SYMBOLIC IMMERSION PROCESS:
AN EXPLORATORY STUDY OF LEARNING THROUGH
INTRINSIC PROCESSING

BY

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A thesis submitted in conformity with the requirements
for the degree of Doctor of Philosophy
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ABSTRACT

In this thesis, I examine the imagination as a tool for learning, specifically how it can be directed to create psychological and physiological changes. I explore this by using the imagery theory and technique that I have created called the Symbolic Immersion Process (SIP). The SIP is based upon the idea that internal images are the center of consciousness, and consequently, they can be used as a means of learning, transformation and psyche/soma reconstruction. I examine how the SIP can be used as an alternative or complementary approach to wellness in terms of both psychological and somatic transformation. This situates intrinsic learning and self-reconstruction as a unique approach to wellness because it is juxtaposed against the empirical/positivistic model of traditional paradigms.

The particular question that I asked in the thesis was: to what degree could the SIP, which is an intrinsic process of reconstructing symbols that are directed to emerge from the imagination, promote emotional, mental and somatic well being in the case of an HIV seropositive person? For this inquiry, I conducted a 15 month case study, with a follow-up one year afterwards, of an antiretroviral drug-naïve HIV seropositive male using the SIP in order to analyze how the symbols that were consciously generated and directed during the procedure.
were physiologically -- in this particular case immunologically -- and psychologically efficacious.

Finally, this thesis explores the question of the mind and body conundrum and proposes that they be treated as a whole, rather than dualistic or mechanical, system. My intrinsically based theory proposes that the symbol is the nexus of mind and body, and thus is an essential tool for bridging the socially constructed separation between psyche and soma.
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# TABLE OF CONTENTS

**ABSTRACT** .................................................................................................................... II

**ACKNOWLEDGEMENTS** ................................................................................................. IV

**TABLE OF CONTENTS** ................................................................................................. V

**INTRODUCTION TO SYMBOLIC IMMERSION PROCESS** ........................................... IX

**CHAPTER OVERVIEW** ................................................................................................. XI

**CHAPTER 1 - THE GENESIS OF THE SYMBOLIC IMMERSION PROCESS** ............. 1

- Nocturnal Moments .................................................................................................. 1
- Meditation and Healing Arts ................................................................................. 2
- Destruction and Reconstruction .............................................................................. 8
- The birth of the SIP ................................................................................................. 10
- The SIP in development ......................................................................................... 12
- A summation of the SIP ......................................................................................... 16
- The SIP in a broader context .................................................................................. 18

**SUMMARY** ................................................................................................................. 19

**CHAPTER 2 - PSYCHONEUROIMMUNOLOGY: THE MIND-BODY/ BODY-MIND CONNECTION** ......................................................... 20

- Dualism .................................................................................................................. 20
- Monism .................................................................................................................... 21
- Interactionism ......................................................................................................... 22

**PSYCHONEUROIMMUNOLOGY: THE SCIENTIFIC APPROACH TO THE MIND AND BODY** ................................................................. 23

- Behavioral and psychosocial influences on the immune system ....................... 24
- Interaction between the immune, the nervous, and the endocrine systems ......... 26
- Stress and immunity ............................................................................................... 28

**STRESS AND IMMUNOSUPPRESSION** ..................................................................... 30

- Chronic and life disrupting stress and immnosuppression .................................. 31
- Intermediate or Short Term Stress and Immunosuppression .............................. 35

**CONCLUSION** ............................................................................................................. 36

**CHAPTER 3 - HEALTH AND THE WHOLE SYSTEM** .................................................. 38

**THE MANIFESTATION OF ILLNESS** ........................................................................... 40

- Physiological weakness .......................................................................................... 41
- Specific physiological responses to emotional precursors ................................. 42
- Varying physiological responses to emotional precursors .................................. 43
- Specific behavioral and coping patterns ................................................................. 43
- Multiple psychosocial and behavioral factors ....................................................... 44
- Summary .................................................................................................................. 46

**THE MIND IN RELATION TO THE BODY: THE BODY IN RELATION TO THE MIND** ................................................................. 46

- The placebo effect .................................................................................................. 47
- Somatization ........................................................................................................... 50

**TREATING DISEASE** .................................................................................................. 53

- Philosophy determines treatment .......................................................................... 55
Self-regulation ........................................................................................................ 142
Spatial orientation ................................................................................................. 144
Direction .................................................................................................................. 145
Self-challenge: Focusing on the tension................................................................. 146
Desire towards movement ...................................................................................... 146
The source: How not why ...................................................................................... 152
The foundation: Wholeness .................................................................................... 155
SUMMARY .............................................................................................................. 158

CHAPTER 8 - DAVID: METHODOLOGY AND CASE STUDY .................................. 160
HIV ............................................................................................................................. 160
PSYCHONEUROIMMUNOLOGIC RESEARCH AND HIV ........................................ 162
  Life stress and coping styles ............................................................................... 162
  Psychological factors ........................................................................................... 163
  Intervention .......................................................................................................... 164
RESEARCH OBJECTIVES AND HYPOTHESIS ..................................................... 165
METHODS ................................................................................................................ 166
  Participant ............................................................................................................ 166
  Measures .............................................................................................................. 168
  Procedure ............................................................................................................ 168
  Methodology ....................................................................................................... 168
DAVID: THE CASE STUDY ..................................................................................... 169
PHASE 1 (16 WEEKS) ........................................................................................... 169
  General sessions ................................................................................................ 170
  HIV ....................................................................................................................... 178
  Results ................................................................................................................ 182
  Summary ............................................................................................................. 183
PHASE 2 (26 WEEKS) ........................................................................................... 183
  General sessions ................................................................................................ 184
  HIV ....................................................................................................................... 196
  Results ................................................................................................................ 198
  Summary ............................................................................................................. 199
PHASE 3 (30 WEEKS) ........................................................................................... 189
  General sessions ................................................................................................ 190
  HIV ....................................................................................................................... 192
  Results ................................................................................................................ 197
  Summary ............................................................................................................. 198
CONCLUSION ......................................................................................................... 198
TABLE 1 ..................................................................................................................... 200
TABLE 2 ..................................................................................................................... 201
TABLE 3 ..................................................................................................................... 201

CHAPTER 9 - DISCUSSION .................................................................................. 202
  Personal goals ..................................................................................................... 202
  Thesis development ............................................................................................ 204
  Discussing the findings ....................................................................................... 208
CONCLUSION ......................................................................................................... 211

APPENDIX A ......................................................................................................... 213

vii
APPENDIX B .................................................................................................................. 214
APPENDIX C .................................................................................................................. 215
APPENDIX D .................................................................................................................. 216
APPENDIX E .................................................................................................................. 217
REFERENCES .................................................................................................................. 218
INTRODUCTION TO SYMBOLIC IMMERSION PROCESS

There is no such thing as a purely psychic illness or a purely physical one – only a living event taking place in a living organism that is itself alive only by virtue of the fact that in it psychic and somatic are united.

(Fritz Mohr in Cousins, 1989, 89).

This thesis examines the question of how the imagination can be directed to create psychological and physiological changes. I explore this by using the imagery theory and technique that I have created called the Symbolic Immersion Process (SIP). The SIP is based on the idea that internal images are the center of consciousness, and consequently, that they can be used as a means of learning, transformation and psyche/soma reconstruction. For this inquiry, I conducted a 15 month case study, with a follow-up one year afterwards, of an antiretroviral drug-naïve HIV seropositive male using the SIP in order to analyze how the symbols that were consciously generated and directed during the procedure were physiologically – in this particular case immunologically – and psychologically efficacious.

Doing this thesis served two main purposes for me: (a) I used the writing of the manuscript to present the theory and practice of the SIP. I have been designing and developing this process for the past seven years. Having worked with over 100 people, I have refined the ideas and procedure into the construct that is presented in this thesis; and (b) I examined how the SIP could be used as an alternative or complementary approach to wellness in terms of both psychological and physiological transformation. This particular investigation asked the question: To what degree could this intrinsic process of reconstructing symbols that are directed to emerge from the imagination using the SIP promote emotional, mental and somatic well being in the case of an HIV seropositive person?
As the gateway to internal symbolic content, the imagination is extensively examined in this thesis where it is ontologically viewed as both a representational mechanism and base or root of the psyche. In this way, it serves as a tool of and access point to the self; that is, a means through which transformation may be brought into being. This situates intrinsic learning and self-reconstruction as a unique approach to wellness because it is juxtaposed against the empirical/positivistic model of traditional paradigms. I further argue that we can understand more about how learning and change of all kinds takes place by exploring the symbol and its multifaceted materializations. Thus, examining our internal semiotic system can help us to develop efficient and effective ways of treating the whole person.

Given that images are experienced as real for the individual because there is no physiological distinction between a concrete and an imagined encounter -- the body produces the same physiological responses (Leuner, 1969) -- the imagination is clearly a viable tool for exploring transformation in both psyche and soma. The idea here is that the imagination allows the intrinsic to be depicted and because of the "realness" of the encounter, the exchange can be a means of reconstruction if it is directed towards transcendence, which is the function of the SIP. Therefore, an actual event or situation need not take place: transformation can be achieved because the image is experienced as "real". The ability to enact a situation through the metaphor allows the individual to interact with the symbol as the actual. This suspension of reality, so to speak, makes the image an important tool through which learning and reconstruction can occur.

Finally, this thesis explores the question of the mind and body relationship and proposes that they be treated as a whole, rather than dualistic or mechanical, system. My theory, which, as indicated, is intrinsically based, proposes that the symbol is the nexus of mind and body, and thus is an essential tool for bridging the socially constructed separation between psyche and soma.
Chapter Overview

Chapter 1 is a personal account of how I developed the SIP. The mind/body relationship is examined in Chapter 2 through the research done in the field of psychoneuroimmunology (PNI). Chapter 3 explores various studies conducted on how the mind interacts with the immune system and affects the individual in terms of health and well-being. I argue that the relationship is interactionist and that the philosophic position determines the form that the treatment will take. In Chapter 4 I describe various immuno-enhancing intervention techniques that have been studied. I particularly focus on the imagination as an intervention process. The theory of the imagination, what it is and how it can be utilized, is developed in Chapter 5. The last chapters focus on the SIP and the case study. Chapter 6 explains the theory behind the Symbolic Immersion Process and Chapter 7 describes the process. Chapter 8 outlines the case study that I conducted using the SIP. Finally, Chapter 9 interprets and summarizes the research findings.
CHAPTER 1 - THE GENESIS OF THE SYMBOLIC IMMERSION PROCESS

In my dream, the angel shrugged and said,
If we fail this time,
it will be a failure of imagination
and then she placed
the world gently in the palm of my hand
(Brian Andreas, 2000).

Although I began developing the Symbolic Immersion Process (SIP) seven years ago, it is more accurate to locate the roots of its genesis within myself, emerging out of my predilection for reflexivity, which is described as the connection to that which is inner, such as the subjective journey and self-reflection (Marcus, 1994). As early as my adolescent years, I was fascinated with spiritual and intrinsic growth, which led me to explore two areas of interest in the first half of my twenties: (a) dreams and (b) meditative and healing practices. The first remains a strong part of my life, whereas the second underwent a complete revision, leading to the SIP.

**Nocturnal Moments**

Dreams have been the cornerstone of my personal and theoretical development because it is here that I was initiated into the symbolic realm. As I began to study the contents of my dreams in earnest, avidly inscribing my prolific nocturnal metaphors, I realized that I not only had an aptitude for dream recall, but I also had an innate ability to comprehend and translate the meaning of symbols. This investigation led me to construct theories about consciousness and the cosmos that evolved as I explored the nature of symbolism.

I was not only studying my own dreams, but also those of the many friends who brought their nocturnal journeys to me for translation — even some who were long
distance would write letters for this purpose. This interpretation was never impositional; that is, I did not ascribe a scripted meaning to the symbols, but always taught others how to make their own personal associations to their metaphors (I do not believe that a general meaning can be applied to an individual’s images). This dream study led me to the practice of consciously transforming my conflicting dream stories. For example, if I had a frustrating dream where I was unable to board the train which I was desperately trying to reach, I would change the metaphor upon awakening: the allegory would transform to me being able to enter the train easily and perhaps even exploring its interior. This practice of reconstructing images was the embryonic stage of the SIP.

So entrenched was dreaming in my life that I wrote the following poem:

Nocturnal Liaisons

These balmy nights of mysterious dreaming:
They sail in and out of my life
Like rowdy messengers streaming
Down a vista of dim lights, creating strife
In this murky landscape, impressing upon
My mind their tales of incongruencies.
These dreams lurk incessantly in the dark pond
Of an illusion created by these stealthy thieves
Who wait surreptitiously in the background.
Rapidly they descend upon this unwitting lady,
Entrapping me in a time bound
For dispersing the fears of my emotional captivity.
These nights string together messages
Coded with imagery which hide in dark
Places where they’ve existed through the ages.
These unreconciled stories have entrenched a mark
So deep and uncompromising that these strangers
Can steal into the depths of my confusion
And like magicians release wild creatures
So that finally I can meet my illusion (1994).

Meditation and Healing Arts

This study of dream symbols was interfaced with my exploration of meditative and healing practices. For four years I was a weekly volunteer at a meditation and
healing night at a United Church, where these services had been conducted for over 20 years. I also took many of the weekly courses this group offered (one year of doing their classes on healing therapy allowed one to volunteer in the service). This combination of learning and practice provided me a wonderful opportunity to investigate alternative ideas of transformation.

*Meditation*

My experience of meditation, both personally and with a group, became another method of exploring inner symbolic content. As I experienced the metaphoric journeys, I began to ask a variety of questions. One of these was what to do with the vivid images that spontaneously arose as I was meditating, which I did faithfully for half an hour every morning and in my group settings a couple of times a week. I was exposed to two meditative approaches: (a) silencing the mind, and (b) following a scripted visualization. In the case of the former, I sensed that to stop the emerging symbolic material was to cut off communication with very valuable parts of myself.

On the other hand, the idea of following a scripted visualization, such as imaging that I was walking along a winding path until I came to a fountain where I met a teacher or seeing my body healthy and whole, felt like symbols were being imposed onto my psyche. In other words, I felt like I was creating stories that were internally incongruent with the symbolic location of my own psyche/soma. Because of my conflict with these approaches, I eventually developed a process whereby I listened and attended to the information that was spontaneously rising into consciousness through symbolism at the beginning of the meditation, which would then lead to a quiet internal space. This practice became one of the sounding boards for the development of the SIP.
Healing

This period was also a time of my own personal healing. In the first three years of my twenties I suffered from Hashimoto’s thyroiditis. This is an autoimmune disease that leads to a chronically inflamed gland because abnormal antibodies (autoantibodies) attack the thyroid tissue. The progression of the disease is slow and can lead to a swelling of the gland as well as the complete or partial inability to release the thyroid hormone, thyroxin. Symptoms include intolerance to cold, weight gain, fatigue, and facial swelling. It is thought that the development of the disease is a result of genetic disposition, and it is found more frequently in women than men. The disease is easily corrected with the replacement hormone levothyroxine.

I was actually diagnosed with a thyroid problem at the outset of my teens -- about 14. It ran in my family: my mother’s two sisters suffered from thyroid conditions as well. I remember experiencing mild symptoms during those years -- scratchy eyes, easily tired, and I would weaken after exertion. I also recall losing my voice whenever I taxed my body; for instance, during exam times my voice would disappear. When I was 20, the problem became full-blown and was very debilitating: I was exhausted in the extreme and simple things like walking up a flight of stairs drained me. I also experienced what I can only describe as a foggy brain. Over-exertion would lead to weakness. As a result, I had to curtail most of my activity. My thyroid gland was swollen and protruding, and I gained weight and had a “puffy” look.

Despite my history, however, I remained undiagnosed for over one year. My blood tests came back normal, and I was treated as a psychosomatic complainer. For instance, two doctors asked me if I had boyfriend troubles. One of them suggested that I find a boyfriend so that my symptoms would disappear, and the other advised me that in
time I would find the man who would treat me well. Another physician thought I was having separation anxiety from my mother (I was 20). Although they all sent me home with a clean bill of health, it was very clear to me what the problem was, and my thyroid gland protruded as evidence. Irrespective of any emotional correlations, I knew that I had a physiological imbalance.

Finally, I found a doctor who treated me based upon the visible glandular swelling, my history and symptoms. She prescribed hormone replacement and sent me to an endocrinologist. The latter performed a needle biopsy and diagnosed me with Hashimoto’s, which he described as a debilitating but treatable disease that was often undetectable in blood tests. He informed me that I would need to take the hormone replacement for life or the symptoms would return. Thus began my hormone treatment. I dropped some weight, and I no longer had to curtail my activity.

But this story did not end there. Two years later, when I was 23, I focused on healing myself, and I succeeded in doing just that. The truth is that I do not consider this to be the most spectacular event in my life. It may sound like a fascinating story, but it was really a matter-of-a-fact occurrence for two reasons: (a) my sense of and aptitude for spirituality, and (b) my emotional associations to the illness.

In the first case, I had a very deep sense of connection to a spiritual consciousness that was functioning in my life long before I ever meditated or had any labels to define the experiences. I became particularly aware of this spiritual capability when I was about 21 because a variety of energy states would spontaneously and frequently occur within my body without me engaging in any type of activity to create them. These states would arise at any given point in my day and without stimulation: at work, during times of...
contemplation, entertainment, crises, and so on. They would be either disconcertingly intense or relaxingly calm, and as a result, I both loved and feared them.

The Chinese refer to this energy as chi or the life force, although when this began, I had not heard of such concepts. However, I was spontaneously and naturally evoking this energy with very little understanding about what was happening to me. I experienced these states as intense energy moving throughout my body: There would be a visceral heat, my face would flush, my body would pulsate, and I would feel internally and spiritually connected to self and beyond self (e.g., cosmos). So when I decided to heal my thyroid condition, I spent a weekend concentrating on evoking this energy state within my body, which by then was organic to my experience of self, and in this way my healing process began.

I began experiencing new physiological states. I started heating up, especially when I slept. For the first month, I felt like I had a massive sunburn across my back. I also felt my throat frequently pulsing, and I was unable to wear turtlenecks during the first year because they were obtrusive. My body underwent enormous changes returning to its pre-Hashimoto state — for the first time in my adult life I could see the bones of my chest. I was overjoyed. I had more energy than ever, and things that I had taken for granted as myself, like a weak voice, scratchy eyes, cloudiness in my head at the end of the day, and being easily drained, all disappeared. Other smaller symptoms changed over time, such as excessive scalp and hair dryness, sensitivity to the cold (in fact, I now have a high tolerance for the cold), and losing my voice. A “me” that I had never known, whom I was very happy to discover, emerged. Needless to say, 13 years later, I have not suffered any symptomology. In fact, the healing was incremental, and I strengthened with time although, like any life, mine has not been without stress.
The beginning of my physiological healing marks the time when I began attending the meditation and healing courses hoping to understand more about what was occurring in my life and to develop myself. This is when I started to examine the emotional and mental correlates to the illness. In some ways, this is ironic considering that I suffered without treatment when I was told that my problem was emotional, not physiological. These physicians’ responses to me reflected the biomedical philosophy of separating the mind and body instead of treating the self as a whole. However, I believed that to maintain my new state of equilibrium, I needed to transform the dysfunctional relationship between psyche and soma that had stimulated my inherited weakness (the thyroiditis). Thus, I worked to change aspects of myself: I focused on communicating rather than withdrawing, feeling my emotions rather than withholding them, and I remembered how to cry because somewhere along the way I had forgotten how to do so. My transformation occurred on four levels: physiologically, mentally, emotionally and spiritually.

I do not know what a needle biopsy would presently demonstrate about the condition of my thyroid. What I do know is that the effects of my healing experience were very different than the effects of taking the hormonal replacement. Although the latter restored equilibrium, there were many residual symptoms, like tired eyes and bloating. The healing, on the other hand, was more like a cure as I do not suffer from the disease at all, and I did for so much of my life. I will also say that I consider the healing to be more of a self-commitment than some extraordinary feat, and I that trite analysis like “mind over matter” dismiss the inner revolution that occurred. A more accurate statement would be mind at one with matter.
Destruction and Reconstruction

This period of engaging in meditation and healing practices was a very exploratory time for me; however, I did not find a niche. Neither did it dispel my feelings of searching for something that I could not find or help me to fully understand what I was experiencing within myself. So, for the most part, I still felt spiritually isolated, disconnected and undefined. But this changed when my life erupted in a way that allowed me to finally understand that which had previously confounded me, made me challenge much of what I had been exploring and re-route my path. At that time, I was 27, married for only two years with a new baby son and faced with the realization that my then husband was imbalanced with violent tendencies. So I left him. Refusing to seek any help, he proceeded to descend into his own personal hell, and wanting to take me with him, he stalked, harassed, and violated my personhood for about six months.

Violence is never a pretty story to tell, but this experience completely transformed my outlook and took me to places within myself that had kept eluding me. In this way, much of what I had been seeking to understand, like the pieces of the puzzle that I could not find, finally fell into place. One of these pieces was the connection that I made to the deep and dark emotions inside of myself. I asked: Having dedicated so much of my time to inner processes, how is it that my “outer” life could have descended into such chaos? If my inner self was truly at peace, how on earth could my outer relationship be such chaos, for surely they could not be so incongruous? Furthermore, how could I have been so blind when I had worked so hard to see?

From that point on, I ceased to be involved with the service where I had volunteered. Although I certainly respected what they were doing, I felt that I had learnt all that they could teach me, and it was now time for me to develop in other ways. I have
never since had an urge to return to that or any meditative or healing group. That time was over for me, and I set off on my own journey. I realized that my exploration thus far was entirely one-dimensional: I had been so focused on trying to get to the "light", so to speak, that I had to keep avoiding or denying the "dark", which invariably left me stuck in the very space from which I wanted to escape. So I was half-developed, and this was creating enormous conflict in my life. I was determined to change that.

The first place that I started was with my nocturnal metaphors. I noticed that the dream images mirroring my life were frequently being reconstructed in my dreams, sometimes towards a resolution, sometimes towards conflict. At other times, they remained stagnant and unmoving. However, this was never a linear process. For instance, I would have a dream about me interacting with "Z", whom I would interpret as being weak, scattered and angry. Z would turn up at another seemingly unrelated time in my dreams as having changed; now she was strong and together. At another time again Z would be the same scattered and angry person, and I would be frustrated with her for being like this. I understood that these dream symbols represented my self, but they also mirrored my relationships and external experiences. So Z would seem to have the characteristics of an acquaintance, for instance, and the dream would represent how I was experiencing a situation. But the dream was occurring inside of me and so was my internalized self.

From these two points I theorized that if these symbols represented me and reflected my experiences in the world, not just as a retrospective relationship, but equally as a prospective interaction that was communicated and experienced via the present, then a reconstruction and redirection of my symbols must mean a reconstruction of self and a redirection of my life. I wrote at the time:
My thesis is: Life draws us into experiences to examine the way we see things. This can help us to grow, change, and accept the self. Dreams address illusionary perceptions of self, and it is out of this relationship that symbols return so that we can work through ourselves. The key, then, is not avoidance but to be like a warrior moving into an experience armored with self-awareness. Often our awareness is retrospective — after the fact, so the mishap has already occurred. But we can speed up the process of “unsticking” behavior by reprogramming the symbols before their time. This has the effect of moving us to the next step and evolving us internally, which in turn has the power to affect our external world. The two are indivisible.

Everything in our external world acts as symbols and representations of meaning in our dream life. So too is the external a symbol of our internal world. There are two points here: the symbolic repetition can make us either take a look at ourselves and choose to reconstruct, or it can make us reinforce who we are and perpetuate the cycle. It is up to us to either challenge these states or ignore them and let them continue ad infinitum. Our external is no different to our internal world although we view the latter as tangible because it has form — we can touch it — but can we not also do that with our internal experience? When dreaming are there not chairs and people and things? Everything that we experience internally is what we experience externally, and the two collaborate to manifest our structure of life. All existence is symbolic of something: Our outer world symbolizes in concrete form and our inner life in nebulous forms. Perhaps this is the great cosmic laugh.

This is where symbolic visualization comes in for reprogramming the intrinsic creative power, but it is next to impossible to manifest without aligning and confronting the internal states that compromise us and letting go of that which prevents achievement. Hence by desiring the ultimate goal [future], we take the necessary steps to get there, and in doing so we make telos [the ultimate end] tangible. This desire is the step, imaging the program, and life the process. The best way to know where we are at within ourselves is to look at our life, the people in it and situations. These tell us where we are internally, and where we are internally will tell us where we are externally, and the cycle goes on. Now welcome to “reality” (1994).

The birth of the SIP

My work in symbols occurred in synchronicity with my personal reconstruction, which was described above. At that time, I was sometimes asked to do energy work with people, and during one of these sessions a woman spontaneously moved into a disturbing symbolic space. Because I could not leave her in this state of disequilibrium, I directed her to move through her metaphors by transforming her story from a powerless allegory to one of control and power. Very happy with the results of our work together, she told
others about it, and in this very simple way, my practice and what later came to be called the SIP was borne.

Right away, it was very clear that I had found my niche, and the feelings of personal displacement that I had carried with me evaporated. Doing this made it impossible for me to ever return to where it was that I had been before the demise of my marriage. For these reasons, I regard the end of my marital relationship and all that was connected with it as experiences that brought me to myself, which finally located me where I belonged. Doing this work also made it possible for me to finally utilize the talents and abilities that I had been unable to employ, and for this I am most grateful. Home is a nice place to be.

I have worked with a diverse assortment of both sexes from a variety of cultures and age groups. Thus far, over 100 people have tried the SIP with me, always hearing about the practice via word of mouth. The participants choose how it is that they want to proceed: Some are satisfied after a few sessions and others come over a long period of time. There are several reasons why people will do this work with me, although it is usually because they want to transform their own lives. With respect to the process itself, some are specifically interested in non-traditional approaches to well being, either because they are dissatisfied with traditional approaches or because they are themselves attracted to my ideas and method. Others, who are simply working with me based on the reported efficacy of the procedure, do not even realize that it is considered an alternative/complementary process.

My work with the SIP has been mostly on a part-time basis since its inception because I have attended school at the same time. I returned to do my undergraduate work in the Independent Study Department at the University of Waterloo in 1994, where I took
courses in psychology and the psychology of religion. My final year was a thesis. I did a study with four women where I used the technique of consciously transforming unreconciled dream metaphors into the desired allegory. From there I went on to do my Masters at OISE/UT, which led into my PhD program in the Department of Curriculum.

**The SIP in development**

The SIP has evolved considerably from its early days in the following ways: (a) a theoretical premise has been constructed, (b) it is more efficacious in terms of producing change, (c) the body is included, and (d) the focus is on how to create change rather than why the problem occurred. These developments resulted from the experience of doing the process with others, which has been a window into the world of symbols, and my own personal growth.

**The theoretical premise**

When I began the process of symbolizing the self, the work was heuristically based. Because my experience of symbols was such a natural part of my own reality and the procedure was founded more on talent than theory, it was very challenging to transform the abstract into something concrete without losing its essence. In those early days, I was not clear about the purpose, whereas now I definitively state that the focus of the work is to create change. This definition came about because people were coming to me out of a sense of personal dissatisfaction and as a result, transformation became the modus operandi of the SIP. My intent has always been to effectively develop the process so that the participants could achieve their desired results.

Before a basic theoretical premise was established, each person was treated individualistically. However, I began to observe patterns of symbolic formation, which
allowed me to theorize about meanings. (These ideas are presented in length in Chapters 6 and 7). I do realize that these repetitive symbolic associations manifested because of the manner in which I presented my questions (in Chapters 7 and 8). For instance, when I asked a person about a feeling state with which she or he was having conflict, such as frustration, she or he would spontaneously and without any prompting usually choose one of four metaphors: rubber (the most common choice), gelatin, metal or rock. These responses were certainly a surprise. When I first began seeing that rubber was such a popular symbol during the early aspect of the process, I thought that it was the oddest metaphor to choose (and I do not suggest symbols, except for fire, which is the letting-go part of the process). I was also struck by its ordinariness.

But after a while, it began to make a great deal of sense. The people who came to me were describing conflict that they were unable to resolve within themselves, which motivated their choice to seek outside assistance. Thus, they must have attempted to work out the issue on their own but to no avail. So when they went to this inner tension via the symbol, it was often experienced as rubber, which in this context was typically described as something that you can pull but which will always return to its original form. But rubber was used in other contexts as well. The participants' problems were also frequently symbolized as rock but as this was resolved, it became rubber, which meant it was now more flexible.

