniques that are branch from Guided Imagery, supplying the therapist with a vast amount of tools to pick from. The integration of Guided Imagery and therapy has produced a list of types of imagery (Dryden & Palmer, 1995):

- Anti-future shock imagery prepares the individual for a future feared life-event and changes.
- Positive imagery utilizes pleasant scenes for relaxation training.
- Aversive imagery utilizes an unpleasant image to help eliminate or reduce undesirable behavior.
- Associative imagery utilizes imagery to track unpleasant and pleasant feelings.
- Coping imagery utilizes images to rehearse different scenarios to reach a behavioral goal or manage a situation.
- "Step-up" technique exaggerates a feared situation and uses imagery to cope with it.

These different types of imagery were created to meet objectives of different psychotherapies. Each has its own purpose and use.

Beyond its effectiveness, Guided Imagery is easily accessible and conducted. The process usually requires little to no equipment and can be administered in almost any situation.
The main concern is in the preparation and set up. To optimize the benefits of the directive imagery the participant’s senses have to be dimmed and muted. The conductor has to create a space that decreases external influences so the participant can closely follow his instructions. (Hall et al., 2006). The more attention and time the conductor spends on preparation the more effective he will be. He should take the time to review the technique and have an idea of how he would proceed.

The same attention has to be given to the participant after the directive has been given. There are precautions to take after the individual has completed any type of Guided Imagery activity. The deep trance and relaxation the participant experiences can cause difficulties with concentration and execution of fine motor skills. He should not drive or handle any vehicles or heavy duty equipment. The participant may not be able to quickly react or function at a normal capacity. The conductor should allow ample time to ease the participant out of his relaxed state. The participant needs to slowly awaken his senses and let them regain consciousness. If the participant did not get the opportunity to be gradually guided out of a trance, his senses may experience shock. Guided Imagery starts the journey by silencing all five senses. During the journey, the senses are directed to activate. They are activated according to the conductor’s instructions. The conductor suggests what the participant should see, smell, hear, tastes and feel (Hall et al., 2006). By the end of the journey, the senses are brought back to reality and the participant is instructed to take notice of the surroundings before he opens his eyes. The participant should also have time to recap and evaluate the experience instead of immediately diving into the next task.

The goals of therapy using Adlerian psychology as defined by Harold Mosak are (Dreikurs & Mosak, 1973):
• Fostering social interest.
• Helping clients overcome feelings of discouragement and inferiority.
• Modifying clients’ views and goals, that is, changing their lifestyles.
• Changing faulty motivations.
• Assisting clients in feeling a sense of equality with others.
• Helping clients to become contributing members of society.

**Techniques for Relationship Building**

It is important for trust to be established before therapy can begin. The therapist has to win respect and offer hope in order to motivate the client to self-disclose and make changes (Nystul, 1985). In a traditional psychotherapy setting, the client focuses on self-exploration. The fear of meeting a new person and being in a strange space is intimidating. It is common for the client to use mechanisms like denial, rationalization and even suppression for protection. There are times when being an empathetic and attentive therapist is not enough. Experienced therapists can use Guided Imagery to quickly tap into the client’s unconscious mind. The therapist can overcome the client’s defensive mechanisms and breakdown resistance when working with the unconscious mind (Miller & Utay, 2006). This barrier can be broken using the meditative qualities of Guided Imagery. The most frequent places used as positive imagery are the beach, the garden, the woods or the forest. These solitude places connect the individual to nature and the inner being.

The professional can create his own Guided Imagery script to meet the client’s needs or compile scripts from different resources. A relaxation script is a useful method to lead the client into a tranquil state. In that state, the client will lower his guard and be keener to develop a relationship with the therapist. The beach is a scenic peaceful place most people find to be
calming. Instead of physically transporting the client to the local beach, the professional can mentally take the client out of the therapy room and onto the ocean shore without leaving the comfort of his office. The process only takes up a portion of the therapy session but the effects are long lasting. The client’s tranquil state may continue throughout the entire session.

Inner Health Studio (Raudebaugh, 2012) provides a valuable, “Beach Visualization Relaxation,” script that can be used in the first phase of Adlerian Therapy. In a composed voice and manner, the therapist reads the script as follow:

1. Get comfortable. Sit in a supportive chair or lie on your back.

2. Relax your body by releasing any areas of tension. Allow your arms to go limp... then your legs....

3. Feel your arms and legs becoming loose and relaxed...

4. Now relax your neck and back by relaxing your spine.... release the hold of your muscles all the way from your head, down your neck....along each vertebra to the tip of your spine...

