

Guided affective imagery psychotherapy¹

Leonore Kottje-Birnbacher, Düsseldorf

1. Historical Development

Guided affective imagery psychotherapy (GAI) uses imagination processes as a medium for change and healing. It is in this way connected to probably ancient and widespread healing traditions, as the human capacity to express a situation in images and to comprehend new approaches using images and metaphors was already used in antiquity and in all known shaman rituals, in which healing images always play a central role. The meaning of dreams was already known in ancient Egypt (see the story in the Old Testament of Pharaoh's dream about the fat and skinny cattle, which was foretold by Joseph). Healing sleep and the processing of what occurs during said sleep also played a central role in the Greek *Epidaurus*. In the Middle Ages, Ignatius von Loyola developed a spiritual healing and manner of development based on imagery in his program for spiritual retreats around 1550.

During our century, psychoanalysis concerned itself early on with the interpretability and therapeutic use of dreams (Freud, interpretation of dreams) but hardly for other imagery processes. It has therefore remained at episodic discoveries. The psychoanalyst Silberer experimented around 1909 with intentionally provoked dreams on the threshold of sleeping or waking and determined that they contained applicable symbolic representations of pre-known emotional tensions and moods. C.G. Jung recommended to his patients to relate imaginatively with their subconscious at home. He called this "active imagination" (1916). I.H. Schultz (1932) discovered that spontaneous imagination of colors and images occurred during deeply relaxed states of relaxation through autogenic training. Happich described in 1932 how he set patients into a lightly relaxed state, suggested imaginary motives to them, and then accompanied them verbally during their imaginings.

H. Leuner started from these suggestions in 1948 at the age of twenty nine. The levels of the "image consciousness" seemed to have a great therapeutic power to him. He began to

¹ Reprint from: Kottje-Birnbacher L. (2000) *Guided affective imagery*. In: Reimer C und Rüger U Psychodynamic Psychotherapies. Textbook of Analytic Oriented Psychotherapies. Springer, Berlin, Heidelberg, New York, pp 151-176 - with authorization of the Springer publishing house.

systematically examine the legitimacy of these levels of consciousness by allowing healthy and neurotic patients to imagine under experimentally varied conditions. He wanted to find out whether daydreams were accurate and reproducible reflections of the state of the inner soul, and whether they could therapeutically be influenced. Leuner published the results of his examinations in 1955 in the work *"Experimental Guided Imagery as a Clinical Method of Psychotherapy"*. He described the procedure in this work in a form still used today and gave good technical suggestions as to how difficulties can be dealt with that could occur during the process of imagining. Many of the motives accepted later on in this work as "standard motives" (i.e. meadow, stream, mountain, house, first name, significant person(s), hitchhiking, mud hole, cave entrance) are described there, and important fundamentals of the therapeutic effectiveness are experimentally worked out. For example, Leuner discovered images, which always developed by repeated imagining to the same motive and seemed to be an expression of a problem from their symbolism (so-called "fixed images"). When one explained the symbolism of the images to the test subject and then put the motive in the imagination again, a new image (so-called "transformation phenomenon") resulted, though only after plausible interpretations were suggested. Purposely given false interpretations caused no changes. The images could also not be influenced through hypnotic suggestion. They seemed to be independent from the will of the test subject, as they could neither purposely be produced nor deliberately avoided. Each person could generate only his own type of image.

In 1955 Leuner also published *"Symbol Confrontation—a Non-interpretable Procedure in Psychotherapy"* and in 1957 *"Symbol Drama—an Active Non-analytical Procedure in Psychotherapy"*. In both of these essays he described the basic concepts of an effective therapeutic relation to symbolic figures: Leuner stimulated the imagination of archaic symbols through a suggestion to imagine and to observe a mud hole or a cave entrance for a while, then additionally proposed that something would come out of the mud hole or the cave entrance. These figures were often very alarming to the test subjects. Leuner spoke of "gargantuan dread" that sometimes appeared. He then demanded that his test subjects, despite their fear, observe these creatures and then describe them in vivid detail. After thirty minutes maximum, the creatures were substantially friendlier and/or weaker. He then urged the test subjects to slowly approach the creature and, if possible, to stroke it. Leuner interpreted this series of events as the tracking down of important symbols with

cathartic outflow of affective excitement and assimilation of split-off complexes, and he suspected that therapies could become shortened through these series of events.

In 1957, he further developed this confrontation technique to a "symbol drama" through the discovery of other therapeutic "direction principles". There were instructions for "destroying and reducing", "feeding and enriching" (for example, through feeding animals), "reconciling and embracing" (for example, through stroking), "conjunction and annexing" (through melting together or eating everything) plus the use of "magical effective liquids" (especially blood, sperm, wine, poison, but also water) and of "inner leaders" (familiar friendly symbolic creatures) as aids. One clearly sees here the close similarity to Jungian psychology and to the world of fairy tales and myths. Leuner took his ideas for his treatment with symbols from these sources. Amazing transformations of the symbols occurred through the stimulating activities suggested by the therapist using the direction principles. These transformations led directly to clinical recoveries, while the simple repeated remembering of difficult situations in the imagination brought no change. The images obviously reflected the psychological situation and their changes could be reached in two ways—either through the test subject making a new decision after receiving a clear interpretation, or through a different behavior of the test subject prompted by the therapist on the symbolic level.

Leuner emphasized that symbol confrontation required an experienced therapist, as surprises were to be expected. His procedure appears to be breathtakingly courageous, especially when one considers how much of the knowledge of today was unknown at that time. The successful endurance of frightening situations with close therapeutic accompaniment is common practice today, but did not exist in the middle of the 1950's, as the first works of Skinner, Wolpe and Eysenck were only published then. The usual therapeutic position of that time was free-floating attention. But after the craziness of the Nazis and the war, much had to be sifted through, the traditional was no longer unquestionably valid, one had to orientate oneself anew.

The understanding of the symbolism of the images was deepened in the work "*Landscape Imagery as a Metaphor of Dynamic Structures*" published in 1959. Leuner described diagnostically fundamental structural characteristics of the landscape panorama which differentiated between neurotic and normal people (uniformity, inhospitability and

infertility, incompatible contrasts, constriction of the field of vision). He showed therapeutic lines of development in images (extension and differentiation of healthy areas, delimitation and reduction of neurotic areas) and their possible promotion through therapists. *"The Associative Method in Symbol Drama"* came out in 1964, in which Leuner described the promotion of the associative process on the image level. He could produce emotionally dense picturesque memories, which were connected partly by age regression.

The methods of guided-affective imagery were so to say substantiated through these works. In the following years, they were more thoroughly theoretically thought through in constant exchange with the further development of analytic oriented psychotherapy. The methods were modified treatment-wise and tested on various groups of patients. Indication criterion and special features of treatment were established, new motives for special problems were developed, and the method was adapted for various setting conditions (ambulatory and stationary individual therapy, group therapy and couple therapy). In 1970 Leuner published a first systematic introduction in GAI as a book, and later in 1985 a detailed textbook. The AKGB was founded in 1974, which offered then the institutional framework for the promotion of the scientific interpretation of imagery processes and for the development of a systematic curricular education of GAI therapists. A few years later the founding of GAI-societies occurred in other European countries (especially in Switzerland, Austria Sweden and Holland). GAI conventions take place every two to three years since 1978.

2. Definition and Delimitation

Leuner called his method either "images from the inner self" (katathymes Bilderleben) or symbol drama until 1970. Afterwards the term "images from the inner self" asserted itself until 1994 when the total method was called "guided affective imagery", in order to clarify that it concerned itself with an integral therapeutic proposal. In Holland and Sweden GAI trades under the name "symbol drama" and in the Anglo-Saxon speaking countries as "guided affective imagery".

The word "katathym" comes from the Greek "kata" meaning from within and "thymos" meaning simmering, stormy, the heart, the blood, the soul, vitality, emotion; things are

called "katathymios" which one has either on the mind, in one's thoughts or in the heart. These things should be reflected through the images independent from conscious desires.

Guided affective imagery (GAI) is a psychodynamic psychotherapy, which makes unconscious motivations, conflicts and defense mechanisms visible with the aid of images from within and deals with these unconscious matters. The clarification and handling of conflicts is the first effect of GAI. At the same time, other processes are furthered which have proven themselves to be therapeutically relevant. The second effect is the filling of affective holes: Within the framework of a controlled regression in the service of the ego according to Balint (which is produced through relaxation and letting the images flow from themselves), suppressed impulses can otherwise surface from the too seldom encountered primary narcissistic, oral, anal or oedipal area and can be satisfied in imaginative performance of actions. The third effect is finally the spontaneous unfolding of creativity on the level of the imagination, through which an expansion of the ego-structure occurs. The patients discover creative, new solutions to problem situations themselves and try out new venues of experience.

The following special features of GAI are listed in order to delimit it from other methods also using imagination:

- Imaginings are not the same as visualizations. Visualizations are willfully produced and directed imaginations which play a large role in hypnotherapy (Bölcs 1997; Revenstorf 1985). Optical imaginations and verbal communication are thereby prompted. Neither the feeling in other sense modalities nor actions come about, as opposed to imagining a "katathym" in which involuntary sensory modalities are experienced.
- GAI works on a psychodynamic background of understanding by contact with the resulting symbols. The symbols are understood as the depiction of inner object relationships. Opportunities for problem solution and trial runs are used, but they should unfold individually and creatively, and are not systematically and realistically planned. This distinguishes GAI from behavioral therapy, which, for example, constructs a stimulation hierarchy through a systematic desensitization and then carries out a step-wise confrontation in relaxation. In GAI, the therapist provides an

appropriate degree of stimulation during the spontaneously developed, encoded symbolic imagination.

- The conversational principle, that the therapist is in constant contact with the patient and supports and stimulates him, differentiates GAI from the advanced level of autogenic training and active imagination according to C.G. Jung.

3. The Therapeutic Process

3.1 Basic position and Setting

The basic therapeutic position and the general therapeutic setting correspond to those of psychodynamic psychotherapy. The goal of the therapy is the working through of the actual conflict and the healthy further development of the personality of the patient in a self-reflexive process. The frequency of hours is normally one hour per week, but GAI can also be employed more or less frequently. Most treatments consist of 25-50 hours, but longer therapies of 80-100 hours can occur. The therapy takes place sitting opposite each other. Many patients lie down for the duration of the imagining phase in order to relax better, and for others lying down is not comfortable. Therefore, one should discuss the advantages and disadvantages of these possibilities in order to ensure that the respective patient feels comfortable with the GAI.