It should be noted that although I presented the above examples with generic associations to the symbol, this is not how I proceed in the SIP. Here, generic symbols do not exist, and instead, each individual creates his or her own images and makes his or her own associations. So I can certainly say that the constant use of these symbols — rubber, gelatin, rock and metal — is absolutely fascinating to me.
Another frequently observed pattern is the attachment that people have to the very thing that they want to change: They initially symbolize their problem places with attractive symbols; for instance, pain is represented as a beautiful flower. Additionally, I notice that participants often need to be taught *how* to learn. The following is an example of a person in a scenario that opens up the opportunity for learning because she is in a symbolic place that she wants to change:

Person (P): The ground is dry and unhealthy. I don’t like it like this.
Nicola (N): So what does it need?
P: For me to take care of it.
N: Okay.
P: But I don’t know how to. I’ve never done it.
N: Well, do you want to try?
P: But how? I’ve never done it.
N: Well, what does it need exactly?
P: Water.
N: Let’s start there. By doing it you will learn.

**Efficacy**

I do not suggest that the theoretical premise of the SIP is an absolute, but one of my main goals with this process is to make the work as efficient and user friendly as possible. Thus, the format that I have instantiated (described in Chapters 6 to 8) causes the SIP to be more efficacious and allows for faster transformation when compared to the early procedure. This present design also makes it easier for the participants to work with their symbols independently, whereas previously they relied more on me to get them to places of transformation.

**The body**

I started the SIP focused on mental and emotional symbolic representations, but soon expanded into the visceral metaphor. In this way, the body became the central tenet of the process — soma being viewed as the house of mind, emotions and spirit. So the
body is used as the metaphor for connecting mind and emotions into a whole unit, which is efficacious because the body is profoundly self. This evolution came about as a matter of process; that is, many of the techniques that are an inherent part of the procedure arose because I needed to devise creative ways to keep people transforming their metaphors. For example, when a person suggested a feeling state as a problem, say isolation, and he or she sought to resolve this by connecting other feeling states to it, such as “I am isolated because I am sad”, it made it very difficult to create transformation. Thus, I decided to try moving the participants into their body by asking them to locate their feelings in soma. In this way, the mental/emotional and thus abstract state became a concrete symbol and allowed for greater change.

Additionally, people would often describe physiological reactions to the feeling-states during the SIP. For instance, when depicting a place of conflict, a person would comment in pain, “I am getting a headache.” I would then ask him or her to go to the headache and take it out of the body. She or he would do this and the headache would disappear. This fascinated me, particularly as no one seemed to notice that he or she had just changed a physiological, thus concrete, state and defied the laws of logic. With experience, it became very clear that the line between psyche and soma is very blurry. This division is a human construction — the progeny of a dualistic paradigm — that is used to explain our existence, and it is my belief that any boundaries that do exist are permeable. The SIP, thus, resolves both psychological and physiological conflicts.

Creating change: How not why

I initiate the SIP by focusing on the why or cause of the problem being presented — the deterministic approach — but soon realized that this only led us (the participant and I) into a continual cycle but did not show us how to get out of it. It is very
natural in our culture that in seeing "an effect one looks for a cause" (Bronowski, 1978, 25), which is what participants constructed because I was asking why the problem occurred rather than finding out how it was functioning in their lives. Once I realised that seeking the cause only led into a feedback loop and so delayed transformation, I quickly sought more efficacious ways to get the participants through to the other side of the tension. So now "why" is only the context for the problem, and "how" to transform is the process that is taught. This is described fully in Chapters 7 and 8.

More importantly, people want me to teach them how to grow, learn, and become "unstuck", rather than fixate on the causative associations. Many explain that although they may understand why they operate in a certain manner, they are bereft as to how to create the desired change. This is not to imply that we do not explore causative associations, because this is an essential aspect in order for the participants to understand the self, but we do not remain there. Again, causation is only viewed as a personal construction and context to explain situations or behaviour, and we move rapidly into how to resolve the problem once such knowledge is gained. In other words, the purpose of the format is to teach how one can create change. So it can be said that the SIP functions first to extinguish old behaviours and then to recondition the mind, emotions and body towards a new state of being in order to create wholeness and well being.

A summation of the SIP

The basic premise of the SIP is that symbols are the building blocks of the mind/body and that they provide a direct means of communication within and between psyche/soma. The fundamental idea is that by breaking down and reconstructing symbols, an individual can learn to perceive the world in new ways rather than simply restructure the old.
Individuals who choose to work with me do so because they want to learn healthier ways of approaching their lives; in other words, new ways to function. In the SIP, the entry point into psyche/soma is usually through the symbolic representations of states that the individual has labeled as problematic, for example, anxiety. The process of symbolizing problem states (in this case anxiety) allows the person to: (a) learn about and understand his or her relationship to the affective states, (b) challenge these symbols and any attachment that she or he has to them, and (c) deconstruct them. In my experience with the SIP, out of this last process of deconstruction, there is an organic propensity for psyche/soma to create symbols that balance the problem states. Psyche/soma will orient towards the complement or opposite of the initial quandary (anxiety), which in this example would be calm and peace. The participants are taught to symbolize these freshly emerging symbols from within themselves in order to gain knowledge of and understand the new ways of being (calm and peace versus anxiety). In general, this is a very creative process of learning and reorientation.

The act of subjectively symbolizing is a way to experience affective states in a concrete way and a way to teach individuals how to personalize her or his experience. She or he can use this intrinsically based knowledge about self (the symbols of calm in this example) in order to recreate these newly emerged states by using the symbols within his or her own daily life. In this way, she or he can redirect psyche/soma from the problem state (anxiety) to the state of harmony (calm and peace).

I have illustrated these ideas in depth in Chapter 6, where I describe the theory and Chapter 7, where I describe the process using short vignettes from actual sessions with various people. The SIP is process-oriented, and the case study (Chapter 8) is illustrated very much like Melanie Klein’s (1961/1975) work, *Narrative of a Child*
Analysis. While the SIP may vary from person to person, so that each session cannot be replicated exactly, I can, however, say that the results are quite standard, such as the sense being more in control and personal betterment.

The SIP in a broader context

The idea that symbols can be used for the purpose of psyche/soma transformation and healing is not a new idea and can be traced back to antiquity. The art of shamanism (a shaman is a medicine man) is practiced through altered states of consciousness, which is the land of the imagination and dates back 20,000 or 30,000 years (Harner, 1980). Quite interestingly, there is a considerable similarity between traditions across a wide geographical span – Africa, Asia, Australia, Europe, and the Americas. The dominance of dualistic and mechanical paradigms usurped the wisdom of the imagination in the West, although there is a rising interest in alternative/complementary practices to well being. In terms of health and the body, imagery has been most commonly been linked to cancer remissions, made popular with the work done by the Simontons (Simonton et al., 1978) and Achterberg and Lawlis (Achterberg, 1985; Achterberg et al., 1994), but it also used in other areas, such as bio-feedback (Green and Green, 1986). On the psychological side, imagery has been theoretically explored in cognitive and symbolic interactionist theories; however, it usage has been mostly reserved for transpersonal therapies, such as Jung’s active imagination (Jung, 1973) and Assagioli’s psychosynthesis (Assagioli, 1971), Schultz’s autogenic training (Schultz and Luthe, 1959) and Ahsen’s eidetics (1977). The latter two (Schultz and Ahsen) use imagistic psychotherapeutic techniques to treat both the mind and the body. Although I am aware of these ideas and practices, I
do not situate or contextualize the SIP within these paradigms because the process did not emerge from them, but rather from within myself.

**Summary**

I have provided a synopsis of my personal journey through which I developed the ideas and practice for the approach that I call the Symbolic Immersion Process (SIP). All of this began with myself and grew from within me. This theory and process are explained in depth in Chapters 6 and 7 respectively and culminate with a case study in Chapter 8. The focus in the ensuing chapters is on the relationship between the mind and body because this thesis explores how the SIP can be efficacious in terms of treating physiological, in this case immunological, malfunctions.

This idea of using an intrinsic learning process to create well-being within the context of a physiologically defined illness is a different ontological model to that which is proposed biomedically. The biomedical paradigm favors a specific approach to disease: a specific treatment for a specific illness (Benson and Friedman, 1996). In other words, the theory is to discover and overcome a single cause of a disease rather than to bring the whole system into balance. The ideas that are proposed here are not located within the context of traditional biomedicine, which stresses universalism, reductionism and materialism. However, this does not suggest that the findings are not legitimate. As Myers and Benson (1992) point out, although “specific thought patterns . . . are neither material nor reducible and must be implemented in different ways for different individuals, their effects are, nonetheless, predictable, reproducible, and measurable” (9).
CHAPTER 2 - PSYCHONEUROIMMUNOLOGY: THE MIND-BODY/ BODY-MIND CONNECTION

Since the body reflects the brain, and the brain reflects the mind, and the two (brain and mind) are not separate while we have a body . . . it can be inferred that becoming aware of the body means becoming aware of the mind (Green and Green, 1986, 559).

The relationship between the mind and the body is a philosophic inquiry that has mystified humanity throughout its history. This investigation is essentially an ontological exploration: it is the desire to understand that which constitutes reality and the nature of consciousness. Contemporary philosophic debate surrounding the mind and body connection is concerned with defining mental and physical consciousness and their relationship to each other (Broom, 1997; Wilson, 1980). The literature falls into three main schools of thought: dualism, monism, and interactionism. Dualism separates psyche and soma, monism postulates a material reality, and interactionism is the union of the two. In this chapter, interactionism is examined through the biopsychosocial model of psychoneuroimmunology, which is the investigation of thoughts and feelings (psycho), the nervous system (neuro), and healing (immunology) and their interaction with each other (Fanning, 1988).

Dualism

Much of modern thought is the by-product of Cartesian dualism which posits that the contents of the mind are comprised of thoughts (for example, beliefs, assumptions, ideas, intentions) and feeling states, such as emotions. This is distinguished from the spatio-temporal world where matter is transformed through physical action. Such a distinction creates the dialectics of perception and action (Irani, 1980). Perception is where the material interacts with
and affects the body through its senses leading to mental apprehension and deductions about extrinsic reality. This is juxtaposed to action where an intention to act only materializes through stimulating the body, such as the nervous system, which then creates action in the external world. In dualism, the mind and body are compartmentalized and separated, independent of each other. Thus, the mind is immaterial and the body material.

**Monism**

Monists, on the other hand, view the brain as purely material and the mind as entirely reducible to matter (Dennett, 1991; Pribram, 1971). Unlike dualists, identity theorists hold that the mind and the brain are synonymous and as the body does not generate mental events; the interaction is in one direction only (Eccles, 1994). Although monism accounts for states of consciousness, they are simply passive biological functions, and “the mind is a ‘bundle’ of conscious sensations and sensationless thoughts, which are the subjective qualities of objectively distinguishable structures and functions of the nervous system” (Kunzendorf, 1990, 9). Pribram (1971), for instance, who is known for his pioneering theory that the nature of the brain is holographic and who accounts for both internal and external reality, nevertheless reduces all of these processes to neural discharges. The mind and its functions are part of that information-processing, self-regulating electrical unit. It is a closed, biological structure: the brain creates and achieves growth through its system of encoding and recoding. Thus, the mind is simply a part of the brain’s neural activity, in other words, epiphenomena. The brain, then, is “uncompromisingly physical” (Endleman, 1989,10). Consciousness is a psychoneural process. As a result, “the ontology of the unconscious is strictly the ontology of a neurophysiology capable of generating the conscious” (Searle, 1992, 172). Monism posits the brain, not the body, as the center of cognition.
Interactionism

Materialism subsumes all mental and physiological states into a purely biological, adaptive context that is attractive scientifically because the mind and body can be observed, measured, predicted and explained. Such an evolution, however, does not account for the dialectics of culture and socialization, self-identification and processing. Neither does it explain the phenomenological aspect of human existence. "The assertion of double-aspect or an identity theory of the relation of body and mind cannot, by itself, support an inference to an underlying identity" (Irani, 1980, 70). Where is creativity, the imagination, or personal identity? How does this account for future possibilities? By compartmentalizing the mind and body into two distinct, independent entities, psyche and soma are disconnected, fragmented and separated. "Materialist solutions fail to account for our uniqueness" (Eccles, 1994, 180).

Interactionist theories of the mind and body, however, attempt to reconcile the separationist philosophy underlying dualism, the one-sidedness of monism and the mechanical approach of the two. Dualistic interactionist models, such as the one proposed by Tart (1990), posit the brain as "the link between consciousness and the physical world" (45) and in doing so locates the brain as the center of consciousness. Consequently, the body is separated and like monism, the movement is in one direction. Eccles (1994), on the other hand, presents an interactionist paradigm which states that certain physiological events produce certain psychological processes in the mind and that this is a bi-directional exchange: some mental events generate some physical transformations in somatic states. An interactionist theory where "the mind and body both exist, and they interact" (Fanning, 1988, 308) emerged around the 1980s as a field of biopsychosocial investigation called psychoneuroimmunology (PNI). Although this study rarely explores the philosophic debate of the mind, and in fact mostly approaches mental states as a biological function, it is an important scientific examination of the
interaction between these two previously disconnected areas. This mind/brain and body debate will be examined more fully in Chapter three.

The field of psychoneuroimmunology, which will be explored in this section, demonstrates that the psyche and soma are interactive and function in a feedback loop pattern. Thus, transformation, whether constructive or destructive, is occurring at both the psychosocial and biological levels at the same time. Furthermore, the research shows that biopsychosocial changes occur in multiple ways and on multiple levels.

Psychoneuroimmunology: The Scientific Approach to the Mind and Body

The idiom psychoimmunology can be traced back to as early as 1964 when George Solomon created the term (Solomon and Moos, 1964). However, it would not be until nearly 20 years later, in 1980, that the name psychoneuroimmunology (PNI) would come to be coined by Robert Ader (Ader, 1981) subsequent to his groundbreaking research which showed that the immune system can be conditioned (Ader and Cohen, 1975). In this way, the investigation into the relationship between the mind and the immune system was seriously started, an inquiry that challenged the traditional view that the immune system is autonomous (Maier, et al., 1994).

In attempting to teach rats to avoid water, Ader and Cohen (1975) paired saccharin, the conditioned stimulus (CS), with cyclophosphamide, a drug which creates nausea and stomach problems, as the unconditioned stimulus (UCS). The rats, however, not only learnt to avoid the water as is typical of conditioning, but also died when the saccharin was administered alone. Thus, the rats were not only conditioned to avoid the nausea, but their immune system was also being conditioned to suppress its function. From this Ader concluded that the immune system can be conditioned, which also implies the central nervous system (CNS) and the immune system communicate with each other.
The body of research that has since followed demonstrates that there is a triadic interaction between the immune, the nervous and the endocrine systems (Zanker, 1994). The flow of hormones, neuropeptides and cytokines which travel through the blood (Kaku, 1998) communicate in bi-directional pathways among the psycho-neuro-endocrine-immune systems (Friedman et al., 1996). In order for internal homeostasis and balance to be maintained, the organism is dependent upon the interaction between and communication amongst these psychological, neural, endocrine and immune processes (Ader, 1996). In other words, systematic and holistic harmony is reliant upon the integration of these subsystems (Booth and Ashbridge, 1993). Thus, a change in one system affects the other. This change is bi-directional and can be either immuno-enhancing or immuno-suppressing (Felten et al., 1991).

**Behavioral and psychosocial influences on the immune system**

Biological systems, such as the immune system, exist in a state of internal homeostasis unless there is a disruption. As a result, much of the research in psychoneuroimmunology has focused on the effect of stress on the organism because of the psychological and physiological pressure that stress places on the whole system (Biondi and Kotzialidis, 1994). Stress is commonly defined as an organism's psychological and physiological incapacity to contend with external demands (Johnston, 1997). However, understanding the vastness of stress and human response processes is a very complex matter. Although stress is not easily defined, the literature tends to fall into two theoretical categories: non-specific and specific theories.

The former is the traditional biological view of stress pioneered by Hans Selye, an early researcher studying the effects of stress on the immune system. Selye’s non-specific model (1936) views stress as the body’s general (non-specific) response to a variety of demands (Selye, 1956). Stress is an adaptive biological process that is a reaction to the external environment which causes a disruption of the organism’s system, such as hormonal increases from the
pituitary and adrenal glands. He identified this as the General Adaptation Syndrome (GAS) which consists of three stages that depict the specific physiological processes to protracted stress. Initially, there is the *alarm reaction* or flight or fight response, after which is the *stage of resistance* where the organism adapts to the stress if it is not prolonged. Finally, there is the *stage of exhaustion* where the organism’s system deteriorates after protracted exposure to stress.

Specificity approaches, on the other hand, focus on intrinsic response processes. Challenging the general response and inductive non-specificity paradigm, other physiological stress models hold that different stressors produce different reactions. For instance, different stressors produce different autonomic and neuroendocrine responses (Watkins, 1997). There is also research suggesting that there are a variety of stress responses to the same stressor (Zacharaie, 1994), and other research that shows that organ systems that are weak react to stressors in a patterned manner (Bieliauskas, 1982).

While this research has traditionally focused on the physiological aspect of stress, the more recent psychosocial findings challenge the strictly biological response models. These findings suggest that the psycho-neuro-immune interactions govern the system. On the one hand, there are theorists who view stress as initiating at the behavioral level; therefore, the physiological effects are a secondary process (Bieliauskas, 1982). This view contrasts with traditional beliefs that see stress as a primarily biological adaptive process; thus, the psychosocial factors are secondary (Dunn, 1996). A more holistic model, however, explores stress as a complex and dynamic interaction of various psychological factors (such as depression) and physiological factors (such as immunologic responses that are bi-directional and interconnected).
Interaction between the immune, the nervous, and the endocrine systems

The body is protected from infectious substances, such as viruses and bacteria, by the network of cells that comprise the immune system. Immunologic cells are dispersed throughout the body although most of them can be found in the thymus, spleen, lymph nodes, bone marrow and mucosa lining. The immune system is responsible for, amongst other things, reacting to antigens, the foreign agents that invade the body; for its production of antibodies, proteins that engulf and attack the antigens; and for producing substances, such as cytokines, the immunologic chemical mediators. It is the leukocytes, or white blood cells, which protect the body and produce antibodies. Lymphocytes, the most significant of the white blood cells, consist of the T and B-lymphocytes, phagocytes and Natural Killer (NK) cells. Each cell is responsible for different functions. T-lymphocytes are a part of the cell-mediated system. They are mostly comprised of Helper T-cells (which make the immune cells aggress), the Suppressor T-cells (which repress other immune cells), and Killer T-cells (which are responsible for destroying viruses and cancer infected cells). B-lymphocytes produce antibodies as a response to the presence of antigens in order to combat the bacteria. Finally, phagocytes not only destroy bacteria but also communicate the existence of foreign bodies to the immune system, and Natural Killer cells are responsible for destroying cancer cells (Bloom, 1980).

There are two types of immune system responses: humoral immunity and cell mediated immunity. The humoral immunity response produces free antibodies through the proliferation of B-lymphocytes that attack the antigens that circulate in the blood stream. Cell mediated immunity, on the other hand, attacks the antigens inside of the cell through the T-lymphocytes, which unlike antibodies, are incapable of attacking free-floating antigens.

Recent findings demonstrate that the immune system communicates with the endocrine and nervous systems and that each can modulate the functioning of the cells within its system or
connected to the other systems. The brain and the immune system stimulate, secrete and synthesize a variety of identical molecules by which they communicate. For example, cytokines, steroids and a variety of neuropeptides or neurohormones mediate many response signals (Friedman, et al., 1996). The immune system responds to different antigens that are regulated by the CNS and the neuroendocrine systems of the body. Research shows that leukocytes are responsible for both modulating the nervous system’s production of neuroendocrine peptide and for producing stress-associated peptides and hormones that were previously considered to be solely the function of the CNS (Watkins, 1997).

Thus, the function of these systems may be reciprocally influenced by the proteins (e.g., cytokines and neuropeptides) produced by immune cells. The lymphoid organs and the other immunologic structures, for instance, the bone marrow where cells are produced and the spleen where such cells are stored, are also richly innervated by the autonomic nervous system (Felten and Felten, 1991). They share the same neural connections or receptors for neurotransmitters (such as catecholamine neurotransmitter receptors), hormones and cytokines. For example, a variety of leukocyte functions can be suppressed or stimulated by the nervous and endocrine system’s release of hormones (Watkins, 1997). Moreover, the terminals of the sympathetic nerve endings in these immune organs make contact with lymphocytes themselves. Thus, “the brain is physically connected to the immune system” (Maier et. al, 1994, 1006). This is a reciprocal, feedback loop so the immune system is also physically connected to the brain; in other words, the body is in the brain.

Homeostasis is achieved because of the integrated manner in which the CNS modulates the immune function through efferent (brain) autonomic and neuroendocrine pathways and the immune system modulates the brain function through a variety of afferent (body) pathways. In this way, these systems can react to physiological and/or psychosocial challenges. Thus it is that
the two systems affect each other in a bi-directional feedback manner, that is, impulses that regulate the organism act on the immune system from both the efferent arm (the CNS) and from the afferent arm (the immune system) to the CNS through cytokine mediation (Kaschka, 1997).

**Stress and immunity**

When the organism is exposed to stress, whether it is physiological (for instance, the presence of antigens) or psychosocial (for instance, depression, which will be discussed further in this chapter), it generates a neuroendocrine-immune response. On the physiological side, when an antigen invades the body, the immune system responds by releasing cytokines. The hypothalamus reacts to the elevated level of cytokines by increasing its neural output which creates two separate pathways from the CNS to the lymphoid organs: the release of corticotropin releasing factor (CRF) from the hypothalamus and the activation of the sympathetic nervous system (SNS). In the first instance, the release of CRF stimulates the pituitary gland to release adrenocorticotropic hormone (ACTH) and the neuropeptide Beta-endorphin. ACTH induces the adrenal to secrete corticosteroids and glucocorticoids that suppress the immune activity (Blalock et al., 1985). With the other pathway, the CRF stimulates the SNS to release norepinephrine (NE) or the circulating cytokines cross over into the CNS through the sympathetic neurotransmitters containing NE that are found in lymphoid organs, which can cause immunosuppression or enhancement (Clancy, 1998).

Psychosocial stressful situations are known to activate both the autonomic nervous system, whose cells react through neurotransmitters and the endocrine system, which responds by releasing hormones. The CNS regulates the immune system by either inhibiting or enhancing immunity through these neuroendocrine and autonomic pathways. Thus, CNS and endocrine changes affect how the immune system responds. These systems are able to cross communicate through two neuro-endocrine axis: the hypothalamic-pituitary-adrenal axis (HPA) and the
sympathetic-adreno-medullary (SAM) axis (Zanker, 1994). The hypothalamus, pituitary and adrenal glands are interconnected, and this union of the neural and hormonal responses through the HPA axis is a physiological adaptive mechanism via which the organism contends with stress in order to maintain homeostasis.

The sympathetic nervous system (SNS) or stress response creates changes in the CNS and endocrine systems. The hypothalamus, which is the main connection between the immune system and the CNS, and the adrenal glands work together to produce hormones: the hypothalamus releases the corticotrophin releasing factor (CRF) that in turn causes the adrenal cortex to produce plasma catecholamines (for example, epinephrine and norepinephrine) and the corticosteroids (for example, cortisol) (Zacharaie, 1996). Their release influences the different immune cells and functions because of their immunosuppressing qualities (Dunn, 1996). For instance, the biochemical changes that occur as a result of this adrenal activity affect the production and circulation of cytokines. Cortisol, for example, which is one of the major glucocorticoids, impedes cytokine production, inhibits both the activity of the NK (natural killer) cells and the responsiveness of antibodies to various antigens, and decreases the proliferation of white blood cells (Friedman et al., 1996). The CRF release from the hypothalamus also causes the release of ACTH and beta-endorphins, and some interleukins (Dunn, 1996; Biondi and Kotzakidis, 1994). These affect the immune system in different ways, such as NK activity and proliferation. The greater the distress, the greater the immuno-suppression.

It is important to note that although there is a general biological response to stress that involves the HPA and SAM axis, stress is nonetheless not a single type of response. Various physiological and behavioral responses to stress occur (Zacharaie, 1997). For instance, according to Watkins (1997) the flight or fight reaction, which is connected to emotions such as anger and fear, create different SAM reactions. The fight response stimulates norepinephrine,
whereas the flight response activates epinephrine. Conversely, submissive responses, which are associated with feelings of despair and helplessness, involve the HPA axis. Because individuals typically oscillate between aggressive and submissive emotions when responding to stress, the resultant over-production of these hormones creates a destructive cycle for not only the body and the immune system but the mind as well.

**Stress and Immunosuppression**

Numerous animal and human studies have been conducted on the relationship between stress, the immune system and illness. The results of this research demonstrate that stressful events, which affect both behavioral and CNS functions, also influence the immune system. Studies by Monjan and Collector (1977) show that variables, such as the type of stress, its acuteness and temporal span, influence immune responses. Furthermore, stressors affect the organism differently in two areas: the characteristic of the stressor and the characteristic of the response. Thus, the immune system will have a different immunologic response to one stressor, such as lymphocyte responsiveness, and the organism can have a similar immune response to different stressors.

Human research is less easily controlled than animal studies, must be conducted in vivo, and is limited to environmentally occurring stressors. A variety of studies suggest that stressors may negatively affect the immune system by decreasing its resistance levels and making it susceptible to certain infectious diseases, such as herpes simplex virus and the Epstein Barr virus (EBV) (Kielcot-Glaser, 1991). There are two types of stressors that are discussed in relation to immunosuppression: *chronic or life disturbing stress*, such as bereavement, divorce, and depression, and *acute stress*, such as medical students’ examinations. According to Schneiderman and Baum (1992), stress that is acute can create responses that are short-term
because the stressor subsides or the organism adjusts to the situation. However, acute stress that is traumatic or life disrupting can result in an extended stress response. Likewise, the inflexibility of chronic stressors or the inability to adapt can lead to a long-term stress response.

It is important to understand that this response demarcation varies due to numerous psychological and environmental factors that influence the impact that stress has on the organism, such as the individual’s ability to cope. When psychosocial factors are taken into consideration, stress is a far more multifaceted process to define. Because stress affects different people in different ways, the personal and cognitive context is as relevant as the external or physiological stressor. Furthermore, the subjective interpretation, not just the physiological response, is as important in determining the experience, duration or even existence of stress. Therefore, factors such as coping styles (Lazarus, 1977), types of stressors, whether minor (e.g., Kielcolt-Glaser et al., 1984) or major (e.g., Bartrop, 1977); personality (e.g., Kobasa, 1979); conditioning (Ader and Cohen, 1975); and social conditions, such as isolation (e.g., Kielcolt-Glaser et al., 1984) have to be considered and often have been shown to work inter-relationally.

**Chronic and life disrupting stress and immunosuppression**

**Bereavement**

Bartrop and colleagues (1977) were the first to investigate bereavement and its effect on the immune system of 26 subjects. This investigation was conducted with individuals by measuring lymphocyte responses two and six weeks after their spouse had died. There was a significant decrease in the Con A (concanavalin A) stimulated lymphocyte function after the six week period when compared to the age and gender matched control group. Their T and B cells, DTH (delayed-type hypersensitivity) responses and immunoglobulins remained the same.
A similar investigation was done by Schliefer and colleagues (1983). They conducted a prospective study of 15 men whose wives were terminally ill with breast cancer. The immune system was tested before and after the death of their spouse. There was no significant change in the number of T and B cells, but their lymphocyte proliferation to the mitogens PHA (phytohemagglutinin), Con A, and PWM (pokeweed mitogen) was significantly lowered in the first two months after bereavement. At the end of the bereavement year, most of the participant’s mitogen responses returned to their pre-bereavement level.

Bereavement, however, rarely occurs without a variety of other emotional factors that affect the experience of bereavement. A series of studies on bereavement and depression were conducted by Irwin and colleagues. In the first study, they measured the NK activity and T cell numbers in two groups of women whose husbands were either terminally ill or who were recently bereaved (Irwin et al., 1987a). The Social Readjustment Scale (SRS) was used in order to assess the rate of the depression. The newly pre- and post-bereaved women who had a moderate to high SRS level also had reduced NK activity when compared to a control group of women with healthy husbands. A prospective study also conducted by Irwin and colleagues (Irwin et al., 1987b) examined whether the lower NK numbers were related to the death or the depression. No difference was found between the pre and post-bereavement period, but the increase in depression was correlated with a decrease in NK cells. These studies suggest that how one responds or copes with the stress, in this case death of a spouse, has a greater significance to immune responses that the actual stressor.

