

10-1-2011

Healing Images: A Historical Outline of their Use in Western Medical and Psychotherapeutic Traditions

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The soul never thinks without a picture. (Aristotle)

THE ANCIENT LITERATURE of numerous cultures abounds with accounts of spectacular cures resulting from the imaging process. These accounts are now being corroborated by a growing body of clinical and experimental evidence. The effectiveness of mental imagery in the treatment of a wide variety of problems has been convincingly documented (Sheikh, 1983). This paper outlines the use of imagery in Western medical as well as psychotherapeutic traditions. It concludes with a discussion of the reasons that make imagery an excellent healing agent.

Use of Imagery in Western Medical Tradition

To Westerners of this century, it might appear that the use of imagination in healing is not part of our culture. Yet, this is untrue. In fact, the ethical code of honor accepted by all physicians today pays tribute to the mythical founding family of medicine who contributed a method for healing by the imagination. The oath begins: "I swear by Apollo, the Physician, by Asclepius, by Hygeia and Panacea and by all the Gods and Goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant."

Dreams and visions universally have been the most common method of diagnosis and treatment. But it was during the Grecian era, a time when the art of medicine flourished, that imagery-based diagnosis and therapy were systematized and incorporated into the standard approach to disease (Achterberg, 1985).

The figurehead of this movement was Asclepius. He probably was a

mortal, but in the *Iliad*, Homer presents him as the son of Apollo who was brought into heaven by Zeus as a demigod. Asclepius' immediate family shared in his healing power. His wife, Epione, soothed pain; his daughters, Hygeia and Panacea, were regarded as deities of health and treatment; and his son, Telesphores, represented convalescence or rehabilitation.

Asclepius became the patron of healing for centuries, and his influence extended far beyond the borders of Greece. Asclepius seemed to satisfy the need for a personal, compassionate divinity; hence, wherever he was introduced, he replaced or merged with the local healing deity. The legend of Asclepius merged with that of the Egyptian god of healing, Imhotep, and with the god Serapis of the Ptolemics. Within Christianity, Saints Damian and Cosmos carried on the healing traditions of Asclepius (Lyons & Petrucci, 1978).

A testimony to the influence of Asclepius is found in the over 200 temples, or Asclepia, which were built throughout Greece, Italy, and Turkey both to pay tribute to him and to foster the practice of medicine. These Asclepia were the first holistic treatment centers. They were located in picturesque areas and contained baths, recreational facilities, and places of worship. All who sought treatment were admitted, regardless of their ability to pay, for Asclepius taught that a physician was primarily someone to whom anyone who was suffering could turn.

At the Asclepia, dream therapy or divine sleep, which later was renamed incubation sleep by Christian practitioners, was perfected as a diagnostic and therapeutic tool. Most of the patients who underwent this treatment were seriously ill and had not responded to other treatments. In preparation for dream therapy, the patient fasted for one day and did not consume wine for three days, thus attaining spiritual clarity to receive the divine message. Then the patient went to the temple to await the gods. Insight and consequently healing occurred during the state of consciousness immediately preceding sleep, when images appear unbidden. At this time, the image of Asclepius would emerge — a gentle but powerful healer, carrying a rustic staff entwined

by a serpent — and he would either cure or prescribe treatment (Achterberg, 1985).

Many cures have been ascribed to Asclepian dream therapy: the blind, deaf, lame, impotent and barren, and those afflicted by innumerable other diseases have left stone images or written accounts of their cures on the temple walls.

Aristotle, Hippocrates, and even Galen have their roots in the Asclepian tradition and were convinced that imagination played a central role in health. Aristotle proposed “that the emotional system did not function in the absence of images. Images were formed by the sensations taken in and then worked upon by the *senses communis* or the ‘collective sense.’” Also he felt that images of the dream state deserved special notice. In *Parva Naturalia*, he advises, “Even scientific physicians tell us that one should pay diligent attention to dreams, and to hold this view is reasonable also for those who are not practitioners but speculative philosophers” (see Achterberg, 1985, p. 56).