5. Breathe deeply into your diaphragm, drawing air fully into your lungs.... and release the air with a whooshing sound....

6. Breathe in again, slowly.... pause for a moment.... and breathe out.....

7. Draw a deep breath in.... and out....

8. In..... out.....

9. Become more and more relaxed with each breath....

10. Feel your body giving up all the tension.... becoming relaxed.... and calm.... peaceful....

11. Feel a wave of relaxation flow from the soles of your feet, to your ankles, lower legs, hips, pelvic area, abdomen, chest, back, hands, lower arms, elbows, upper arms, shoulders, neck, back of your head, face, and the top of your head....

12. Allow your entire body to rest heavily on the surface where you sit or lie. Now that your body is fully relaxed, allow the visualization relaxation to begin.
13. Imagine you are walking toward the ocean.... walking through a beautiful, tropical forest....

14. You can hear the waves up ahead.... you can smell the ocean spray.... the air is moist and warm.... feel a pleasant, cool breeze blowing through the trees....

15. You walk along a path.... coming closer to the sea.... as you come to the edge of the trees, you see the brilliant aqua color of the ocean ahead....

16. You walk out of the forest and onto a long stretch of white sand.... the sand is very soft powder.... imagine taking off your shoes, and walking through the hot, white sand toward the water....

17. The beach is wide and long....

18. Hear the waves crashing to the shore....

19. Smell the clean salt water and beach....

20. You gaze again toward the water.... it is a bright blue-green....

21. See the waves washing up onto the sand..... and receding back toward the ocean.... washing up.... and flowing back down..... enjoy the ever-repeating rhythm of the waves...

22. Imagine yourself walking toward the water.... over the fine, hot sand.... you are feeling very hot....

23. As you approach the water, you can feel the mist from the ocean on your skin. You walk closer to the waves, and feel the sand becoming wet and firm....

24. A wave washes over the sand toward you.... and touches your toes before receding...

25. As you step forward, more waves wash over your feet... feel the cool water provide relief from the heat....

26. Walk further into the clear, clean water.... you can see the white sand under the water.... the water is a pleasant, relaxing temperature.... providing relief from the hot sun... cool but not cold....

27. You walk further into the water if you wish.... swim if you want to.... enjoy the ocean for a few minutes..... allow the visualization relaxation to deepen.... more and more relaxed... enjoy the ocean....

28. Now you are feeling calm and refreshed...
29. You walk back out of the water and onto the beach...

30. Stroll along the beach at the water’s edge... free of worries... no stress... calm... enjoying this holiday....

31. Up ahead is a comfortable lounge chair and towel, just for you...

32. Sit or lie down in the chair, or spread the towel on the sand.... relax on the chair or towel.... enjoying the sun.... the breeze.... the waves.....

33. You feel peaceful and relaxed.... allow all your stresses to melt away....

34. When you are ready to return from your vacation, do so slowly....

35. Bring yourself back to your usual level of alertness and awareness....

36. Keep with you the feeling of calm and relaxation.... feeling ready to return to your day....

37. Open your eyes, stretch your muscles... and become fully alert... refreshed... and filled with energy.

The therapist has to remember to be considerate about the amount of time this script requires. It takes several minutes to tune out all the senses and become engulfed in the experience. It takes even more time to come back to reality from this imaginary vacation.

**Techniques for Information Gathering**

The concern at this point of therapy is to figure out, in the client’s perception, what and how his life would be different if the symptom or problem was no longer present. He is also interviewed to reveal family information, personal perspectives and important values.

Assessments have a dynamic feature, they is not static. Information gathered can change throughout therapy (Corsini & Manaster, 1982). An inexperienced helper may think he needs to be the expert and somehow force the information out of the client but there are techniques that can ease the process.

Memories are selective. One retains the memories that are useful and or beneficial to his current situation. Early recollections are mental images created by the individual that project
private ideals and misconceptions. It also extensively contributes to the process of gathering personal information in Adlerian Therapy (Strauch, 2007). The therapist should not be concerned about the accuracy of the memory. The purpose of early recollections is to reveal how the individual views himself, others and the world around him. There are general themes and convictions hidden within each early recollection. When the individual is able to identify the misconception that is leading to majority of his problems, he can readjust his thinking to solve present discrepancies in his life (Kopp & Dinkmeyer, 1975).