Spousal bereavement has also been connected to mortality rates. For instance, Helsing, Szklo and Comstock (1981) studied spousal bereavement on 4,000 subjects, and they found that for 10 years following their spouses’ deaths, there was a higher degree of mortality among
members of the bereaved group. This was particularly so for those widowers who were between the ages of 55 and 74.

Bereavement is of particular significance for HIV seropositive gay men whose intimate partners may also have contracted the disease. Kemeny et al. (1995) did a longitudinal study of 1,637 HIV+ gay and bisexual men to see if those men whose partners had died of AIDS in the past year experienced immune system responses. Blood that was drawn before their partner's death was compared to the blood that was drawn up to 13 months subsequent to the partner's death. Compared to the nonbereaved control group, researchers found a decrease in the lymphocyte proliferative response to PHA and an increased level of immune activation (neopterin levels) among members of the bereaved group.

Depression

Depressive states have been connected to a weakened immune function. Schliefer and colleagues (1989) studied the immune functions of 91 patients ranging in age, sex and degree of illness who were diagnosed with major depressive disorder (MDD) and who were hospitalized and ambulatory. They were also free of drugs that are known to affect the immune system. There was no significant difference in immune measures between this and the control group. However, when the gender, age, degree of illness and hospitalization were considered, there was a significant difference in age-related immune effects between the patients and the control group in terms of the number of T helper (CD4+) cells and mitogen-induced lymphocyte activity. The degree of the depression, as with bereavement, was associated with the change in the immune measures.

Irwin et al. (1987c) also studied 19 depressed patients who were medication-free. They had lower NK activity when compared to an age and gender-matched control group. Kronfol et al. (1983) had comparable findings. They studied a group of patients who were also medication-
free and diagnosed with a depressive disorder. They had a significantly lower T lymphocyte response to mitogen stimulation.

Depression, however, is often a response to uncontrollable life situations in healthy individuals. Kielcolt-Glaser et al. (1987b) studied 34 caregivers of family members with Alzheimer’s disease (AD). The participants were measured for depression, and this was compared to the age, education and income matched control group. The subjects were significantly more depressed and their immune function was lower (lower amounts of T lymphocytes and helper T lymphocytes) than the control group.

McKinnon and colleagues (1989) studied the victims of The Three Mile Island nuclear power plant disaster over a six-year period. Their B-lymphocytes, NK cells and T suppressor/cytotoxic lymphocytes were significantly lower than those in the control group who lived 80 miles away. They also showed other immunologic differences with increased antibody titers for the latent viruses, herpes simplex and cytomegalovirus.

**Marital Disharmony and Divorce**

In another study by Kielcolt-Glaser and colleagues (1987a), 16 women who had been separated or divorced for one year were compared to 16 married women who were matched for age, progeny, marriage length, and socioeconomic position of spouse or ex-spouse. The study group had reduced mitogen responses, a significantly lower number of T lymphocytes, higher antibody titers to Epstein-Barr virus (EBV), and greater depressive symptoms than the control group. In a larger study, 38 women who were separated or divorced women separated or divorced for at most six years were sociodemographically matched against 38 married women. The study group showed a greater degree of depression, higher antibody titers to EBV, and lower helper T cells (Kielcolt et al., 1987a).
Intermediate or Short Term Stress and Immunosuppression

Medical exams

Kielcolt-Glaser and colleagues conducted various studies in the 1980s on the effect that exams had on medical students in an attempt to explore how acute or short term stress affects the immune system. They also wanted to investigate if immunologic changes increase the chance of catching contagious diseases such as the common cold virus (Kielcolt-Glaser and Glaser, 1991). They found a decrease in the NK activity of the students during their examination period when compared to the pre-examination time (Kielcolt-Glaser, Garner, et al., 1984; Glaser, Rice, et al., 1986). Further studies found that there were differences in immune responses during the examination period. The NK cell and the total T-lymphocyte numbers, the mitogen responsiveness, and antibody titers to EPV had all decreased when compared to before the examination time (Glaser, Kielcolt-Glaser, et al., 1985a; Kielcolt-Glaser, Glaser et al., 1986; Glaser, et al., 1986). Another study by Workman and LaVia (1987) found a decrease in T cell proliferation to PHA system responses that continued up to four weeks after participants' examinations. It was not until the sixth week that their immune system returned to its original measure, which was taken one day prior to the examination.

Psychosocial factors also contribute to immunologic responses. Students who had an above median score of loneliness in the UCLA Loneliness Scale and who were experiencing stressful situations also had lower levels of NK cell activity and reduced T lymphocyte proliferation to PHA than those students who had a below average loneliness score (Kielcolt-Glaser et al., 1984). The former also had significantly higher antibody titers to EBV (Glaser et al., 1985a).
Summary

This research suggests that chronic stress, which arises due to events such as death or divorce of a spouse and long-term uncontrollable stressors, affects the immune system because individuals are unable to adapt to the situation when compared to their more stable control groups. It appears, then, that our ability to cope with stress depends on the duration of the SNR (sympathetic nervous response) response or how long it takes to return to homeostasis. In terms of immuno-suppression, the research demonstrates that there are general immunologic changes that occur as a result of chronic stressors. For instance, there are lower numbers of helper and suppressor T lymphocytes and NK cells, decreased proliferation of lymphocytes to Con A, PWM, and PHA, and higher antibody titers to EBV. Combined factors such as bereavement and depression also have to be considered in the psychological mediation of stress as it impacts the immune system.

Likewise, intermediate stressors, such as examination stress, also seem to affect immune functions. These effects include lower levels of helper and suppressor T cells and proliferation of T cells to PHA. NK percentages and their activity are reduced, and antibody titers to EBV are higher. In addition, psychological variables such as loneliness also appear to negatively affect the immune system's ability to respond to stressors.

Conclusion

The PNI research forces us to examine the mind and body relationship as an integrated rather than a separated system. Given that the CNS, the endocrine system, and the immune system interact, it is clear that psychosocial stressors influence health. In other words, that which impacts the body also impacts the mind and vice versa. Having demonstrated that there is a connection between the mental/emotional, behavioral/social and the immune system, continuing to accept the idea of the mind and the body as separate entities would be
epistemologically and methodologically incorrect. What is undeniable, instead, is that psyche and soma are intricately interwoven, and this translates into psychosocial factors that being intertwined with immunologic functions, such as modulation and disease mediation -- and perhaps even disease genesis.

The interaction between stress and these systems is, however, a complex one and forces us to ask what this implies for both physiological and psychological well-being. Such issues as social support, the ability to cope and reduce stress, are some of the questions that need to be addressed so that the impact of stress can be mediated. What is clear is that an individual's response does not occur in a physiological or even psychological vacuum but instead depends on many variables, such as his or her experience with and extent of the stressor, loneliness and depression. The main therapeutic question that this poses is how the response of the individual can be shaped so that stress associated events, which tax the system, can be buffered.
CHAPTER 3 - HEALTH AND THE WHOLE SYSTEM

There is an unfortunate tendency to ignore or depreciate phenomena for which we have no mechanistic explanation (Ader, 2000, 10).

The PNI research showing that the mind and body are interconnected has enormous implications for the care of the person, be it health or otherwise. It demands a whole system approach. Such an approach would contrast with the traditional biomedical model, which views the body as mechanical and causation as biological, and which focuses on pathology and compartmentalizes analysis. Intervention is approached generically and is physiologically based. In addition, the patient is viewed as a passive recipient to both the disease invading the body and to the treatment provided by the physician (Pelletier, 1979).

This “mechanistic physiopathology” (Sheikh et al., 1979) does not adequately describe or explain the multiplicity of human experience in health or in illness. On the one hand, those who are part of the mental health disciplines struggle to study the mind based on the empirico-positivist paradigm. However, this model is so mechanized that concerns such as the mind-body relationship, which is the central tenet for psychosomatic investigation, invariably prove to be theoretically and practically troubling. As a result, those in the field grapple “apparently perpetually, with the question of the transduction of mental phenomena into physical phenomena, and vice versa” (Carlson et al, 1980, 251-2).

On the other side is the biomedical model that views the brain “as a computer running the body machine. Physicians find little place for wonder or ecstasy, only reason and objectivity. Training makes them happy to accept the idea that brain-events are mind-events” (Martin, 1997,
55). These rigid and non-pliable boundaries are limiting, and it would be apt to recognise that the body that is "mutable and interactive" has a greater capacity to be transformative than an organism that is "tightly compartmentalized [and] poorly articulated" (Murphy, 1992, 23). Once the mind is validated to be as substantial as the body, it can then be seen to play a role in the healing process alongside the body (Bolletino, 1997).

The systems model, such as the one proposed by Bakal (1992), attempts to reconcile the dualistic conflict. This paradigm argues for an approach that views all systems as interrelated: all parts of the system operate together, not separately, and as a whole. Therefore, all change affects and is connected to change in other aspects of the whole entity. In addition, the system strives to maintain a constant state of balance or homeostasis. In terms of health, this means that if the mind or body is negatively affected, so is the entire system. The idea that a person is a whole system rather than a collection of biological cells which may be diseased (Weiner, 1977) means that humans are not isolated organisms that function autonomously, unaffected by extrinsic occurrences (Lachman, 1977).

When well-being is considered more broadly than within a biological context, it begs for expansive approaches that go beyond simple mechanistic theories. Sharpe and Wessely (1997), for instance, define illness as the feeling of physiological disturbance and disease as a measurable or tangible physiological problem. According to Zachariae (1996), health is "optimal coherence" while disease is a "disregulation of complex systems":

The maintenance of health may be said to depend on the maintenance of the optimal coherence within and among all levels of an organism, and we should be able to identify both psychological and immunological mechanisms that facilitate this process while supporting the identity, self-image and integrity of the person. Conversely, disease is promoted by dysregulation and disconnection of these processes. . . . The health status of an organism can be seen as related to either adequate or inadequate self-regulation, and disease can be viewed as dysregulation of complex systems rather than simple "mechanical" failure (25).
The challenge that is posed by examining questions of health which go beyond physiology is that we are forced into intangible areas of psyche/soma that are not as easily defined or treated by biomedicine due to the complexity of the human condition. But as Engel (1997) argues, the biomedical movement towards a biopsychosocial approach is a valuation of humanness. PNI findings force us to ask these questions, which could be previously dismissed as irrational. For instance, if disease is greater than cellular structures how does disease not only progress but how and where does it start? And how can we utilise the mind in terms of health?

What is clear is that while a great deal of emphasis has been placed on understanding the processes that underpin the physiological etiology and mediation of disease, there has historically been far less interest in the investigation of the symbolic processes that are also part of disease etiology. As a result, complex physiological responses to mental stimuli are not clearly understood and have only recently gained some scientific credibility with the emergence of PNI. But this research is in its early stages, and at this time, poses more questions than it has yet answered. However, considering that these findings demonstrate that the mind and body are interconnected, I argue that the question of how the mind interacts with the body needs to be explored in depth and in conjunction with, rather than as an addendum to, biomedicine.

**The Manifestation of Illness**

There are many different theories about the manifestation of illness when the mind is considered alongside the body. When the person is considered as a whole, so that the experience of wellness is not simply physiological homeostasis and illness is not just a mechanical breakdown, various factors are considered in the genesis of disease. These are referred to as *specificity approaches*. Theories about how the mind and body connect in illness can be divided into five categories: (a) physiological weakness; (b) specific physiological responses to...
emotional precursors; (c) varying physiological responses to emotional precursors; (d) specific behavioral and coping patterns; or (e) multiple psychosocial and behavioral factors.

**Physiological weakness**

This theory holds that the weakest regions of the body, due to factors such as genetics, injury or conditioning, are the areas that will be most susceptible to emotional and mental stressors. For instance, there is organ sensitivity; that is, those who have systematically experienced problems with an organ system tend to have a conditioned organ response to psychosocial stressors. This organ weakness erupts after the continual exposure to stressors. Isenberg et al. (1992) examined 10 different studies that researched the relationship of emotions and asthma symptoms. They found that there were asthmatic symptoms in reaction to the induced emotional stressors in 40 per cent of the participants. In studies of Crohn’s disease (Helzer et al., 1984), it was found that in 50 per cent of those with the disease, there was a relationship between psychological disturbances.

According to this theory, there can be systemic weakness due to contagion. Robert Heilig and Hans Hoff, for instance, hypnotised three subjects who had the herpes virus and asked them to recall difficult past events. All of the participants had subsequent outbreaks of the herpes virus (Hafen et al., 1996). Kemeny et al. (1989) also studied 19 herpes simplex virus type-2 (HSV-2) subjects who had recurring outbreaks in the six months prior to the study. There was a correlation between describing a high degree of stress and a lower level of CD4 cells and CD8 (suppressor/cytotoxic T-lymphocytes). Those who reported depression also had a reduced number of CD8 cells.

This theory also investigates those who are genetically disposed to disease. Vogele and Steptoe (1993), who conducted research on hypertension in schoolboys who were genetically
predisposed to it, found that it was more probable for those boys who repressed their anger to have high blood pressure reactions during tests for mental stress.

Thus, according to this theory, the person either has a physiological weakness that is vulnerable to and weakened by emotional factors, or the individual, having developed a physiological weakness through repetitious experience, will be disposed to that weakness in the face of any given stress. The difference between these two is that in the former case, the factors are genetic, and in the second case, the weakness manifests due to environmental reasons, such as viral contagion.

Specific physiological responses to emotional precursors

The idea that there are specific physiological responses to emotional precursors is a theory that postulates an intimate and specific connection between somatic responses and emotional stimuli. It is believed that there are specific psychological and emotional reasons for the etiology of an equally specific disease. Although this theory is generally thought to be too narrow in outlook (Bieliauskas, 1982), a common belief is that a disorder represents or symbolizes a particular physiological state. The body, then, is trying to communicate emotional issues to the individual through the illness. It is the body’s language. For instance, constipation is the manifestation of holding onto emotional states. The illness is “a metaphor for, and a partial symbolic working out of” the emotions (Broom, 1997, 6). Chiozza (1998) provides a symbolic meaning for a range of illnesses. The skin, for example, symbolizes a container for self-identity. Thus, the manifestation of psoriasis is related to the person’s suffering from a lack of close contact and affection early in life. Respiratory illnesses, on the other hand, symbolize a lack of encouragement, and so forth.

W. J. Grace and D. T. Graham (Hafen, 1996) connected disease to personal and environmental states. They interviewed people who suffered from 12 different ailments, and
they found them symbolically connected to their emotional states. For example, those with diarrhea desired to eliminate something in their lives, and conversely those who were constipated were stalwart in their intent to overcome their difficult situations.

*Varying physiological responses to emotional precursors*

This theory holds that different people experience different somatic responses for the same psychosocial precursors; that is, specific emotions for unspecific responses (Kemeny and Laudenslager, 1999). Stein et al. (1991) linked depression to a variety of immune system dysfunctions, such as herpes simplex virus and Epstein-Barr virus (EBV). Depression has also been linked to cancer. A 17-year prospective study was conducted on 2000 males who were all in healthy physical condition. The results of the investigation found that the higher rate of depression in the early years of adulthood, the greater the likelihood of ensuing cancer development (Watkins, 1997).

*Specific behavioral and coping patterns*

There has been a substantial amount of research about the relationship between personality and somatic disorder. Temoshok (1990) describes a “Type C” coping style as an acquiescent, martyring, complacent, pleasing, powerless personality type who withholds emotional expression, particularly those that are considered negative. This sort of compliant and powerless coping style causes the person to repress his or her feelings, which creates tension in the body and a reduction of somatic awareness. Bakal (1999) believes that denying and withholding emotions which have both psychological and physiological correlates, leads to a systematic unconsciousness that factors in the occurrence of disease. Temoshok does not suggest that these coping styles are the singular causation of immune disease and illness, but he
emphasizes that there are strong correlational factors between this personality type and the
development of disease.

Much of this type of research examines the specific personality characteristics that relate
to specific illnesses. It is hypothesized that there are, for instance, cancer personality types who
have low self-esteem, who refuse or repress what they consider to be negative emotions, such as
anger, and who are passive and pleasers (LeShan, 1959; Temoshok and Dreher, 1992). The
WITTEN study (Zanker, 1994) was conducted with 50 cancer patients. Thirteen of them had
colon cancer and 37 had breast cancer. It was found that the expression or suppression of anger
affected the release of adrenocorticotropic hormone (ACTH) and Beta-endorphin secretion.
ACTH and Beta-endorphin modulate the immune system: an increase in their production leads to
a suppression of certain immune functions. Expression of anger was correlated with a decrease
of ACTH secretion and decreased Beta-endorphin levels. This compared to an increase in
ACTH levels amongst those patients who had suppressed or controlled their anger.

Friedman and Rosenman (1974) have also devised a system for relating personality types
to coronary illness. They found that there are certain behavioral and personality characteristics
that are synonymous with the disease: Type A and Type B. Type A individuals are intensely
competitive, impatient and time-driven. Beneath this drive is usually a deep-seated sense of
personal inadequacy. Type B, on the other hand, who may also be achievers, are not as
competitive or time driven. Rosenman et al. (1975), having conducted an eight and one half-
year study of coronary heart disease, found that Type A behavior was a contributing factor to the
disease.

Multiple psychosocial and behavioral factors

The idea that disease is a combination of multiple psychosocial, behavioral and
physiological factors whose interconnection contributes to disease causation is the basis of this
theory. These causes may not be independent factors in the illness, but when considered interactively with other variables, they contribute to the total etiology and may occur differently in different diseases (Bovbjerg, 1994; Bolletino, 1997). For instance, emotional issues or personality traits may not appear as a causative factor of lung cancer when considered alone, but when combined with other elements, such as behavior (e.g. smoking) and/or heredity, it can be seen to have greater impact. Consequently, Bovbjerg (1994) suggests an interactive model for treating cancer. In this way, behavior and psychosocial factors must be considered alongside physiological reasons as etiological in disease. “Individual risk factors have to be multiplied and not simply added to yield the total risk” (Bovbjerg, 1994, 419).

Thus, personality and stress are seen as a part of the behavioral choices that cause cancer; if a person copes with stress by smoking six packs of cigarettes a week, then stress is a very important dynamic in lung cancer. This shows that considering personality factors singularly can lead to inaccurate conclusions. For instance, Bertolotti et al. (1994) found no correlation between Type A behavioral patterns and coronary disease amongst 73 blue-collar workers in Italy. They suggest that this is indicative of either cultural differences or a weakness in the relationship between personality and coronary disease. Bovbjerg, on the other hand, suggests that in linking psychological variables with immunologic changes the researcher must consider behavioral variables as well.

Bovbjerg’s argument is supported in a study conducted on cigarette smoking. Those in the study who were not depressed had similar NK activity when compared to other nondepressed smokers and nonsmokers. On the other hand, those smokers who were diagnosed as depressed had lower NK cell activity compared to their nondepressed counterparts (Kielcolt-Glaser and Glaser, 1999). In view of the size of the effect, it would seem that the effect of depression on the immune system was greater than the carcinogen, and when these two are factored together rather
than alone, behavior proves to be far more significant than single parameter studies can demonstrate.

**Summary**

These findings show that there is an intimate relationship between the mind and the body. Bolletino (1997) believes that the examination and search for the specific causes of disease is purposeful for enhancing the individual’s ability to heal him or herself (Bolletino, 1997). However, specificity theories of disease etiology can be very limiting when considered independently. It seems more accurate to state that multiple factors lead to illness. For instance, not only have psychological states such as depression been linked to asthma, but so have organ weakness and personality traits (Watkins, 1997b). Eysenck (1994) proposes a *synergist model* for cancer and this idea can be applied to other diseases. Synergy is defined as “the combined effect of drugs, behaviours, genetic factors, etc. that exceeds the sum of their individual effects” (165). He argues that independent risk factors, such as smoking, alcohol, stress, and genetic predisposition do not impact cancer mortality when considered independently, “but their effects may be synergistic” such that they “do not add (the additive hypothesis) but multiply” (164). As a result, univariate investigation, evaluation and treatment is an undesirable approach for researching and treating illness.

**The Mind in Relation to the Body: The Body in Relation to the Mind**

This inquiry into the mind and body relationship cannot be complete without examining the mind as it relates to health, because the interaction of psyche/soma raises important questions about the nature and manifestation of physiological states. The placebo effect and psychosomatic illness are two such areas that force us to ask how the mind functions in conjunction with the body and the body with the mind. For instance, if it is believed that the
source of psychosomatic illness is mental/emotional, then the bi-directional nature of the organism is denied. Furthermore, how does one decipher what illness is defined as psychosomatic and what is not? Is it not more accurate to say that all illness has elements of both psyche and soma? These questions can only be explored by examining the mind as it interrelates with the body.

The placebo effect

We know from placebo data that the mind has an effect on the body. A placebo response can be defined as any nonspecific effect attributed to the placebo in whichever form it takes, whether treatment, process, pill or person, but which does not contain the pharmacologic or particular properties to induce such an effect (Ader, 2000). Before the heralding of technological advances, much of the effect attributed to Western medicine can be considered to be the effect of the placebo, as many of the procedures that were done and medicines that were prescribed were later discovered to be biomedically ineffective (Shapiro and Shapiro, 1997).

A case in point was a surgical procedure that was done as late as the 1950s called internal mammary artery ligation. It was used to alleviate coronary heart disease pains. As many as half of the patients who underwent the surgery felt that their pain had improved, two-thirds of whom believed their improvement to be significant, and these changes were demonstrated on the electrocardiogram. The surgery was conducted on over 100,000 people before it was tested against placebo surgery; that is, where an incision is made under general anesthesia but no actual corrective procedure is performed. There was no difference in the results between the corrective surgery and the placebo operation, and thereafter, the procedure was stopped. It is now known that this practice has no medical basis (Hafen et al., 1996).

With the heralding of the scientific approach to medicine in the nineteenth and twentieth centuries, the use of placebo diminished and with it, the willingness to embrace that which
cannot be explained in empirical terms. It is estimated that as recently as the 1950s the placebo was knowingly used as a form of treatment in 40 per cent of primary care patients (Shapiro and Shapiro, 1997b). Even today, many prescriptions are written that have no proven effect for the condition that is being treated, a case in point being the prescription of antibiotics for the common cold, although they have no proven effect on the influenza virus.

Placebo treatment may take the form of a pill, a drug, surgery, etc. It is most efficacious in alleviating certain types of problems: pain relief, psychological distress, such as depression and suffering, but there is no evidence that placebos hold any curative powers in terms of actually eradicating disease (Spiro, 1998). The placebo appears to be most effective when it is administered in the form of surgery, when it is conducted outside of the controlled research environment (Fisher and Greenberg, 1997), and for treating inconsistent and temporary illnesses, such as headaches. For instance, Hunt (1991) found that two-thirds of migraine sufferers reported at least a 50 percent pain reduction with placebo while acute pain sufferers experienced substantial respite with placebo (in Shapiro and Shapiro, 1997).

Numerous studies have substantiated the placebo as effective in treating physiological and psychological illnesses. Shapiro and Shapiro's (1997) assessment of data on the placebo estimate that its effect can be found in a range of 21 to 58 percent of the cases they investigated. Pharmacologic studies indicate that between 30 and 50 percent of depression cases respond to placebo. Placebo effects are estimated to be 59 percent as effective as tricyclic antidepressant, 65 percent as effective as lithium, 58 percent as effective as nonpharmacological insomnia treatment and 55 percent as effective as injected morphine and other similar analgesics. In their own 1980-1983 mixed sociodemographic group studies, Shapiro and Shapiro found that 51 percent of these patients had a positive placebo response (improvement) and 12 percent had a negative experiences (worsening), while 37 percent of the cases had no placebo response (no
Fifty-seven percent of the sample experienced placebo side effects; that is, new symptoms.

Placebos are also known to counter the effects of drugs and to produce paradoxical negative effects. Wolf (1950), in an early study, demonstrated that the placebo can affect the efficacy of a drug. Pregnant women reported a reduction of nausea and vomiting after taking a drug that he said would reduce their symptoms, although what he actually gave them is a drug that induces these reactions.

There are various theories that attempt to explain the mystery of placebos. One is that the placebo is an analgesic response to pain (Levine et al., 1978): pain is decreased through the neurotransmitters that modulate the reduction of pain by increasing the release of endogenous opiates. Thus perceived, the placebo is a biological reaction that creates the concomitant physiological changes (Fields and Price, 1997). How the brain does this is believed to be a conditioned response: the participants’ expectations, whether under the supervision of their physician or as part of a drug study, supposedly affect their responses. According to Ader (1997), one’s beliefs are a result of conditioning, and they influence both psyche and soma. Through earlier learning, one derives meaning about a pill or the physician. For instance, care is connected with the role of the physician—she or he is symbolized as an agent of healing (Brody, 1997). Consequently, faith, belief, expectations, hope, and so on, affect outcomes, and the body will respond accordingly (Kirsch, 1997).

Emotional responses, such as anxiety and fear, are also linked to the analgesic effect of placebos. Findings show that the greater the report of anxiety, the greater the placebo effect (Shapiro and Shapiro, 1997; Fields and Price, 1997). Price and Fields (1997) suggest that the desire for a resolution of symptoms and the expectation of relief are significant factors in the analgesic effect of placebos.
In summation, the placebo effect provides substantial evidence that the mind and body are intricately linked. It seems to suggest that there is some inner prompting that can be activated to create physiological changes. Despite theoretical attempts to explain the placebo, it is essentially a scientific mystery, attesting to the phenomenological aspects of humanity that exist outside the realm of reason. The placebo response substantiates that the mechanical approach to psyche/soma, which separates phenomenology, limits our understanding of their dynamics.

Where the placebo response is weak, its lack of efficacy is premised on the participant's ignorance. Its effect is imagined to require a powerless subject in a passive role. Instead, the power or authority resides with the physician or the amorphous drug despite the fact that these are only symbols of healing. It is only a short step to ask then how individuals can develop their own internal metaphors in order to activate their innate healing capacity. That there is an intrinsic healing power within the human is clear from placebo therapy, but the question that needs to be asked is how can this be activated in a conscious rather than accidental or random method? It is to this question that I will turn in the next chapters. In the rest of this chapter, I will examine the mind and body relationship.

**Somatization**

Placebo research suggests that the mind has the power to influence the body. However, such assumptions may lead to a fundamental misinterpretation and confusion about that which constitutes psychosomatic experience. On the one hand, psychosomatic illness and placebo effects can be dismissed as "all in the mind" and illusory (Ader, 2000). "Psychosomatic medicine suffered from the reductionism implicit in the idea that functional afflictions were only imaginary" (Murphy, 1992, 22). On the other hand, it can lead to the mistaken belief that the mind has greater power than the body, so that if one "cures" the mind, then the body will follow.
These dualistic approaches to the mind-body relationship result in a psyche/soma conundrum that is explained as either body or mind. In terms of psychosomatic illness, their connection is usually described as psychological disturbances that are converted into physiological symptoms. So although the psyche is associated with soma, which is more inclusive than traditional reductionist approaches, this one-dimensional resolution of the conflict does nothing to transform the inherent dichotomy. Thus, while these researchers expand their parameters of health, they do not fully grasp the breadth of an integrated psyche/soma paradigm (Sivic, 1998).

According to Sharpe and Wessely (1997), when an individual’s illness is not evident, she or he is commonly told that the problem is mind-related. If it cannot be measured, then it must not exist in tangible, physiological terms. “This mentalist approach conceives of functional somatic symptoms as psychiatric disorders produced by mental mechanisms” (Sharpe and Wessely, 1997, 172). The genesis of the physiological problem is thus in the mind or emotions. These authors describe two mentalist or psychiatric approaches: the psychodynamic theory and the distorted information processing concept. The psychodynamic theory proposes that somatic symptoms are a manifestation of unacceptable emotions. Normal homeostasis is disrupted by difficult emotional responses, such as depression, anxiety, feeling out of control, and so on.

The other is the distorted information processing concept, which argues that the person fixates on a minor problem until it is exaggerated or enlarged into a major one. Martin (1997) describes this as creating the illusion of disease, making one think that something is wrong even if it is not, inducing destructive behaviour and as a result changing one’s biochemistry. Anxiety, for instance, produces physiological changes, such as headaches, churning guts or palpitations, and these in turn may be incorrectly construed as indicative of disease. Essentially, then, “somatization disorder is a psychiatric category describing patients expressing psychosocial
distress in the form of bodily symptoms” (Broom, 1997, 15). For instance, the Royal College of Physicians and the Royal College of Psychiatrists report that as many as half of the individuals who are out-patients claiming physiological problems are really afflicted with psychological issues (Martin, 1997). This relationship between the mind and body, therefore, assumes that psychosomatic disease is “fundamentally immaterial, rooted in mind/spirit, with the physical as secondary or derived” (Broom, 1997, 144). According to Sharpe and Wessely (1997), “this dichotomization is further complicated by moralistic prejudices which assume that illnesses classified as mental imply a degree of personal weakness or inferiority on the part of the sufferer” (173).