But it was Galen who was the first one to provide a detailed outline of the relationship between mind and body. He proposed that the patient’s images or dreams provide valuable diagnostic information. For instance, images of loss, grief, or disgrace indicate an excess of melancholy (black bile), and images of fear or fighting reveal an excess of choler. Galen was aware of the vicious circle created by an excessive humor that produced corresponding images, which then exacerbated the humor; and he stressed that the cycle had to be broken in order to regain health (Binder, 1966; Osler, 1921).

The Asclepian tradition and the art of healing through imagination survived the gradual ascendancy of the Christian Church and its purge of pagan gods. Statues of the Asclepian family, the caduceus symbol, and the Hippocratic oath have endured perhaps because they stand for a value inherent in the art of medicine — respect for humanity. As Hippocrates said, “Where there is love for mankind, there is love for the art of healing” (see Achterberg, 1985, p. 57).

Within Christendom, however, the miracles of healing were no longer ascribed to the Asclepian family but rather to Saints Cosmos and Damian. These two men worked tirelessly to provide medical care until they became victims of the Diocletian persecution (278 A.D.). Churches dedicated to them were always open to the sick. The primary method of diagnosis and therapy in use was incubation sleep, a variation of the Asclepian divine sleep (Lyons & Petrucelli, 1978). During the state of drowsiness preceding sleep, the patient would have images of Saints Cosmos and Damian, who would offer a diagnosis and a cure (Achterberg, 1985).

Imagination continued to play an important role in the Western healing traditions well into the Renaissance. For instance, Paracelsus, a famous physician and the founder of modern chemistry, restated a theme common among the ancient Greeks — that is, the individual is comprised of three elements: the spiritual, the physical, and the mental. He reportedly said:

Man has a visible and an invisible workshop. The visible one is his body, the invisible one is imagination (mind).... The imagination is the sun in the soul of man.... The spirit is the master, imagination the tool, and the body the plastic material.... The power of the imagination is a great factor in medicine. It may produce diseases . . . and it may cure them.... Ills of the body may be cured by physical remedies or by the power of the spirit acting through the soul. (Hartman, 1973, pp. 111-112)

Paracelsus also maintained, “Man is his own healer and finds proper healing herbs in his own garden, the physician is in ourselves, and in our own nature are all things that we need” (Stoddard, 1911, p. 231).

Physicians of the Renaissance still considered health to be a matter of equilibrium, and their therapy consisted of adjusting imbalance. Hence they prescribed arousing images for the phlegmatic personality and used joyful images to combat melancholy. Shakespeare reflects this view in the introduction to *The Taming of the Shrew*.

For so your doctors hold it very meet:
seeing too much sadness hath congeal'd your blood,

And melancholy is the nurse to frenzy:
Therefore, they thought it good you hear a play,
And frame your mind to mirth and merriment,
Which bars a thousand harms and lengthens life.
(Act I, Scene I)

This holistic approach prevailed until the 17th century when René Descartes (1596-1650) proposed a revolutionary view. He defined the mind as a separate entity. He maintained that the mind or soul, terms he used interchangeably, is “entirely distinct from the body . . . and would not itself cease to be all that it is, even should the body cease to exist” (McMahon & Sheikh, 1984, p. 13). This dualistic view, which gradually won over Western thinkers, quite radically changed the approach to disease.

Imagery in Pre- and Post-Cartesian Medicine: A Comparison

In the pre-Cartesian period, no mind-body problem existed. Both mental and physical events had their roots in a common substrate, a biological soul. But Descartes proposed that mind and body are mutually exclusive entities. Therefore, mechanistic physiopathology became the dominant approach to disease (McMahon, 1976).

In the holistic era, imagination — a faculty of the biological soul — was considered to be a very significant psychophysiological variable. Aristotle had proposed, “The soul never thinks without a picture” (Yates, 1966, p. 32). He also felt that the emotions always were activated by imagery. Of course, the images were believed to provoke certain physical effects. That is, when the imagination conceived an image, spirits activated the brain and then aroused the heart, and the vividness and persistence of the image determined the extent of its impact on bodily functions. It is interesting to note that imagination was considered to be more powerful than sensations; therefore, dread of an event was viewed more harmful than the event itself. Images were considered sufficiently potent to be used to gain conscious control over autonomic or involuntary functions, and it was thought that images could even imprint

traits on embryos in the womb. Charron stated in 1601 that imagery “marks and deforms, nay, sometimes kills embryos in the womb, hastens births, or causes abortions” (McMahon, 1976, p. 180).