The early recollection process combines Adlerian theories seamlessly with Guided Imagery. Early recollection has the client using visualization to obtain personal information. The early recollection method requires the client to think back and envision a memory. The therapist has to work towards taking the client back to that place and time. The more vivid the memory, the easier it will be for the client to recall (Strauch, 2007).

During visualization, associative imagery can be identified to track positive or negative emotions. The client can figure out what images correlate to good or bad feelings. For example, a client envisions a swing outside of his childhood home and reflects on how safe and comforting it felt. But when he envisions a car he feels nervous and anxious. Early recollections can help the client find images that function as aversive imagery. When the client is engaged in a destructive behavior, he can use aversive imagery to stop the behavior. Aversive imagery is a form of covert sensitization (Thompson, 2003). A smoker, through visualization can imagine himself become nauseous every time he proceeds to light up a cigarette. After several times of correlating smoking with nausea, he will be less inclined to smoke.

The execution of collecting an early recollection takes a lot guidance and practice. It has a simple step-by-step procedure but there are several key points the therapist has to be aware of.
He should be familiar with the traditional format of recording early recollections before altering the process to better fit his needs. Dinkmeyer and Kopp (1975) created a series of steps, arranged like a script for therapists to use:

Think back as far as you can to the first thing you can remember...something that happened when you were very young (it should be before you were seven or eight years old.) It can be anything at all—good or bad, important or unimportant—but it should be something you can describe as a one-time incident (something that happened only once), and it should be something you can remember very clearly or picture in your mind, like a scene.

Now tell me about an incident or something that happened to you. Make sure it is something you can picture, something specific, and something where you can remember a single time it happened.

Phrases such as "we were always," ..."would always," ...
"used to,"... or "would happen" suggest incidents that occurred repeatedly. Ask the student to choose one specific time which stands out more clearly than the others and tell what happened that one time. If one particular incident does not stand out over others, eliminate this event and choose a different early memory which can be described as a single incident.

Before moving on to the next memory, ask the following questions and write down the student's responses:

Do you remember how you felt at the time or what reaction you had to what was going on? (If so), please describe it. Why did you feel that way (or have that reaction)?

Which part of the memory stands out most clearly from the rest--like if you had a snapshot of the memory, it would be the very instant that is most vivid and clear in your mind? How did you feel (what was your reaction) at that instant?

Our experience indicates that, although we can begin to see a student's basic beliefs and motivations in the first memory, the accuracy of these interpretations increases when they are based on additional memories. The counselor's assessment thus should be based on at least three memories. Typically, from three to six memories are collected ...

It is necessary for the memory to be spontaneous. Spontaneous memories are most revealing and significant to the individual at the present time. Interpretations of early recollections are subjective but it still provides information on the individual’s complete life
style. A set of supplementary directions by Thomas Sweeney (2009) provides professional with more guidance on assessing early recollections:

1. Is the individual active or passive?
2. Is he/she an observer or participant?
3. Is he/she giving or taking?
4. Does he/she go forth or withdraw?
5. What is his/her physical posture or position in relation to what is around him?
6. Is he/she alone or with others?
7. Is his/her concern with people, things, or ideas?
8. What relationship does he/she place him/herself into with others? Inferior? Superior?
9. What emotion does he/she use?
10. What feeling tone is attached to the event or outcome?
11. Are detail and color mentioned?
12. Do stereotypes of authorities, subordinates, men, women, old, young, etc. reveal themselves?
13. Prepare a "headline" which captures the essence of an event; for example, in relation to the women's recollection of the ice cream, Girl Gets Job Done!
14. Look for themes and overall pattern.
15. Look for corroboration in the family constellation information.

Robert Bartholow also formed a questionnaire to further aid therapists in assessing clients’ early recollections. The following inquiries can be answered in the therapist point of view or the client can become involved and the therapist can directly ask him to answer these questions (Bartholow, 2009):
1. Is it self-focused? We-focused? Could it reflect negatively or positively on level of social interest?