At the other end of the spectrum is the approach that the problem is not “all in the mind” but “all in the body”, connoting some kind of imbalanced homeostasis due to a problem such as a virus. However, both of these positions — whether mentalist or biomedical — assume that the mind and body are split. Disease is either one or the other. “Phrases like ‘meeting place between mind and body’, or ‘the mind/body connections’, are questionable in that they presuppose a separation of mind and body, or that separate entities are coming together. This is misleading if the notion of a dualistic separateness of mind and body is a faulty conceptualization” (Broom, 1997, 20).

What this critique demonstrates is that both models are inefficient in explaining or describing the dialectics of the mind/body relationship and subsequent somatic manifestation. In attempting to reconstruct this newly emerging science, Sharpe and Wessely (1997) “propose an integrated psychophysiological approach to the clinical care of patients suffering from functional somatic symptoms” (173). They prefer the term functional somatic symptoms, which does not place the disruption, be it physiological or emotional or both, in the either/or category. Instead, their approach “implies that there is a real abnormality in the way the organism is functioning,
and as such sets the stage for a more open minded approach” (171) (italics mine). Thus, the body and the mind are communicating together. As was demonstrated in the previous chapter, our feelings are in our body and vice versa. We can choose to listen to ourselves through our body, through our minds or through both. As Bakal (1999) states:

Somatic awareness is at the cutting edge of the mind-body interface and represents a way to truly empower individuals in their efforts to maintain or restore good health. Somatic awareness constitutes an innate wisdom that people have about their own psychobiological health. . . . For virtually all symptoms, diseases, and illness conditions, the mind’s awareness of the body sensations has a very significant role to play (4).

**Treating Disease**

Many questions are left unanswered due to the imbalances that the biomedical and mentalist paradigms create because of their one-dimensional perspective. It needs to be asked, for instance, why it is that approximately one-fifth of individuals seeking attention for physiological problems at the primary care level are unable to be diagnosed by their physicians, and a significant proportion of these complaints prove to be chronic symptoms (Sharpe and Weissely, 1997). In other words, there are physical symptoms but no measurable disease. In fact, it is believed that 50 per cent of all primary care patients are somatizing (Wickramasekera, 1998). This makes the examination of the mind and body correlation not only an epistemological and a methodological concern, but also a practical one.

There are conflicting responses to this quandary. Martin (1997) believes that “one consequence is that huge amounts of time and money are wasted on diagnostic tests and treatments for elusive diseases” (46). He explains, for instance, that stress is concomitant with behavioural changes, such as lack of sleep. As a result, the afflicted individual will be exposed to comments from acquaintances regarding his or her unhealthy appearance and suggest a
doctor's visit. This causes the person to believe or agree that there is a physiological problem causing symptomology such as headaches.

Given the plethora of research that connects the mind and the body, Martin's analysis seems trite and dismissive, particularly when one considers the high percentage of individuals who are experiencing what are labelled as psychosomatic disorders. According to Spiro (1998), the success of modern medicine makes it difficult for the biomedical community to acknowledge that they are unable to help a variety of illnesses that would benefit from a more holistic approach. "The growth in specialisation over the past forty years has made it hard for mainstream doctors to treat patients with complaints that are not reflected in images from their X-ray, CAT scan, or other machines" (Spiro, 1998, 7).

What is clear, however, from the behavioral approach to illness is that vague and amorphous factors like stress affect our health, but they are a part of our lived experience, and so they cannot be avoided. The body responds because, as the research shows, psyche and soma are inseparable. Furthermore, these experiences are real to the individual, and to treat the problem as if it is "all in the head" because there are psychological correlates is problematic. "We have stress; it is a part of life that's not going to go away. At the same time, it is not the amount of or severity of stress that matters, but rather the way we handle our stress that affects our immune system" (Moran and Schultz, 1996, 32).

The question of how behavior and stress affect the body must also be combined with the question of how psyche/soma issues, such as health, will be approached, managed, and treated. Bakal (1999) believes that identifying the problem is as important as the treatment that is provided and that health professionals need an understanding and vocabulary for the individual's internal and physiological experiences as they relate to the symptoms. It seems that although physicians are trained to diagnose and treat the body, "half the complaints that they hear prove to
have no medical cause. They find themselves poorly prepared to deal with illness and pain except by turning complaints into diseases through their technological pursuits" (Spiro, 1998, 12).

Although it may be premature to formulate a trajectory of how the recent understanding of the mind and body relationship will impact health treatment, I do not agree with nonspecific positions like Bovbjerg's (1994). Specifically, I take issue with his comment that the PNI findings may or may not contribute to our understanding and treatment of disease (in his case cancer), which ignores the implications of what it means to bring the psyche/soma paradigm into the mainstream. I believe, instead, that the contribution or impact of PNI and other mind-body research cannot be understood without examining what it means to take interactionist approaches seriously and how this affects healing. These issues are explored below.

**Philosophy determines treatment**

First of all, prevention, treatment and healing are determined by the philosophic position that is taken. In other words, how the organism is constructed is relevant in terms of how one decides to treat illness – whether from the perspective of the mind or the body. For example, when all disease is taken to be biological, then the treatment is solely physiological. If one takes a dualistic position, then it is either mind or matter. "Depression offers a good current example: once deemed the result of repressed anger, now it seems to be in the serotonin re-uptake system, to be relieved by chemicals" (Spiro, 1998, 56). If one is holistic, on the other hand, there is an attempt to balance, not separate, the two sides. According to Broom (1997) virtually no one considers the possibility that other dimensions of personhood may play important roles in the pathogenesis of 'hayfever'. We encourage one another to see this as purely physical: any possible collateral 'story' is excluded. This illness is physical: there is no question about it. On the other hand, a muscle tension headache will commonly be construed as emotion-related and classed as psychosomatic, or nonorganic. In this instance the mind is seen as influencing the body. This would not even be considered in the hayfever example. Thus in medicine we continue to appraise all physical conditions in a dualistic manner, and as long as we continue to
exclude other person dimensions from conditions like hayfever we appear to be justified in this approach (148).

I argue for a combined approach to health care because when the biopsychosocial factors are considered alongside the physiological factors, this allows for a variety of treatments. It also has to be considered that irrespective of the efficacy and success of any healing or therapeutic process, such as current biomedical treatment, it cannot be without its own limitations because humanity is so diverse. “If we had a medical practice in which the physical and the psychological (and other dimensions) were attended to equally we would likely have no such sense that the psychological was prior and we would be left only with a pragmatic decision as to which dimension we should expend our energies in to give the patient the best possible outcome” (Broom, 1997, 141).

**Constructing the psychic link**

Secondly, understanding the psychic link is as important as the fact that there is a link. It is taken for granted that different drugs are more efficacious than psychological processes in treating different illnesses. Because one drug is not effective does not imply that all drugs are ineffective. Yet, such a liberty is not granted to psychosocial therapies, and instead they are treated as the same. Schleiffer (1999) points out, for instance, that the initial psychoimmunologic research that was applied to AIDS proved to be disappointing, and the funding focus therefore shifted back to traditional biomedical research. The hegemony of biomedicine allots it far more room for error than research on psychosocial processes. It is my argument that psychological interventions should not be treated generically. The question that now needs to be asked as PNI research emerges out of its infancy, is not simply whether there is a mind/body connection (for this has been demonstrated), but how can effective mind/body links
be established and what treatments are most effective? The question then is not whether there is a link, but what is the link?

What needs to be considered, of course, is that psychosocial and behavioral techniques are not typically “quick fix” approaches and require more individual effort. “Reducing stress and modifying the diet to cure and prevent ulcers is much harder than swallowing pills and potions - no wonder medical practice focuses on biologically detectable organic lesions and their biochemical and immunological deviations, for they are easier to remedy than the social, cultural, and economic issues that cause so many medical problems. This ‘reductionism’ still rules medical practice” (Spiro, 1998, 6). Spiro (1998) further points out that if pharmaceutical remedies such as antibiotics are able to cure an ulcer then the biomedical community feels no requirement to explore the factors and stressors that may contribute to its genesis. For instance, psychotherapy instead of traditional drug treatment has been occasionally given to patients with irritable bowel syndrome and there was considerable improvement (Hafen et al., 1996), but how common practice is this form of treatment?

**Opportunity for choice**

One of the most exciting and important aspects of the biopsychosocial approach to health is that it allows for greater choice as compared to treatment that is limited to the biomedical model. “Somatic awareness . . . is an internal conscious referent that provides the individual with the means to make choices and lifestyle changes that can contribute to improving the health of his/her overall psychobiological system” (Bakal, 1999, 5). Individuals need to be more aware of the possibilities that are available so that they can choose the routes that they would like to take, and they also need to be aware that choice is theirs.

Sheard’s (1994) research suggests that the percentage of people interested in unconventional treatment for cancer is a conservative figure of 10 per cent, with this number
growing, particularly amongst the educated, middle class populace. He cites the Eisenberg et al. 1993 study in which a telephone survey was conducted with 1,539 adult participants across the U.S.A. who had a lower than average rate of ill health. The researchers found that in the preceding 12 months, 34 per cent had used their operational definition of unconventional medicine, which were 12 different treatments that are not traditionally taught in medical schools or used in hospitals. Seventy percent of these visits were made outside of their doctor’s knowledge. Extrapolating this data to the whole of the USA, it suggests that at least one form of unconventional therapy was used by approximately 61 million Americans in 1990. The estimated cost of this treatment was $13.7 billion. Between 1990 and 1996, the rate of usage increased by 45 per cent, with 75 medical schools now teaching complementary and alternative practices as part of the curriculum (Jonas, 2000).

There are similar findings in Canada. Eidenger and Shapiro (1984) surveyed 190 metastatic cancer patients in the 1980s. Although only seven per cent had tried or were using non-traditional treatments, 70 per cent said that they would utilize them if they were accessible to them (in Sheard, 1994). By 1990, one in five were reported to be participating in complementary medical practices (Crellin et al., 1997). Less than a decade later, a CTV/Angus Reid group poll conducted in 1997 showed that 42 per cent of Canadians use alternative medical treatment (Kelner, 2000). In Europe, 590 million pounds were spent for homeopathic drugs and 1.45 billion pounds for herbal remedies in 1991.

Research has shown that individuals will most often search out unconventional therapies because of chronic health problems. In recent interviews conducted with 34 people, dissatisfaction with conventional medicine and treatment was cited as the reason they chose unconventional treatments (Watkins and Lewith, 1997). Demographically, there are similarities

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1 The response rate was 67 per cent.
amongst those who use unconventional forms of medicine. They are most likely to be white, between the ages of 25-49, college educated, earning relatively high levels of income (Kelner, 2000; Crellin et al., 1997; Jonas, 2000; Sheard, 1994).

Citing Marcia Angell’s comments in the New England Journal of Medicine (1985) that the idea of a tuberculosis personality would have been summarily dismissed when the tubercle bacillus was discovered as causative of the disease, Biondi and Kotzalidis (1994) point out the one-sidedness of such arguments. Angell and others who support this type of view, they claim, ignore a variety of other factors, such as the selective contagion of the disease: some people get it and others do not. It is also important to realize that not all people want to take drugs. Many are inclined to explore routes to healing that are empowering, and want to make lifestyle changes. To suppose that all people are satisfied with only somatic treatment is a very arrogant assumption. So those who, like Angell, agree that psyche/soma links are frivolous or irrelevant because drug treatments will eventually supercede any psychic correlations are misguided in their assumptions that all consumers are interested in drug treatment.

Unfortunately, the extensive application of biomedicine makes the efficacy of other treatments that are labeled as unconventional approaches invisible. The idea that drug treatments alone can cure all illness is erroneous because of the complex interaction of emotions, mind and body. It is clear from PNI and placebo research that there is a inner power that can be harnessed to create change and these choices should be available for the consumer instead of only pharmacological options that treat the person as solely a biochemical organism. Combined approaches allow healing to occur on many levels at the same time, and the person can opt for self-regulation, medical intervention or a combination of many treatments.

Finally, the efficacy of the treatment needs to be considered. Dependent upon the disease, certain therapies will work better than others and be more cost effective. Illness is also
not generic and because an illness manifests physiologically does not necessarily mean that the best treatment is biochemical.

**Caution relevant only in terms of treatment**

When we consider the synergistic philosophy (the multiplication rather than the addition of factors), it may be impossible, perhaps even irrelevant, to determine the leading or most instrumental psychodynamic cause of the illness. Instead, we need to ask what kind of intervention treatment also has a synergistic effect and study these possibilities. However, because of the relatively weak ground upon which the biopsychosocial approach is founded in terms of its biomedical efficacy, it faces the bias that any ineffectiveness in its treatment is viewed as a total ineffectiveness. (This is not true for the medical model.) Sheard (1994) comments that the “unfortunate consequence” of the divide between conventional and unconventional treatments in medicine “is the potentially vicious circle of exclusion of unconventional therapies from mainstream medicine. They are rejected on the grounds of not having been scientifically evaluated and in turn are not scientifically evaluated because they are outside of the scope of a biologically based body of scientific knowledge” (181). Sheard argues, however, that “science is not a theory, it is a method used for obtaining reliable, repeatable, shared knowledge” (181). That biopsychosocial treatments are effective in some cases is also true of the biomedical model.

**Conclusion**

The therapeutic use of the mind/body connection, like any form of therapy, requires an in-depth examination and understanding in order to be used in the treatment of illness. Linking the mind to physiological correlates opens the vista to exciting possibilities when one considers the power of placebos and the psychosomatic relationship. It seems that our minds and bodies
follow a path that is less linear and more boundary-free than the reality that science has scripted. Hence, it would be very easy to assume that if psychosocial factors play such a substantial role in disease etiology, then they must also be efficacious in the healing process. But such assumptions are hasty, and we need to be cautious about generalizing treatment based on causative or psychoneuro-immunological links and over-emphasizing mind efficacy.

After all, the very explicit reasoning runs, if the pituitary gland is embedded in the brain and if it monitors and controls so many hormones and neurological connections, it should be able to marshal armies of immune cells to deal with cancer. I compare the pathological forces of cancer to the Nazi armies that ravaged Europe: they overwhelmed small countries from Norway or Greece in no time at all (Spiro, 1998, 75).

This does not mean, however, that because the biopsychosocial relationship is so complex that it should be overlooked as a healing tool, which is oftentimes the case for phenomena not easily tested. Funding is provided for biomedical research because it is assumed that curative treatments will be discovered, but as biopsychosocial investigation flounders through its discovery period, it is not allotted that type of privilege. According to Biondi and Kotzalidis (1994), "scientifically based professionals are prone to seeing psychoimmunology as being invaded by people who propose untestable models, over-extrapolate from data, and draw unsubstantiated conclusions" (5). Many of these methodologies have not been tested in order to be scientifically verified. One case in point is imagery. However, the dearth of substantiated findings may result from the lack of sound methodological approaches, and consequently this very provocative area of study begs for the opportunity to be explored.
CHAPTER 4 - IMMUNOENHANCEMENT AND THE IMAGINATION

It has to be considered how a nonmaterial mental event, such as an intention to move, can influence the subtle probabilistic operations of synaptic boutons (Eccles, 1994, 55).

The bi-directional relationship between the immune system and the CNS, which describes how the mind affects the body and the body the mind, has enormous implications in terms of how illness is understood and treated. That psychosocial factors influence the immune system suggests that such variables can affect the individual in both the manifestation of and recovery from illness. The degree to which stressors influence health varies from person to person and from illness to illness because styles of coping with stress are as important as the stress itself. Given this, intervention processes that aid coping styles are of particular significance because of the deleterious impact that stress potentially has on the organism. However, the fact that stressors such as bereavement affect physiological and psychological states, including morbidity rates (Bartrop et al., 1993), suggest that different forms of previously considered alternative treatments, like imagery techniques, offer not only preventative therapy against disease but also a prospective for coping with and treating illness.

In this chapter, I examine how coping styles affect the genesis and progression of illness along with several intervention processes that have acted as immunoenhancers. I specifically explore the use of imagery for immunoenhancement. This focus on the imagination will be the basis for the ensuing chapters.
Coping Styles

Coping styles are important considering the impact that stress has on organisms. Because of the variety of ways in which individuals react to and cope with stress, research has shown that certain personality types are more susceptible to the effect of stress than others as described above. Numerous studies have been conducted in order to examine how behavioral and psychological variables, such as hardiness, support, attitude, and so on affect the body.

Hardiness

The theory that organisms cope with and respond to stress in individual ways (Lazarus, 1977) is the basis for Kobasa’s (1979) research work, which focuses on psychological patterns and their relationship to health. In her initial study, she conducted interviews with 200 executives and found that there was a correlation between personality and well-being: the more that the participants displayed what Kobasa labeled “hardiness”, the better the reported health (Kobasa, 1984). The concept of hardiness is founded in three different personality traits: commitment, control and challenge. Commitment entails a substantial and profound feeling and attitudinal approach to oneself, family, career, and social relationships. Commitment provides these individuals with a sense of meaning and direction in their own lives and the lives of others. Where commitment is strong, one’s sense of personal contribution is very robust. Without this state of commitment, one experiences feelings of disconnection and alienation from others and oneself.

A second aspect of hardiness is control, wherein the person perceives him or herself as being in command of how he or she reacts to life’s situations. Choice (Kobasa, 1990) is an important aspect of control: the feeling that one has the power to choose how one wants to be and react. This control is not over others but over oneself and one’s ability to influence the
outcome of one’s life. It is, in other words, a position of power, where a dynamic sense of responsibility is assumed for and over one’s life. The opposite of control is a sense of helplessness, despair and victimization, where the person feels that he or she does not have the wherewithal to contend with life’s situations.

Finally, challenge refers to the capacity to enthusiastically embrace the idea of growth and change as a positive not a threatening aspect of life. Those with this trait feel excited, confident and determined when posed with challenges, and they expect favorable outcomes. Conversely, the person who does not have a hardy personality perceives challenge with a sense of helplessness, isolation and fear.

Kobasa’s research, which was measured and assessed using patient report, psychological scales and symptoms, presents a model of stress behavior that interprets stress as a subjective experience. Her idea posits that one does not need to be a passive victim of stress but can be a resourceful instigator against it; therefore, it is not necessary to avoid stress in order to be healthy. For instance, Antoni (1999) found that amongst 37 HIV seropositive gay men who had experienced Hurricane Andrew, those who had a greater coping self-efficacy displayed not only less post-traumatic stress syndrome and psychological stress, but also lower norepinephrine-to-cortisol levels. From this standpoint, learning how to cope with stress, not that there is stress, is the relevant factor for physiological and psychological well-being.

Other coping styles

Support is another significant factor in coping styles. Support may be familial, social or personal faith. Woods and colleagues (1999) studied the connection between religiosity, emotional states and the immune system in 106 mildly symptomatic HIV-seropositive gay men. The participants were asked to respond to a series of questions that were based on religious coping styles and behavior. Although both styles of religious approaches resulted in lower levels
of depression when compared to the nonreligious control group, those whose behavior was more religiously inclined in terms of prayer, reading religious literature, and so forth, had significantly higher levels of CD4\(^2\) cell counts and percentages.

Social support is an important issue in HIV/AIDS cases due to the complexity of the illness and the social stigma that surrounds the disease, such as isolation, rejection, and homophobia. In a five-year prospective study by Theorell and colleagues (1995), it was found that during the early stages of the research, there was little change in CD4 counts for those men who had a low level of social and emotional support when compared to the high level social support control group. However, in the latter stages of the study, there was significant change. For instance, by the fifth year, those who had low support had a decrease in CD4 count nearly double that of the control group. Other studies show that those who are socially isolated are, amongst other things, more likely to be depressed (Grant et al., 1988) and have higher mortality rates (House et al., 1988).

Many other coping styles have also been researched in connection to wellness. The idea that negative emotions, such as pessimism and hopelessness, have a detrimental impact on health while positive emotions, such as optimism and hope, are beneficial to health have been the subject of various studies. Reed (in Ironson et al., 1997) found that, regardless of AZT use or the level of early CD4 cell counts, gay men with a fatalistic attitude who had contracted AIDS had a survival time that was shortened by an average of nine months when compared to less fatalistic men. This was particularly the case when negativism was combined with bereavement. Kamen-Siegel and colleagues (1991) also found in their study of the elderly that those with a negativistic

\(^2\) CD is the numerical system that is used to classify antigens that are expressed on the surface of leukocytes. The human immune deficiency virus (HIV) is a chronic infection that leads to the continual depletion of CD4+ T-lymphocyte cells (CD4 cells) (Lida et al., 2000). As the CD4 cells are the principal location for the HIV infection, their numbers serve as the main signifier of immune competence and predict the course of the disease (Mulder and Antoni, 1994a).
and hopeless attitude had a lower rate of helper T-lymphocyte cells when compared to their suppressor T-cells as well as depressed immune responsiveness.

When exploring the effect of emotions on the body, it is also important to understand how they affect the choices one makes, which in turn has serious health consequences. That is, personality and emotional states are connected to behavioral choices. Flannery (1987), in his study of healthy Harvard students, found that those who were disease-resistant made choices such as limiting their use of substances connected to drugs; for example, caffeine, sugar and nicotine. Physical fitness was often a part of their lifestyle as well as relaxation time.

**Beyond Coping Styles:**
**The Multifactorial Relationship Between the Mind and Body**

The idea that coping styles impact the body is a subjectivist model of health: the individual has the power to influence his or her well-being. However, the examination of personality, behavior and coping styles is a complex issue, and problems such as socioeconomic position, race and gender are dynamics that have not yet been considered or measured in these studies. For instance, Kobasa's studies on hardiness focused on mainly white middle-class people. "Hardiness" and an optimistic outlook may be more easily attained by a person in a higher socioeconomic position, but a sense of control, personal power, and so on may not be as simply learnt by persons who are in a lower socioeconomic position, particularly when factors such as race and gender are considered. For instance, Antoni and Goodkin (1996) note that the cervical neoplastic changes that are etiologically associated with cervical cancer are disproportionately prevalent amongst African-American women in low socioeconomic positions whose life situation can produce emotional states of helplessness and powerlessness. Their studies show that these psychosocial factors are correlated with higher rates of cervical abnormalities.
Although I will not attempt to cover this vast issue here, the social conditions of the individuals or group are relevant considerations that cannot be dismissed when theorizing about personal responsibility. For instance, 25 percent of women versus 10 to 15 percent of men suffer from depression (Nolen-Hoeksema and Girgus, 1994). In the research thus presented, depression is viewed as behavior. Seligman (1991) attributes the fact that women are twice as likely to be depressed to be based on the female tendency (i.e., personality and coping style) to over-ponder and over-analyze their problems. Thus, he sees the higher rate of women’s depression as connected to coping styles rather than the result of socioeconomic issues. However, women work in different jobs and occupations than men, almost always with lower status and pay. And whether employed or not, they have the majority responsibility for household work and the care of the children and other family members. . . . The data for the majority of countries report that free time and time for personal care are significantly higher for men (United Nations, 1995, 105-106).

A 1994 survey of women in Canada, for example, showed that 52 percent of married women who are fully employed have all the responsibility for the housework, 28 percent had most of it and only 10 percent shared the responsibility (United Nations, 1995). Thus, such issues as hardiness, sense of power and depression cannot be simply attributed to personality and the capacity to cope. Likewise, Bakal (1999) points out that the rate of tonic hypertension is two times greater for African-Americans than for the white populace. Drawing on Krieger and Sidney’s (1996) study, he attributes this to be due to racial discrimination and the powerlessness that is caused by living in a white-dominated culture. He extrapolates this to apply to any group that is in a socially disadvantaged position.

The age-old question: Biology or environment?

The other distinction that needs to be considered in this discussion about the

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3 It may also be noted that women have lower levels of serotonin than men which, when combined with environmental factors, cause depression to manifest.
psychological aspect of disease etiology is the difference between endogenous or biological/genetic and neurotic or environmental causes (Feinberg, 1992). If one takes the biological route, well-being is based on neurotransmitters; for instance, depression is caused by the ineffective release of brain chemicals, such as serotonin, by the neurotransmitters (Schloss and Williams, 1998). Therefore, repeated stress weakens the already vulnerable system. Post (1992), however, has demonstrated that the neurochemical decrease of serotonin release is a conditioned response. Thus, if one is exposed to repeated, long-term stressors, the body learns to respond biochemically. This would also mean that it can be re-conditioned, not just mentally but also biologically.

Depression, then, can be the result of genetic, psychological and/or environmental factors. So once again, etiology, it seems, is a relative thing. The question that must be asked then is whether drug therapy is the only method of treatment or can the body be reprogrammed? Fisher and Greenberg (1997) make no distinction between biological and psychological responses. They argue that placebo changes are just as much biologically induced as are changes due to drugs. Citing Baxter's (1992) work, they point out that "successful psychotherapeutic treatment of obsessive-compulsive symptoms produces brain imagery changes parallel to those resulting from successful drug treatment. The talking (psychological) and drug based therapies are both equally biological as defined by brain imagery measures" (Fisher and Greenberg, 1997, 5). The two therapies activate neurochemical responses. Greenberg and Fisher (1997) also point out that the line between endogenous and neurotic depression is very fine, and there are no agreed upon or reliable distinctions. When different systems for measuring endogenous depression were used in two separate studies (Greenberg et al. 1992), the range for defining it was between 25 and 27 percent to 62 and 75 percent respectively. Furthermore, in studies
comparing drug treatments and psychotherapy, there was little difference in outcome between the two approaches.

It has been argued here that the genesis of psychological and behavioral states are not easily determined, but as these conditions affect the body -- indeed they cannot be separated -- then the method of treatment is the relevant question in deciding how to create the desired changes. Thus, such statements as "while emotions do not cause cancer" (Bolletino, 1997, 87) seem erroneous because they treat emotions as separate from the body. A more appropriate question, then, would be what causes illness? If one takes Bolletino's position, it could be said that the body causes illness, but that emotions are part of the biochemical make-up of the body, that they occur in the body, and hence, that they are the body.

Summary

Although the focus of this thesis is personal development, it is understood that the individual or group cannot be examined without a context and that claims of personality and behavior do not occur in a vacuum but entail a very complex relationship between external and internal factors. I venture into this controversial area focusing on the internal rather than the external and arguing that learning rather than biological states are a locus from which healing can occur, as a way to treat physiological and psychological imbalances (rather than as a philosophical argument). The idea that learning certain life skills can affect health is important when investigating the means through which changes can be brought about. Thus, extrinsic and biological causes are not being disregarded. In fact, the two cannot be separated, just as the mind and body cannot be separated.

If, as the research reviewed here has demonstrated, psychosocial, emotional and behavioral choices factor in illness, then how can coping styles and psychological states be utilized in terms of healing? Furthermore, with the PNI research demonstrating the bi-
directional relationship between the immune and nervous systems, how can the behavioral and coping styles that detrimentally impact health be changed? And if they can be changed, how can reconstruction and learning occur?

**Intervention and Immunoenhancement**

Immunoenhancement is based upon the premise that if the immune system can be suppressed by stress and negative emotional states such as depression; conversely, then, positive emotions such as hope, joy, and peace should be immunoenhancing. This is an important area for research because it suggests that we can modulate our own systems. Biological self-regulation has been demonstrated in a variety of procedures, such as imagery, which are capable of affecting the autonomic nervous system (Hall, 1984). In this section, I briefly examine several immunoenhancing intervention processes — psychotherapy, hypnotization, relaxation, and imagery — before I turn to the imagination, as the principal process that I will explore for use in learning, health, and well-being.

**Psychotherapy**

Antoni and colleagues (1990, 1991) conducted various studies with people with HIV/AIDS using psychotherapeutic processes to examine how such intervention affects the immune system. 65 homosexual men who had not been tested for their HIV serostatus were randomly selected for a 10-week study. They were divided into cognitive stress management, exercise intervention, and control groups, and halfway through the study, a serostatus testing was conducted. At the end of the study, the HIV+ men in the cognitive behavioral intervention group had, along with other positive changes, a noteworthy increase in their CD4 numbers and natural killer cell counts. The exercise intervention group had non-significant increases in their CD4
numbers and NK cell counts. Comparatively, the control group had substantial decreases in their NK cell counts with no change in the CD4 numbers.

**Hypnosis**

The therapeutic use of hypnosis can be traced back to James Braid in the 19th century (Weitzenhoffer, 2000). Hypnosis has been used as a psychological means of treating a variety of physiological problems, such as allergies (Barber, 1994; Morrison, 1988), intestinal problems (Farthing and Gomborone, 1997), and asthma (Mrazek and Klinnert, 1991).