The key to a correct evaluation of the role of the imagination in the pre-Cartesian period lies in realizing that imagery was regarded to be as much a physiological phenomenon as a psychological one. It was believed that a vivid and persistent negative image spread throughout the body and wrought its mischief, which soon became manifest in physical symptoms. Since healers of this period believed images to be capable of causing disease, it follows that they also looked to images for their therapies (McMahon & Sheikh, 1984; Sheikh, Richardson & Moleski, 1979).

After Descartes’ dualism had taken root in the Western mind, imagination was stripped of its role in disease and wellness. During the 18th and 19th centuries, several protests were voiced, but the dualistic trend prevailed.

Use of Imagery in Western Psychotherapeutic Tradition

When psychology emerged as a separate science in the late 19th century, interest in the arousal function of imagery became apparent, and William James’ theory of “ideo-motor action” was received very favorably. It seemed that the time was ripe for a renaissance of Aristotelian theory. But this was not the case. The behaviorists successfully eliminated all mentalistic concepts from the arena of serious research (McMahon & Sheikh, 1984). Watson (1913) regarded mental images as mere ghosts of sensations with no functional significance whatsoever. Klinger (1971) notes that from 1920 to 1960, there was a moratorium in North American psychology on the study of inner experience, and not even one book on the topic of mental imagery was published. However, in Europe the situation was not quite the same. European clinical psychologists and psychiatrists continued to evince significant sensitivity to the inner realm of imagery and were relatively unperturbed by the rapidly increasing influence of behaviorism in America. Several factors aided the continuation of this largely subjective approach to

imagery in Europe: (1) many experimentalists left Europe during the two World Wars; (2) German and French phenomenology influenced European clinical and scientific systems; (3) the subjective approaches to the investigation of various aspects of the inner experience, proposed by Jung, affected many European practitioners; and (4) Europe had been influenced by subjective Eastern psychology (Jordan, 1979; McMahon & Sheikh, 1984; Sheikh & Jordan, 1983). It must be noted, however, that although European clinicians were successful in escaping the stranglehold of behavioristic formulations, until very recently, they were unable to elude the powerful influences of Cartesian dualism. Consequently, with a few exceptions, the use of imaginative skills was confined to the treatment of only the so-called psychological problems and was not applied to physical ones.

European Contributions in the 1900s

The notable contributions to the clinical use of images in the early 1900s include the work of Pierre Janet, Alfred Binet, Carl Hapich, Eugene Caslant, Oscar Vogt, Johannes Schultz, Ludwig Frank, Sigmund Freud, and Carl Jung (see Sheikh & Jordan, 1983, for a review). Of all these, Jung's contribution played the most significant role in the imagery movement in psychotherapy. He regarded mental imagery as a creative process of our psyche to be employed for attaining greater individual, interpersonal, and spiritual integration (Jordan, 1979). Jung stated:

The psyche consists essentially of images. It is a series of images in the truest sense, not an accidental juxtaposition or sequence but a structure that is throughout full of meaning and purpose; it is a picturing of vital activities and just as the material of the body that is ready for life has a need of the psyche in order to be capable of life, so the psyche presupposes the living body in order that its images may live. (Jung, 1960, pp. 325-326)

By recognizing the reciprocity of the psyche and the body, Jung indicated his belief in the mind-body unity as a life process and proposed that imagery

is a vehicle of perceiving and experiencing this life process (Sheikh & Jordan, 1983). Jung remarked that when we “concentrate on a mental picture, it begins to stir, the image becomes enriched by details, it moves and develops... and so when we concentrate on inner pictures and when we are careful not to interrupt the natural flow of events, our unconscious will produce a series of images which makes a complete story” (Jung, 1976, p. 172). Jung’s therapeutic use of imagery is best represented by the method he termed “active imagination.” For details of the method, the reader is referred to other sources (Jung, 1960; Sawyer, 1986; Singer & Pope, 1978; Watkins, 1976).