The therapy session begins with a period of discussion in order to evaluate the current state of the patient before the patient is permitted to imagine. The session also ends with a discussion before letting the patient go, asking the patient how he currently feels and what is now lingering from the images. The periods of imagining can vary (between approximately 10-40 minutes, at least 15-25 minutes) and can also be varied in frequency (approximately every second or third appointment, or only occasionally), depending upon what function they serve in the therapeutic process. This differentiation will be discussed later on in this work.

The Beginning of the GAI-Therapy

The therapist will first endeavor to get an overview of the actual life situation and the case history, then assess the structural niveau, the dominant conflict and the interrelated connections according to OPD-criteria. A careful exploration of the resources and the external and internal goals of the patient is important as well. The therapist can also check the patient's suitability for GAI within the framework of this beginning diagnostic procedure.

For this, the therapist carries out a short daydream exercise for most patients, the so-called "flower test". He asks the patient to do a short exercise, namely to relax, eventually to close his eyes and to imagine a flower which appears before his inner eyes. The patient should then describe this flower and the therapist will ask questions, through which the image will for the most part become more concrete and shaped. After such an imagining, the patients realize often quite astonished that the flower has something to do with themselves. There are large and small flowers, radiant and inconspicuous, flowers with firm or with weak stems needing support, rooted and uprooted, lush and withering, single or growing in groups. What type of flower appears from the variety of possibilities is not a coincidence. Apart from the remnants of the day, the inner affinity determines the structural characteristics of the flower. When the patient can apply the flower to himself and to his actual situation, the principle of symbolization (which GAI makes use of) becomes clear. He will therefore become motivated to work further with images. One can then schedule this work with him as part of the therapeutic setting. A daydream lasting 15-25 minutes can take place every two or three appointments in order to clarify the inner situation of the patient. The patient can lie down during the GAI or sit in a chair. It is just important that he relaxes and focuses on his inner images.

Example

A woman civil engineer about thirty years old, competent in her work and stocky in build, who avoided private and erotic contact with men up to now and who sought out a fifty-year-old male therapist, should imagine a flower during her third appointment.

A huge sunflower appears that looks like a painting. The flower has a long, thick stem and conspicuously small petals which seem to be out of proportion. It hangs somehow in the air. Then the image changes itself to a small, lovingly-cared-for garden surrounded by a jungle. A dainty plant stands in dark brown, loose earth in the cultivated square. It is also a sunflower, a bud with a thin stalk.

The patient climbs over the low fence and touches the plant. It feels tender and supple. One must be very careful not to snap it off through touching. The patient feels the soft hairs on the stem, the leaves are rough and cool. She likes this flower and would like to let it remain standing there. She is positively touched at the end of the imagining.

The image reflects quite nicely the life situation and the therapy expectations of the patient. The working persona seems to be stable, but is only an image that blows in the wind. It is not

grounded. The real, lovingly-cared-for inner flower is very tender and as a bud not yet touched or deflowered. The patient is afraid to be hurt by contact, i.e. the flower could snap and then not be able to bloom any longer. The impenetrable jungle outside the small cultivated flower bed may well be a metaphor for unfamiliar wild urges. The patient signals her fear and her hope to the therapist that the flower will be carefully nurtured in her therapy and that it can expand her life.

Further examples

A 26-year-old male student who has not yet detached himself from his parents, imagines a rose bush in the front yard of his parent's home.

A 35-year-old housewife who begins therapy because of multiple fears sees a type of cushion of small blue flowers that she cannot name. They are growing in the shade, do not smell and feel tender and vulnerable. A large gerbera-like flower with large petals and a weak stem is growing next to them. The stem is supported by a stick so that it does not bend. The woman sees herself reflected here in the nameless, modest small flower, but sees her likewise insecure husband who compensates through counter-phobias in the big, brighter flower that cannot stand alone, but requires a supporting object.

The appearance of various flowers is quite common in GAI, mostly as an expression of conflicting ego-parts, but also as a representation of important relationships (mostly symbiotic self-object relationships). Two flowers appear often especially with anorexics (Kessmann and Kessmann 1988 and 1990), for example, a bright, fascinating orchid and a meadow flower. Both can exist quite modestly, but are nothing special. The emotional assessment of these flowers can change from one moment to the other. The patients cannot decide between the flowers, but rather swing back and forth before they find the accurate standard of measurement for themselves.

Implementation of Imagination: Relaxation and Introduction

When it seems that the right moment has arrived during the appointment, i.e. after the situation has been discussed and there is room for an emotional deepening of the experience, the patient is to be asked whether he would like to try a session of GAI. He is then asked to relax. It should be asked the first time whether he would prefer to sit or to lie down, whichever way would be best for him to relax. After the session of GAI, it should be

discussed as to what was good and what he would prefer to do differently. The same position that had proven itself to be best for the patient can then always be repeated.

Patients who have difficulty trusting another person prefer mostly to sit in a chair, do not want to close their eyes but rather stare straight ahead. Other patients who enjoy being taken care of and pampered prefer to lie down. A thorough relaxation is therapeutically important for patients who are bodily very tense and for psychosomatic patients, so that enough time must be taken for it and attention should be paid to success. The relaxation can be induced with relaxation suggestions by the therapist depending on the predilection and former experience of the patient, or by the patient himself using the basic principles of autogenic training. Patients who are very tense prefer to use the Jacobson technique with its alternating sensations of tensing and relaxing. For patients whose main therapeutic goal is not relaxation, a few easy calming suggestions from the therapist such as : "Please take a seat / lie down as comfortably and relaxed as possible. Be calm. Try to focus your attention inwards,...to feel your body...and your breathing as it comes and goes...and maybe you can gradually picture images before your inner eye, something like a meadow, or whatever wants to come ...Everything is fine, ...and when an image comes, then describe it to me." The instructions speak to the initiative of the patient. The patient should turn to his inner world. The therapist supports him in this matter.

Possible Problems at the Start

If the patient does not react to the instructions within the next 10-20 seconds, the therapist will do something to maintain the contact. It is not recommended to let the patient alone too long, as one does not know how he is doing or what feelings, images or thoughts are surfacing during this time of relaxation. The therapist can make his presence known with an "hm" to show that he is there and is waiting for an answer, or he can ask questions such as "What is happening now" or more specifically "How are you doing at this exact moment?". In this way he signalizes that he wants contact, that it must not be images, just something as to the patient's state with which one can proceed further. The most patients who do not say something spontaneous immediately have not yet formed a clear image and therefore do not say anything. In this case, the first priority is to determine the current state of the patient clearly and possibly develop an image from it.

Example 1

P: Everything's dark. I can't see anything.

T: Okay. How are you doing then?

P: Oh, good. I feel free and calm.

T: Yes, good. Do you want something?

P: No, just to lie here. This feels good.

T: What are you feeling right now?

P: The couch feels warm and solid. It feels good here.

T: What else are you aware of?

P: I don't know. I'm not having any other thoughts. I just feel good and am getting reenergized.

T: Hm.. How does that darkness look exactly? Can you describe it for me more thoroughly?

P: It's simply dark around me...but it's nice...

T: Hm...Is it more of a warm or a cold darkness?...a hard or a soft kind?

P: ...more soft and cool.

The darkness does not allow itself to be clarified, although the therapist attempts this. The patient feels however well therein. She breathes regularly and her face is relaxed. Even though she does not see anything concrete, this sequence reflects her inner condition (i.e. she withdrew in a depressed state after an insult from her husband). The sequence also reflects a good feeling towards a good therapeutic relationship. She obviously has the feeling of being in good hands with the therapist.

During the discussion afterwards, it occurred to the patient that during her childhood she crawled into a small alcove under the stairwell where she could cry to herself in peace. She withdrew into this "long-standing" stress reducing condition in the conflict with her husband that seemed to be insurmountable to her. She must be therapeutically retrieved here.

Example 2

P: I see two different meadows and cannot decide. The image springs back and forth so much.

T: Could you maybe describe them both?

P: Yes. The first is a lush early summer meadow with flowers and grass about 25 cm high. The other is more barren, sort of steppe-like, a few barren bushes, otherwise nothing...

T: Hm

P: It stretches on like that endlessly...

T: Hm

P: The first meadow is bordered at the edge by a pine forest.

T: Yes, the first is very lush and with a forest on the edge and the other so very large and quite dry.

P: Yes. And I can't change anything there. They jump back and forth so much.

T: Hm. Which meadow do you prefer?

P: The lush one, naturally. The other one scares me more.

T: Would you want to go to the lush meadow and to start there...maybe to walk around it first or to look around it more closely?

P: Yes, good....

It was possible here for the patient to start without a problem and with the permission of the therapist with the pleasant meadow first and to save the other for later. It occurred to him during the discussion about the two meadows afterwards how different he felt in his private and professional lives. The 25-year-old got off to a good start professionally in his first job after the university and the work was fun for him. He had, however, few contacts privately, no friends and was lonely.

Example 3

P: Everything is dark.

T: Hm. Can you describe this darkness a bit more specifically?

P: There is a sort of color shadow, a shimmering, a pulsation in my left eye. It is uniformly dark in my right eye.

T: Hm. So, something is happening on the left side. Something is pulsating there. Wait and see how it develops itself further.

P: It seems to me right now as if there is a small stone wall there and as if I am sitting on it as a small child. There is also a path that leads home there.

The patient can develop her image further from here. The beginning was presumably therefore difficult for her because she always thinks that she does everything wrong anyway. Her mother never trusted her to do anything, did homework with her for hours at a time and doubted her slowness. The request to describe an image seemed to make her feel pressured at first. She became restless. She wanted to say something but did not trust herself to. Just the

suggestion to simply wait with the implication that it would somehow be better calmed her down so much that she could expose herself with an image.

Conclusion of the Images

The images should be withdrawn after 15-25 minutes. The patient has had time to develop his inner scene, to take a good look and to take in or to feel what is important to him at that moment and also to feel how that affects him. The therapist will then ask him whether he could gradually end the image or what he would still prefer to do. The therapist will then ask the patient to once more take everything into himself, to say goodbye to the image and to reverse the relaxation.

The patient needs a few moments or even a few minutes (depending upon the depth of his journey within) in order to be back in reality once more. The images end gradually. One can let them pass in review and ask him what was especially important or what had especially touched him. Further impressions come which he thinks about, for example images, feelings or notions not expressed during the GAI, or something he wonders about, or other assessments in retrospect. The therapist can also selectively give the patient his impressions, what had touched him in a certain way, what had surprised him, or what he had found new. Interpretations are not beneficial at this point of time, because they classify the events cognitively too quickly and this classifying could cut off the process of winning an impression through movement and enrichment. The patient should take a walk for a while after such stirred-up images and let the image subside before he sits himself in his car and drives home.