Because hypnotherapy has been effective in treating a variety of disorders, Hall (1990) has investigated its use for immuno-enhancement. He conducted a one-hour hypnotic-like process for the purpose of enhancing the immune system. Some of the participants showed a stronger immune system response with an increase in lymphocyte and white blood cell count and lymphocyte proliferation to Pokeweed mitogen subsequent to the hypnosis.

Studies done by Thesleff-Pederson (1974) also support these findings. After injecting eight highly hypnotizable subjects with purified protein derivative (PPD), he asked them to imagine that the immune cells in one arm respond strongly while the immune cells in the other arm respond mildly, a process that the subjects were to repeat twice each day using an audio-tape of the session for 72 hours after the initial process. There was a significant difference in each of the arm’s immune response when compared to the control group who were injected but not hypnotized. This indicates that hypnosis can affect immune system responses.

In another study, Bongartz (1992) instructed his participants to imagine relaxing scenes. The findings showed that the white blood cell count was significantly lower than when the subjects watched a movie or did arithmetic exercises. Olness and colleagues (1989) also studied the effects of self-hypnosis on 57 children who had two sessions in a two-week time span. The children were either instructed to increase the immunity of their saliva if they so desired or were
specifically instructed to increase the immunity of their saliva. When compared to the group who were given a choice and to the control group who were not hypnotised, those who were given specific instructions had significant increases in their salivary immunoglobulin A (SigA) levels.

**Relaxation and biofeedback**

Relaxation techniques have been found to be effective in treating numerous emotional as well as physical problems (Borkovec et al., 1978). Biofeedback, for instance, is one form of relaxation training that is primarily used to treat physiological disorders such as pain and stress related conditions. It is a technique whereby participants learn to monitor and control various physiological processes that are usually considered to be involuntary, for example, the muscles, heart rate, glandular activity and temperature (Gans, 1980). The premise of biofeedback is that physiological processes are paired with mental and emotional processes, and this relationship is a bi-directional feedback loop (Gaarder, 1971).

Relaxation practices ranging from biofeedback to progressive muscle relaxation and meditation are often used in conjunction with the other techniques of hypnosis and guided imagery. While there is no universal consensus explaining why relaxation techniques work -- Schwartz (1975), for instance, believes that relaxation processes are effective because they decrease the level of arousal whereas Benson (1975) theorizes that it is due to the reduction of sympathetic nervous system activity -- they are known to reduce levels of stress. The PNI research has shown that stress acts as an immuno-suppressor; therefore, it can easily be deduced that relaxation is connected to immuno-enhancement for that reason alone.

Numerous studies have been conducted. Kiecolt-Glaser and colleagues (1985) examined the effects of relaxation training on a group of 45 geriatric patients. Compared to the two control groups, the research group had an overall increase in the T lymphocyte response to
PHA and NK cell activity while the antibody titers to HSV (Herpes simplex virus) and distress levels decreased. They also studied how relaxation techniques could act as a defence against examination stress (Kielcolt-Glaser et al., 1986). The study group was taught hypnotic/relaxation training one month prior to the exam period. This group demonstrated less distress and apprehension during the exam period and higher percentages of helper T cells when compared to the control group that were not taught these techniques.

Peavey and colleagues (1985) studied 16 healthy subjects (out of 41) who had self-reported high stress levels and reduced immune responsiveness (low phagocytic capacity). The intervention group, who were trained in biofeedback relaxation techniques, not only reported decreased levels of anxiety but also showed an improved immune responsiveness when compared to the control group. This study compares to the research done by McGrady and colleagues (1992) who studied the effects of training 14 healthy participants in 30-minute biofeedback-assisted sessions for a four-week duration. When compared to the control group, blood samples from those receiving biofeedback showed that the white blood cells and neutrophil levels had decreased and the lymphocyte proliferation response to phytohaemaglutinin (PHA) had increased.

**Guided imagery**

The imagination is a process that has long been explored in relation to the psyche. In recent years, guided imagery and relaxation techniques were brought into the mainstream as a method of physiological processing through the studies that were done with cancer patients (Simonton, et al., 1978; Achterberg, 1985; Achterberg and Lawlis, 1984). The research done by Simonton and colleagues (1978), which illustrated that visual imagery could be used for immunoenhancement in cancer patients, was further studied by the team of Achterberg and Lawlis (1980, 1984). They were able to predict cancer prognosis through the spontaneous visual
images that were drawn by the cancer patients based on the quality (vividness or weakness) of the drawings. These studies promoted the idea that guided imagery, usually combined with relaxation and breathing techniques, could be used to activate the immune system by imagining different immune activity; for example, visualising powerful immune cells, usually the NK (natural killer) cells, destroying the cancerous tumour.

Gruber and colleagues (1988) studied 10 patients with metastatic cancer who were taught guided imagery and relaxation techniques and given biofeedback sessions for a period of seven months. They found that the immune cell function increased. In a later study, Gruber and colleagues (1993) worked with 13 breast cancer patients who were taught guided imagery techniques, relaxation and biofeedback training for 15 months. They found significant changes in NK activity, lymphocyte responsiveness and amount of peripheral blood lymphocytes.

Hall and colleagues (1991) also conducted a one-year study with 10 metastatic cancer patients that combined progressive muscle relaxation and guided imagery. The subjects were asked to create a personal image where they would see their immune system destroying the cancer. This exercise was to be done twice a day. Blood samples were drawn monthly, at which time they also met with the group for further training. At the end of the study, there were significant increases in both Con A and PHA responsiveness. The NK cells and T lymphocytes were also positively affected.

Eller (1999) studied how intervention techniques of either guided imagery or progressive relaxation would affect the quality of life and perceived health status for persons living with HIV. She studied 69 subjects for the duration of six weeks and found that those in the mid-stage of the disease were most affected by the intervention in terms of perceived health status, but not for quality of life, and more so for progressive muscle relaxation (20%) than the guided imagery (11%) as compared to the control group (8%).
Auerback and colleagues (1992) provided guided imagery treatment along with biofeedback treatment to 132 males who were HIV+. Compared to the control group, those who were given this intervention had decreased HIV related symptoms and increased hardiness and vigor. There were, however, no changes in CD4 cell counts.

**The Psychophysiology of the Imagination**

Because the relationship between the central nervous system and the immune system is bi-directional, it has been shown that intervention techniques can influence and affect health and well-being (Murphy, 1992). While much of this research is preliminary and poses many unanswered questions, the data demonstrates that emotions and behavior play a part in physiological processes. One of the general questions being asked is the role that learning serves in immune restoration (Ader et al., 1991), and my particular interest is the function of images and symbols as a learning tool that aids in health and well-being. It is believed that the imagination does not just play a role in mental imagery immunoenhancement techniques, but that imagery is also the base of hypnosis (Nucho, 1995) and biofeedback (Simonton, et al., 1978; Nucho, 1995; Green and Green, 1986).

This suggests that imagery is an area of great importance in terms of understanding the mind-body connection and promoting wellness. The imagination is a system that allows for communication between the mind and body. In terms of physiological processing, images can be the means to experience, know and reconstruct the body. Visualizations may stimulate the cells' sensory modalities and in this way produce healing (Achterberg and Lawlis, 1980). Imagery is also used as a means through which individuals can take an active part in their own health -- both physiologically and psychologically.
Before the 1960s, it was generally believed that the autonomic nervous system could not be voluntarily controlled (Richardson, 1994). However, the pioneering work of Luthe and Schultz (1969) has effectively demonstrated that this system can be self-regulated. Luthe's autogenic training technique, which involves relaxation and imagery, alters the physical body; for example, there are changes in temperature, blood pressure, and white blood cell counts. White's (1978) work is even more imagery specific. He measured the amount of saliva produced when 30 participants were asked to vividly imagine 10 separate food items that they had individually ranked in order of their preferences. Those in the group who were vivid imagers had a greater salivatory response for their favorite foods and decreased salivation for their least favorite. This shows again that the autonomic nervous system does not distinguish between actual and imagined events; that is, it responds to the two in the same physiological and psychological way. It is, in fact, believed that the neurons that are stimulated when we imagine are the same ones that are stimulated when we engage in the identical external activity (Achterberg and Lawlis, 1984). Hebb's (1968) neuropsychological theory proposes that imagery is related to specific interconnected neurons that can stimulate each other, and that these links between the neural networks are the foundation for learning.

Imagery is also known to work with the body's healing mechanisms (Rossmann, 1987). The transformations and newness that occur through conscious interaction with the imagination can create physiological changes as well (Epstein, 1989). Epstein argues that this is because images allow the individual to transform the somatic problem into a symbol, and this allows the person to manipulate the image as if it were real.

Mind, emotions and body

But exactly how can imagery affect the body? Jordan (1984) links different regions of the brain with interconnected pathways that modulate the choice of images and the depth of
emotional reactions to this imagery. Imagery, according to this approach, influences affective responses and because the endocrine and nervous system (HPA axis) are linked, it is impossible to distinguish differences between the emotional and cognitive systems. One does not occur without the other; that is, for every affect there is a cognitive process (Goosens, 1994, 128).

Considering the connection between the neuro-endocrine and the immune systems, any change in one creates a change in the other. Besedovsky and Del Ray (1991), for instance, found that immune system activation can create electrophysiological changes in the brain. According to Watkins (1997),

neural stimuli that have been previously associated with aversive stimuli can not only illicit unconscious behavioral and physiological responses, but they can also elicit powerful immunological responses (15).

Clearly there are reasons why emotions impact the body. Hormones, which are released by certain parts of the brain, are connected to a variety of emotional reactions (Dolan, 1997). Hormones are also known to affect health; thus emotions affect the body. For example, chronic disease, such as high blood pressure, has been connected to hormonal changes that are caused by emotional responses (Henry, 1986). What this shows is that there are neurochemical effects for all feelings, thoughts and ideas. Emotions such as aggression, anger, anxiety and despair release an excess of hormones that have deleterious effects upon the body and the immune system, even when it is at rest.

Watkins (1997) points out that the brain has both conditioned and rational ways of coping with stimuli. The thalamic regions are connected with sensory responses: visual, auditory, somasensory, gustatory, and olfactory. These systems are neurologically linked to the amygdala. It is, therefore, hypothesized that this region of the brain is intricately involved in emotional processes (Jordan, 1984). Watkins (1997) shows that the amygdala depends upon associative matching for its responses:
As a result the amygdala may initiate the same behavioral or physiological response to the new stimulus that it generated during the original 'matched' stimulus. . . . Our reactions to stressful stimuli often bypass the cortex and initiate behavioral and physiological responses independent of rational thought (14).

However, the neocortex has the ability to supersede the immediate affective reactions to stimuli that is aversive. "The medial prefrontal cortex has been shown to play a pivotal role in extinguishing classically conditioned emotional and physiological responses" (Watkins, 1997,14). There are also pathways between the neocortex, along with the temporal and limbic areas and the parietal lobe. They interact with each other, and they not only appear to control how images are selected but also the attendant depth of the emotional responses. Thus, these connections are the basis of emotions and meanings connected to the images (Jordan, 1984).

Candace Pert (1984) has done fascinating research linking the mind with the body. Her work demonstrates that mind and body must affect each other because they are two inseparable aspects of one great whole. The nerve receptors that are found in the immune system recognize hormones called peptides that are not only found in the central nervous system, but also in the endocrine glands and immune system. Peptides are hormones that act as mind and body messengers or mediators through which the cells in the body can interact and communicate with each other. There is a triadic communication among these peptides, their receptors and the CNS, endocrine system and the immune system. Identical peptide receptors can be found throughout all the cells of the body and the same peptides are active on these three systems. These neuropeptides, which biochemically parallel the various emotions, are known to affect behavior due to this intimate connection between the brain and body. What this means is that emotions affect all of the cells in both our brain and body.

If the brain is awash with volatile immune system cells and not merely linked by the nerve impulses, then we are looking at a more integrated system — interactive and analogous system. . . . The immune system becomes the mobile extension of the brain within the body . . . feelings reflected in chemistry, chemistry reflected in chemistry, chemistry reflected in feelings (Hoffmeyer, 1999, 205).
In other words, our minds are in the cells of our bodies.

The imagination and the mind (not brain): Defining the mind

This examination of the mind and body raises the question that was asked in the first chapter: What defines the mind and the brain? Most of the PNI research does little to address this conundrum. Instead, because PNI is based on the traditional biomedical paradigm, most of the findings treat the two synonymously, assuming that mind and brain are identical.

It would seem that because “scientific discovery became interpreted in the culture of science as due solely to rigid compliance with a thoroughly nonproblematic, unmysterious, rational scientism” (Laughlin, 1997), this results in the mind’s connection to the body being described in neurological or biochemical terms. Thus far, the “mind” has been repeatedly referred to in a neurological manner, and the imagination has been explored in terms of its physiological changes. The mind is treated as a biological brain, and vice versa.

This is the very problem that Dienstfrey (1999) challenges in PNI research. According to him, “most mind-body research stays a good body’s length away from the mind. The research is framed and interpreted as if the mind . . . did not exist” (229). The research shows that psychosocial factors affect physiology, but its effects are explained as “physiological pathway[s] that somehow [are] activated by the event to which the subjects are subjected and that then, ultimately, leads to the particular health outcome” (230). These explanations do not account for the mental awareness through which the individual can identify a situation and through this attach meaning to it. “Awareness links body to mind and creates . . . the assorted health outcomes associated with social support, stress, whatever” (230). He concludes that “medical findings of mind-body make no sense without the mind” (231).

Monists, on the other hand, construct the mind in neurological terms (Searle, 1992). While this epiphenomenal take on consciousness may account for abstract or mental states, it is
viewed only as biological adaptation. Stapp (1993), for instance, locates symbols as the foundation or building blocks of consciousness. "Symbols," he says, "are . . . the currency of consciousness and the destruction of any of them must cause a reduction in the person's mental universe" (164). But, according to him, this does not constitute a mind: this is a brain.

However, Stapp's epiphenomenalism is confused on two levels regarding mental states: (a) the idea of the mind as a homunculus that exists in another brain, and (b) the supremacy of the mind over body. In the first case, his theory of a non-mechanical mind is one that is immaterial, an amorphous consciousness that resides outside or inside of the parameters of the brain, "two computers, one material, and one in some mysterious realm" (165). If this was the case, he argues, a brain-damaged person would still be able to use his/her limbs and would not be puzzled over the presence of ghost limbs. "In the homuncular theory it would seem that the homunculus could first decide to raise the arm, and then interact with the brain in order to bring about its desired end, and that the conscious event would therefore precede the neural activity that leads to the motor action" (165). He believes, instead, that the brain has the quantum-mechanical characteristics that are both mindlike and matterlike. It is "one single computer . . . the mind/brain" (36).

Bakan (1980), on the other hand, argues that the mind should not be constructed as only neurological. "We must be careful," she states, "to avoid reducing human feeling, however context specific, to desire defined only in terms of biological urges" (145). Bakan, instead, constructs a mind that correlates with the brain that is an organizing and directing system.

When the infant smiles at another, that metalevel consciousness or awareness as primordial self-awareness is there as originating direction into the object-level stemming from the metalevel organizing itself. But notice, however accurately the mind may correlate with the brain, the mind organizes the brain, or we revert to either dualism or epiphenomenalism (152).
Stapp’s other argument is that the tiny homunculus who is doing our thinking for us would need another homunculus, and another, ad infinitum. According to Hoffmeyer (1999), it is an “absurd idea” to conclude from models of the brain “that there is ‘someone’ inside the brain” (201) for the same reason. So, they argue, only one brain is required. But their rationale applies to their own brain theories as well. From where did the brain begin? An analogy might be the Big Bang, but that does not resolve how such a cosmic phenomena came into being. Something always leads to something that takes us nowhere in particular. If we are simply neural firings, that is also a phenomenon. How, I ask, did that come to be? Thus, the same reasoning that dismisses mind enigma is the same rationale that I can use to dismiss mind as neural firings. I do not accept the idea that “even though consciousness is a neurological phenomenon its unity is a function of the body’s own historical oneness” (Hoffmeyer, 1999, 202) because this still does not explain what consciousness is. How does nature come to be nature? Thus, I find Stapp and Hoffmeyer’s biological argument no less phenomenological than mine.

Finally, Stapp’s (1993) neurological approach is mentalist. That is, it lacks body awareness: the brain is the center of the human universe and the body is peripheral or secondary. Consciousness is only brain, not body; it “exercises top-level control over the neural excitations of the brain” (81). While PNI research challenges brain dominance, arguing instead that the flow is bi-directional (between mind and body), their paradigm is one-directional, locating consciousness in neurological processes. “According to this paradigm, behavior is to be explained by microstructures, such as organs, cells, organelles, genes and ultimately, perhaps by elemental particles” (Nucho, 1995, 6). The philosophical questions regarding the nature of mind and the nature of body are not seriously considered, and as a result, the traditional biomedical paradigm (treating the human as a set of component parts) remains in place. I believe that this one-directional paradigm (the mechanistic worldview) prevents PNI research from
understanding how to make an efficacious connection between mind and body that would establish a holistic (versus mechanistic or reductionist) wellness paradigm, although this field of investigation (PNI) can possibly rectify this imbalance by examining the existential nature of the mind as it is connected to the body, rather than reducing the findings to physiological processing.

Furthermore, I propose the imagination as a means to bridge the gap between the mind and the body that has been constructed with reductionism.

In this thesis, I attempt to correct the one-sidedness of monism and dualism (reductionist theories) by defining consciousness as embodied (both psyche and soma): our body is the means for and manifestation of the tangible and our mind is the means for and manifestation of the existential, although these two are intricately connected and function symbiotically. The mind, then, is not just an existential question and “the lived phenomenal body is more than a physical entity” (Walton and Madjar, 1999, 4). Our body is the only way of our being mentally and physically present in the world. Consciousness is the center and that center is everywhere throughout body and mind.

In fact, I like to think that consciousness is form because it is the body, exists everywhere in the body, and the head or brain is simply one component of the body. I liken the idea of consciousness to water, which is hydrogen and oxygen combined. Independently these gases are invisible to the eye until they combine to form a substance, and that substance can take different forms — liquid, solid or somewhere in between the two. In this way, consciousness is not a homunculus that is above, below, or beside. Instead, consciousness is the body and the mind, and they reside as partners and mates. The mind, then, is “incarnated in the body” where the “the human being is a subject-object phenomenon” (Sorri and Gill, 1991, 44). In this way, psyche and soma can never be separated and are instead pathways to each other; in other words, access points. “The body is flooded by the mind and the mind is the axis of the body. The mind
is a dimension of the self as is the body, and thus, neither can be referred to without at the same time referring to the self” (Sorri and Gill, 1991, 48).

Likewise, Merleau-Ponty’s phenomenological approach stresses subjectivity as the core of human experience. To him, the body is conscious of itself as a body and is focused on the meaning of being human (Merleau-Ponty, 1962). His ideas challenge objectification that is separate from personal experience, and the body is viewed as the gateway between the inner and the outer worlds. Its reality is both, and they cannot be separated unless we separate them through our constructions and perceptions of reality. “Since the body reflects the brain, and the brain reflects the mind, and the two (brain and mind) are not separate while we have a body . . . it can be inferred that becoming aware of the body means becoming aware of the mind” (Green and Green, 1986, 559).

In summation, then, monism is not a solution to dualism. While dualism recognizes the dichotomy in nature, it flounders by compartmentalizing it instead of treating the polarities as complementary parts of a whole system. Thus, there is the abstract (mind) and there is the concrete (matter), and “never the twain shall meet”. Thus, it is the interpretation of nature’s polarizations and what was done with this understanding that is the short-comings of dualism. Instead of treating nature as a unit, dualism approaches it as divided and separated. The two are not part of a unified whole, which are different manifestations of the same thing, but are instead compartmentalized and alienated, considered to be disconnected, independent and unrelated to each other. It is either this (mind) or that (body). “At the bottom of this is an epistemological problem which originates in viewing the body as matter and the mind as air, understandable only in terms of matter. The legacies of this approach are its limitations in providing knowledge but not understanding” (Aragno, 1992, 30).
Imagery: Towards mind-body unity

Although the mind and body are not the same, as the head on one side of the coin is not the same as the tail, they are part of the same organism or system. So they are symbiotic. The difference lies in the fact that soma is obvious, and that is concretely measurable, while the other is more amorphous and can be measured only through symbolism, metaphors and the imagination. Mark Johnson (1987) agrees. He replaces Cartesian mind-body dualism with the idea that cognition is not exclusive to the mind but is also an embodied process. In fact, he reverses the order of things and argues that the mind is influenced by and fashioned from the body as it relates to and interacts with nature and our external experiences. While my approach is based on the two acting together at the same time, like him I agree that the nexus of our body and mind is the imagination. The mental image can thus be described as the “living cell of mental life”, as intricate as the cells of our body (Tolaas, 1986).

Therefore, physicalising images, that is, manifesting them through psyche/soma, provides a concrete means to understand and utilize symbols (Kunzendorf and Sheikh, 1990). In my view, such a process can bring about change. In Ahsen’s (1977) view, the body is the means through which the image can be brought to bear. He believes that the eidetic, which is an unusually vivid image, allows for the neurological event that is stored in the body, in terms of memory, to be resolved. According to Dolan (1997):

in the eidetic notion of imagery, the image is the only direct connection between mind and body: a visual image which elicits a truly psychosomatic response that blends the psyche and soma into one unitary structure. Throughout the eidetic image one arrives at that single visual formula which is significantly a psychosomatic occurrence and through which a healthy or abnormal relationship between psyche and soma can be demonstrated (4).

Ahsen’s (1999) image is a tripartite ISM phenomenon where the image contains visual information (I), physiological information through somatic experience (S), and connected to these two, is the meaning (M). This triple code ISM image binds it to the emotional expression,
the bodily experience, and the meaning that is tied to this, which is a personal or subjective interpretation. In this way the image serves as an operational entity with pragmatic intentions. “We obviously cannot consider the image a mere pictorial entity apart from its relation to the body, because where else is the image situated if not in the body?” (Ahsen, 1999, 4).

Ahsen (1999) believes that experiences that are personally associated with the body are forgotten through the process of time. He refers to this as dessociation. Somatization results when the tripartite ISM unit internally disconnects. With the dissolution of the ISM structure, the unresolved conflict later emerges through physiological disorder, which is connected to indistinct and vague, often misunderstood, emotions, such as anxiety or fear.

Thus the person may suffer from an event’s relevant somatic dimensions in the form of psychosomatic illness, such as asthma, colitis, hypertension, etc. These neodissociated or dissociated fragmented states or symptoms may recur over and over as an attempt at recomposition of the original event (Ahsen, 1999, 4).

His eidetic therapy “is a form of psychoneurological change brought about through potent field activations. The eidetics, being highly repeatable and reproducible structures, have steady neuroelectrical fields, for which reason they” are able to be transformed more easily than thought processes (Ahsen, 1999, 4).

Ahsen’s views are supported by research which shows that individuals who are labeled as psychosomatic share a fundamental psychic structure that is characterized by a diminished or total inability to freely fantasize (M’Uzan, 1974; Sheikh et al., 1979). Sheikh and colleagues (1979) also note that the behavioral traits of the average person who is classified as a low-imager is comparable to the personality traits of patients who are labeled psychosomatic. They show that when compared to individuals who are able to fantasize freely, those who are low-imagers share the characteristics of being disconnected from their interior selves and having difficulty accepting their inner lives. For instance, depressed people who frequently suffer from psychosomatic problems are unable to have imagistic experiences such as fantasies and
daydreams and are more inclined to focus on the extrinsic rather than intrinsic/feeling states. “Indications concerning the relevance of mental imagery to psychosomatic problems appear to be ample. Imagery seems to have the potential to provide whatever psychosomatic patients lack” (Richardson and Taylor, 1982, 110). This is true not only psychologically but biologically as well. According to Kunzendorf and Sheikh (1990), when those who are depressed cease to imagine vividly, the sensory neurons that are innervated through intrinsically experienced images are prevented from being activated. In turn, this inhibits the functioning of the immune system whose neurons are linked with imaging. As a result, they argue, immuno-deficiency and diminished health are connected to depressive states.

What this research suggests is that the body interprets and stores experiences through images and that this function can have an immense effect on health. Again my principal question is how the imagination can be developed in order to create change, considering that vivid images produce the same physiological responses as the actual event or situation (Sheehan, 1967) and that individuals suffering from emotional depression and psychosomatic symptoms happen to be low-imagers.

**Conclusion**

The PNI, coping and intervention studies all indicate that disease is not exclusive to the body but is connected to the mind and emotions. The mind, thus contextualized, is not simply a biological process. This allows for mystery and the imagination, the nexus where the mind and body meet, to be the means through which psyche/soma can be connected because internal images are experienced as concrete structures within one’s inner realm. It is against this intrinsic imagistic backdrop that emotions are evoked. Images can therefore be transformed and
adjusted to create physiological and psychological changes. Therefore, the imagination and imagery can be powerful tools for reconstruction.
CHAPTER 5 - THE IMAGINATION IN ACTION

Mental images are in a deep sense organic, representing a pattern of relations between the tensions existing in a living being. Their function is itself a living process, and therefore, as complex as all living processes are (Tolaas, 1986, 35).

The imagination is a vast and complex field of study. In general, our awareness of internal processes and experiences is typically referred to as mental imagery (Richardson, 1983b). Imaging is an organic human function, but because it is an intrinsic experience, it is very difficult to observe, measure and define. As a result, the term imagery tends to be vague and ambiguous (Finke, 1989). A basic assumption about mental imagery is that the brain stores sensations in the form of images. We construct our understanding and experiences of the world and ourselves using our senses: the visual, auditory, kinesthetic, and so on. Our senses, then, can be seen as both experiential and representational. We interpret these sensory events through cognitive processing, and those occurrences that arise from immediate experience are referred to as percepts. On the other hand, those responses that arise with no stimulation are called images (Richardson, 1983a).

Early epistemologies of knowledge, such as the philosophy of Aristotle, viewed symbols as the primary mode of thinking and all other forms as secondary. In the early part of the twentieth century, however, Oswald Kulpe, leader of the school of thought psychology, rejected the idea of mental imagery being relevant to cognition. This belief was further reinforced by behaviorism, which stressed a more concrete approach to thinking. For instance, from 1940 until about 1960, Psychological Abstracts referred to imagery only five times (Kaufman, 1979). However, after the 1950s, mental imagery gained interest and repute again with cognitive theorists who considered images to be a function of the brain through which thought is derived.
Cognitive psychology attempts to explain mental imagery in terms of its nature, content and function. In this way the relationship between imaging and human cognition, such as perception, memory, linguistics and problem solving can be described and understood (Logie and Michel, 1991). However, cognitive approaches reduce images to epiphenomena, and thus limit their definition, whereas those theorists who embrace the phenomenal and physiological aspects of imagery allow for a broader meaning, understanding and application of imagery.

**Cognitive Approaches**

Cognitive psychologists argue that images are a process of the brain (Richardson, 1999) which is likened to a computer. In other words, it is a biological neural process (Kosslyn, 1983; Kosslyn and Pinker, 1983; Kunzendorf, 1990) where images can reveal their meaning through form (Kosslyn 1980).

Discerning mental images, therefore, is held to depend on the criteria by which we are willing to consider an image a manifestation of nervous activity, whether inferred from behavior or more directly detected by some mechanical means (Bisiach and Berti, 1990, 67).

The imagination, then, is a processing system that is primarily considered in the context and as a substructure of memory (Aanstoo, 1987).

In general, the experimentation of cognitive theorists with imagery has led them to suggest that the act of imaging is intertwined with memory and perceptual recognition (Rollins, 1989). Two competing views of images have emerged from this research: images as percepts and images as representations (Tye, 1991; Murray, 1987). The “image as percepts” theory connects the imagination to sensory experiences derived from previous events. Image making, then, is iconic. It is an internal process whereby the mind can mimic and replicate external pictures and objects in order to retain visual experiences in sensory mechanisms for short-term memory (Shepard and Cooper, 1982). The image is picture-like or photographic in the manner...
in which it depicts and reproduces previously experienced external objects and sensory events in a direct relationship with the outside world (Paivio, 1971). In this way we can accomplish acts without needing the object or organism present (Cooper, 1991).

Conversely, the “image as representation” is the linguistic/semantic model by which imagination is connected to language and meaning. Mental representations are theoretical postulates attempting to analyse propositional attitudes, such as beliefs and desires, and mental imagery represents these propositional attitudes so that they can then be explained semantically (Warfield and Stich, 1994, 4). According to Horowitz (1983), images that are retained in memory for the long term undergo two types of transformation. One is that there is decreased vividness, and the other is that they transfer into other representational forms, such as linguistic/semantic modes.