2. Is something happening to the subject?
   i. By a force or forces (person, persons or situation)?
   ii. Is the force male or female?
   iii. Is the event a negative or positive experience?
       If negative it suggests “victim.”

3. Is the subject under the control of an outside something or somebody?
   If so, it suggests a controller to counter control.

4. Is there a “victim,” in the early recollection?
   See items 2, 4, 6, 12 for possible “victim.”

5. Is there cooperation (negative or positive) with others?
   Positive could suggest social interest.

6. Is the early recollection one where the subject is being treated (or felt as if) unfairly or unjustly?
   Suggests a belief that life is unfair, and/or sees self as a “victim.”

7. Is the subject feeling humiliated and embarrassed by the event?
   Suggests over-concern for what people think.

8. Is the subject feeling happy, comforted, joyful, good by the event?
   It could suggest that this event and positive feelings represent to the subject the “ideal situation,” or it could mean the subject simple sees life in a positive way.

9. Is the subject able to deal with the circumstance in the early recollection?

10. Is subject being rescued by someone and by what is sex?
    Suggests dependency, and/or lack of problem solving.

11. Is the subject immobilized or overwhelmed? Or defeated?
    Suggests feelings of inadequacy.

12. Does the subject triumph in the event?

13. Do they feel good about it because he/she solved the problem or task?
    This may suggest need to succeed or it could suggest simply that subject is a problem-solver.

14. Or do you feel good because you won over another?
    This would suggest the person is competitive.
15. Is there performance or pride of accomplishment in the event?  
   Suggests success need.

16. Is there a “put down,” from someone else (parent, sibling(s))?  
   Suggests “victim,” and/or doesn’t measure up.

17. Is the early recollection an incident where the subject is alone, not  
   involved with others?  
   Suggests the subject is possibly a “loner,” and/or lacking in social  
   interest.

18. Is the early recollection about an observing experience- reporting  
   something he or she saw but not actually participating in it?  
   This suggests a person who is more of an observer in life, less of a  
   participant. The person is also a visual person.

19. Does the person treat himself or herself “special,” or by others?  
   This person may expect to be treated special, and/or be exempt  
   from rules that govern others.

20. Is the subject getting things, or are things going his or her way?  
   This suggests a “getter.”

21. Is the memory frightening (expressing fear), or is there danger in the early  
   recollection?  
22. Suggests the subject sees life as frightening or life is dangerous.  
   Fear memories often suggest the subject is controlling and overly  
   cautious.

23. Is the early recollection of the subject or others are out of control,  
   physically or emotionally?

24. Is the subject losing or has lost control?  
   This suggests the subject values control.

25. Is the person confused in the early recollection?  
   This suggests the person dislikes not knowing something, or wants  
   to know everything about a situation.  
   This also may be a hint of control tendencies.

26. Is the position of the person above or below someone else or of an object?  
   Does the person comment on his or her smallness?  
   These infer an up or down, below or above perspective.  
   Hints of inferior (below) to superior (above) movement.
27. Is the person doing the right thing, or the wrong thing? Or is someone else?
   This suggests rigidity in right and wrong, also a critical attitude.
   This person may strive to be righter, or righteous.

28. Is the person being good? Or is he or she being bad and feeling guilty?
   This suggests a need to be good (not always for the right reason, or good to be “gooder,” or avoid negative consequences).

29. Does the early recollection have lots of detail and color?
   This suggests artistic or aesthetic tendencies.
   Sometimes excess detail suggests perfectionism and/or compulsiveness.

30. Is the person led by someone else, or taken somewhere (to school)?
   This suggests being controlled, hence, may be a controller.
   It may also suggest dependency.

According to Bartholow, early recollections have various themes and typologies. His questionnaire enables the professional to recognize what themes or typologies apply to the way the individual thinks and behaves. Bartholow’s list of themes and typologies includes (2009):

- The getter
- The pleaser and one who is too concerned what people think of them
- The good one
- Needs to be/do right
- Controllers
- Competitive
- Achievement and success
- Victims and martyrs
- Rebels, center of attention
- Rule breakers
- Artistic traits
• Social interest
• Superiority and comfort seekers.

By categorizing what themes and typologies the client fits, it can drive him towards finding the appropriate solutions to his problems on his own.