The actual discussion afterwards to work through the images is best not held until the next appointment, so that the patient has time to let the images sink in, to work his way through them, for example, by painting or journaling and to collect his impressions. It is useful at this later point in time for the therapist to accentuate the main points and to make connections.

3.2 Effect of the Setting

Establishment of the Experiencing Sphere and the Processing Sphere

Two planes of communication are established through the introduction of GAI within the framework of the psychodynamic therapy. The *imagination plane* is raised by the *plane of discussion*. The experience dominates on the imagination plane and cognitive processing is

dominant on that of discussion. This arrangement has a sequence of consequences. Firstly, the *alternating between the experiencing and the processing* is established and practiced as something that is self-evident. Each sphere receives its own area and is limited through the other. This structure is internalized through time and is then available as a fright-reducing, inner pattern for dealing with progressive and regressive tendencies.

Secondly, the two planes are accentuated in their *distinctiveness* through their explicit delimitations and through varied behavior of the therapist. The sphere of the imagination becomes *a protected experiencing and processing sphere* through relaxation and intensive emotional accompaniment. The patient should simply outline here what situations develop before his inner eye, without abstracting from the secondary process level. The relaxation promotes the sinking-into-oneself and the concentrating on oneself. The patient is then asked to describe his inner world image-wise, to project his otherwise maybe only confusedly felt bodily sensations, needs, fears, expectations and behavior patterns into the images of his own accord. The patient will then examine these images and share them with the therapist (Pahl 1980). The images string themselves together associatively. The patient can take them in, can move himself within them and work on his conflicts with the help of metaphorical execution of actions.

The sphere of the imagination can become in this way a type of *transitional sphere* according to Winnicott: The patient creates his images. He is omnipotently in charge of them, shapes them creatively and shares them with another person. A feeling of inner reality and liveliness comes into being through the contact between the internal and the external world. The setting requirements of GAI demand the formation of a protected and comforting sphere, as the patient is in a relaxed state and is never alone. He has an unobtrusive and dependable companion in the person of his therapist, who gives him ideas and stands by him. This type of accompaniment is a new experience for the patient. It serves as a tension-reducing structure, will be internalized (Ullmann 1988; Lippmann 1990) and strengthens the coherence of the ego-structure of the patient.

The plane of discussion maintains complementary accents--the *meta-communication* dominates on it. The patient and the therapist work here together maturely and cognitively-oriented in order to understand the emotions and the relationship constellations which establish themselves in the imaginings (and in real-life situations). –A feeling is naturally on

the other hand produced through the realization of a new connection. Experiencing and reflecting do not permit themselves to actually be separated from each other. The type of cooperation between the patient and the therapist is clearly quite different on both planes.

Therapeutic Relationship

While the inner conflicts of the patient show themselves in the images, the therapist functions as a companion. Leuner (1980) compares the *therapeutic relationship in GAI* with an expedition, in which the patient does his research as a diver at the bottom of the sea, while the therapist is the expedition leader in the boat above supervising the oxygen supply and giving instructions via radio. This is the basic model: The images make a re-experiencing of the original object relationships possible within the supportive framework of a protective therapeutic relationship, said relationship being relieved through the images from affective pressure (Leuner 1985 and Lang 1982). Therefore, the relationship with the therapist is not only constantly full of trust and cooperation, but is also influenced by the transference release of the therapist and the transference expectations of the patient, as is unavoidable in all relationships. "Enmeshment" (Pahl 1982) develops through the interaction with each other, that is, misunderstandings based on the development of transference and counter-transference. The therapist endeavors for this reason to identify and to comprehend quickly a veering-off in the discussion in order to maintain the positive working relationship.

While the transference onto the therapist serves as a manifestation level for the neurosis, GAI additionally uses the plane of imagination for the representation of the conflict willingness of the patient. The patient experiences his manner of feeling and of behavior reflected here in a quasi-reality. He can clearly feel them, think them through once more and evaluate them anew. He is prompted through this to shape his realistic frame of reference more appropriately. A silent, positively-tinged parent transference onto the therapist can serve here in the long run non-interpreted as the background of the development while the mutual efforts of the patient and the therapist are focused on the comprehension of the images in which the experience of the patient is especially vividly depicted. The result here is that the characteristics of the arrangement of the therapeutic relationship, the feelings of transference and counter-transference and reported interaction sequences from daily life are necessary only as a confirmation of those things already felt and seen in the images. The relationship to the therapist should always be explicitly worked on, though, when signs of specific, not-yet-analyzed transferences are perceptible. Such signs can be expressed through the symbolism

of the images (transference images onto the therapist), or through the contact during discussions with each other, or through discrepancies between the relationship in GAI and in discussion. The "reading" of the transference and the reflection of all therapeutic decisions within the complex relationship network between the therapist and the patient is of utmost importance for a successful therapy (Rosner 1998). The awareness is made easier through the emotional conciseness of the images as additional sources of information, but requires a thorough analytic oriented education for a proper interpretation and processing.

The use of imaginings as a projection plane has the advantage that the work with GAI places fewer demands on the ego-strength of the patient as long as a trusting relationship to the therapist is established. Experiencing internal conflicts in the sphere of the imagination in the company of a dependable and competent therapist is much less stressful than experiencing conflicts in the relationship with the therapist. When the relationship to the therapist becomes strained through intensive transference processes, the therapist can only be available as a helper to a certain degree. He then takes on threatening traits to another degree. This two-sided use of a relationship demands considerable readiness from both involved parties in dealing with affects and it also involves the risk of a temporary or total non-functionality.

3.3 Giving of Motives

Standard motives

Patients are presented with motives first of all at the beginning of the therapy as a starting point for the imaginings. These motives are for the most part the so-called *basic motives of GAI* developed by Leuner—meadow, stream, mountain, house and edge of a forest. The therapist gets a complex impression of the personality of the patient through the giving of these motives because of the extensiveness of themes that could develop from them. Meadows and streams usually imply especially nice, pleasant experiences in our cultural associative context, which is desirable as a beginning experience with this new medium. Conflicts can, however, also appear that are in a symbolic encoded form and are therefore for the most part well tolerated.

The symbolic reading of the images is relatively easy with these motives because every therapist has seen many different meadows, streams, mountains and houses during the course of his education and while working with patients. The therapist can then diagnostically

classify the individual design of the patient. He can thusly focus his attention during the first few GAI-sequences primarily on the dialogue produced with the patient and then find out how the patient wants to be accompanied in GAI based on the non-verbal signals and the changes in the content of the images--that is, whether questions will affect him in an encouraging or in a demanding way; whether he needs time to orient himself and prefers to be left in peace until then or would quickly feel left alone; or whether he wants to develop the scene to a large extent independently and actively tackle the world or would rather passively pause and wait. The therapist must find an appropriate, helpful type of dialogue for each new patient, like a mother must get to know the characteristics of each new baby, and how out of the mutual exchange an attunement, a synchronization of the contact with each other develops.

The standard motives will now be discussed separately in order to give a concrete impression of the extensiveness of the possible symbolism.

Meadow

The current mood can be depicted by the *meadow* in the form of its lushness or meagerness, through its being broad or narrow, in the type of weather found there and the season of the year. The patient shows his present mood and his manner of tackling the world in the course of this. Some people like to make themselves comfortable, some like to make themselves useful, some like to experience something and others don't know what they want and cannot decide. Symbolic figures, i.e. self-representations or object-representations in the form of trees, animals or people can occur in the meadow with which the patient comes in contact. Spontaneous age regressions can also occur, in which the patient feels like a child and relives vivid memories or long-forgotten feelings.

Example 1

A 40-year-old female colitis patient finds herself in a pretty summer meadow with blue and yellow flowers. She lies down and enjoys the setting, but soon becomes restless and feels that she must go home because the housework is waiting.

This patient has internalized the formula "first work and then pleasure" so much that there is never time left over for fun. She does a large part of the work which is to be done at home and at work with a mute resentment, but feels that the others could help out a bit instead of leaving everything for her to do. She never, however, puts up a fight and never asks for help. It became very clear to her through this GAI what she herself contributes to this pattern, as no

work was actually waiting for her and no one besides herself took her away from the beautiful meadow.

Example 2

A 35-year-old healthy woman who has been married for fourteen years and has two children comes into therapy because she has fallen passionately in love with another man. A beautiful summer landscape appears for the theme of meadow. She wants to take a walk. The path soon reaches a junction. She can turn off into a thin beautiful forest or stay in the summer meadow. She goes into the forest and comes to an old cottage with a bench for sitting in the sun in front of it. One can unlatch the door. Inside there is a table with two chairs. The cottage seems at first to be old and a bit gone-to-seed, but once she opens the shutters, it seemed as if the cottage had just been exited. A teapot still sits on the table. She sees a stove and a wide bed in the background. The patient leaves the cottage quickly.

During the discussion afterwards, she thinks that the cottage seems to be a secret love nest. This area had lain dormant (gone-to-seed), but she rediscovered it when she wandered from the straight, sunny somewhat monotonous path via the meadow.

Example 3

A woman with a moderate educational background imagines a meadow from her early childhood. There are nice places there to hide in the shrubbery. In a house nearby is, however, only horror. Many relatives live there after the war herded together. Poverty, nagging and squabbling over who had taken what from whom reign. There is nothing nice there. She sees the kitchen that all must share and also the room for her family with three beds—for her parents and her older brother, but she cannot find a bed for herself. She feels very young, maybe five years old. Figures appear in the kitchen. They seem to be like zombies—pale, gray and silent. The patient is paralyzed with fear and wants to get away from there. The therapist asks her to go outside to the meadow again and to look for a safe place. The patient crawls into the furthest corner in the shrubbery, covers her hiding place with twigs, rolls herself in a blanket and can stay there at first.

The patient feels relatively safe with the therapist—she manages to activate one of the few good memories she has during the motive presentation and, at the suggestion of the therapist, to look for a safe place and to go into it. The negative figures, however, exert a downright pull. The patient cannot remain in the meadow and ends up in the threatening house against

her will. She needs help in order to temporarily calm down and to refuel. The therapist takes on the roll of a caring mother, something which the patient did not have before.

It is useful to accompany the first GAIs resource- promoting, i.e. to share good moods unquestionably and to help solve complex situations. The therapeutic relationship will be strengthened through this and pleasant experiences in the imagination sphere have a calming, healing effect producing, for example, an improvement of symptoms in psychosomatic patients.