The Image as Phenomena

Because the cognitive scientific approach to the imagination is based upon the empirico-positivistic model, it not only ignores the phenomenological aspect of mental imagery and the imagination but also limits its very definition. The idea that mental imagery is simply epiphenomena, emerging from “the architecture and evolution of the visual systems of higher mammals” (Kosslyn and Pinker, 1983), is a functional route that allows scientists to observe and measure the imagination. Tart (1990) argues that the psychoneural approach “predicts, for example, that a physiological correlate of any and every kind of experience can ultimately be found. It further predicts that no mental functioning can occur in reality that violates the basic physical laws and systems operation of the brain, although the brain may produce illusory experiences that seem to violate basic physical laws” (40). Furthermore, he believes that while we might find it convenient to distinguish certain types of ostensibly mental activity from physical processes for semantic purposes, this distinction is really
fictional: all experience is, in principle, completely reducible to and identical with physical activity within the brain (Tart, 1990, 39).

Such reductionism refuses to examine the complexity of imagery and the imagination and completely ignores the fact that the imagination does not function under the same spatio-temporal and linear laws of the material world. To denigrate this process as illusory prevents the opportunity to understand the meaning of the imagination. The idea of the imagination as primarily a processing mechanism limits and constrains how it is explored and creates the problem of explaining in physical terms the relationship between mental properties, such as desiring and non-material propositions (Field, 1994). “Unless challenged, contemporary culture will progressively regard Homo sapiens as Homo biologicus – something in the order of a highly evolved, intricately wired, and socially verbose fruit fly” (Pam, quoted in Aragno, 1992). In Richardson’s (1994) view, mental imagery “is not an epiphenomenon but a genuine phenomenon that has psychologically [and physiologically] significant consequences” (11) (parentheses mine). Some of these consequences have already been examined in the PNI research and will be elucidated further in this chapter.

What is particularly interesting about the psychoneural theory of imagination is that it denies the relationship of imagery to the body. Imagery as epiphenomena should theoretically have no transformative effect upon the body, and yet research demonstrates that it does. As Quill (1999) points out, contemporary models of psychology are based on reductionist thought where mind asserts no causal value on the physical. This is the same parsimonious approach that is found in traditional biomedical epistemologies. However, as Felten (1991), a pioneer in the field of PNI, asks, “Can we afford to ignore the role of emotions, hope, the will to live, the power of human warmth and contact just because they are difficult to investigate scientifically and our ignorance is so overwhelming?” (1119). I ask the same question regarding the imagination and its role in the human condition.
Cognitive approaches also constrain the area of imagery by contextualizing it in memory and external inferences. However, if imagery is simply memory, how does transformation and change occur? This is an issue that I consider in depth later in this chapter. The question of the ontology of imagery is not simply a philosophical consideration. It is my position that the mind and body are inseparable parts of the same whole; thus, when we understand the dynamics of mental imagery, we are also understanding the dynamics of the body. I also contend that the use of imagery can have a significant impact on health and well-being for both psyche and soma. This will be explored more fully in the next chapters.

**Imagery typology**

Cognitive approaches may limit the understanding of imagery, and there is still no universally accepted theory that can be used to define the act of imaging. Thus it may be more accurate to state that imagery is a generic term used to explain a wide range of human experiences and situations (Hill and Baker, 1983; Richardson, 1994). This array of imagery association is most often connected to (a) cognition: perception, representation and memory; (b) learning: problem solving, creativity, intuition and novelty; (c) fantasy: make believe, illusion, hallucination; and (d) mind/body healing: transformation and spirituality (Segal, 1971). To contend with the multiplicity of mental imagery, Hill and Baker (1983) prefer a “continuum based” model. Such a solution allows for an inclusive and all-encompassing view of imagery, ranging from the concrete to the abstract; structure to the structureless.

What this demonstrates is that imagery is paradoxical in its very nature. While on the one hand it frees us from structure because it is abstract, at the same time it cannot exist without structure (Forisha, 1979). This broader view of imagery allows for, amongst other things, theorizing about phenomena and the mind/body relationship. Images can be thought of as either spontaneous or unconscious reactions to both extrinsic and intrinsic occurrences, or they can be
directed by and into consciousness, manifesting in visual, tactile, auditory, kinesthetic, olfactory, or gustatory ways (Horowitz, 1978). Images exist existentially as metaphors within oneself and concretely as symbols outside of oneself, and the two interact in a cohesive and interconnected manner. They can be immaterial (inside self) and material (outside self). In essence, they are a dynamic structure.

In summation, imagery is a generic term that is ambiguous to define. Richardson (1994) suggests that “users impose on themselves an obligation to make their own usages clear” (36). In the next section I will explore imagery and symbols within the context of the imagination in order to define how it is that I am approaching the area of imagery. Specifically, I will examine the dialectics of imagination as memory and as a nascent knowledge in terms of self-reconstruction — self being synchronized mind and body. I explore this as an intrinsic means of and an initializing root to new learning and self-transformation through the imagination’s symbolic structure.

The main thrust of this investigation will be the imagination as an access point to fresh insights. What does it mean that the imagination is potentially a source of original, creative material? Are the symbols anthropomorphic manifestations of consciousness or is there a transcendent nature to them? Does memory derive these manifestations or is it possible that there is nascent knowledge devoid of memory or culture? If so, what effect does this have upon us physiologically and mentally?

A Topography of Imagination: An Exploration of Imagination’s Landscape

In order to have a complete understanding of mental imagery, I am examining this area within the larger context of the study of the imagination. In this thesis, I construct imagination as a multidimensional system that can be ontologically viewed as symbol producing.
"Imagination is most simply defined as the symbolizing function, the function of forming mental images" (Fairweather, 1981, 81). According to Fanning (1998), “we think in images, not in words, in fact, words are simply symbolic representations of specific images" (i), and although this statement is debatable, the idea demonstrates that symbols are theorized to be foundationally connected to human cognition and consciousness.

Intrinsic images and metaphors are a language — the language of the imagination — and thus, a means of communication. The image that represents an absent object is an example of symbolic language. This can be regarded as memory. Another, although less measurable consideration, is the image as an original, creative manifestation of the imagination. “Thus, with the use of imagery, we may recapture our past, enrich our present, and shape our directions towards the future” (Forisha, 1979, 8).

In Occidental societies, the imagination has been historically constructed as a representational body that replicates what is already in existence (Morris, 1993); as a body of creation, whose images are original (Kearney, 1988; Drake, 1991; and as a fictitious body that is fanciful, whimsical and unreal (Slom, 1983). The idea that the imagination is memory, suggesting that it is a derivative of previous experiences, is pervasive in many theories. Thus described, imagery is a symbolic code “which preserves information” that is made available as needed to the large scope of mental processes (Flemming, 1983, 100). In other words, it is contextualized by the tangible world of culture and through the intersubjective experience of one’s feelings. Maxine Greene (1995) suggests that the imagination is the portal via which understanding and meaning from the past make their way into one’s present consciousness.

A reflective grasp of our life stories and of our ongoing quests, that reach beyond where we have been, depends on our ability to remember things past. It is against the backdrop of those remembered things and the funded meanings to which they gave rise that we grasp and understand what is now going on around us (20).
She believes that it is the imagination, not logic, which is needed to rework and reshuffle these experiences in order to bring forth new learning. Newness arises through the reinterpretation and reorganization of what has already occurred. In this way, new insight is brought forth.

Harold Rugg (1983) states:

It is basic to my theory of the imagination that all the contents of the mind - perception, imagery, memory, thinking, feeling, and imagination - all are powered by fusion of outer-inner drives; stimuli from the real world culture of moving people and things, integrated with the stimuli from the inner flux of remembered imagery, motor tendencies, and unconsciously produced metaphors-images, symbols and concepts (292) (italics mine).

There is also the idea that imagination is nascent consciousness, serving to bring forth organic newness. Renee Brimfield (1988) describes this idea of imagination as “characterized by liberation” (253). This allows us the freedom to create the new, trust the intuition and expand beyond the banal, mechanical and every day. “Thus, the imagination is beginning... It is rife with the nascent... We are detached from the outside world, unencumbered by prior expectations, timeless, selfless, outside of space, of society, of history” (253-4).

I am raising this question about how new learning, understanding and insight occur within and through the imagination, that is, whether it is memory or nascent, because the construction of the imagination determines how it is utilized for growth and transformation of psyche and soma. The view of imagination as memory is a deterministic model based on a reordering of what is already known whereas the nascent view suggests that there is the possibility for something other than what we know or have experienced to erupt.

**The Language of Imagination**

In order to unravel the question of the imagination as a means of transformation, it is important to understand it at its base, the symbol. Symbolism is the precursor to and the foundation for all human development. Given this description, the image can be constructed as the smallest component of the imagination, as the cell is to the body. In other words, it is the
"gene" of the human symbolising system, which is the imagination, and all of its concomitant manifestations: language, cognition, metaphor, myth, art, transmutations, and so on. Thus perceived, the image is the building block from which all else emerges.

According to Barten (1980), no matter what form the symbol takes or the source from which it emerges -- whether it is evoked through pre-existing experience or is part of the creation of experience and cognition -- to study symbols is really to study human knowledge. Hence, in both an historical and a developmental context, images are primary, existing before language. Essentially symbols are the basis of cognition and thought, and words are simply the structure used to describe them (Piaget and Inhelder, 1971; Langer, 1942).

Given that the language of imagination is symbolic, and "language allows the deliberate transformation of things" (Bakan, 1980, 145), then the imagination can be said to be a reorienting and transforming human structure:

Everything that we perceive and our sense organs process is constantly being transformed into symbols -- these constructed vehicles of meaning are our elementary ideas. And this transformational process, which constitutes mind, is symbolization (Aragno, 1992, 147).

As lexical structures are one of the means through which symbols become form, these linguistic and semantic processes that are derived from symbols are also the means through which intersubjective and extrinsic communication can be established, self-consciousness derived and transformations occur. The manifestation of language is only one aspect of the potential intelligences that arise out of the symbol.

Erich Fromm (1957) divides symbols into three major categories: conventional, accidental and universal. Conventional symbols are part of our daily speech; they are the things that we see, touch and feel. They are memory. We learn early in life to represent objects, feelings, and experiences, whether they are present or absent. From these we infer meaning.
The conventional axiom for symbolism is as a representation of something, such as a sign and the creation of secondary images, such as art.

The accidental symbol’s meaning, on the other hand, is subjectively derived, and its meaning can only be understood individually. For example, the person who has had a boat accident gives the boat a personal interpretation that is different than that in the dictionary.

Finally, there is the universal symbol that is part of the experience of all human beings. These are derived from the environmental, emotional, thought, and sensory experiences shared by all. The physical world is witnessed by all people, for instance, the sun, and all humans are privy to emotional and thought responses with physiological correspondents, such as joy or sadness. “The universal symbol is rooted in the properties of our body, our senses, our minds, which are common to all men [sic] and therefore not restricted to individuals or to specific groups” (18). So in Fromm’s view,

symbolic language is a language in which inner experiences, feelings and thoughts are expressed as if they were language which has a different logic from the conventional one we speak in the daytime, a logic in which not time and space are the ruling categories but intensity and association. It is the one universal language the human race has ever developed; the same for all cultures throughout history. It is a language with its own grammar and syntax (Fromm, 1957, 7).

In this description, then, the symbol is the foundation of thought and language, connected to and emerging from intrinsic and extrinsic experiences. This act of symbolizing, according to Aragno (1992), is a biological process, part of the human heritage that is at once organic and adaptive. She constructs a developmental and evolutionary model of the symbol where “the gradual development of symbolization . . . unfolds along a continuum from prerepresentational somatic, through sign, signaling, and protosymbolic phenomena, to the full flowering of the symbolic function proper” (233). This structural model of the psyche and symbol proposes that knowledge emerges in a linear manner: it exists first in an elementary, undifferentiated abstract and protosymbolic form before it manifests into expression through a portal of communication
that shapes it, such as language, art, body, and so on. For instance, Marshak (1972) suggests that
the engravings and notations that were made in primitive cultures demonstrate the mind's
organic tendency to process and transform information into knowledge through symbolism. It is
therefore the genesis of all intellect and reason.

According to Aragno (1994), the biological propensity to symbolize is also part of our
evolutionary adaptation:

The unique potential for symbol making, the symbolic function, as the distinguishable
generic advance over a more generalized mammalian capacity for form recognition,
furnished Homo sapiens with a mechanism which provides the foundation for
evocative representation, the creation of secondary images, the organization of events
in time and space, the capacity to hypothesize, plan, and imagine, that ability to
elaborate meaning. And it is again via an innate propensity toward "knowing," by
distilling meaning and manipulating ideas, and projecting future results via concepts
derived from this knowledge, that mankind [sic] has devised and refined skills in
utilizing environment. Adaptation, intelligence, and symbolization are synonymous
(151-2).

The symbolizing structure thus presented evolved in order to represent cognition. Peter Munz
(1973), on the other hand, believes that symbolizing emerged as an attempt to convey feeling-
states that cannot otherwise be articulated. Believing that myths are not simply isomorphisms of
the external, he makes the important distinction between sign and symbol. The former is simply
a duplication of its signifier. Thus, it is objective and measurable as its meaning emerges from
that which it denotes, which is similar to Fromm's conventional symbol. The symbol, on the
other hand, cannot be assessed that starkly, for it has a more complicated connection to whatever
it is symbolizing, such as feeling-states, situations, and so on. Munz's argument is that the
metaphor is essential to human development because it allows for the expression of
consciousness or feeling-states that would otherwise remain ineffable; thus it provides form. As
one expands and elaborates the metaphor, this increases self-consciousness. So the imagination
arises out of the need for self-realization, as the means through which feeling-states can be
expressed. This continual reshuffling of images allows the human to reconconstellate, recombine
and rework the metaphor for greater self-awareness. This is the "transposing impetus", and creation arises through the serialized process of substitution/transformation.

These theories imply that humans exist in a symbolic universe (von Bertalanffy, 1968), and what this suggests is that the outer world is not very different from the inner realm. "Not only is language a conscious re-creation of our world of experience; the world of experience is also a concrete representation of language. Thinking and acting become one, they constitute a complementarity" (Jantsch and Waddington, 1976). Thus, the only difference between the two is our construction and experience of them: the external is concrete until we internalise it, at which time it becomes abstract, and the internal is abstract until it is made into form, at which time it becomes external. This may be what Michael Talbot (1991), who discusses Pribram's holographic\(^4\) model of the brain, is implying when he points out that feelings such as love, joy, sadness, and so on are experienced by us as internal realities whereas external reality is experienced as that which is outside of us: rain on our skin, the sound of music, and so forth. According to Talbot, however, this is not an accurate perception. So although it may seem that the person or object is outside of us, the image is on the surface of our retinas; thus, it is inside of us. Conversely, pain that we feel when our body is injured is a neurophysiological process that is occurring in our brain; so it is not where it seems or feels to be.

Thus perceived, it would appear quite impossible to construct a model of origin. For instance, did the biological ability to symbolize that Aragno postulates develop as a means of communication and cognition, allowing for consciousness? Or does it suggest that the imagination and its organic symbolising structure is consciousness and that all else is simply a derivative of it?

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\(^4\) A hologram is produced when a single laser light is separated into two different beams. The first one is bounced off of the object that is photographed while the next one is permitted to collide with the beam that is reflected from the first light. The result is an interference pattern.
In Munz's view, the event is what shapes the symbol. "Once the proper role of symbols, be they natural events or reshuffled events (i.e., myth and metaphors), is understood, it becomes clear that a myth and a metaphor do not stand for a natural event; but that the natural event is itself the first link in the typological series" (78) (Italics mine). Thus, Munz, while recognizing the human need for self-instantiation through the symbol, grounds this idea in the thing or object as the determinant of this psychic function. This is not very different from Aragno who views the external as shaping the symbolizing function. Her ideas are strongly influenced by Freud (1938), who constructed a model of psyche that is memory-derived and embedded in biological processes. The instincts, which Freud considered to be a primitive, regressive aspect of the psyche, arrive into consciousness through memory.

According to Aragno (1994), experience happens on the outside and is internalized and represented via symbolic processing:

True symbols are personal creations, which, in their condensation of various experiences and abstraction of these into new form, come to stand for, or represent them... Symbolization is the transformation of experience into concepts... Yet symbolization is also a transforming process which produces structural reorganization, not a transformation or redistribution of energy (381).

Thus, her linear biological/adaptation theory by which symbolic representation emerged from its primitive protosymbolic form does not explain phenomena. Experience for Aragno, like Munz, is derived from external events that are therein subjectively interpreted, as feeling states for Munz and as cognitive states for Aragno, through symbolising conscious experience.

The Birth of the Imagination

Jean Paul Sartre (1936/1962), who, like Munz, argues against the imagination and image being treated as though it was a thing, on the other hand, believes that there is a difference between the object and the image, and that the problem arises when the image is approached as if it was synonymous with the object, when the two (as Paivio [1971] argues) are viewed as
having the same "essential identity". Sartre argues that the image has a different "existential identity" from the thing that it suggests. The symbol, then, is not a reproduction. However, unlike Munz' idea of a simple reordering of what already exists, Sartre posits that the image is a spontaneous creation that "keeps teaching us something" (63) (Italics his). It is one of the variety of ways in which consciousness is simply consciousness. "An image is a certain type of consciousness" (146) (Italics his). In his view, then, the image, which is a consciousness, does not arise by some extraneous penetration into consciousness.

Although Sartre posits the idea of image as consciousness itself, there is no explanation as to how it can simply be conscious. He suggests that consciousness is willful and, as the image is admitted into consciousness, it is consciousness made external. "An image is a consciousness of some thing" (1936/1962, 146). This does not, however, define or explain, as do the other theorists, how it can be that the image is conscious, and it is not clear how imagination guides or brings about insight and change.

However, the argument that the symbolic system arose out of the need to express the ineffable for self-realisation or from biological adaptation suggests a consciousness that is linear and logical, whereas the manifestation of imagination itself runs counter to such a deterministic paradigm. The paradigm also leaves no connection to or interaction with the body: it is simply a mental or emotional process with no physiological correlates. Munz' analysis, for instance, defies the very system he claims to be supporting. From where did internal feeling-states and the need for self-awareness emerge if the cues were taken from the environment? These deterministic, linear models do not provide me with a sense that the authors understand the imagination, which functions without the constraints of measurable or conventional logic (Fromm, 1957). These frameworks do not provide room for "accidents" if all is based on what has gone before and is only a reshuffling or reconstruction. Evolution seems too tidy. Insight
strikes me as redundant. How could memory or external experience serve to provide insight and permit growth? How could they have any effect upon the body?

One theory regarding the birth of newness is that focus brings forth insight, which is the function of imagination (Sloan, 1983; Rugg, 1983; Martindale, 1990). There are four successive stages towards the emergence of insight: preparation, incubation, illumination or inspiration, and verification or elaboration. Preparation is the stage where one studies and considers the issues that are related to the problem that one is addressing. During the third stage, the creative event takes place. It requires a mental state that is removed from the problem, "where attention is defocused, thought is associative, and a large number of mental representations are simultaneously activated. Such a state can arise in two ways: low levels of cortical activation and comparatively more right-than left-hemisphere activation" (Martindale, 1990, 103). These ideas are very similar to Harold Rugg's (1983) argument that knowledge emerges from the imagination based on intense concentration on the problem, scanning via imagination and completion, which is the knowledge.

Douglas Sloan (1983), drawing on the ideas of David Bohm, also believes that the imagination is the means through which insight is accessed and argues against it being split from knowledge creation in favour of analytical thinking. He posits that "all genuinely new knowledge comes by means of passionate, energy-filled insight that penetrates and pierces through our ordinary way of thinking" (141) (Italics mine) and that "essential throughout . . . are attention and energy - an intense awareness of the question to be asked and a passion for pursuing them" (148). Thus, the image comes first, not the logic. However, insight is located in memory. Sloan contends that although the imagination is "an indispensable vehicle for meaning, . . . it is not the source of new meaning" (175). Insight, as postulated by Bohm, arises out of the imagination, but the images are based on memory. The imagination simply
recombines previous images, metaphors, and so on that come together to create new symbols. "It would seem that creative productions always consist of novel combinations of preexisting mental elements" (Martindale, 1990, 89).

**The rise of consciousness**

These arguments, although advocating for the imagination as a source of knowledge that actually supersedes logical, hypothetical models, makes two deterministic assumptions: that one must first have the question before insight and transformation can occur and that insight and knowledge are memory based. Furthermore, transformation is simply seen as a mental process. It seems that while these theorists are arguing in support of the imagination as the centre of insight, not analysis, they use linear, logical paradigms to support their hypothesis. In this way, they maintain the system they are opposing and do not look to the way that the imagination itself functions as the cue to understanding psyche/soma consciousness, learning and transformation.

I am not at all convinced that transformation and insight occur, as has been argued, from passionate attention to a question, that knowledge is simply a reshuffling of memory or that symbolic consciousness emerged from environmental cues. Neither am I convinced that a primitive protosymbolic stage linearly evolved into higher cognitive states. I am wary of these simple and tidy analyses based on my own experiences with the imagination, where it seems to inform me before I actually seek the question. It is as if I come to an internal sentient place -- perhaps an understanding or a sensation -- that leads me to ask questions that I would not have asked without having had the intrinsic experience first. So, it is as if I have the answers within me, and the questions come afterwards. An example of such are my experiences with dreams where I seem to be informing and providing myself with insight, which therein leads me to questions. Furthermore, in my dream state, I make decisions regarding an event before the external situation occurs, and so I seem to follow the course of my imagination and not the other
way around. Symbols lead me, not I them. In other words, I experience my internal consciousness as prompting me, not I it. Therefore, the cause and effect model of experience before knowledge does not work for me. Instead, I believe that it is the way or nature of the imagination; that is, the manner in which it functions, for example, without a linear, time-space continuum, that makes me re-look at consciousness and the world as it has been structured for me. It is because the imagination runs so contrary to the logical, concrete world that I have been propelled to seek further illumination about my body, the environment and myself and to therein challenge suppositions.

Through these experiences, I am led to the idea of the imagination guiding us to understanding, self-definition and insight. It can shake up our idea of the world before we actually frame a question. I contend, then, that symbols, which are not located in one’s personal memory, can arise spontaneously. I also contend that they provide the groundwork for knowledge acquisition and that knowledge acquisition can be transformative for both the mind and the body. Since the imagination does not follow the rules, so to speak, of linear logic (thus, constructs of the imagination where it is seen as fanciful and whimsical “fluff”), it is possible that unknown symbols can manifest that are not linked to experience and that organic learning can spring forth through the images. This construction is not a reshuffling of the old or based on external experience. Furthermore, I contend that the imagination can lead us to knowledge and transformation rather than we being the guide that leads it to consciousness.

This intrinsic human nature, which supersedes personal memory, is expressed in Carl Jung’s idea of archetypes. His ideas shed some light on what it is that Sartre was perhaps inferring when saying that the image is just consciousness being consciousness. Jung divided symbols into two categories: those from the personal unconscious and those from the collective unconscious (Jung, 1926, 1947). Symbols derived within the personal unconscious are based
upon the individual's conscious and recent life scenarios; thus, memory. However, he also claimed that there are fixed symbols which are primordial images. These he called archetypes; they are images that have always been in existence, cannot be changed and are part of the psyche of all human beings in every culture throughout the world. These archetypal symbols serve to expand consciousness, and it is because of them that self-realisation is brought to bear. Thus, they are transcendent.

If, as Jung contends, there are archetypal images, then there is room for the idea that there is a symbolic realm which lies outside of memory that contains its own intrinsic knowledge. When these archetypal symbols manifest into consciousness, it could be possible for this to lead to the questioning of oneself, one's worldview, and so on. In this way, new insights are brought to bear because of and through the symbol, leading to knowledge, discovery and transformation. Bachelard (1971), using Jung's idea of archetypes, believes that "images are primary psychic realities. In experience itself, everything begins with images" (84), and that an image, such as the root, "is always a discovery" (84). It seems, then, that by losing touch with our imagination we separate from the deeper layers of wisdom residing inside of us as humanity and as individuals (Fromm, 1957).

Although Jung's idea of archetypes does not rule out the cause and effect paradigm (that humans materialize images to gain consciousness), his ideas transcend the memory-only paradigm. "As a plant produces its flower," he states, "so the psyche creates symbols" (1958, 53). Thus, humans are a symbolising species. Certainly Danesi's (1993) hypothesis (which is not unlike Aragno's [1994]) that the evolution of language began with the image supports this idea. He traces the historical roots of the symbolising capacity to two million years ago. "Homo habilis and Homo erectus" he claims, "had the capacity to form images of sense impressions and of the affective responses" (68). Although his conclusions do not lead to an analysis of a
symbolising human nature (instead, similar to Munz and Aragno, Danesi concludes that
“consciousness emerged when such neurological internalizations of bodily experience were
forged into iconic signs by the imagination” [68]), his data certainly supports the idea, as do the
other theories, that the nature of the human is to symbolize.

Thus, it is also possible for the order to be reversed: that the symbol prompted the
awareness of the bodily experience, feeling-states and environment, which is what brought
consciousness and awareness of all states, mind and body, to bear. Perhaps it is not an either/or
situation. That is, the symbolising system did not emerge before memory but occurred at one
with memory, synchronistically, which means that they are not exclusive from each other but
instead, support and validate each other.

By switching the spatio-temporal order, the symbolic function is synchronistically
objective and subjective, memory and beyond memory. This view is echoed in Paul
Fairweather’s (1981) theory of the imagination. His psychotherapeutic work with symbolism
treats the internal as "at once psychic and physical, coherent and substantial because it underlies
both consciousness and matter" (10). On the one hand, objective symbolism is consciousness
that is the actual form, such as a table or chair. On the other hand, subjective symbolism, which
is “real” for the individual, is "image consciousness.... It is ... the aspect of the symbol which
is the experience of the individual" (10). On the subjective level, the image is distinguished
from a symbol because it is the individual's own personal image of what a symbol represents.

Fairweather approaches the symbol as transcending memory and having at its base the spiritual
or cosmic nature of the human. The symbol, he believes, is representative of that root as the
source of all acts of consciousness:

Thus, the more a man [sic] understands about the nature and function of symbols as
symbols and the more he understands of his own particular use of symbols, the more
he understands his own nature (16).
This transcendent aspect of the symbol, which transmutes the nature of experience and
knowledge, may be the key to the growth that emerges beyond memory and could help explain
where and how nascence is brought to bear. Engaging with symbols leads “towards the
fulfillment of human potentialities through creative development of man’s [sic.] basic biological
impulses into a higher and harmonic order. . . . It is a healing process which seeks the maximum
transcendence of psychic limitation through symbolic ascension and dissension” (Assagioli,
1965, 310-11).

Jung (1968) called this the transcendent function. He believed that symbols act as the
tool via which consciousness is activated towards increasing self-creation. Transcendence
intensifies awareness and leads to self-actualization, which occurs through contact with
archetypes. The archetypes, as the primal part of every human being, are an inherited
consciousness that is contained within each one of us. Unlike Aragno and Freud’s primitive
symbol, however, Jung’s archetypes are not representations of the unconscious, but instead they
delineate its form of depiction. Archetypes arise into consciousness through symbols; that is,
they make themselves known to consciousness using symbols. Jung believed that the drive to
become conscious is an inherent aspect of the collective unconscious. This is the reason why the
psyche is predisposed to symbolizing. Without symbols, archetypes have no means of becoming
conscious. They are how the primal or archetypal instincts manifest themselves, like the clothes
that one wears. They are the a priori source of all the unconscious’ ways of functioning that is
greater than personal experience (Jung, 1971). This is what Castoriadis (1975) referred to as
“originary phantasmatization [which] preexists and presides over every organization of drives,
even the most primitive one, that is the condition of the drive to attain psychical existence”
(287).
Symbolizing and transformation, therefore, are based on an idea of consciousness that reaches beyond the context of memory to provide for new experiences (Epstein, 1989). What is interesting about theories of the transcendent function are that they suggest an expansion beyond the known into territories of the unknown and mysterious. This entails, then, a breaking down and breaking away from the memory model that views transformation as a reshuffling or reordering of that which is already established. In general, transpersonal approaches, such as Jung’s, emphasize the ability of the human to expand to encompass a greater awareness of self and the cosmos (Drake, 1996).