More recently, several French, German, and Italian clinicians, all significantly influenced by Jung, have investigated the potential use of imagery as a method of psychotherapy. The most prominent of these approaches include Desoille’s (1961, 1965) Directed Daydream, Fretigny and Virel’s (1968) Oneirodrama, Leuner’s (1977, 1978) Guided Affective Imagery, and Assagioli’s (1965) Psychosynthesis. The first three of these four approaches have some basic similarities. The term “oneirotherapy” (from the Greek *oneiros*, meaning “dream,” hence also known as “dream therapy” or “waking-dream therapy”) has been used to describe all three therapies (Much & Sheikh, 1986; Sheikh & Jordan, 1983).

1. All three oneirotherapies employ extended visual fantasies in narrative form to obtain data concerning the motivational system of the client. These fantasies are generally preceded by an attempt to induce relaxation.
2. Products of visual imagination are used in conjunction with associations, discussion, and interpretation.
3. Generally, the client is presented with certain standard symbolic scenes as the starting images. These scenes are presumed to reflect common areas of conflict.
4. With respect to assumptions and interpretations, all oneirotherapeutic procedures are psychodynamic in nature. These methods rest on the belief that the symbolism inherent in visual imagery constitutes an

affective language that expresses unconscious motives without fully imposing them on conscious recognition. Therefore, it is assumed that the participant will show less resistance to the expression of the underlying motives (Sheikh & Jordan, 1983).

In general, these methods have been reported to be effective in uncovering the structural details of the client's personality, in discovering the nature of the affective trauma, and in quickly ameliorating the symptoms. Fretigny and Virel (1968) mention a few other advantages of their use of imagery, which can be applied to all three approaches. They claim that: (1) mental imagery can be used with persons who find systematic reflection difficult due to their low level of sophistication; (2) the use of imagery circumvents the snares of rational thinking; (3) this approach discourages sterile rumination; and (4) mental imagery aims directly at the individual's affective experience (Sheikh & Jordan, 1983).

Compared to most European approaches, Assagioli's psychosynthesis is more holistic and eclectic. One of the goals of psychosynthesis is to enhance the personal and spiritualistic potential of the individual. To achieve this goal, Assagioli and his followers have employed Western analytic, behavioral, and humanistic procedures along with Eastern meditative techniques. In psychosynthesis, the human personality is considered to have a number of layers of awareness. The goal "is not only the explication of these various levels of awareness and the relief of personal difficulties. Rather, its goal is a thorough reconstruction of the total personality, exploration of the various levels of personality, and eventually the shift of personality to a new center through exploration of its fundamental core" (Singer, 1974, p. 109).

Mental imagery is only one of the many methods employed in psychosynthesis. Assagioli uses several imagery procedures that reflect the principles discussed by Jung, Desoille, and Leuner, along with conditioning and cognitive restructuring techniques. In interpreting the images, accompanying verbal associations and other relevant information are utilized. Every element of the im-

age is believed to represent, at one level or another, a personality trait, albeit distorted, displaced, or projected. Identification with all aspects of the image drama is regarded as a means of assimilating repressed material in socialized form and expanding the boundaries of the self (Sheikh & Jordan, 1983).

One must credit the European clinicians not only for keeping alive the clinical use of images in the wake of behaviorism but also for providing a rich heritage of therapeutic procedures, for keeping us in touch with the unavoidably phenomenological nature of perception, and for building a bridge between Eastern and Western approaches to the understanding of the nature of human consciousness (Jordan, 1979; Panagiotou & Sheikh, 1977; Sheikh & Jordan, 1983).

Current American Approaches

During the last three decades, imagery has risen from a position of near disgrace to become one of the hottest topics in both clinical and experimental cognitive psychology. Experimental and clinical psychologists of varied persuasions have made imagery the subject of their inquiry, and they have produced a considerable body of literature documenting that images are indeed a powerful force.

Due to space limitation, it is not possible to present a detailed discussion of various American imagery approaches to psychotherapy. Interested readers are referred to other sources (Sheikh, 2001; Sheikh & Jordan, 1983; Singer, 1974; Singer & Pope, 1978). However, it is possible to categorize the numerous existing imagery approaches in America into the following six broad groups.