Stream

The second motive, the *stream*, is a symbol for the river of life, for the unfolding of the development of the soul. The quantity, the speed of the current and the quality of the water say something about the assessment of the inner vitality and affectivity. The direction of the stream and its surroundings are also interesting, such as varied natural banks, canalization, water falls and rapids, seeping-away or becoming marsh-like. Drinking from the spring can do one good as a motherly symbol of origin and being nourished. Refreshing oneself and washing in the water are worth mentioning. The direction towards the source of the water can be seen as the path to the past and the path towards the mouth of the water is seen as an imagination about future developments.

Example 1

A 47-year-old male patient sees himself first of all by a raging mountain stream. The roaring captivates him. The path between the slippery cliffs is dangerous. He prefers to go downstream where it is calmer. The stream widens after a while into a river. Reeds and old trees are growing on the banks. A boat with a pair of paddlers glides effortlessly here. The paddlers wave. The patient sits under a weeping willow and sees an elderly couple with a dachshund, which always runs to the cows and barks. Playing children let toy boats swim. Downstream lies a small city. A baroque bridge with bronze nymphs crosses over the stream to the market place. The market place is totally round. There is a town hall and a church there, and in the middle there is a beautiful fountain between four old trees.

The patient seems to have been totally moved by the last image, but says in the discussion afterwards that he had just put together an imaginary idyllic pathway. He came into therapy because of a difficult relationship with a woman that was important to him. This relationship seemed to him to be the first one in his life that had a good chance for the future. He grew up

in a catholic milieu and wanted to become a priest, something his mother wanted him to do. He struggled arduously with his forbidden urges (slippery path along the waterfall). He broke off his education because he fell in love with a woman twenty years older than himself. He does not want to experience these blunders and times of confusion from his youth once more in GAI, but rather wanders downstream into the future. His fascination with being a couple shows itself several times through the paddling couple and the peaceful elderly couple. His fascination with femininity is shown through the dachshund always running back to the cows, through looking at the nymphs on the bridge with enjoyment and through being deeply touched by the fountain in the market square that is like a pattern surrounded by trees and houses. He can let in such feelings in GAI, but takes them back immediately in the discussion afterwards.

Example 2

A 32-year-old depressed female patient who has not yet developed her own life concept but is instead still internally tied to her parents even though she has not lived with them for years sees herself when the theme stream came up a stream on a path that runs along a muddy field. A ditch comes from the left and crosses the path. It cannot be seen, though, from the right side but obviously flows further underground through a pipe. Old bottles and other garbage lie at the crossing of the path.

This life stream was canalized in the figurative sense early on. The patient had to help her parents since her childhood. There was no room for her own wishes. She disregards herself (garbage) and still cannot find a direction for her future life.

Mountain

The *mountain* can first of all be observed from a distance. Its height and form say something about the level of demands of the patient. Narcissistically structured people are in the habit of imagining impressive large mountain ranges which seem to not be climbable (for example, in the form of a smooth, steep sugarloaf). Depressive feelings of inferiority express themselves conversely through uninteresting, small ranges of hills. Dealing with the performance of an assignment shows itself in the ascent of the mountain. Does the patient accept the assignment or does he try to evade it by picturing himself, for example, immediately on the peak of the mountain without having dealt with the path there, or by not considering it to be worth it to climb to the top? Does he feel that he can easily deal with the path or that it will cost too much effort? Does he give up easily when obstacles arise, or can he not imagine dealing with

a difficult assignment successfully. Or is he ambitious, loving the challenge, tending also to overtax his strength, or even considers only the hardest path to be worth his while? Finally, the mountain peak is also interesting. How does the patient feel when he arrives at his goal? Is he satisfied, or does he feel lonely and far away from the others, or even totally exhausted from the exertion? What does the panorama look like? What sort of other mountains are there (i.e. rivalry theme)?

Example 1

A 36-year-old female patient, who in the meantime (after 8 therapy appointments) little by little perceives her parents to be unsure of themselves and who perceives her life to be arduous and having little success, sees an artificial-looking mountain as one sees in a large electric train set lay-out. A piece is broken out of the left side and one can see that it is hollow inside. She wants to go out of the room with this model train set. The weather is nice outdoors and she sits on the bank of a small lake.

She can no longer accept the values of her parents as natural and definitive for herself. An otherwise non-perceptible rage towards her parents shows itself indirectly through the bizarre artificiality of the situation. The dominant impulse is at the moment to go away and to refuel. She can then deal with her parents renewed.

Example 2

A 28-year-old female patient, who because of a close oedipal father relationship cannot up to now get involved in a relationship with a man of the same age, sees during her 33rd appointment (after she has worked through this relationship a bit) the former "home mountain" that she climbed on Sundays during her childhood. She climbs the mountain in GAI and does not find the real-life castle at the top with its massive tower, but rather a ruin partially grown over with ivy. She understands immediately what that means symbolically. She is affected by it and sad, but finds it also good that the massive building does not obstruct the panorama. She sits down in a sheltered corner on the sunny side of the building. She sees a hiker below who is climbing up towards her and she hopes that this is her new boyfriend.

Example 3

A 35-year-old male patient, who gives the impression of still being very timid after his mother constantly criticized him and whose father seemed to be unreachably distant, sees on the one hand a meager mountain meadow and on the other hand a snow covered mountain top above

the clouds without any contact with the ground. He goes across the meadow. The therapist asks him to look at everything calmly and to pick out a good path. After this suggestion, he finds a small hollow with a rock that is suitable shape-wise for sitting. He stops to rest there. The therapist asks him whether he has anything with him to picnic. He has an apple. The patient sees the embodiment of his parents in the meager meadow and in the far away mountain top. During the discussion afterwards, he says spontaneously that he found the calm, supportive manner of the therapist and her confidence that he would find his way very pleasant. The hollow with the sitting-rock and with the apple is therefore probably a transference image.

House

Different parts of the personality and life areas can appear in the *house*. It can be influenced both by the actual self-representation as well as by old experiences of occupancy or non-occupancy (see Klessmann and Eibach 1993). There are cozy, comfortable houses, as well as styled or dilapidated. A house can at first appear completely different from the outside as from the inside, or the frontage can be well cared for while the back side appears dirty and neglected. A house can be easily accessible or closed like a person, bright or gloomy. It can stand alone or together along with other houses on the street. Many people enter their GAI-house completely matter-of-factly while others hesitate as to whether they may enter, whether they are welcome there. The verbal area shows itself in the kitchen. How the bedroom is furnished gives information about sexual wishes and fantasies. One can find old things in the attic (furniture, clothing, toys, old letters and photo albums) which give rise to memories. Stockpiles can be stored in the cellar, but sinister vaults can open up in which half-starved, repulsive, ostracized figures live. The family house appears often with young patients, which can be a sign of not yet accomplished inner detachment from the parents. Another house from the childhood can also come about which is full of memories of security and coziness and is suitable for expressing corresponding yearnings and feelings of transference.

Example 1

A 42-year-old female patient comes into therapy after the fourth broken partner relationship and the fourth completed vocational training because she questions her constant need for motion and challenge. She questioned whether it had something to do with her childhood. Her mother was manic depressive and had numerous suicide attempts. Her father cared for the family enormously and compensated for the mother.

When the theme "house" came up, she sees an odd, inharmonic house. It appears to be cut in half. It has roof sloping only to the right instead of a gable. She goes inside hesitantly. There is a small room in the front of the porch where one can sit down. Behind it is a room that has almost no furniture. She does not like the house and wants to get away. She goes into the forest that lies to the right-hand side. She finds a small, cozy house there in which she wants to stay.

Nothing about the house occurred to her of her own accord. It was just pleasant for her. The therapist asked her, however, whether the halved-house had something to do with the mother who was absent and could not offer the children a protective roof because of her illness. The patient is flabbergasted. She cries often in the following weeks and tells how awful it always was to leave the mother behind alone in the clinic and how much gloominess was given off by the ascetic, conscientious father who had been up to then idealized.

Example 2

A woman, who emigrated to another country as an 8-year-old child with her parents, sees an abandoned house with closed shutters when the theme "house" comes up. The door is only latched and she gets inside easily. It is dusty, dark and smells musty inside, but is quite tastefully elegant. Large portraits hang on the wall in the living room. She opens all the windows and finds the house quite nice. She considers whether she could maybe rent it. In the study she sees a desk, books and an old chest. Inside the chest are old receipts and a skull just like in her grandfather's study in the old country. She goes up the stairs and her grandmother is suddenly standing there, white as a ghost but not threatening. The therapist suggests to the patient to talk with the grandmother. The patient is very sad as a result of this and asks her grandmother why all this had to happen. The patient cries a lot. Her grandmother also looks very sad. They go downstairs into the living room and talk with each other.

The patient explains during the discussion afterwards that she had a good relationship with her grandmother as a child. Contact with the grandmother was broken off through the emigration and the patient's life was radically changed. She heard only negative things about her grandmother from her parents. She could not reconcile these properly with her own memories. She did not comment on it, but pushed her feelings aside because she had no time anyway to attend to them. The old feelings resurfaced in GAI. The little girl's grief, the feeling of being lost and that of being unsure opened up again and the grown-up woman can track down the feelings and sort through them.

Example 3

A 34-year-old female patient could not find a house at all at first when this motive was given to her in her seventh appointment. There simply appeared no house, but she found herself on a path lying between fields and meadows. When she followed it, it kept going forwards and even in the distance she could not find a house.

During the tenth appointment she encountered a shut-down construction site. It was no longer being worked upon there, but there was a solid foundation with massive damage on the left-hand side. She asked herself in the discussion afterwards what could have damaged her foundation so much. She learned by talking with her older siblings about their childhood that she had been sent to relatives for half a year at the age of five because of a high-risk pregnancy of her mother and that she came back home very still and changed. Through researching these relatives, with whom very little contact had been maintained, she can reconstruct a sexual molestation not only on herself but on two other children. The former experience constellates itself repeatedly in GAI-sequences and allows itself to be worked through in small doses here.

In the 38th appointment, a house appears in GAI spontaneously for the first time, this time an inn. The therapist asks her to go inside and to look around. It has a large, somewhat unpleasant lounge with much coming and going, a few guest rooms and a very small not-very-personal-appearing private wing at the back of the house for the landlady and her husband. The patient feels that the house suits her well. She personally supports many people after all effectively and quickly and without nonsense. She also explains how she herself has very little private life.