While Jung’s transcendent function allows for a greater or expanded consciousness, it does not recognize the body in relation to the symbol. In fact, the underlying weakness in nearly all of the theories thus presented is that they are mentalist in approach: subsumed within their ideology, which can be inferred by the absence of somatic reference, is the mind and body separation. The mind, it is argued, emerged from the symbol, but where is the body in all of this? That these theorists are progeny of reductionism and dualism is evident in their one-dimensional examination and analysis. As a result, the body is overlooked and not considered in relation to the transformative nature of symbolism, which prevents the development of a deep and comprehensive understanding of and approach to the nature of symbols.

Akhter Ahsen, however, does not fall prey to such limitations. While deeply philosophic about the nature of the imagination, he views soma and psyche as one indelible whole. “The image never exists detached from the body relationship, or from the relationship with meaning; these three parts never exist separate from each other” (Ahsen, 1999, 4). Like Jung, he recognizes an innate psychical function. This he called a heightened state of consciousness that is greater than memory and that allows for creativity and change. Central to Ahsen’s symbolising theory is the eidetic image. It originates from the Greek term eide, which is the
imagistic self whose purpose is to be seen, particularly in terms of its vision towards the future (Ahsen, 1991). The eidetic is described as a subjectively experienced and particularly vivid visual image (1) that is specifically marked by its perceptual and sensory qualities which, when experienced, has both a physiological or somatic response (S) and an awareness of meaning (M) connected to it (Ahsen, 1984). (This is mentioned in Chapter 3). Ahsen believes that movement, not stasis, is the natural process of life; therefore, the spontaneously occurring internal image has contained within it the components for growth, transformation and newness (Ahsen, 1985). The eidetic image, according to Ahsen (1989), emerges at points of conflict that allow for resolution and reconciliation to occur. This new construction takes place at both psychological and physiological levels. Hochman (1994) provides a good summary of Ahsen’s eidetic states. “The eidetic,” she claims, “defeats the bias imposed by memory, strengthens physiology and engages cognition and semantics without being limited by them as it reaches toward profound meanings” (8).

Ahsen also makes the distinction between constructive and destructive images. The latter is connected with phobias, trauma, somatic illness, and so on that restrict or destroy human potential and development. The positive image is the eidetic that allows for the new to emerge. This is compared to memory images which carry “a preconceived interpretation of the event and are therefore resistant to new structuration” (Ahsen, 1979, 22). As a result, growth and transformation can only occur through the imagery that emerges out of buoyant states of consciousness, which is the eidetic.

It is of central importance for the growth and expression of consciousness . . . that the images which contain the potential of high consciousness develop from an inert state to activation in a progressive fashion, when attention is paid to them . . . In ordinary limiting states of consciousness, as, for instance, in memory, one uses partial, biased, and distant envisioning of the original experience. The central function of high consciousness imagery is to contribute fundamental enrichment to one’s experience . . . High consciousness images represent total activation of the organism. Interaction with these images provides a view into the innermost psychical dynamics, a personal encounter with the energy and freedom (Ahsen, 1979, 22-24).
These need to be released in order for the individual to develop a successful life perspective.

Imagination Beyond the Space-Time Continuum: Towards the Future

What Ahsen’s theory of eidetic imagery allows is a grounding or embodying of the new and transcendent properties of the imagination which had usually been separated by theorists from soma in this chapter. This imagination is a symbolizing system that is both memory and beyond memory. In such a context, history and possibilities are constructions about meanings rather than an actuality or reality: the past and future are relevant only in terms of their presence in our lives. This is the essence of subjectivity that allows for the transcendence of the actual by “paradoxically introducing into the present more than the physically present. Generally speaking, subjectivity achieves an evaluative temporal synthesis that goes beyond the physically present by indicating the future” (Bakan 1980, 142).

According to Aanstoo (1987), imaging is fundamentally a spatio-temporal experience of which there are three components: remembering, imagining and anticipating. First there is remembering. Here imaging gives presence to an object that is not perceptually present. “The temporal orientation is towards the past. Remembering is an imaging of a presence given as ‘that which was’” (63). Next there is imagining where imaging gives presence to “‘that which is as if’. Its temporal orientation is towards the present” (63). Finally there is anticipation by which imaging gives presence to “‘that which may be’. Its temporal orientation is towards the future” (63).

This spatio-temporal thinking opens the door to very complex and intricate, even spiritual, questions about existence — questions with which empirico-positivism is very uncomfortable given the “institutionalized neglect of the non-linear” (Kellert, 1993, 134). But as a structure and mechanism for transformation and change of psyche/soma, an enormous amount
of potential is lost if the imagination is only viewed as a memorial. We are forced to ask these questions since the multiplicitous imagination and its symbolizing function are the basis for so much of what we revere as human (cognition, language, art, etc.). A full appreciation of it is needed so that we can access our diverse possibilities. If it is indeed that "the very nature of our brain, and its mode of producing our world of meaningful experience, are inherently intuitive", and that "our brains are constantly feeding forward into a world of anticipated experience, and testing those expectations against a fulfilling field of perception" (Laughlin, 1997, 32) through the imagination, then we are forced to examine this symbolizing function in all of its dimensions, not simply the ones that are non-threatening to a deterministic worldview. In this way, we can more effectively tap the capacity of this symbolizing function.

Part of this exploration will involve understanding the multidimensional structure that is the imagination. According to Laughlin (1997), "the problem is not solved by rationalizing the essential intuitive source of creative knowledge but by studying the way science proceeds when it is successful at being creative" (22). What this entails, then, is exploring the depths verses the span (Wilber, 1996) of the psyche/soma through the imagination. What is most striking about Ahsen's psyche/soma eidetic is that the closer that he gets to theorizing about the body, the more transcendent the philosophy and the greater the abstract, which is not necessarily true for some of the mentalist theories. Laughlin (1997) goes on to say that

neither cleavage to the ineffability of truth, nor limiting knowledge to formal scientific epistemologies will wash for any domain of empirical exploration, least of all for the exploration of consciousness. While it is quite common in science to disclaim the value of "mysticism," the fact is that the further one explores into the areas of uncertainty relative to knowledge, the more one's results seem "mystical" or "occult." The only way a scientist can avoid the "mystical" aspects of scientific discovery is to stay well away from socially recognized domains of uncertainty. But then that scientist's ideas will likely contain nothing new or interesting (28).
Holism

In many ways, quantum mechanics directs us towards an holistic worldview which is a perspective that is distinguished by its compelling impulse toward unity (Keeson, 1991, 45). The word holism has its roots in the Greek word “holos” which means whole. A system that is whole is continually evolving and emerging, not set and predetermined; it is integrated rather than separated. Such a worldview emphasizes an inner motivation that is in union with the outer.

“The central tenet of the holistic worldview . . . is its emphasis on the integration of life with the outer physical, social world” (Miller, 1990, 59).

On the other hand, the stability of Newton and certainty of Descartes are reductionist strategies that compartmentalize and reduce things to their smallest component parts. This worldview fragments and splits objects or subjects into pieces in order to understand them. Because this approach is linear, divisive and empirical, it rejects intuition and inductive reasoning. In other words, that which cannot be measured empirically is dismissed or at best, ranks beneath that which is quantifiable. Therefore, we are pushed into “an ‘either/or’ problem-solving and decision-making mode. Holism, however, challenges these assumptions about reality.

The third great twentieth-century change in science is the recognition of a profound wholeness in nature, of a fundamental inseparability and entanglement of those aspects of nature that have formerly been conceived to be separate . . . Moreover, the separateness of man [sic.] within nature that had formerly seemed to be entailed by science is now reversed. The image of man described above places human consciousness in the inner workings of a nonlocal global process that links the whole universe together . . . If the world indeed operates in the way suggested by Heisenberg's ontology then we are all integrally connected into some not-yet-fully-understood global process that is actively creating the form of the universe (Stapp, 1993, 213-214).

Thus described, nature (and that includes humanity) is not made up of parts within wholes: it is made up of wholes within wholes (Sense, 1990). The idea of an emerging rather than dictated philosophy is at the heart of this vision. Holism is all encompassing. It views all parts (e.g.,
cosmos, human, nature) as connected, and it does not create an alienating system (as does reductionism) that stresses one way as being more relevant than the other. Finally, a holistic vision allows for the inner, the intuitive, and the mysterious — thus the imagination — to be recognized and addressed. Holism, then, is a post-science approach that incorporates the imagination, aesthetic, emotional, mysterious, spiritual and intuitive alongside the empirical. This is what Schwab called a “polyfocal conspectus” (1978/1971, 61); that is, a heterogeneous perspective verses the narrow homogeneity of the one-dimensional technological and atomistic paradigm.

Conclusion

While trying to provide credence for the imagination, there has been a tendency to validate and explain it using deterministic and mentalist structures. Such analysis, while acknowledging the imagination’s relevance, does not consider it as a propelling factor of consciousness. The analyses still locates the “center” as outer awareness looking into the imagination in order to draw forth changes, verses the imagination being the driving force that leads to consciousness, growth and learning. Therefore, the mind retains its hierarchical superiority over the imagination and the body. I have argued, however, that it is possible for the answer to lead to the question, the answer, so to speak, being the imagination’s prompting us towards discovery. These ideas locate the imagination as a transcendent mechanism via which the nascent is brought to bear. “It has been a long time since we stopped considering mythical thought to be primitive and inadequate and therefore inferior to logic” (Chiozza, 1998, 2).

The idea of a transcendent imagination challenges the structured, linear worldview that bases existence on what has come before it. This is the logical, measurable paradigm that dismisses the broader idea of spatial time not bound by conventional constraints. Indeed, the
imagination functions counter to linear time and to logical, measurable, structured frameworks. Thus, rather than only looking towards the imagination to bring forth new learning and insight, we could also learn much by looking towards the imagination itself for understanding. So “rather than getting stuck in trying to analyze the paradox, we should simply let it open us up” (Van Eenwyk, 1997, 70). The imagination, then, can teach us new insights about the order of things, and by examining how the imagination and its symbolizing nature functions could provide us with a fuller and deeper comprehension of the mind, body, and the physical world around us. I believe that this understanding is important in terms of the mind/body relationship and healing.

It is the concept of nascence; in particular, that takes the imagination beyond the boundaries of linearity. In this way, growth of all kinds goes further than the logical or past. The idea of nascence challenges epistemologies that emphasize the rational, and it establishes another dialogue for and ontology of logic that is broader than deterministic paradigms. By juxtaposing the imagination with the structured, the former does appear unreal, nebulous, nonsensical and even ethereal. However, dismissing the symbolic because it appears illogical through the eyes of reason in turn rejects what could otherwise be a rich contribution to understanding how the reconstruction of self — mind and body — occurs via a mechanism within the self that does not fall under the laws of the rational.

It would seem that a great loss of what it means to be human is incurred when what appears as illogical is structured and bound by rational rules in order to appropriate the untenable into the capsule of reason. Instead, it may be more fitting to allow the imagination to inform us about structures of reality, so to speak, that are not limited to these laws of logic. Arnold Berleant (1991) poses similar questions when looking at the aesthetic being measured against the logical. He describes Western culture as being built upon “cognitive primacy of science, the
universality and exclusivity of truth, the objectivity of knowledge and the hierarchical order of being" (xxiii). "Art," he states, "has become . . . a symptom of this" (10). He argues that the aesthetic has been measured by these standards and made valid by being able to fit into this rigid, irrefragable model. Therefore, he calls upon aesthetics to challenge these axioms. He states:

Aesthetic theory is not intellectually derivative or subsumed under philosophic disciplines mistakenly considered more basic. It also means repudiating the tendency to regard the arts as an essential adjunct to practical studies. . . . It may, in fact, be more enlightening to reverse the conventional order of influence and consider instead the implications of aesthetics for social and philosophic thought in general. For the phenomena of aesthetics reach to the very source of perception and meaning in direct experience, and thus, they become in some sense foundational. While there is no truly primary experience, no "given", so to speak, the arts bring us closer than any other social form to the immediacy of the human world as we live it. . . . Like the fundamental axioms of metaphysical systems, the basic concepts of aesthetics do not lend themselves to logical demonstration. At the start of a primary inquiry we can only establish methods of proof, not utilize them (210).

While Berleant situates his argument within the context of the aesthetic, his discourse challenges the ideas of linearity that are used to measure and validate the unstructured. Like the arts (and it has been argued earlier that art has emerged from the symbolic), the imagination and the intrinsic do not operate under the same laws as the orderly and absolute. Therefore, to make the non-actual valid through the confines of reason forces the intangible to be compromised. This is a loss, for, as Berleant has also posited, much knowledge and understanding can be derived from the illogical.

It is within the context of the illogical that the idea and possibility of nascence, which cannot be founded in determinism, can be explored. It is here that the principle of the metaphor experienced as the actual; that is, the metaphor is physically, mentally and emotionally encountered as real, is particularly relevant and important. In a representational example of an image, that is, where it is an experience within one’s range of knowledge and understanding, to spontaneously imagine and respond to an item would be a result of conditioning. However, if a
person envisions an item or state that is not within her or his knowledge range, then her or his imagination would have to ascribe qualities and sensations that would be peripheral to her or his own learning. This is an example of what could be constructed and explored as the nascent, because then the imagination takes over, so to speak, and the person creates her or his own understanding of the image that is outside of her or his range of experience.

Within the framework of the logical, this is seen as fantasy and unreal. However, if we explore this suspending the laws of logic, the metaphor can serve as a means of nascent knowledge, keeping in mind that the image is a spontaneous occurrence, not an image that one is made to imagine. With the intrinsic presenting an unfamiliar image with which to interact — remember that the image is experienced as real by the imaginer — new learning and states can be brought to bear, which are not necessarily deterministic. Thus, I argue that one can not only develop and grow from images but through images. This, then, is the other means through which learning is derived from within.

Another point to consider is that if “the basic nature of imagery” is to “represent what they represent by exhibiting their form” (Toolas, 1986) but the symbol is abstract until it is form, and it is only when it takes form that it becomes a symbol, then the symbol is what it is. That is, by becoming itself — the symbol — then, it is its self, and otherwise it is unconscious and unknown, thus non-existent or not real. Instead it is abstract and nebulous — not its self or nature. The same could be said of the mind — it is only mind when it becomes form, which is neurological. It becomes neurological, so then it is neurological. “The spiritual . . . only constitutes itself effectively as spirit on the condition of becoming flesh” (Marcel, in Wood, 1990, 61). This would suggest that there are multiples of undiscovered “selves” that exist within us that are without a form, and as a result lie dormant and unused — not the self — unless we give these abstract states or “selves” a form. These forms can emerge through experience; thus we
come to know ourselves from the outside and this is premised upon the past. Or these forms, as I have so far argued, arise from inside as "they"/we seek consciousness. This is the nascent being born, and I believe, as this thesis will show, that we can direct these protosymbols into form.

Furthermore, when this basic element, the protosymbol, is made manifest, it can have a synergistic impact (multiplying rather than additive) on psyche/soma particularly when its existence is substantiated and established as self.

From a purely materialistic, mechanistic stance . . . phenomena (like visualization, dreams, meditation) are given little credence, since quanta of energy involved are not considered capable of having an effect upon a large system such as the body. . . . Again, this is a misconception, since engineering and cybernetics have demonstrated that small amounts of energy can be amplified until they have an extensive effect, just as triggering a photoelectric cell can open a large sliding door (Pelletier, 1976, 34).

Consciousness, then, exists at all times, but we can only become aware of it when it takes form, and the initial form that it takes is symbolism. This would therefore imply that the symbol as the founding root and source for all manifestation of both mind and body. Attention must then be paid to bringing these symbols to life.
The past decides the present to the extent that
the world is a machine.
The future decides the present to
the extent that the world is creative.
To create something new,
we need the future.
To persist in something old,
we need the past
(Wolf, 1984, 102).

The Symbolic Immersion Process (SIP) towards mind and body integration is a theory
and technique that I have developed for the past seven years. The goal of the SIP is
transformation and growth. The symbolic journey is a directive that guides psyche and soma to
work together for the purpose of learning, reconstruction and cohesiveness. The image is the
central tenet of the process, and it is the means through which the metaphor is reworked and
transformed. In this way, the self that is explored through its representative, the symbol, is
combined into a larger and more expanded metaphor.

The self-metaphor is widely used in a variety of transformational processes, and one such
method is the art of narrative writing (Diamond, 1999; Connelly and Clandinin, 1990).
Narrative is the idea that as stories are told and retold, the stories transform. By encountering
our lived experiences, the process of reliving and retelling challenges our history, and so change,
growth and learning emerge. “Self-narrative provides a lens for the reconstruction of our
experience rather than a simple window opening onto reality” (Diamond, 1999, 239). In this
way, “self is then enlarged so that the meaning and contents of experience are dialogized within
and between aspects of ourselves and others” (Diamond, 1999, 239). By constructing and
reconstructing our reality over time, we produce a succession of narratives with multiple endings
and possibilities. As we make meaning out of the stories that we are telling and retelling,
narrative becomes a means for birthing and recreating the self. It is a process of emergence, the result of which is reconstruction of personal practical experiences (Connelly and Clandinin, 1990).

Diamond (1999) describes the self as “composed of an individual’s changing internal conversations, recollections, forecastings, hopes, and voices” (235). According to him, narrative is a means of accessing the “first person voice” (236) that is a strong tool for portraying experience. When this voice is blended with third person voices, the self-narrative expands. It becomes a balance of being very close to the self, but at the same time separated from it to reflect upon it. First and third person accounts construct reality, reconcile dichotomies, and expand the self. Narrative’s way is symbolic rather than linear. “We may also come closer to eventually understanding more clearly the relationship between imagination and rationalization” (Conle, 1996, 321).

This is also the idea of the SIP, but instead of narrative, I use symbolic journeys via the imagination as the means through which an individual’s story can be told and reconstructed for learning. During this process the person is able to reflect upon and see the self in the first and third person voices and characters, acting as both the observer and participant. The body is used as the text of the story, and it is the means through which the metaphor stretches beyond itself into the material and becomes reality.

This chapter provides the theoretical tenets of the SIP. I outline the ontology of the process, which acts as lead-in to the next two chapters where these ideas will be illustrated, first as a general process (Chapter 7), and then as a case study (Chapter 8). In this way, the ideas that are presented in this chapter may be better understood.
The SIP Theory of Self

In this section, I outline the basic theoretical context of the SIP. The ideas that are contained here are a result of my work with symbols, and they form the basis of the process that will be described in the next chapter. These views are premised on the belief that psyche/soma exhibits certain lawful behavior, and I propose a model founded on what I believe these laws to be. The definitions and terms used here are not meant to be a universal manifesto about what constitutes the symbol in regards to psyche/soma, but instead the philosophy upon which the SIP is based. This has been developed through my innate connection to symbolism and the process itself.

Self-definition

In SIP, the basis of the self is the symbol, and the two are viewed as synonymous. Symbols are organic to the nature of self and the manifestation of self-symbols is a process that is at once memory and beyond memory. The self as a whole is a composite of infinite symbols; thus it is multiplicitous and each part of the unit is represented in the form of an independent symbol. These individual symbols can combine indefinitely to form increasingly complex systems that are both immaterial/psyche and material/body, and they are dependent upon each other for existence. The relationship is reciprocal and bi-directional. So the idea that in moving towards the self "we leave behind the material constructs of physical (four dimensional) space-time and slowly descend into the reaches of dematerialised timeless inner space" (Fischer, 1986a, 21) could not be true without the nebulous being equally able to reach out from its depth to emerge into the material self.

The belief that the self is constantly expressing its identity through the emergence of symbols is the heart of the theory. In fact, it is the symbol that allows for the self to be expressed, and without it there would be no sense of self-identification. In other words, the
symbol forms the structure for defining the self. In this way, self and symbol co-exist together and form a rhythm of identification that can be either healthy, unhealthy or a mixture of the two. Symbols are then projected from this foundation of self and their manifestations are infinite. Thus, the materialization of a combination of given symbols can emerge in multiple ways so that it can be impossible to recognize the source or beginning. The symbol, in other words, wears many masks and any given symbol can appear in a variety of costumes.

There are two routes to the manifestation of symbols: the external and the internal. These two are intimately connected and cannot be separated from each other, although on an individual level one may orient in one particular direction over the other. The external is, of course, the vista of experience and is the place where concrete memory is formed. We interact in the world that is made of symbols -- all external life is represented symbolically -- and we derive experience and learn to construct ourselves as we interact with the extrinsic. Taken as a solitary unit, this is the land of the obvious; however, the internal changes the context of the external from that which is concrete to that which is constructed. Thus the internal is interacting with the external in a dynamic state of creation and/or destruction.

If it is assumed that the internal is simply an isomorphism of the external, then all learning and transformation are dependent upon the outer for its realization. In the SIP, however, the focus is the symbol as an infinite intrinsic source of possibilities that can be directed into consciousness by bringing symbols into the concrete through the body. In this context, experience is not in a mind -- mind instead is the aspect of experience that is symbolic (Morris, 1993). The fundamental difference between approaching the symbol from the external versus the internal is that the former is dependent on the outside for symbolic presentation, which is essentially a powerless position, whereas the latter depends upon the intent or
concentration that is given to that intrinsic symbol for its emergence, which is essentially a position of control.

**Wholeness: The dominant theme**

In Gestalt theory, the whole decides the meaning of its parts, rather than the whole being determined by its parts (Perls, 1951), but in SLP the opposite is equally true — the part must determine the meaning of the whole as well, and the relationship is viewed as equal and interactive. Theoretically ideal wholeness is a state of equilibrium where the parts, in this case, the symbol as a unit, co-exist in harmony with all other parts/symbols. But wholeness is very hard to define absolutely because the imagination and its base, the symbol, are infinite in possibilities so that a part on its own is a whole, just as an apple seed is whole by itself, and a part when it is within an apple. So although the whole is dynamically shifting and moving, a part/symbol can expand its parameters and combine to become enmeshed as the whole or more accurately the *dominant theme* if consciousness habitually returns to or rests in that particular symbolic place. In addition, the symbol may have a preferred manner of expressing itself; that is, it may be inclined to either express itself somatically, mentally or emotionally. Despite the fact that it may lean in one direction rather than another, it will eventually affect all areas.

Because extrinsic reality is limited in terms of conscious awareness — for instance, we cannot see, hear, or feel everything at once — psyche is forced into one-dimensional space or fragmentation in order to materialize. A symbol, then, is whole within itself, but by manifesting or becoming consciousness, it fragments, so to speak, from the whole in order to be expressed. In this way, infinite associations and meanings are attached to the equally infinite symbols. Thus, a symbol will invariably be a construction. Because it cannot tangibly exist as a solitary unit — it is amorphous on its own — it is dependent upon these constructions and its combination with other symbols for its existence or materialization. For these reasons, then, the symbol needs
to be connected by interacting and merging with multiple symbols of meaning that form the basis of its inner and outer relationships.

The symbol can be described as bounded consciousness. These boundaries, however, are permeable. Traditional psychological models construct a conscious/unconscious epistemology to explain this condition, but in the SIP, psyche/symbol can never be unconscious, but the human can be. In other words, the symbol is infinite but human consciousness or awareness is mortal and limited. Wholeness, then, is determined by where the symbol, in its human or material condition, orients itself most frequently (the dominant theme), which then forms the basis of self-identification for both psyche and soma. This symbolic orientation is based upon the variety of interacting forces: the external, cultural, biological, intrinsic, and so on. These produce the metaphor of the ever evolving self.

**Balance and the foundational self**

The symbol, as has been noted, does not exist as a solitary unit, but it also cannot exist except as a complement to another. Thus, its very nature is duality, such as mind and matter, and this constitutes a whole. "Emotions and cognitions are naturally created as opposites. Because there is hunger, eating is pleasurable. Work makes feasts enjoyable, and love makes hatred so terrible" (Tunner, 1994, 24). These complements exist either in conflict, harmony, or indeterminacy, and this is usually dependent upon the type of symbolic construction - whether positive, negative or neutral - that it is given either at the birth of the symbol or as it combines with other symbols of meaning. "Fear, for example, has a positive factor of curiosity, and love has the negative factor of exhaustion." (Tunner, 1994, 24). In the SIP, which brings self-symbols to the surface, it is the nature of the reconstructing symbols to gravitate towards its complement for balance or homeostasis. It is as if the symbol or self longs for the parts of itself that have been denied or ignored due to separation or abandonment.
Kompa (1994) describes the state of balance as "idealized homeostasis". It is "the theoretical perfect interaction of the human mind and body. It is a state of perfect balance, the balance that is desired within ourselves, with others as well as within our environment. A balance is desired within all energies in the universe, specifically, the energy within oneself" (xi). Kompa, however, is singularly lofty in his construction of homeostasis: it is all that is good. But symbols are not inherently bad or good — it is their combination and construction that defines or energizes them. "To assess human adaptation as if it were a static event is to deny the very nature of this truly dynamic process" (Siefert et al., 1994, 5). Thus, a symbol exists in an innately neutral or balanced state, but when it interacts or combines with various self-symbols, it takes on imbued meaning. For instance, the symbol of control that is combined with peace, love, and health is a constructive combination whereas control combined with anger, hostility, and pain is destructive.

Homeostasis, thus presented, can occur on the axis of all that is healthy as well as on the axis of all that is unhealthy. The psyche/soma no more orients towards symbols of light than to symbols of dark. Rather, it orients towards balance, and this may not necessarily be a stable or constructive state. For instance, psyche/soma can balance states of aggression by usurping them with states of passivity, so that the homeostatic axis revolves around one or the other system, not both. The dialectical push and pull or tension that is created between the polarities results from the conflict that arises as one system displaces the other, whether out of exhaustion or dominance. In this way, imbalance becomes structural. Conversely, inner equilibrium that rotates on an axis of health is where the two poles can co-habitate and co-exist in harmony and communication — a respectively symbiotic relationship.

The orienting self-symbols, which form the foundation of psyche, are the most basic symbols to understand in the SIP. In the process, this orienting center is the place where
psyche/soma organically resides or moves towards: this is its habitual residence, the home of the dominant self-symbols and the main frame of self-identification. So if the orienting or foundational self-symbols are destructive, then homeostasis will be less than ideal and in fact destructive to self, whereas orienting symbols that are constructive build the self. It is important to remember that the symbol is both psyche and soma. As symbols need form in order to exist and know themselves, they are persistent unless challenged. In other words, they do not easily relinquish their position because to do so would mean the demise of the symbol, and therefore, loss of identification. Consequently, psyche/soma is very attached to its identity or sense of ground: it needs definition to be conscious because without this there is nothingness or emptiness.

Thus, psyche/soma will sustain its state of homeostasis – ideal or malfunctioning – in order to survive. When psyche/soma is malfunctioning, intervention is required in order to prevent destruction. There are many ways that this can be brought about. From a strictly external point of view, soma can be fixed biomedically and extrinsic symbols can be adjusted for psyche, such as a change of career, purchasing new clothes, and so on. In the SIP, however, the movement is inwards. These basic symbols get reconstructed in order to create change in both the mind and the body.

The fundamental premise here is that order for psyche/soma does not necessarily imply wellness or health. In the SIP, order is a state that is habitual: it is a comfort zone. Therefore, chaos can be predictable. This construction of order may be best comprehended from a larger context. For instance, the social “order of things” in the West has institutionalized slavery and women have been held to be hierarchically inferior to the male. Such an order requires that the dominant state maintains its hegemony and the weaker position adheres to these rules. However, if order is established on a more equitable system, all of the parts would co-exist more
harmoniously. What this means is that it is not so much that there is a dominant theme but what that dominant theme is — whether it is healthy or unstable. In the SIP, the ground upon which the dominant theme or self-symbols is based is the most important place to understand and develop, and it is also fundamental that a ground be present. This base forms the foundational self and may be any combination of symbols — self-building (constructive), self-demolishing (destructive) or self-sustaining (neutral). The purpose of the SIP is to construct a foundation that is positively self-instantiating.

Growth

Instability in psyche/soma occurs due to a disruption of the self-symbols, and although this is caused by many factors, it is fundamentally the result of homeostatic disturbance. From the intrinsic perspective of the SIP, disorder erupts when external and internal factors challenge the dominant self-symbols, and a tension arises between the parts or symbols. In fact, in the SIP there is really no way to differentiate the intrinsic and extrinsic: they are based upon and united by the symbol. Psyche/soma constructs disorder or chaos as anything that disrupts its main state, even if this disorder will restore harmony. The dominant self-metaphor, which forms the frame of the self, will be supported by psyche/soma because it is familiar as self: it is the identity until enough disruption occurs to weaken or even shatter the central frame. This is a very difficult process because the next step is to break through or deconstruct this structure, and when the self is established around and identified by this edifice, reconstruction can be very threatening to the dominant self-symbols. Invariably, the self will experience a sense of separation from the larger wholeness — even when this "wholeness" is an unhealthy or unbalanced state — by challenging the main frame. For example, disequilibrium occurs when one’s self-symbol rotates around being strong and its complement, weakness, is viewed as inferior and opposed to self. This results in a tension of the complements/opposites, and the balancing factor, weakness, is
perceived as a threat to the dominant self-symbol, strength, which forces psyche/soma into separate camps in order to escape from the conflict or stress. Ironically, this only perpetuates the cycle and instead of relief, the tension and imbalance gets reinforced. The only way out of the cycle is to marry the complements/opposites in harmony. The SIP does this by challenging the dominant theme that drives psyche/soma to embrace its complement because of the organic drive towards balance.