**Techniques for Interpretation and Goal Setting**

In the third stage of Adlerian Therapy, coping imagery and step-up technique can encourage goal setting. Using coping imagery the client can reduce the stress associated with future situations. The client can visually rehearse how he can manage the stress. The step-up technique relies on visualizing the worst thing that possibly could happen to figure out ways to handle a future situation (Thompson, 2003). The therapist can assure his client that he is in a safe place and most of the negative consequences will not occur. The activity is simulated by the mind. The client may experience a flood of emotions but the therapist is there to supervise. At any point, the therapist can stop the directive to stabilize the client’s emotions. If the client fears meeting new people on his first day of work he can use coping imagery to go over different scenarios and practice socialization skills. The same client can use the step up technique to imagine being rejected and or humiliated by his co-workers. In such an extreme and threatening situation he has to learn how to manage.

Jacquelyn Small, Licensed Social Worker and founder of the Eupsychia Institute, created a Guided Imagery directive, “Meeting your Shadow,” that incorporated coping imagery and the set-up technique (Small, 2012).

1. Close your eyes, and begin to tune out the outside world.
2. Allow your body to settle down…and release the tensions of the day.
3. You can use your breath to gently enter into your body, letting go of any tightness, or discomfort you may be feeling…
4. Softening the body…

5. Letting go…

6. Remember, you have a body but you are not your body only.

7. Feel yourself surrendering to your inner Self and allow your consciousness to just float around through the inner experience that follows.

8. Take some time now to check out your emotions.

9. See if any are rocking around in your body anywhere.

10. If so, just breathe your breath into these emotions until they begin to quiet…

11. Becoming still like a lake with no ripples…

12. Allow your emotions to settle down…

13. A lake with no ripples can perfectly reflect the sky, just as quietened emotions can perfectly reflect your truth…

14. Take a few balanced breaths and feel your emotions beginning to release you, becoming open and receptive to whatever spirit wants to bring forth during this experience…

15. And remember, you have emotions, but you are not your emotions…your emotions come and go.

16. Now, take a little time to clear your mind…

17. See if you have any ideas or expectations floating around in your brain…If so, feel them beginning to release, leaving your mind free and clear as a beautiful blue and cloudless sky…

18. Feel yourself leaving this concrete reality for awhile, as though you are drifting into space…

19. Just relax…and feel yourself deepening…a little more…and a little more…

20. Now, from a deep place within your mind, envision yourself dressed as you are today sitting by yourself on a sofa in an empty room.
21. You are quietly reflecting back over your life…all those experiences, some of them painful, that you've been through…

22. Just allow some of these events to surface as you sit here alone on the sofa…The times you were terrified…lost…or alone…

23. Or times when you've lost someone dear through separation, or death…

24. Just let yourself be with these memories…

25. Now, reflect on that part of you who just couldn't handle some of these situations–who had to go underground and be private about how you felt…

26. Take some time to reflect on the whole quality of your childhood…

27. As you sit in deep reflection, you look across the room and notice a trapdoor in the floor that you'd not seen before.

28. It is closed.

29. Note what the door looks like…

30. As you look into it, you begin to hear something stirring underneath the door…

31. And you get up and walk toward the door…

32. Notice what you are feeling…

33. As you go forward, you decide to put on a violet cloak that is hanging on a hook, and to light a candle to take with you…

34. These are gifts from your Higher Self…

35. Take some time now to put on the cloak, and to light the candle…

36. Stay very close to your feelings as you do this …

37. Now, open the trap door and peer in …

38. Notice what happens … and allow the imagery to unfold …

39. Now, see your shadow as plainly as you can…
40. And remember, you are in charge of this experience: you can bring your shadow up into the room, or you can go down into the cellar where it lives.

41. If you are willing, encourage your shadow to reveal itself more fully …

42. See how it's shaped … or dressed … its stance … or attitude …

43. Now, call it by name!

44. Have your shadow speak to you if it will, and tell you what it needs …

45. Attend now to what it says or shows you …

46. See if a dialogue begins between you and it; just allow this to unfold spontaneously. Perhaps you need to say something to your shadow …

47. Allow the two of you to relate … and stay very close to your feelings as the images appear …

48. Gradually, now, the images begin to fade in a mellow whitish-grey light.

49. Allow the scene to fade … and as the shadow is dissipating, love it as much as you can!

50. Feel this love in your heart–as much as you can muster … and thank your shadow gratefully for whatever it did or didn't do with you just now … for just being who it is …