In the 53rd appointment, the theme house is suggested to her once more. She has in the meantime fallen totally in love for the first time. She sees a thatched, small, white house that is standing in the dunes and is surrounded by a small, lovingly-cared-for garden. She finds a kitchen inside, a living room with a large, cuddly fur on the floor. Upstairs in the gable is a nice bedroom with a wide bed and a bathroom next to it. This house is still a wish house at this point in time, but it can surely firm itself up internally, something that was not possible before.

Edge of the Forest

The motive *edge of the forest* is suitable as the stage for the appearance of symbolic figures. They can come out of the darkness of the forest into the meadow already established in it as a

good place to reside, so that the dreamer can observe them there precisely and establish contact with them without having to enter their world of the forest. The therapist supports the patient in this matter through his contribution of his presence and the questions he asks the patient, and when necessary his suggestions to the patient. Various figures can come out of the forest, depending upon the personality structure and the actual situation. Timid or gentle or threateningly aggressive aspects can dominate. It will be discussed later in this work in more detail the handling of symbolic figures using the so-called direction principles.

Example 1

A schizoid young man sees at first a timid deer coming out of the forest that runs away when it sees him. Establishing contact is not possible. His girlfriend then comes out of the forest. They are both happy to see each other. They lay down next to each other in the warm meadow and enjoy the situation. He begins, however, to fear that the girlfriend will become impatient and will want to leave. The therapist encourages him to maintain the contact, for instance to hold her hand in order to feel how she is doing. It is successful. He calms himself down and a tender game of hand-holding develops.

Example 2

A female patient, who is currently working on her relationship with her mother, from whom she did not feel loved enough (the mother always favored the patient's sister considerably as the sister resembled the mother more), sees a giant wild pig come rushing out of the forest. It could trample her down. The therapist tells her to seek shelter behind a large tree without letting the animal out of her sight, and to describe it precisely. It throws a fit in the meadow, leaves deep tracks behind, looks enraged and infuriated, but then gradually calms itself down a bit. The therapist asks whether the patient could throw it something to eat. She does not want to at first, but does it. She gives it lumps of meat, especially pieces of the liver and the heart. The animal eats everything, still looks hungry and becomes more to eat. It finally trots back into the forest. The patient feels exhausted but calm after this scene. In the discussion afterwards, she says that she sometimes also feels the same as this wild pig. She also says that this is very frightening for her, and that she could stick at nothing. She therefore recognizes a self-aspect, i.e. her own blocked violent feelings of jealousy, rage and hate.

Giving of Motives

The giving of a motive makes the start of imagining easier for the patient. The motives work as crystallization centers, that is, something concrete is provided by them with which the patient can begin and which develops according to his inner dynamics. The giving of a motive means a structuring of the inner situation and because of that a release: an image is called up from the hardly overseeable wealth of possibilities. The motive as far as the symbolism goes should in the course of this bring about a depiction of the patient's situation or at least not contradict it. It would not be very fitting when one would offer a patient a marshy hole or a volcano as his first motive in a therapy. It would also not be very sensitive to offer a depressed patient the motive of a beer garden. The therapist can achieve as well a certain dosage of the level of regression and the affects through the type of motive, depending upon whether he chooses a motive that is more realistic or encoded, superficial or archaic.

The therapist therefore converts his diagnostic assessment of the situation into what he feels is a suitable motive. When the patient finds the motive appropriate, he feels rational and will begin with the formation of the image. When he, however, does not find the motive appropriate, he will have trouble with forming the image. The patient can react severely irritated depending upon his ego-strength, personality structure and the degree of inappropriateness of the motive. He can see nothing, have headaches, or feel dizzy. Anxiety and fear can develop, or in other words, signs of feeling abandoned. At the opposite end of the pole of possible reactions, the patient can develop his own image without paying any attention to the prompting of the therapist. Many possible variations of "resistance" lie in between the two poles. Confusion at the beginning occurs especially frequently, for example, seeing fog initially or initially racing images that gradually slow down until the patient can stay with one image. A disassociation from the situation can occur, in which it seems to the patient that he is sitting in a movie theater and watching a film. Images can also surface that reflect the current transference situation to the extreme case, for instance, of a bizarre, seemingly artificial iceberg. The deviation of the dialogue is the hardest to recognize when the patient produces images that are not relevant. The patient carries out his assignment virtuously without experiencing something essential. Boredom and reduced inner coherence are indicators for necessary questions during the discussion afterwards as to what was wrong here and what was being avoided.

Further Motives

Besides the basic motives discussed above, there are seven motives that belong to the canon of the so-called standard motives as *middle* and *advanced motives*, and are therefore practiced especially within the education to GAI therapist. These are designed less broad-spectrum, but are rather directed selectively to specific conflict areas.

Aggression: Lion

A *lion* is suitable as a representative of aggressive possibilities. The patient is asked to imagine a lion. This can live in free wilderness or else behind bars in the zoo or in the circus. It can lie there lazy and lethargic and sleep, or it can hungrily rip open a prey or attack a person. Sometimes it is also seen more like a big cat with beautiful soft fur. The patient wants to then maybe pet it or to ride on it.

Motives with Sexual Implications

Leuner tried to address the field of sexuality through the motives *rose bush* and *hitch-hiking*. Men should imagine a rose bush on the edge of a meadow and are then prompted to pick a rose and put it on the table at home. Difficulties can arise here that correlate to sexual difficulties. Some men have, for example, inhibitions about breaking a rose. Some see wilted blossoms as a symbol of faded opportunities. Some want to give the flower to their mother. Women, on the other hand, should imagine that they are walking along a street after going on a long hike and are tired. It is afterwards suggested to the woman that an auto immediately drives past and the driver stops and asks whether she wants a ride. It is then interesting what type of person the driver is, whether the woman gets into the car and how the scene develops further.

These motives are discussed controversially in the meantime, because very concrete ideas of the sexual experience of men and women are present in them, which were valid in the last century but are no longer valid today. These motives are for this reason in the meantime currently either replaced through others or elaborated. For example, a *rose garden* or a *fruit tree* are suitable for obtaining feminine aspects of the self-image. The imagining of a *knight* or a *motorcycle* are suitable for obtaining masculine aspects. Erotic fantasies show themselves in the gentle variations of the lion image. The willingness to devotion and the desire of conquest of both sexes can be addressed with a *sailboat*. Sociability is shown

through the motive of a *beer garden* or something similar. References to sexuality are always found in the design of the house motive (atmosphere of the bedroom).

Ego-ideal

Parts of the self, especially ego-ideal imaginations can appear concisely when the patient is asked to spontaneously name a *first name of the same sex as himself/herself* and to then imagine the person to whom the name corresponds. As a rule, a person is imagined who has characteristics that the patient would like to have himself and that are lacking in him. This process can stimulate a clarification of identity, rivalry and jealousy problems.

Encounter with Significant Persons

Object representations can be directly or indirectly adjusted. Important *significant person(s)* (father, mother, siblings, supervisor, etc.) can appear directly *as real people* and then be stimulated to an encounter or to a clash with them. They can also first appear *in disguise* such as a tree, elephant, cow, etc. when the corresponding feelings are not yet perceptible and must first show themselves before they can be processed further. The mimic and the behavior of the imagined figures sometimes correspond in the process to that of the symbolized significant person, but can also correspond to the inner views of the patient. In order to emerge from the possible breathtakingly intense and fast cycle of projection and projective identification, it is important that the patient only observes at first and does not take any action.

When the patient cannot yet be expected to handle a direct encounter with his inner objects, he can also be asked to imagine a *forest glade* from which he can calmly observe what sort of interactive scenes develop between the various animals that appear there. Even more cautious is the imagination of *three trees* in order to stimulate the representation of the emotional relationships in a family.

Cave, mud hole and *volcano* belong to the group of the so-called "advanced level motives". They all require much GAI-experience, as they can generate intense emotional reactions. Archaic figures can appear from the cave or from the mud hole. The volcano is itself a symbol for archaic simplistic eruptiveness. *Nightmares* can also be focused on in GAI in order to take a closer look under the watchful protection of the therapist and to possibly find a more satisfactory solution.

Many more motives have been added in the meantime to these basic motives in the preparation of more effective therapeutic GAI-strategies to overcome specific difficulties. Some are *resource promoting* (for example, the imagination of a protective room, or a situation in which one feels comfortable; the imagination of a helpful figure--people, animals or fairytale figures can appear here; a cloud; an island; a mud bath). Others are *clarification oriented* (for example, a corridor as a miniature of inside one's own body; or the personification of various ego-parts). These cannot be discussed further in the framework of this introductory text.

It should at any rate have been made very clear:

- that the imaginations are suitable to reflect the actual internal emotional situation with its needs, fears, conflict tension and moods.
- that diagnostic references are obtained of the patient's structural niveau, his ego-functions, his habitual attitudes, his willingness to change and his conflicts through the type of design (Klessmann 1990),
- that depictions of self-representations, object representations and the therapeutic relationship let themselves be seen in the symbols,
- that the therapist gives the patient implicit suggestions through the giving of certain motives. The suggestions should first seek to establish a good basis or to work through a specific topic more thoroughly. They should more or less be fitting and have an effect on the further development of the therapy. They should therefore be thought through thoroughly.

3.4 Therapeutic Dealing with Imaginations

How does one then deal therapeutically with the images and what can they achieve in the total concept of the therapy? I would like to discuss this more concretely. First of all, the possibilities of the accompaniment of the images will be discussed, followed by a description of the available technical methods, ensued finally by an explanation of the effect on the therapy.

The therapist endeavors during a GAI session to interpret the symbolic contents of the image, that is to understand the contents as a communication about the self-image of the patient, about his relationship to objects and about his current feelings regarding the relationship to

the therapist. In the course of this, he should be aware of the hypothetical character of this attempted interpretations and of the possible multiple determinations of the images. The fact also remains that his understanding of the situation controls his own behavior. Mistaken evaluations of the situation will have the consequence of an inadequate accompaniment. As long as the therapist remains alert and empathetic enough, he will notice signs of irritation from the patient and will attempt to correct himself.