1. A number of imagery approaches that are based largely on the Pavlovian and Skinnerian models constitute the first group. They highlight the surface relationship between images and emotional responses as well as the ability of images to act as powerful stimuli. These procedures consist of several variations of counterconditioning and emotional flooding (Sheikh & Panagiotou, 1975; Sheikh & Jordan, 1983). These procedures include systematic desensitization (Wolpe, 1969), implosion therapy (Stampfl & Lewis, 1967),

covert conditioning (Cautela, 1977), coping imagery and stress inoculation (Meichenbaum, 1977), and many others.

2. The second category is composed of the procedures advanced by a number of clinicians who believe that mental images effectively give us a clear understanding of our perceptual and affective distortions. Unlike the cognitive behavior therapists, proponents of these approaches do not resort to explanations in terms of conditioning principles. Beck (1970), for example, explains the conditioning effects of repetitive fantasy in cognitive terms. He states that the repetition of images provides important information and clarifies cognitive and affective distortion for the client. Gendlin and his associates (Gendlin, 1978; Gendlin & Olsen, 1970) employ "experiential focusing" to clearly comprehend all aspects of the feeling. They claim that emergence of an image frequently moves the client from a "global sense of feeling to a specific crux feeling." This image "typically becomes quite stable as the feel of it is focused on and even refuses to change until one comes to know what the feeling it gives one is. Then one feels not only the characteristic release, but the image then changes" (Gendlin & Olsen, 1970, p. 221). Morrison (1980) emphasizes "the value of retracing early developmental experiences in order to apply the adult's more adequate construct system" and thus to better understand those experiences (p. 313). In Morrison's emotive-reconstructive therapy, images are the primary therapeutic agent.

3. The third class includes a number of approaches that basically consist of imagery rehearsal of physical and psychological health (Achterberg, Dossey, & Kolkmeier, 1994; Naparstek, 1994). The client may be asked to imagine a malfunctioning organ becoming normal or to practice in imagination a healthy, interpersonal relationship. No complicated theories are offered except the assumption that sane imagination will eventually lead to sane reality (McMahon & Sheikh, 1984). No one can claim credit for developing these procedures, for they have been around for centuries (Sheikh, 1984, 1986, 2001).

4. The fourth group consists of image therapies with a psychoanalytic

orientation. Prominent among these approaches are “emergent uncovering” (Reyher, 1977) and “psycho-imagination therapy” (Shorr, 1978). Mardi Horowitz (1978) is another psychoanalytically oriented clinician who has made important contributions to the study of the role of mental images in clinical practice.

It is noteworthy that Freud was well aware of the spontaneous images experienced by his clients, and he apparently used imagery extensively prior to 1900. But he later abandoned it in favor of verbal free association. Yet, although Freud and his followers tended to avoid the explicit uses of mental images in therapy, several characteristics of the psychoanalytic setting encourage the production of imagery. These include reclining in a restful position, low level of sensory stimulation, use of free association, and emphasis on dreams, fantasies, and childhood memories (Pope, 1977; Sheikh & Jordan, 1983; Singer & Pope, 1978).

5. The fifth class includes the “depth” imagery procedures in which emphasis is on healing through “magical” or “irrational” methods as opposed to rational or reflexive techniques. A prime example of this group is “eidetic psychotherapy” (Ahsen, 1968; Sheikh, 1978, 2001; Sheikh & Jordan, 1981), which relies on the elicitation and manipulation of eidetic images. Every significant event during our development is considered to implant an eidetic in the system. The eidetic is seen as a tridimensional unity. The visual component, the image, is always accompanied by a somatic pattern — a set of bodily feelings and tensions, including somatic correlations of emotions — and a cognitive or experiential meaning. This triadic unity is considered to display certain lawful tendencies toward change that are meaningfully related to psychological processes.