51. Tell your shadow goodbye …

52. Take some time now to appreciate your shadow self … as much as you possibly can … as you begin removing your violet cloak, taking some time to put the cloak away and blow out the candle, putting it back where you found it …

53. Now, you are back on the sofa in the empty room, dressed as your current self, alone once more …

54. Just remain in quiet reflection for awhile …

55. Now, slowly allow your mind to settle back into this reality, and once again become aware of your surroundings …

56. Take your time coming back here …

57. Now feel yourself fully back in your body.
58. *Feel* your body touching your seat.

59. Still retaining all that happened on the inner plane, *feel* yourself being back here fully.

60. Make this feeling real …

“Meeting your Shadow,” carries the participant through a safe passage. It enables the individual to confront his fears and chose the level of contact he has with the threatening entity. Turbulent feelings are contained and released at the client’s pace. After the directive, the therapist works with the client on what he perceives the fear to be. Further instructions can include creating an illustration or story to plan for the next time he is confronted with the same fear. The client can have a set of images or scenarios he can rely on. The client can also create another illustration or story of an exaggerated incident. He could use art or creative writing to visualize what he can do if the fear is attacking or consuming him. When the client feels he has made adequate preparation and has had some practice, he will be more confident and ready to face his fears. It lets the individual know that in any circumstances he has options and there are alternative choices. What he experienced in the past will less likely repeat itself since he has formulated a plan of action.

**Techniques for Re-orientation**

In the re-orientation stage, movement and action is encouraged. The client is motivated to create constructive goals or change basic mistaken ideas and beliefs (Dreikurs & Mosak, 1973). He has completed self-exploration and has insights on what needs to be modified but there is not a simple manual on how to achieve goals and change mistaken beliefs. One’s values and ideals are inset in his private logic and even after it has been examined and explored, the individual may revert to thinking and behavior in the same destructive manner. This is a vicious
cycle. How can one replace or change a pattern he has used since early childhood? One method is to transform a memory to learn new skills.

Richard Kopp, Ph.D., provides professionals with theories and techniques on the use of metaphors in psychological treatment. In his published book, “Metaphor Therapy: Using Client-Generated Metaphors in Psychotherapy,” he constructed a technique that explores and transforms early memory. The procedure requires the professional to ask the client these following questions (Kopp, 1995):

1. “Where in all of this are you most stuck?”
   “In what way is this a problem for you?”
   “Which part of this is the biggest problem for you?”

2. “Can you remember a recent time when you felt this way?”
   (Form an image in your mind of the situation so that you begin to get the same feelings you had then so that you actually begin to feel those feelings now in your body the same way you felt then.)
   “Are you picturing the situation in your mind?”
   “Where in your body do you feel them?”

3. “What is the first early childhood memory that comes to mind right now…the first image from childhood that pops into your mind right now?”
   (If no memory is recalled, say “Take your time. Something will come.”)

4. “What happened next?”
   “What did you (he,she) say/do then?”
   “Describe it as you were watching a play and describing what you see.”

5. “What stands out most vividly in that memory?”
   “If you had a snapshot of the memory, what instant stands out most clearly in your mind’s eye?”

6. “How did you feel at that moment?”

7. “Why did you feel that way?”
   “Why did you have that reaction?”

8. “If you could change the memory in any way so that it would be ideal- the way you would have liked it to turn out-how would you change it?”
(If the client says it wouldn’t have happened, say “If the memory started out the same way, create how you would have liked it to go.”)

   “What do you (he,she) say/do then?”

10. “What stands out most vividly in the changed memory?”
    “If you had a snapshot of the changed memory, what instant would stand out most clearly your mind’s eye?”

11. “How did you feel at that moment?”

12. “Why did you feel that way?”
    “Why did you have that reaction?”

13. “Now I’m going to read back your original memory. What parallels do you see between the memory and the current situation?”
    (Empathetically reflect the client’s ideas.)

14. “Now I’m going to read back your changed memory. What parallels do you see between the memory and the current situation?”
    “Does your changed memory suggest any helpful ideas you might use in the current situation?”

15. Optional-“May I tell you the connections that I see?”
    (If the client agrees, then say, “Let me know which ones seem to fit for you.”)