Accompaniment of the Images

The way of accompaniment, in which the therapist can do the least wrong and which is taught in the basic courses as fundamental behavior, is the so-called "*practiced action*" (Leuner 1980). The therapist should remain in contact in the course of this with the patient, provide sufficient orientation and avoid self-damaging behavior. Regressive tendencies and affects are presented through the dialogue, which concerns itself with the here and now of the images. The patient is led to more specific awareness and feeling through the questions posed by the therapist and also to more self-independence and activity. When the therapist keeps on asking the patient to, for example, look around, to take in details, to hear, to smell, to feel or to pay attention to bodily sensations, the patient learns to combine his perceptions and feelings more distinctly. He also learns to first look at and to describe things that trigger off feelings of surprise, fear or frustration instead of avoiding them or taking flight. The therapist can prompt him to regulate the distance to them through either getting closer to them or to distancing himself from them, and to then feel the difference between the two. The patient can get to know the world of his inner images with this *cautiously-structured manner of accompaniment* and use this for a *modification of structural deficiencies*. The differentiation and training of deficient ego-functions is an essential component of therapy, especially for ego-structurally disturbed patients. This essential therapy component can be acquired not through reason but through *the execution of actions* (Fürstenau 1992). The inner world of the patient fills up with more differentiated and appropriate cognitive-affective schematics in GAI through dialogues with the therapist. These schematics are then available for coping with the outside world.

Example 1

P: I see a meadow. The sky is gray. It is windy and it's raining.

T: Hm.

P: It's raining rather hard. And it's cold outside.

- T: Uh huh. What can you see?
- P: The meadow seems to be big. There doesn't seem to be an end to it.
- T: Are there any kind of trees or bushes?
- P: Yes. There is a group of trees over to the left.
- T: Uh huh. And are there any animals to be seen?
- P: No, nothing.
- T: They most probably have gone to a secure place somewhere.
- P: Yes, most probably.
- T: What's it like for you then? How are you doing there? What are you feeling now?
- P: It's not very nice here. I'm freezing. Everything is rather hopeless. I think that I should also find a secure place for myself.
- T: That's a good idea. What would be possible? Where could you go?
- P: Well, the only thing that I see are the trees over to the left there.
- The emotional situation presents itself first as an image. It is looked at and felt very carefully and is then named emotionally.

Example 2

- P: I'm going along a path. To the right is a dried out steppe. Many boulders are laying around, some dried out undergrowth, a few cacti. I see a high wall to the left, about 5 meters high.
- T: Uh huh. Could you describe the wall a bit more exactly?
- P: It is made of bricks...that is actually unusual for this region. It's really solid--with mortar.
- T: What could there maybe be behind it?
- P: I don't know...but I suspect that maybe a blooming garden is behind it.
- T: Uh huh.—And how far does the wall extend? Does it make a bend somewhere?
- P: That I can't see. It seems to go on a long way straight ahead.
- T: Hm...And is there a gate or such somewhere?
- P: No.
- T: Hm. – And how are you feeling then on this path with the dry, open steppe on the right and the wall on the left?
- Once again, the emotional situation presents itself first as an image. Emotional blockages or gaps in events also show themselves imaginatively, so that a more exact examination of and confrontation with the gaps are possible.

As soon as the therapist and the patient feel more comfortable with each other and have learned to understand each other, the accompaniment can be adjusted more elastically to the requirements of the current situation. In fear-producing situations, the therapist should stay close to the patient and support him. In relaxed situations, he can step back and permit higher levels of associations. During touching moments, he will feel along with the patient, but not intrude. He will observe during active exploration and occasionally give signals of his presence and of his participation.

Associative and creative processes can on the one hand be stimulated through a very *open, supportive manner* of accompaniment. The GAI proceeds then as a pictorial associative process, in which bodily sensations, memories and ideas may also spread out and the attention is not so quickly led back to the image level again. In the course of this, so-called *age regression* occurs easily, in which the patient feels younger and smaller. Frightening scenes from childhood filled with conflict can, on the one hand, surface whose affects should then be experienced anew, withstood, and then processed further in the accompaniment of the therapist. However, pleasant areas free of conflict can surface just as well, in which pleasant memories buried for a long time are present again. These "regressions from the conflict" (Balint) are especially important for ego-structurally and psychosomatically disturbed patients, in order to be able to start anew from existing resources. These situations can expand into deep states of inner contemplation, in which the so-called "*satisfaction of archaic needs*" is possible, that is, where an inner refueling takes place in feelings of intensive well-being, of being one with the surroundings, of relaxation, of repletion, of safety and of oblivion to time. This inner refueling brings on an ego strengthening and an astonishing recovery of the bodily symptoms for psychosomatic patients.

Example (House-GAI)

P: I'm climbing the stairs to the attic. They're steep and rather dirty. No one has obviously been here for awhile. ... There is a real attic up here, a pointed gable, a small window for the chimney sweeps, a lot of junk laying around.

T: Uh huh. What sort of junk is there?

P: A large cupboard, a chest, a few old carved chairs...

T: Uh huh. Do you want to take a closer look at something?

P: I open the chest in the corner...

T: Hm

P: There are some glove puppets... I think that I used to play with them ... the king, the princess, the devil...

T: Hm

P: ...at the bottom are some fairy tale books. I knew them from before—Grimm's fairy tales, Hauf and Anderson, ...

T: Hm

P: And here are my grandmother's glasses in the metal case. And the small pillow that she always laid behind her head in her easy chair.

T: Yes...What now?

P: Oh my, I see myself again—how I played as a small girl on the floor while she sat in her easy chair...Oh, that is a long time ago...Those were the best hours of my childhood (cries to herself softly)...One could forget my mother...but Grandmother was nice.

T: Hm

P: ...and there was always something good to eat at her place—vanilla pudding with raspberry sauce or soured milk with sugar and cinnamon.

T: Yes, maybe you could go back into this situation from then once more?

P: Yes, that's good...I'm sitting there on the floor next to the easy chair and my grandmother is reading aloud to me...

T: Hm

P: That's good the way it is (about five minutes of silence, the patient has a happy facial expression)

T: Do you want to do something else?

P: I want to stay there just a while longer.

The opposite of the open accompaniment is called the selective *focusing and confronting*, which is useful when symbols pregnant with conflict surface and a working through on the symbolic level is to take place. The patient needs support and the removal of anxiety. The therapist will therefore remain in close contact with him and will ask him to describe exactly what he sees, how it affects him and what changes. The therapist will ask the patient to remain calm, to withstand the fear and to only observe and stand his ground. The patient thereby has the experience of being able to stand firm, and the figure gradually loses its menace. It becomes smaller or collapses into itself and moves back into the forest or into its cave. In the following appointments, it is often possible to have a friendly contact with the

symbolic figures who were at first cold or hostile. The therapist can in the course of this stimulate the patient to offer them plenty of food and to stroke them. This "feeding and reconciling" facilitates a loosening up of the stiff disassociation towards the symbolized split-off parts of self or object representations full of ambivalence in the figures.

Example

A female patient has just explained how difficult it is for her to tell her sister that she constantly does not want to play babysitter. She feels angry and helpless.

T: Are you aware of this feeling in other situations, too?

P: Yes, I have this feeling often.

T: Would you like to think about various memories that come to you, let them pass in review and slowly go back in time until you come to a situation that you would like to stay with?

P: ...Various memories are coming...especially from the time when my mother went away and we weren't allowed to be sad...Now I see my grandmother opening the door. The mailman is standing there with a package—a Christmas package from my mother—and grandmother does not accept it. She lets it be returned...(The patient cries intensely).

T: Could you do something?

P: No, I am too young. (She was 8 years old at that time when the mother left the family).

T: Do you think so?

P: ...(cries)...No....I think it's bad, what she's doing there...I fly at her and push her out to the door...but then my father appears gigantic-sized behind grandmother.

T: What does he look like?

P: His face is distorted with rage and he is gigantic.

T: Look at him very closely and describe him further!

P: He shouts at me and shakes his fist threateningly.

T: What are his eyes like?

P: They're blue, sparkingly furious...enraged...hurt.

T: Look at him closely and stand your ground! What do you think about what he is doing to you, that the mail from your mother may not be accepted?

P: (cries out) I think that is really bad...really brutal...

T: Could you tell him that?

P: Yes. I shout at him that I think it is really impossible how he treats us, that he takes out his hurt on us.

T: Look at him closely again. How does his face look now?

P: Flushed, enraged...also irritated.

T: Is he saying anything?

P: No.

T: How does he look?

P: Still enraged.

T: Look at him more closely again!

P: That's hard...He is somehow smaller now.

T: Yes. And now?

P: He somehow collapses into himself and disappears into the living room.

This scene with the father lasts about 5 minutes. The patient feels afterwards very exhausted and relieved. She later asserted that the situation, that intensively constellated itself so often, affected her. During the discussion afterwards a week later, she can see that her current fear of clashing with others has its roots in her childhood helplessness of that time. She was truly in the hands of her father and grandmother as an eight-year-old child. She is, however, in the meantime an adult woman and can assert herself when she ventures to do so. – She re-experienced, on the one hand, her childhood feelings in the symbolic confrontation, but her adult ego is simultaneously present as a resource at her disposal in the meantime (strengthened through the helping-ego of the therapist). This adult ego can look the situation over and assess it anew.

Direction Principles

The so-called "direction principles" are important aids in the handling of the symbolic world in GAI. The development potential, which is present in frequently-occurring emotional constellations full of conflict, can be activated with these empirically proven instructions of conduct. The most important direction principles are: feeding and reconciling, the confrontation, the satisfaction of archaic needs, the winning of helpers, pursuing and reducing (Leuner 1985).

Feeding and Reconciling

Aloof symbolic figures symbolize in general split-off personality parts and object representations full of ambivalence. It has been proven therapeutically to approach these figures in a deliberately friendly manner in order to promote integration. That is why the therapist stimulates the patient with the *principle of feeding and reconciling* to offer the

figures enough food and to stroke them. The immediate consequence of this action is often a considerable affective release and an improvement of the relationship to the primary significant person/people.

Confrontation

The principle of feeding and reconciling does not work with regard to extremely threatening symbolic figures. Rather, a *confrontation* is at first necessary here. Such a confrontation is described above, that is the patient is asked to stare at the figure, to not let it out of sight, but to try to entrance it with a glance and to then report constantly to the therapist what it is doing, what it looks like and what changes in its behavior and mimicry. The patient is brought in this manner to withstand the upcoming fear instead of running away from it and has the experience of being able to stand firm. The paralyzed inner world of the patient gets moving. He feels that he is not so small or at the mercy of others, and that the opponent is not so powerful or threatening as he assumed. Illusionary fantasies of omnipotence and of helplessness qualify themselves, and paranoid-schizophrenic mechanisms as described by M. Klein are weakened through their self-reinforcing interplay of fear and aggression.