6. Recently, a sixth category of imagery approaches has been attracting increasing attention among health professionals. These approaches have resulted from the advent of the “third force,” or humanistic psychology, and of the “fourth force,” or transpersonal psychology. Both of these put emphasis on greater access to experience, on a variety of states of consciousness, and on

increasing realization of our potentials. This orientation has led to the emergence of numerous novel imagery methods, which are derived from European oneirotherapies, psychosynthesis techniques, autogenic training, Jungian active imagination, and from Eastern meditative practices (Perls, 1970; Progoff, 1970; Sheikh & Jordan, 1983; Singer, 1974). These methods include taking an imaginary inventory of the body, having an imaginary dialogue with internal parts of oneself, creating and interacting with an inner advisor in one's imagery, dying in one's imagination, visualizing communication between the two hemispheres of the brain, crawling into various organs of the body for observatory or reparatory purposes, exorcising the parents from various parts of the body, and regressing into the "previous life" (Sheikh, 1986, 2001; Sheikh & Shaffer, 1979; Sheikh & Sheikh, 1996).

Concluding Remarks:

What Makes Imagery an Effective Healing Agent?

It is obvious that imagery is generally perceived as an extremely effective therapeutic tool. Researchers have ascribed the clinical efficacy of images to a variety of mechanisms. Singer (1974) believes that the effectiveness of imagery essentially depends on (1) the client's clear discrimination of his or her ongoing fantasy processes; (2) clues provided by the therapist regarding alternate approaches to various situations; (3) awareness of usually avoided situations; (4) encouragement by the therapist to enter into covert rehearsal of alternate approaches; and (5) consequent decrease in fear of overtly approaching the avoided situations. Meichenbaum (1978) has suggested further simplification. He believes that the key to the effectiveness of the images lies in (1) the feeling of control that the client gains from monitoring and rehearsing various images; (2) the modified meaning or changed internal dialogue that precedes, accompanies, and succeeds instances of maladaptive behavior; and (3) the mental rehearsal of alternative responses that enhances coping skills (Sheikh & Jordan, 1983).

In addition to the processes outlined by Singer and Meichenbaum,

numerous other characteristics of the imagery mode have been credited with contributing to its clinical effectiveness.

1. Experience in imagination can be viewed as psychologically equivalent, in many significant respects, to the actual experience; imagery and perception seem to be experientially and neurophysiologically similar processes (Klinger, 1980; Kosslyn, 1980; Richardson, 1969, 1984; Sheikh & Jordan, 1983).
2. Verbal logic is linear, whereas the image is a simultaneous representation. This trait of simultaneity gives imagery greater isomorphism with perception and, therefore, greater capacity for descriptive accuracy (Sheikh & Panagiotou, 1975).
3. The imagery system fosters a richer experience of a range of emotions (Singer, 1979).
4. Mental images lead to a variety of physiological changes (Richardson, 1984; Sheikh & Kunzendorf, 1984; Sheikh, Kunzendorf, & Sheikh, 1996; White, 1978).
5. Images are a source of details about past experiences (Sheikh & Panagiotou, 1975).
6. Imagery readily provides access to significant memories of early childhood when language was not yet predominant (Kepecs, 1954).
7. Imagery appears to be very effective in bypassing defenses and resistances (Klinger, 1980; Naparstek, 1994; Reyher, 1963; Singer, 1974).
8. Imagery frequently opens up new avenues for exploration, after therapy has come to an impasse (Sheikh & Jordan, 1983).
9. Images are less likely than linguistic expression to be filtered through the conscious critical apparatus. Generally, words and phrases must be consciously understood before they are spoken — that is, they must pass through a rational censorship before they can assume a grammatical order. Perhaps imagery is not subject to this filtering process; therefore, it may be a more direct expression of the unconscious (Panagiotou & Sheikh, 1977; Sheikh, Kunzendorf, & Sheikh, 1996).

10. The failure to think imagistically creates disharmony in the mind and body (Ahsen, 1978; Schwartz, 1984).

In light of the foregoing characteristics of imagery, it seems reasonable to believe that images hold enormous potential for healing, and it is not surprising that extensive claims about the promise of imagery for therapeutic benefits have been made. A large body of recent scientific research on imagery indicates that these claims are justified.

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This paper is a revised version of part of a previously published article in Healing Images: The Role of Imagination in Health (A. Sheikh, Ed.), Amityville, NY: Baywood, 2003. It is included here with permission. The original article was coauthored with R.G. Kunzendorf and K.S. Sheikh.

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