Susan Brokaw, Licensed Marriage Family Therapist and Social Worker, adapted Kopp’s metaphor technique and simplified it into a method called, “Transforming Memory to Change Belief.” Her questions are brief and direct. The procedure stayed the same as the therapist asks the client to visualize and answer the following questions (Brokaw, 2009):

1. Describe the current situation and the feelings you have about it.

2. Describe a recent time when you felt this way about the situation.

3. What were your feelings?

4. Where do you feel those feelings?

5. Place your hand on that spot to anchor those feelings and stay with them.
6. Now, put yourself back into when you were young and felt the same way or take whatever memory that comes to mind.

7. Now, put yourself back into the same situation and tell me how you feel.

8. We are going play with this memory as if it is a story. You cannot change the presenting situation, however, you can change anything you want about yourself. You can change your size, your thoughts, your feelings or your actions.

9. Make changes that will cause this memory to turn out most ideally for you.

10. How do you want to change the memory so it ends most ideally for you?

11. How do you feel as result of this change?

12. So how could you make it even better?

13. How do you feel now?

14. What have you learned from transforming this memory that would help in dealing with your current situation?

Brokaw (2009) explains,

“This process helps the client to change the mistaken core belief at the point at which it was created. Since it was the foundation for all their current actions, they will begin to react differently in all the tasks of life because the core belief has been changed by them.”

**Discussion**

Guided Imagery has been present throughout the history of psychological and medical advances. It has been utilized by various professionals to manage mental and physical ailments. Whatever the purpose may be for using Guided Imagery, the individual should take the time to understand its effects. The experience induces activities in the brain and body. The participant needs to be aware of precautions he should take before and after the process. Guided Imagery is known to be effective in many ways and is also feasible for any population. The directives can
be done alone or can be given by another. For individuals trying to perform Guide Imagery in the comfort of their own home, audios and scripts can be employed. There are numerous printed and electronic sources that provide thorough instructions.

Relaxation is a powerful state of mind. Guided Imagery can relax the participant enough to help manage extreme and intense emotions. The calming effect improves the individual’s mood so he can handle stress, anxiety or depression. The distress can also bring about physical discomfort. Although Guided Imagery is very effective in treating abnormal behavior it can further enhance daily functioning (Kaufman, 2007). People can relate to the challenges of test and performance or stranger and social anxiety. The fears of failing and critical judgment are overwhelming. They cause tension and immobilize one’s ability to perform. Guided Imagery can aid in overcoming the apprehensions of taking a test, giving a speech or meeting new people.

Individuals suffering from physical illness can take advantage of Guided Imagery’s physiological effects. Visualization has a direct influence on lowering heart rate, blood pressure, respiratory rate, and body temperature. It also reduces pain and heightens the immune system. The angst that comes with being ill is hard to avoid. Visualization can channel those feelings into a different source. The individual can imagine himself releasing the rage onto an object or thing. This transferring of emotions can eliminate negativity so he can focus his energy on recovery.

There are numerous branches of psychotherapy studies but there are even more techniques and treatments. For decades, Guided Imagery has been a leading treatment that can be combined with virtually any therapy. It works best with therapies that are solution-focused and goal-oriented like Cognitive, Behavioral, Cognitive-Behavioral and Adlerian therapy. Cognitive therapy centers on the individual’s destructive thinking and irrational responses. The
therapist sorts out the damaging beliefs to alter the client’s thinking. Behavior therapy works on increasing desirable behavior and reducing the unwanted ones. Cognitive and Behavioral therapy combines the two to promote behavioral modification. It explores the client’s course of thinking to implement changes in his conduct and reaction. Guided Imagery has also been adapted into the educational, parenting, business and sport related fields.

Adlerian therapy has certain elements of Cognitive and Behavioral therapy but is also psychoanalytical. It focuses on family dynamics, past experiences, values and beliefs along with adjusting detrimental thinking and behavior (Nystul, 1985). Adlerian therapy is intended to be a brief form of therapy. There are four phases that steer the Adlerian process. The therapist begins by building a relationship with the client. Then he has to gather information about the client’s personal history and interpret the information to create goals. His last task is known as reorientation. He puts the new goals in motion and encourages the client to make the appropriate changes.