Satisfaction of Archaic Needs

The *satisfaction of archaic needs* also described above concerns itself with good experiences finding themselves again with a primary object or a partial object through regression in a positively experienced state of the self-object unit, so that a narcissistic personality strengthening as described by Balint can be achieved (Wächter 1982). Characteristic of this state is an "oceanic" sense of well-being. It develops above all in contact with archaic-positive substances, for example, by bathing in a lake or by drinking from a spring or by lying in the warm sand or in a summer meadow. The therapist stimulates this state through a supportive, sympathetic manner.

Acquirement of Helpers

The *recruitment of inner helpers* in GAI as a possibility of a selective development of resources is indicated especially during the beginning phase of therapy for ego-structurally disturbed patients. Sometimes figures appear spontaneously, which could be considered as helpers or leaders (people, animals, giants, dwarves, etc. – see Lang 1982). Such possible helpers can be found through motives such as "Encounter with a pleasant figure", or the imagining of an "Animal that fascinates me", or the imagination of ego-parts. The imagined

individual figures as aspects of the separate ego may be partly alarmingly helpless or threatening (for example, a baby that is tightly dressed and hungry, an enraged witch dancing around, or an ice-cold, strict-looking God figure). The figures possess at any rate very different abilities, and the patient can enter into a relationship with them in a new way. There are frequently also possible interests directly as helpers in the course of this, such as more or less lively children, rebellious teenagers and diverse animal figures (for example, energetic frogs, cuddly cats, loyal German Shepherds, thieving magpies, etc.). An especially important variant of the use of helping figures is, in my opinion, the opportunity to fall back on the competent adult-ego of the patient in situations in which the patient identifies with his child-ego during an age regression and needs help.

Example

During an imagination, a female patient sees herself as a small girl standing before a run-down house that belongs to her father. It is dark and it's thundering. She does not want to go into the house, but also does not know where she could go to otherwise. The female therapist asks her whether she could go to the small girl as an adult like she is now. She is able to do that well. She takes the child into her apartment, puts her in the bed, sits down next to her and gives her a cup of warm cacao.

By the therapist asking the patient to care as an adult for the fearful child left all alone, she signaled understanding for the neediness of the child, but also asked for the assumption of responsibility and self-care. The patient should activate her own strengths in order to give herself support and protection. This is an important intermediary step before the end of the therapy.

The direction principles all aim at the strengthening of positive self-object aspects and the delimitation of negative aspects. Positive resources should be activated through metaphorical execution of actions and destructivity be controlled or melted down. Because of this, GAI puts on a pictorial-analogous level of information processing during the redevelopment of basal inner structures. The original development of the former self-images and object-images supposedly takes place on this level of information processing (Rohde-Dachser 1989). It is because of this that the opportunity presents itself for ego-structurally disturbed patients, who first of all have little access to their conflicts, to find individual metaphors for their condition and to enter because of that the progressive processes of symbolization and of transformation.

Pursuing and Reducing

The *principle of pursuing and reducing* is the only one that stimulates the direct realization of feelings of hate, rage and vengeance. Strongly aggressive and invalid encountered symbolic figures are pursued and weakened, eventually also killed (Leuner 1985; Lang 1982). This principle can bring about a leap in progress in the treatment of narcissistic personalities with hard-to-control aggressive impulses, but must be used very carefully because of the danger of hidden auto-aggressions and the possible development of massive feelings of guilt. Less experienced therapists are advised to restrict themselves, to delimit aggressions through confrontations and to use representatives instead of the fantasy-ego of the patient.

Example

A female patient has dreamed repeatedly about elephants and would now like to work in GAI with elephants.

An elephant comes out of a palm forest onto a beach. It is very old, has a black hide and is led by a strange man dressed as if in a circus. He tugs it roughly on its trunk. The patient should look more closely at the man. He has a penis or a pistol instead of a head and threatens to shoot the patient. She throws herself frightened to the ground and calls out to the elephant herd for help. The man curses at women and wants to leave. The therapist asks whether she will let him leave, as he seems to be rather dangerous. She answers that: Yes, he is very dangerous and he mutters to himself: "I'm going to get you yet." The old elephant suggests to twist the man's head. The patient twists and twists and in the course of this gets agitated (distorted face, twisting motion of the hands). Suddenly, she has twisted off the penis head.

The patient gives a deep sob and says that one just cannot do that. The therapist replies that before one permits oneself to be shot, one can certainly do it. Now the only question that remains is what is to be done with the parts of the man. The patient wants to throw them into the sea. She gets into a boat with her sister (who became psychotic at 15 and took her life at 18). The sister sings softly to herself, and she knows exactly where they must go. The patient thinks that she must still forgive the man. Then they journey back and the elephant carries them home.

At the end of this appointment, the patient takes a walk for a while. She throws up during this time and becomes sick immediately afterwards with a bad infection that puts her in the hospital for intravenous treatments with antibiotics. Afterwards, she gets better, but she

wonders about her intensive bodily reaction. She asks herself whether her father had molested her sister. She describes details which make it probable that such a thing occurred. Her sister's room was right next to the parents' bedroom. The father went to the sister often and also beat her frequently. The sister withdrew more and more into herself from the age of 12. She then became psychotic. The father kept on bringing her home from the clinic quickly. He could not seem to withstand her absence. The father became ill after his daughter's suicide and died a year after she did. The relationship between the father and the sister was an absolute taboo subject in the family, so much so that the patient had never thought about it until now.

In the GAI, a splitting of the father image is seen in the good old elephant and in the bad pursuing penis-pistol-man. The patient can use the elephant as a helper. The intensity of the bodily reaction proves what kind of emotional chasms can open up with images. Caution is absolutely called for here.

3.5 General Therapeutic Strategies

The therapist exerts an influence on the development of the images and on the existing process of processing conflicts on the symbolic level through the structuring of the setting, the given motives, the type of accompaniment and the specific suggestions for actions. He should in the course of this maintain a balance between calming and structure-building moments. His constant devoted presence is calming. Suggestions that are structure-building include, for example, letting oneself in for specific experiences or interacting with symbolic figures in a certain way. These suggestions show implicit development impulses that should stimulate the formation of more mature, more integrated behavior. They result from the clinical assessment of the situation. Instead of expressing his perception of the situation in a form of an interpretation of the actual condition (how the patient is acting, what he is avoiding, which former experiences are currently lingering), the therapist converts this perception into a formulation of a development assignment. The patient's coping with said assignment leads to the growth of new experiences and inner functional schematics.

In the course of this, it is important to facilitate the patient's continual productive processing of his conflicts through a careful *dosage of affects*, while inadequate ego-functions redevelop through gradual practicing and rigid defense mechanisms can be loosened up on the playful-creative level of the images. It is also important to keep on strengthening the *resources* of the

patient, that is, through the giving of appropriate motives on the symbolic level in order to provide for sufficient "refueling", so that the patient is strengthened for conflict work that arises. Some supportive advance work is necessary especially at the beginning of the therapy before a processing of conflicts can be usefully tackled, especially with ego-structurally disturbed patient. These patients have difficulties with maintaining their boundaries, perceiving their state of health/condition, controlling their emotions, holding their feelings of self-worth reasonably stable, and coming in relatively conformed-to-reality contact with others.

The *techniques* used in GAI are implicit suggestions, which are not directed towards the change in the contents of the imaginings, but instead focus on an expansion of the scope of handling the contents. The techniques extend from the focusing of the attention, to stimulation towards more exact perceiving of and changing of the deepness of the trance (through structured inquiry or empathic co-feeling), to changing of the perspective within time and place (focusing on the present, the past or the future; of leaving oneself, or of coming closer to oneself), to the encouragement of calmly doing something not yet ventured, and to the stimulation of trying out something new, for example, to go around with symbolic creatures in a specific meadow (Ladebauer).

The activities of the therapist during the imaginings have altogether a primary psychosynthetic function. They help to build new healthy structures that cover over or expand the inner structures built-up in dysfunctional difficult relationship scenarios. This psychosynthetic activity is supplemented by the more analyzing, wanting-to-understand the position of the dialogue phases in retrospect. Structural construction and structural analysis therefore fold together with each other, but remain separated from each other through the two working levels, and can be differentially perceived by the patient.

A gradual prolongation of the main focus of the work can for the most part be observed during the *course of GAI-therapies* (Sachsse and Wilke 1987). The imaginings at the beginning of the therapy serve primarily to manufacture a recovery sphere, in which the therapist performs a motherly, reflective and integrating function. This sphere later becomes increasingly utilized for the depiction of inner conflicts and for creative trial actions, whereby the therapist assumes the function of a companion, who gives advice and ideas, and who also pays attention to the appropriateness of the affects and of the behavior.

Imaginations seem to be an especially suitable medium for a redeveloped therapeutic work, as subconscious experience structures, perception components, feeling components and mechanical components are contained therein. These structures and components are not conceptually or verbally stored, but can be expressed in the form of scenes and images. A bridge between the verbal and non-verbal area can be forged through the understanding of the images, and a symbolization process can get going. The experience structures change synchronously through the changes in the images. Various therapeutic methods detected this phenomenon independent from each other (for example, hypnosis therapy, Gestalt-therapy and psycho-drama). Leuner (1955, 1959, 1970) had furnished experimental pieces of evidence for the *functional equivalence between the actual state of the inner soul and the produced images* already during the 1950s. It can also be seen again and again in the clinical field that changes of the inner soul's situation create co-variedly corresponding changes on the level of the images. Conversely, changes in the imagined picture constellation make changes in the experiencing of feelings and of behavior possible. Following this rule, imagined houses, for example, change when the patients fall in love. The houses become more cozy and more romantic. Also, achievements, which could not be managed before, are suddenly possible after successful symbolic confrontations and reconciliations. The assessment of reality obviously also changes with the changing of the images of the inner world.

3.6 Variations in Setting

Treatment with GAI can not only take place on the individual therapeutic level, but can also be used in *group therapy* (Kottje-Birnbacher and Sachsse 1986; Gerber 1990) and in *couple and family therapy* (Klessmann 1980, 1982; Kottje-Birnbacher 1980, 1981, 1982, 1990, 1993; Voss-Coxhead 1989). GAI is used here exactly the same as in individual therapy as a projection area for needs, fears and conflicts, but the difference here being that the main focus lies on the dimension of interaction.

Group Therapy

Group therapy with GAI is based on analytic oriented psychotherapy. Phases of imaginations are integrated here in this framework, whereby many various possibilities exist. Quiet individual imaginations of the participants are an example, which are accompanied by

suggested motives and numerous questions from the therapist. Another example is group imaginations, in which the participants imagine together. The group agrees first of all on a topic, for example, "Exploration of an Island" or "Each Person Changes Himself into an Animal and We Meet as Animals". After this, the participants lay down on the floor in a star-shaped figure, and the therapist gives instructions for relaxation as a prelude to the imagining. Each person then describes the images that develop in his mind (and those he wants to share), A joint group action therefore develops in a quasi-reality that is worked through in the discussion afterwards. The group norms, the basic group fantasies, the formation of compromises, and the individual role assumption with the corresponding biographical background should be made clear there. – A very close emotional interaction between the group participants develops in the group imagination. This interaction vividly depicts the latent desires, fears and defense mechanisms of the participants, in so far as making very valuable working material available and additionally strengthening the cohesion of the group. This procedure requires, though, a certain ego-strength of the participants. The therapist can not only simply observe the group imagination in the clinical setting, but must also occasionally intervene supportively (Rust 1986). One can work well here also with individual imaginations that also produce important material individually, but more likely contribute to a therapy of the individuals in the group and make less use of the advantages of the group.

Couple Therapy

In the couple therapy, the therapist suggests what he feels to be an appropriate topic for a common imagination, such as a house (Each can, so to say, show the other his inner house); trees (Each imagines a tree, then they should look together for a place for the trees and arrange the surroundings jointly); or animals (Both animals should meet, and it is looked at what the animals do with each other); a boat ride together (Closeness is pretended with this. The question is how the couple reacts to this.); a dressing room, in which various costumes are found, which can be tried on (The embodied inner tendencies in there can be indicated in this manner to the other, and one notices the reaction of the partners, which has possibly changed with regards to each other previously); an encounter as children (In the course of this, the emotional depth of the relationship often becomes very vivid.); or a hike in the mountains together (The dealing with performance requirements is shown in the course of this, as are differences in the ability to take stress by alternating straining and resting, and how the partners cope with their differences).

There are many possibilities to bring self-symbols in contact with each other, or to suggest scenarios that suggest the development of variable joint actions. It can then be observed in these scenarios who has which needs, how those needs are expressed, how the partner reacts to this, how/where misunderstandings develop, how each handles disappointments, etc. The therapist functions as a companion during these joint imaginings. He sees to it that each partner expresses himself/herself and gets enough space for free expression. He asks questions when statements made are unclear or incomplete. He challenges the other party to take a position when the partner expresses a wish or an ascription. He takes care that the tolerance levels of both partners are not exceeded. He should carefully observe the emotional enmeshment of the partners in order to work through this during the discussion afterwards. At the same time, he should also provide for a certain normalization of the communication on the GAI-level, promote creative new trial behavior and let good solutions be searched for.

4. Indications and Contra-indications

Indications

The application field of GAI corresponds roughly to that of the psycho-dynamic psychotherapies. For this reason, only the extensions and the limitations specific to the method will be discussed here:

- In GAI, the ability of the patients to verbalize and reflect upon their experiences does not need to be very pronounced, because the image levels are available as additional dimensions of processing. For this reason, simply-structured patients possessing little ability of introspection, but who make an effort to express their experience verbally, are often reached favorably with GAI.
- GAI is especially indicated for patients with deeply rooted defense mechanisms, for extremely rationalizing patients, and for patients who are emotionally blocked or undeveloped. GAI is directed at these patients through its creative element. The patients can differentiate their inner world in the images, as GAI uses basic levels of feeling and perception. These advantages can also be used during treatment in group, couple or family therapies.
- GAI has proven itself to a large extent in the treatment of psychosomatic patients. The pictorial symbolization represents an important intermediary step between bodily sensations and emotions (Wilke and Leuner 1990).

- An important indication for GAI are short-term therapies of 15-30 appointments and crisis intervention, because the focus of the conflict depicts itself quickly and precisely in the images. Moreover, effective processing strategies become available on the image levels that release emotions that develop later and that also clear up the conflict (Leuner 1985).
- GAI can just as well also be integrated as a diagnostic and therapeutic agent into long-term treatments that change the structure of the character.
- A further indicative main focus is the treatment of children and youth, especially the age groups in which a therapy based on playing is no longer possible (Leuner, Horn and Klessmann 1990).

Many case studies about various problems and types of patients can be found in several anthologies, in which information is available about appropriate treatment methods in example form (Leuner 1980; Leuner and Lang 1982; Roth 1984; Bartl and Pesendorfer 1989; Leuner, Horn and Klessmann 1990; Wilke and Leuner 1990; Leuner, Hennig and Fikentscher 1993; Kottje-Birnbacher, Sachsse and Wilke 1997).

Contra-indications

Necessary treatments pre-requisites for all psychotherapies include sufficient intelligence and adequate motivation to change. It must also be considered whether the patient would possibly profit more from a different method of therapy. Accordingly, there are some situations in which GAI should not be used or only used after weighing the advantages and risks with a method modified and well-suited to the individual problems:

- A psychotherapy with GAI is not indicated when the patient does not like images, involve themselves therein only reluctantly and could receive successful treatment without GAI. However, provided that one of the above-mentioned special indications for GAI is opposite of this emotional defense mechanism, the patient could be motivated to GAI.
- An indication of GAI is not given for pronounced histrionically-structured patients when the constant playacting is supported by the images.
- Caution is advised with patients having a lower integration of the ego-structure. The integration of the ego can, on the one hand, be stimulated by a careful utilization of GAI, but, on the other hand, the danger of becoming overwhelmed must be steered in the opposite direction through modifications of the technique.

In addition, working with GAI can cause damage in several situations, so that real contraindications are present in these cases:

- GAI is counter-indicated during an acute psychosis, as the patients could not deal with their images but would rather become overwhelmed by them.
- GAI is also counter-indicated during acute depressive states, as the depression could become strengthened through the reflection in depressed images.

5. Evaluation

It has primarily been worked on the further development as regards contents and the differentiation of the method for a long time, while its analysis on larger groups of patients has gotten little attention. A large study of the effectiveness on 100 patients is being analyzed at the moment, from which first results are expected shortly.

In a controlled study by Wilke (1980), 58 colitis ulcer patients were treated, 23 with psychotherapy with GAI and the rest with analytic oriented psychotherapy with relaxation techniques. Using identical clinical initial medical conditions, the GAI patients were hospitalized less time (39 days in comparison to 50) and the clinical results with psychotherapy with GAI were somewhat superior in the case histories after two years in the control group with regards to relapses in freedom and in the severity of symptoms.

Roth (1990) and coworkers treated 65 women with psychosomatic-gynecological symptoms and sexual dysfunctions and 26 men with sexual dysfunctions using GAI. The symptoms disappeared or were considerably improved in 72% of the men and 84% of the women at the end of the treatment. Case histories of longer than 2 years were known for 60 patients.

Klessmann and Klessmann (1990) treated 50 anorexic female patients on an out-patient basis and followed them for 6 years with case histories. The average weight at the start of therapy was 42,1 kg and at the end of therapy it was 47,1. When the case histories were surveyed, the average weight was 53,8.

6. Perspectives of the Method with regards to Theory, Processing Technique, Higher-Education Possibilities and Questions of Invoicing

Theory and Processing Technique

The available repertoire of motives and intervention techniques in GAI have been sifted through in the last few years regarding their specific effectiveness. They have been differentially and diagnostically organized and developed further. Important new resource-promoting treatment concepts (for example, from Sachsse and Reddemann 1997; Jollet, Krägeloh and Krippner 1989 and 1997) have been developed in the framework of the development of a treatment concept for borderline-patients, especially for the therapeutic stimulation of patients with medium and low structural niveaus. There are also specific treatment concepts in the meantime for several other medical ailments: For example, from Wilke 1990; Klessmann 1988 and 1990; Lippmann 1990; Eibach 1990; Sachsse 1990; and Sachsse and Wilke 1987 for the treatment of psychosomatic illnesses such as colitis, Morbus Crohn, asthma, anorexia, bulimia and heart neuroses; from Krippner and Dieter, in their unpublished lectures from 1995, for the treatment of anxiety patients with regard to the respective structural niveaus; from Dieter 1993, for the treatment of various types of depression; from Salvisberg 1982 and Friedrich, in an unpublished lecture from 1997, for the treatment of obsessive-compulsive disorders; and from Erlanger 1997 for the handling of elderly patients. This differentiation of techniques will certainly continue.

Interest has been shown theoretically in GAI in the last few years on the effect of various psychoanalytical theories (Leuner 1980, 1982, 1994; König 1980; Pahl 1980, 1982 1984; Klessmann 1982) and the effect of other psychotherapeutic theories, especially the systemic and solution-oriented therapies (Fürstenau 1992; Kottje-Birnbacher 1990, 1992, 1997). These considerations will continue to endeavor to find a more consistent theoretical basis.

The future development of the education to GAI therapist is at the moment not foreseeable due to the political situation. In addition to the regional seminars with group events, increasingly constant educational courses are being created within institutes of higher education, such as in Bad Segeber, in Sinzig and in Düsseldorf, which are acknowledged by the health insurance companies.

GAI is billable within the framework of analytic oriented psychotherapy to the health insurance companies.

7. Possibilities for Higher Education

The office of the Arbeitsgemeinschaft für katathymes Bilderleben und imaginative Verfahren (AGKB) e.V. for psychotherapy, Bunsenstr. 17, D 37073 Göttingen, Telephone 0551 – 46754 gives information. The addresses of other GAI-societies can be found here that organize the education to GAI-therapist in central Germany, Holland, Austria, Switzerland, Sweden, Slovenia and the Czech Republic. Introductory courses in GAI take place in the framework of large psychotherapy conferences in Lindau, Lübeck, Bad Wildungen, Langeoog, Aachen, etc. A series of regional seminars is additionally offered by the AGKB, in which GAI therapeutic procedures can be learned in courses constructed to follow each other successively. The method, looked at from a didactic viewpoint, is divided into lower, middle and advanced levels, and is easily taught and learned thanks to its clear structure. In addition to the practice courses, in which the therapeutic handling of imaginations is practiced, theory seminars are offered. The studying of literature, a continuous looking after in regional supervision groups and self-experience with GAI in individual therapy settings and in group therapy settings are required as well. The training lasts approximately 3 to 4 years accompanied by working, and is concluded with the therapist colloquium. A course of treatment is to be thoroughly prepared for this, the procedure substantiated and everything should be documented with tape recordings.

Access to the training for GAI therapist is granted to doctors with a psychotherapeutic educational background, academically qualified psychologists active in clinics, psychoanalysts and children/youth therapists with a psychoanalytical educational background. The basic courses can also be attended by students of medicine and psychology who are in the advanced levels of their studies.