There are a plethora of benefits to using Guided Imagery in therapy. Here is a summary of its positive effects (Miller & Utay, 2006):

- Learn to relax.
- Learn new and desirable behaviors.
- Prepare for changes to deal with in the future.
- Cope with difficult situations.
- Cope with how one behaved in a previous situation in order to feel less shame or guilt.
- Become more motivated in dealing with problems.
- Increasing effective pain management.
- Eliminating or reducing undesirable behaviors.
• Changing or controlling negative emotions in response to a particular situation, event, or belief.

• Experiment with ways to manage stressful or anxiety-producing situations by mentally rehearsing the needed behavior.

Recommendations

In order to become a professional in any profession, practice is essential. But before conducting Guided Imagery, the therapist must personally experience the process. The therapist should believe and trust in the process he is conducting. Although each person’s experience is different, the therapist will be more alert and attentive to obstacles the client may encounter.

To be guided, one is lead or directed by another through a course of action (Cassel, 1991). The facilitator has to be able to accomplish three things to get the most out of Guided Imagery. He must decrease the environment stimuli so the participant can focus. Concentration and focus is critical. The second is helping the client reach a level of relaxation. Pay special attention to the level of noise and lighting within the setting the participant will be in. Soft and soothing music can be incorporated to promote relaxation. This decreases physical distractions and emotional arousals. The third is successfully using verbal cues to implement a set of suggestion in the participant’s mind (Kaufman, 2007).

It is advised that imagery directives be executed in a subdued space. It makes it easier for the client to mentally leave reality, but more importantly it enables the therapist to induce the imaginary senses (Shames, 1996). Instead of just leading the client in seeing an image, the therapist has to wake the other senses. If the goal is to take the client back to an early memory, the therapist must ask the client to actually smell, taste, hear and touch the environment he is recalling. If the goal is to take the client into a serene space, the therapist should describe smells,
tastes, sounds and tactical feelings the client should experience. The addition of different senses manipulates the image and transforms it into a perceived event.

Every stage of therapy can benefit from Guided Imagery. The directive can gear towards the therapist’s goal or towards the client’s goal. Having the client complete a relaxation activity in the beginning of every session ensures a level of comfort. It helps the client leave some of the pressures of the outside world at the door and centers his focus on therapy. If at any point during therapy, the client becomes overtly anxious or out of control, the therapist can also use the technique to ground the client’s emotions. Psychotherapy digs deep and hard at the root of the problem. The investigating process is strenuous and taxing. It can bring out the best and worst in people. When biases and values are being evaluated, the client tends to become defensive. Guided Imagery is a device to keep both collaborators on track.

It is apparent that Guided Imagery can help many types of individuals, from those with insignificant everyday discrepancies to individuals suffering from mild to moderate difficulties, and even those with severe mental and physical illnesses. Below is a list of clinical disorders that have been proven to benefit from the technique (Davison & Neale, 2001):

- Mild to moderate depression
- Generalized anxiety disorders
- Post-traumatic stress disorder
- Obsessive-compulsive disorder
- Phobias
- Sexual difficulties
- Habit disorders
- Chronic fatigue syndrome
Children's behavioral disorders
Stuttering
Acute and chronic pain
Other physical disorders

Guided Imagery has a strong effect on the mind and body. The therapist has to take caution when using the technique with clients who exhibit these conditions (Naparstek, 1994):

- Severe psychiatric disorders
- Cardiac or related conditions
- Depression with suicidal ideation
- Asthma attacks triggered by stress or anxiety
- Seizures triggered by stress or anxiety
- Hysteria
- Pregnancy

If the therapist is not educated on how Guided Imagery will impact these clients, he must consult a medical provider. He should not move forward unless he has done adequate research and study.

There will continue to be research on Guided Imagery for years to come. The validity of its power will be strengthened with every year that passes. Its adaptability to cooperate with other studies and fields keep it in the research and development limelight. Guided Imagery’s mental and physiological impact is endless and may never be completely explained. More innovative techniques will be generated based on the process. The therapist has to make the effort to keep up with new developments along with training and practicing. He must take the time to utilize Guided Imagery in his personal life and in his professional practice. There were
several Guided Imagery techniques tailored to each of the Adlerian therapy phases written within this paper, but the techniques were merely a small sample to help professionals begin incorporating Guided Imagery into their practice. The therapist should seek out academic resources and build upon different techniques to have a variety of treatment for his clientele.
References


GUIDED IMAGERY IN ADLERIAN THERAPY