It is also helpful to focus on the tension which must exist between the subject and the object of knowledge. Although they are in a symbiotic, interdependent relationship, they must not be thought of as in absolute harmony. Regardless of the fact that the body is a condition for their being any known objects, as such, these objects and the body-subject are in a dialectical relationship to each other. In a sense, then, the difference between the subject and the object keeps them apart as much as their commonality keeps them together (Sorri and Gill, 1991, 39).

Psyche/soma functions around symbolic combinations that can operate independently from its complements/opposites but not from other self-symbols. To understand this better, it might help to see the complement/opposite (e.g., psyche/soma) as the husband to the wife and the other self-symbols as cousins or friends. In other words, the complement/opposite is two parts of one whole; for instance, light and dark are complements/opposites, and anger is a cousin to dark. It is the separation from and thus conflict with the complement/opposite that causes psyche/soma disruption and disintegration, and conversely, it is their partnership that promotes joy, harmony and creativity.

The relationship of the complements/opposites may not be obvious on the surface because the symbol is working in tandem with other symbols of meaning. If this interaction is unhealthy, it can provide it with a false sense, so to speak, of balance, connection and security. When the symbolic complements function synchronistically, the system is self-instantiating, but when they are fragmented from each other, confusion, conflict, and in the extreme, annihilation is inevitable. Clearly, then, by psyche/soma orienting in one place (the dominant theme) for the
majority of its consciousness or manifestation, it forces its complementary symbols of meaning into fragmentation. In this context, the complement/opposite will be allowed a voice and presence under two conditions: states of duress when the dominant self-symbols are either weakened or exhausted, or during times of joy when they relinquish control so that their boundaries become permeable.

Thus, fragmentation occurs when the dominant self-symbols consistently usurp its complementary self-symbol for supremacy because psyche/soma prefers the state that forms its self-identity, and thus instantiates its existence, irrespective of whether this is a creative, destructive or neutral condition. Consequently, in fragmentation, the complements hold a weaker position and are only functioning in a compensatory or oppositional fashion rather than working in harmony alongside their now dominant complement/opposite. When psyche/soma habitually reinforces fragmentation, the self maintains a "homeostasis", so to speak, that is imbalanced. This creates an unhealthy system, and reorienting symbols are needed to work in tandem with the dominant theme in order to restore a stable foundation. In the SIP, the creative emergence of reorienting symbols, which work with the laws of balance, are generated to evoke learning and growth.

When the dominant theme has taken over, it must be challenged in order to restore a healthy state of homeostasis. The problem occurs, however, when the one-dimensional dominant theme is associated as self, and the disassociated complements/opposites are perceived as non-self. Thus presented, the complement/opposite is the enemy rather than partner because it is at once a complement and an opposite, and in this context, their differences are separating them. Psyche/soma will, therefore, reject its other side, which is really the half of its whole, because it does not positively identify these intrinsic symbols as part of self. Essentially, then, the symbol does not recognize itself for who/what it is; for instance, when mind views matter as
different from itself. What is needed is for the symbols to recognize and accept their sameness — they are parts of the same whole — in order to re-unite.

This may be illustrated using the example of temperature. Hot and cold are the two parts that constitute temperature. In the extreme, cold clearly feels opposite to hot, and they do not appear to be the same thing. Once they remain “apart”, there is no way to actually experience them as similar — they are different and their polarities are perpetuating the division, although it is possible to experience them at the same time. However, once they come together (the boundaries are permeable), they start blending into each other, and they form the neutral position of warmth, which is the state of ideal homeostasis or balance. The equilibrium and harmony that has been restored is a result of the complements/opposites merging and could not occur any other way. That is, there could be no balance without the complement/opposite. But their union also results in a change of identity: they are no longer either hot or cold, but together are warmth. Although they become something else by joining, they do not lose their essential self (that is, hot and cold), and in fact their union allows them to express themselves as one, rather than separately. In actuality, their intertwinement has broadened their identity. This is the whole, and it is neutral.

What is also significant about this example is that it illustrates the process of growth or destruction: in order for either to occur, it requires a stepping away from the neutral or balanced position. Let us examine growth, for instance. If we never want to change the comfort zone, we remain in the neutral position, and for the purposes of this illustration, this state is idealized homeostasis — warmth. But this also means that we never get to experience all of the dimensions of the whole. If we want to get to know the whole, it requires that we move away from this “perfect” place to explore different aspects of its entirety and this allows us to encompass more of it. Problems occur when, for instance, we step into one area only, say cold,
and ignore hot, or when we get caught up in one space, say hot, and forget to come back to warmth. The extreme would then come to form the "new" place of homeostasis if one habituates there long enough, but this is less than an ideal state. This results in a dominant theme or self-symbol, and over time, if there is no attempt to embrace the complement/opposite for balance, disequilibrium becomes systematic and problems arise.

Energy change and motion are all verbally the same, existing everywhere in everything at all times. A constant is the opposition of change; it is the desired theoretical state of absolutely no change, energy, or motion. A constant is anything that is unchanged, equal, balanced, or the same throughout. Therefore, if everything is constantly experiencing change, then the constant exists ideally only in theory. In actuality, the constant that is desired is minimal change; thus if there exists less change, simultaneously, there exists greater constant (Kampa, 1994, 7).

The above example of temperature can be worked in manifold combinations that are too numerous to be described. However, I will point to a few variations so that the growth, destruction or stagnation (neutral) processes can be more fully comprehended. In the previous example, the starting point was the neutral position of idealized homeostasis. Remaining there, let us assume that this is the whole, which is warmth as it encompasses both hot and cold. However, suppose consciousness is occupying only 20 percent of this space based on its knowledge of and experience with it; that is, it knows 20 percent of warmth. So although this is the ideal state, the understanding of it is limited and superficial. Furthermore, this is also a precarious position because the extremes actually occupy more of the space (80 percent) than the neutral place. The extremes would, therefore, be exerting an influence over the neutral state that forces it to shift position and step out of its zone in order to broaden its horizons, so to speak. This can be either a creative or destructive process depending upon the other self-symbols that are interacting here. Figure 1 illustrates the weakness of the neutral theme and the intensity of the extremes seeking recognition. The gray area is the 20 percent neutral position of warmth, and the two outside circles constitute the 80 percent of the extremes, hot and cold.
Thus far, I have used equilibrium as the point of origin. Let us assume instead that the initializing point is not the neutral zone but the extreme. Let us also establish that these spaces are a result of both intrinsic and extrinsic factors: the latter being experience, which is the symbol premised upon memory, and the former being individuality, which is the symbol based on subjectivity. The intrinsic and extrinsic combine and the resulting symbols of orientation arise from the extremes -- hot or cold. In this way hot, for instance, forms the dominant theme, and thus becomes what psyche/soma learns to identify as itself; that is, this way of being (hot) becomes, figuratively speaking, the “natural” state. On a subjective level, this is homeostasis, and the other side, cold, forms the not-me symbol. This one-sided position can easily lead to unhealthy states. Figure 2 demonstrates this idea. The gray area is the dominant hot which overshadows the weaker cold.

Figure 1. The weakness of the neutral theme and the intensity of the extremes.

Figure 2. The dominant hot overshadowing the weaker cold.
Finally, let us add one more element to the above example: let us consider that all states are the result of learning. We are not considering here the source (cause) of the state or how (intrinsically and/or extrinsically) it developed. Instead, we suggest that the 80 percent hot is a result of learning. Thus presented, the only way for expansion to occur is by penetrating into the other side, which is the complement/opposite, and breaking down the boundaries that divide them. In the SIP, this is done through the evocation of the balancing self-symbols, in this case cold. By stepping back from the dominant zone, hot (remember this is its place of homeostasis and comfort), and moving into the other extreme, cold, this complement/opposite can be developed and nurtured. Although the dominant state loses some of its identity, so to speak, as the two harmonize in the center, this process actually allows the self to gain more of its identity by encompassing its whole. Furthermore, by embracing more of the other and juxtaposing the complement/opposite, choice becomes possible. We can only know how to choose when the complements/opposites are available to consciousness. Otherwise, we remain unconscious, although the symbol cannot be unconscious, of the whole. We need to have the two in order to understand the meaning of the symbol. Figure 3 indicates this relationship.

![Circle](image)

*Figure 3. Harmony.*

Given these illustrations, it may be easy to see that the self can be afraid of the growth process because of the sense of loss that occurs through either relinquishing the dominant
position or stepping away from the neutral, which is the safe, place. In terms of growth, two points are relevant in the SIP: (a) symbolic supercession, and (b) desire or intention. In the first case, the goal of the SIP is to expand the parameters of self. Theoretically, the process views change as a misnomer: the inherent nature of symbols is multiplicitous and infinite. That something is not known only implies that it has not been discovered or utilized, but that it does exist in some type of symbolic form; so electricity existed before its "discovery" but because no one was conscious of it, there was no representation of it.

The SIP holds that psyche/soma cannot change fundamentally because it is already all that it is, but it can grow into itself. Given that there is no end to the psyche and no limit to what it is capable of knowing, and given that where it orients its attention constitutes what it is that it knows, it is not change but supercession that occurs in the SIP. Supercession means that the self expands to encompass more symbols of meaning so that nothing of self actually disappears although it may appear to do so because an expanded self is "different" or rather is adorned with different attire (remember the neutral warmth example earlier). This means that the dominant self-symbols take on a diminished role and allow for the voice and presence of its complements/opposites and other symbols of meaning, or the limited neutral zone expands to encompass more of itself. Thus, the foundational self incorporates a greater field of self-dynamics that is accessed through the manifold symbol.

Because there is obliteration without consciousness, supercession in the SIP is the idea that either the balancing self-symbols need to convince their dominant counterparts about their worth so that the latter can relinquish their state of authority (the way it is) or the extreme symbols need to entice the limited or neutral zone away from its safe place to explore the depths of itself. As a result, the desire and motivation to broaden consciousness are the most propelling factors for growth in the SIP because without the longing for other than what is known,
psyche/soma has no reason, so to speak, to move away from its habitual place of residence. The dominant self-symbols will not step down from their reign without due cause and will actually fight to maintain their status -- remember, this is their identity and thus, existence. In general, desire and motivation arise out a variety of reasons: the most obvious justification for desire is dissatisfaction (e.g., unhappiness in a relationship), while the most propelling one for motivation is force (e.g., war).

**Time**

Because psyche/soma or symbolic change is an oxymoron in the SIP, supercession is premised upon growing into aspects of the self that are unknown. This requires redirecting symbols from the past into the future, and then back to the present. "In fantasy, we can totally exchange the order of spatial and temporal relationships. The nonreversability of time is not valid in fantasy. . . . It makes metaphysics possible" (Forisha, 1979, 23). This is the basis of growth and learning in the SIP.

Imagery is also a tool for facilitating present awareness. When we are liberated from past forms, both verbal and imaginal, we can utilize imagery in the present to enhance our current experience. . . . Thus, with the use of imagery, we may recapture our past, enrich our present, and shape our directions towards the future (Forisha, 1979, 8).

Although science has traditionally viewed systems as unfolding in a linear, impartial and continual manner, clearly not all systems function under such laws, and the inner symbolic realm is one such structure. In fact, the SIP reverses the order of things: what may be considered variances in traditional mechanistic laws, such as non-linear time, are standard in the SIP. Basically, internal symbols can be divided into two categories in regards to time: those that are derived from memory, *isomorphic symbols*, and those that are intrinsic and greater than memory, *metamorphic symbols*. The isomorphic symbols are related to experience. They are symbols that form identity based upon the past and external events. Such symbols are the result of
conditioning. So the present is actually structured through memory, which means that the perception of the moment is in fact only the past regurgitating itself symbolically.

In the SIP, isomorphic symbols are viewed as a context for the self rather than as defining the self. The past, then, is deemed to be no more real than the future -- it is all imagination; so what makes one more real than the other is simply where psyche/soma chooses to situate itself symbolically, whether in the past or in the future, and this forms the now. This idea can be understood by re-looking at the space-time continuum. Efron (in Fischer, 1986b) points out that the present becomes the past as soon as it is conscious because the nervous system only requires about 60 to 70 milliseconds of processing before the present arises. Thus, it takes less than one second for the past, present and future to occur. This is never more evident than when engaging the imagination, and again this is the main difference between the outer and inner symbolic realms: the outer, being material, is real, and the inner, being immaterial, is the imagination. By drawing into the symbolic realm of psyche/soma, reality becomes non-deterministic, non-linear and even surreal as time runs in all directions and psyche/soma experiences the symbol as being real. Because the goal of the SIP is growth, the isomorphic symbols learn to stretch beyond themselves into this symbolic future -- the metamorphic symbol -- which has the power to transform the past through supercession.

In the SIP, then, all symbols are the context for the self, and psyche/soma is directed from the limited environment of isomorphic symbols into the deeper metamorphic self-symbols in order to bring about growth and supercede but encompass the symbols of memory. In this way, the dominant self-symbols are enticed to let down their guard and embrace their nemeses/compatriots. So although psyche/soma can be very comfortable with its symbols of memory -- the past is "known" -- it is still pulled to its other side, the metamorphic symbols. Therefore, there is the dialectical tension of at once longing for and fearing its connection with
its disassociated complements/opposites, but by once again meeting and claiming those parts of self, psyche/soma can embody what has been essentially disowned. In the SIP, these symbols are not understood to be coming from the past. Instead, they are emerging from the symbolic future because they are not recognized as part of psyche/soma’s immediate existence and moving into the present. The symbolic process of letting go of these symbols of memory allows psyche/soma to embrace the future or metamorphic self symbols and bring them into consciousness; that is, materialize or embody them. This act of engaging in metaphors of self that are not part of memory or experience allows psyche/soma to learn a new reality from within. Alan Wolf (1994) describes this idea in the following way:

What does the future need or want from the present? The answer is manifestation. The future reaches back to the present and “shakes hands” with it in agreement that between them and only between them, shall there be a path of least action. To our minds in the present moment, this ghostly apparition appears frightening or perhaps reassuring (Wolf, 1984, 110).

The consideration of these metamorphic symbols challenges epistemologies that regard the acquisition of knowledge as deterministic. So although “in conventional psychological terms, mental phenomena are dependent variables (effects), never independent ones (causes)” (Holt, 1972), in the SIP this gets reversed in order for supercession to be realized, and instead response creates the need for the cause. In this way, rather than awaiting extrinsic symbols to evoke learning, the symbol serves as the stimuli or cause. However, instead of responding in habitual mental and physiological patterns that are represented through the isomorphic symbols, psyche/soma is directed to learn through the metamorphic symbol and in this way expand the self-reference. Because repetition orients self in a certain direction, it is also repetition that will orient it towards embracing these other symbols of self.

Essentially, the deeper psyche/soma goes into itself, the less deterministic laws apply. In the SIP, because self-expansion is the modus operandi, determinism cannot be the route. Thus,
the cause is not considered as important as the effect. For example, on the symbolic level, let us say that darkness is located as the cause of the state of anxiety (effect). Assuming that darkness (cause) is a dominant theme or self-symbol, its repetition makes these two combine together and form an interlocked identity. As a result, a feedback loop is created where the effect (anxiety) becomes so interlaced with the cause (darkness) that they are virtually inseparable. Thus, any experience, internal and/or external, that initiates the symbolic state of darkness will also initiate the anxiety, and vice versa, when anxiety is initiated, so is the state of darkness. In this way, the effect (anxiety) becomes the cause; that is, they interact as one, although they are not complements/opposites, but they are relating as if they were, which forms a destructive cycle.

As emotional/mental states are also physiological states -- stress affects the mind and the body -- this unhealthy relationship is negatively affecting the entire organism.

Because in the SIP systems are perceived to affect each other symbiotically, cause and effect are replaced with the idea of the feedback loop. This means that cause creates effect and effect creates cause at the same time, and although on a superficial level there appears to be a deterministic relationship (for example, one is anxious because one is afraid of losing employment), on an intrinsic level they are symbolically interacting. Thus, it is impossible to locate a singular causal relationship or in fact any cause without that cause also being an effect at the same time. So in order to expand consciousness, psyche/soma needs to step out of the repetitive feedback loop that forms its identity and embrace its complementary symbolic selves that arise from the symbolic future (not part of experience) rather than the symbolic past (due to experience).

This feedback loop theory allows for self-determinism, but in the SIP, self-determinism is true under two conditions: (a) on a deep intrinsic level, and (b) when expansion is desired. In the first instance, self-determinism is apparent when one is connected to deep symbolic levels.
(metamorphic symbols), which are accessed during the process, but on the surface or extrinsically (without examining these metaphors), this may not necessarily appear to be true or valid. In the second instance, nonlinear laws are applied only when some form of symbolic reorientation is desired. Remember that the state of homeostasis — creative or destructive — is a constant and will remain static unless it is required to shift either by circumstance, in which case reorientation retains its deterministic position, or out of desire or intention. The main difference between these two is that the former is a position of powerlessness and the second is powerful and creative. As the participants choose the SIP, the second scenario is always the case.

Summary

This chapter has described the tenets of the SIP. These form the basis of the how symbols are used as a psyche/soma intervention tool, which is described in the next chapter. This interpretation of psyche/soma presents a dynamic relationship between mind and matter that is connected via a complex inner/outer semiotic system. The purpose of these ideas is to create growth, which is the goal of the SIP. Symbols have, therefore, been described in a manner that can best serve the purpose of transformation, although the construction of symbols is not limited to the theories that have been presented here.
CHAPTER 7 - SYMBOLIC IMMERSION: THE PROCESS

It is conceptually essential to make a distinction between willing and imaging. It is true that one cannot bring about an autonomically mediated response by acts of will, but one can bring them about by acts of imaging (Richardson, 1994, 66).

If a person has established a homeostasis that is founded upon an unhealthy state, which is maintained because the internal semiotic system has a proclivity towards preserving perceived balance, how can this system be trained to realign itself? This answer must come from within the symbolic structure that sustains this condition: How can it be engaged to re-orient the whole system? A variety of approaches have utilized the imagination for the purposes of transforming and stabilizing unhealthy states; for instance, transpersonal therapies (Jordan, 1979) and mind/body treatments (Ahren, 1977; Schultz and Luthe, 1959). In this section, I outline how the theoretical postulates that have been described in the previous chapter are applied as the Symbolic Immersion Process (SIP). This is a dynamic learning process by which persons are taught how to participate in their own healing. The examples that are provided in this chapter of the process are short vignettes taken from actual sessions with a variety of people. I use these to illustrate the SIP.

The Initializing Process

I start the SIP by asking the individuals to breath through their nose into the point below the navel. This is not a long initiation process -- between one-half to one minute:

Nicola (N): Breathe and feel yourself drawing inwards. As you breathe, feel yourself going deeper inside, relaxing. Your attention has moved within. As you go deeper inside, locate a scene that represents you at this time. Wherever you are, nowhere is fine, we will begin.
When I have worked with a person more than once, or if they have a specific request or issue, whether physical, mental, emotional or situational, I will take them directly to that part of their body, "Breathe and draw into the part of yourself where you feel this problem resides." These symbols are never imposed. In other words, I do not provide a scripted lead-in or a scripted process. Instead, the images emerge as the participants attend to the questions that I ask them during the process. This will be described throughout this chapter.

Thus, the process of going within to the inner self-symbols is very simple, even though the majority of people with whom I work have never done visual processes. But the SIP is not singularly visual, although engaging with the inner symbols in a visual manner forms a large part of the work. I would not say, either, that I have experienced one person more capable of visualizing than another. The majority has no problem forming images, despite the short lead-in. The simple request to “Give me a scene that represents you at this time” is usually enough, even when participants believe that they cannot visualize. For those who have difficulty beginning, I have a very simple way of connecting them:

Nicola (N): Tell where you find yourself, nowhere is fine.
Participant (P): I am nowhere.
N: Is it dark or light?
P: Grey.
N: Touch it, and tell me what it is like.
P: It is misty, foggy.
N: What does that imply to you.
P: That it is dusk, early morning.
N: Where are you?
P: I am in a field.

Once individuals place themselves in a scene, I keep them engaged in their own story by asking a variety of descriptive questions about their surroundings, such as asking them to describe their experience and understanding of the metaphor. This process is a combination of all the senses: sight, touch, taste, smell and hearing. In the SIP, participants only have difficulty visualizing what they are literally unable to "see" in their own lives. For instance, a person will
not have problems in self-scenes that symbolically represent parts of his or her identity, “I am stuck in a hole. It is hard and deep.” But this same person will have difficulty visualizing the “future”; that is, what she or he does not see as the self, “I am in an open field, which represents freedom, but I can’t see it that well. It’s hard to get a grip of it.” Thus, visualizing is subjectively selective, and I get around this conundrum by utilizing the other senses: I ask them to touch, feel, even taste. It is important in the SIP to keep the participants’ attention focused on their present scenarios and not to let them wander, avoid or abdicate their metaphors. In fact, many of my techniques have evolved out of the need to find creative ways to ensure that the participants attend to the images at hand.

Training the Body/Mind

From an extrinsic point of view, external symbols are concrete (e.g., a chair) whereas internal symbols are amorphous (e.g., joy). However, from the perspective of the SIP, the intrinsic can only be amorphous when it is not in existence. Therefore, the goal is to concretize internal states via symbolic representations in order to learn more about the multiplicitous self and expand its parameters. This is done through the context of the body/mind. The idea of the body/mind or psyche/soma needs to be clarified here. In the SIP, the mind, which is a combination of feelings and thoughts, can be viewed as an entire system, as can the body. Each system uses the other to express itself, and they help to form each other. Thus, they are complements/opposites. The mind, which is not located in the head (the brain is), is everywhere in the body, and the body conversely is everywhere in the mind. The mind, as an independent system, is intangible, and the body, on its own, is tangible, but together they form one structure — human consciousness. In the SIP, in order for the mind (both feelings and emotions) to express itself, it needs the body, and in order for the body to express itself, it needs the mind. Thus, by
using the body as the construct for the mind and the mind as the construct for the body, that which is intangible can become tangible and that which is tangible can become intangible. The decision to distinguish or create self-symbols is a self-regulating feature that is learnt through the SIP.

Self-regulation

Self-regulation is a basic assumption of the SIP. Individuals who participate want to expand their mind/body knowledge through symbolic processes. This need arises when psyche/soma gets located in one-dimensional space; that is, where one state is favored over the other — the dominant theme. In order to develop the other side, the habitual symbols, which the SIP views as body-connected because they are so strongly identified as part of self, need to be diminished enough to allow for the intangible symbols to be concretized. In this way, what is solid gets weakened, and what is amorphous becomes concrete. Such a process allows the person to gain control of both states; that is, the power to change what feels unchangeable and to develop other parts that seem out of reach. In the SIP, an example is:

P: I feel sad.
N: Where is that feeling in your body?
P: It is in my throat.
N: Touch it. What is it like?
P: It is a rock.
N: What does that imply to you?
P: It is something hard to break — solid, permanent.
N: Try to break it.
P: O. K.
N: Now burn the remnants.
P: It is done.
N: How does that make you feel?
P: Happy. I was able to change it, powerful.
N: Where do you feel that in your body?
P: In my chest.

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5 This suggestion of burning (using the symbol of fire) is the only image that I impose in the process. It is based on the theory of letting-go (which I described in the previous chapter and which I explain in this chapter as well) of the symbolic states that the participant has labeled as problematic in order to make room for newly emerging metaphors. It is suggested so that the participants can learn a method of letting-go. Many of them are bereft in knowing how to let go. So I use the fire as a learning tool.
N: Touch it. What does it feel like?
P: It is hard to touch. It is just a feeling.
N: Try.
P: O.K. It is like water.
N: What does that mean to you?
P: Refreshing, life.
N: Let's take it through your body.

All states in the SIP, then, are viewed as a context for the self and not a derivative. In this way, the self is a fluid state that is founded upon the base of growth. That is, it is solid (its base) and fluid (moves) at the same time. This is a very important element of the work, and one that is implicitly taught. Thus, the body/mind concretizes what it needs to learn by symbolically absorbing the new perspective. In this way, it retrains itself, and the new becomes part of who it is. At the same time, the body/mind processes this knowledge by circulating this information throughout. This would take place in the SIP as follows:

P: The pain is rubber in my head.
N: Take it out and burn it.
P: It is gone.
N: Return to your brain. What is it like now?
P: Free.
N: Touch it. What is it like?
P: It is soft. I see light everywhere. It is emanating.
N: What does this do to the brain? How do you feel?
P: The brain is alive. I feel alive.
N: O.K. Let's take this through your body. Absorb the light into your brain. Do not let it just pass over it. Let the cells absorb it so that it becomes part of their constitution, the muscles, the nerve endings. Move it down into you face - the eyes, nose, mouth, throat. Now take it into your shoulders and arms. Absorb it into your bones so that it is becomes part of the constitution, like calcium. Let your muscles absorb it, your blood, the cells. Move it into your chest and heart and absorb it into the cells, muscles...

I do this through the body. After this has been completed, I ask the participants to circulate this through their blood:

N: Now that you have absorbed this through your body so that it is part of your structure, circulate it through your system as your blood. Move it down to your feet and back up to your brain, then back down again. With each flow, increase the intensity of the movement, so that it increases and builds. You are aware then that it is solid as your bones, your organs, your skin, but it is moving as your blood. Now describe: what does this do your body? What is your mental state? Your emotional state?
In this way, the individuals can concretize and stabilize the newly emerging state through the structured part of their body, and at the same time, utilize this by learning how to move it throughout their system. This establishes a balanced organism: the structure is the foundation (solid) and the circulation is the flexibility of self (fluid).

**Spatial orientation**

The spatial orientation of the SIP is the present; that is, participants are taught to locate themselves in the moment — wherever they are. They, then, remain in that symbolic space in order to ascertain and understand its meaning in terms of the self. Once they grasp its content, they can work at redirecting their images. In general, particularly in the early stages of the work, the participants make choices that reflect their habitual responses, such as “I’m going to stay here in the dungeon”. These type of choices are challenged in the work, (this is covered in depth later), and it is this challenge that directs the participants into other symbols for learning and self-expansion, which is the purpose of the SIP. In this way, the present moves into the future. That is, the participants locate themselves in other self-symbols, and the goal is to train their psyche/soma how to maintain this orientation, which is always the acceptance and integration of the complement/opposite.

The major challenge that this symbolic movement poses is the acceptance of the “other self” or space. For example, in this following metaphor, the participant has spent some time exploring her present state, which has been one of conflict and discord (the dominant theme or past/present). After confronting this image, her psyche/soma orients her in the other direction (the complement/opposite or future/present):

P: The place is beautiful. It is lush and idyllic. It is so peaceful and calm. Oh, but this is just my imagination. This cannot be real. Places like this do not exist.
N: What makes this place any less real than the other place [the one of discord]? Are they not both your imagination?
P: I guess so. It’s just that I’m accustomed to the other place. I’ve never been in a place like this. It’s strange.
N: Well, do you want to get to know it?
P: Yes, I think so.
N: O.K. Touch it. What does it feel like?

Thus, once the self supercedes the present or habitual space for another, psyche/soma must learn to integrate this knowledge. The idea in the SIP is that if the new state or metaphor can occur in this moment, it can expand to exist in other moments once such a symbolic space is learnt. This is very much an incremental but non-linear process. That is, one does not retrogress into the "old". Instead one occupies a certain space within self, which may "feel" old because of its repetitive or dominant nature. Through the SIP, one can learn to make the choice of whether one wants to be in the "old" or the "new", the new being an integration of that which has been (old) and that which can be; that is, the expanded self. It may be noted here that the SIP does not advocate for the new over the old. In other words, the old is not "bad" and the new is not "good". Rather, the SIP teaches self-expansion so that individuals may have greater choice in their lives, and one needs to open up to the new, so to speak, in order to have that option. The key to the process is self-regulation. Therefore, the focus is not whether uncomfortable or undesirable spaces occur, but that something can be done when they do, which is the re-orientation of symbols.

Direction

The SIP is a directional process. Unlike Jung's active imagination, for instance, it is not simply a spontaneous eruption of images and metaphors that travel along their own unchecked vista. Instead, it is bounded by growth according to the theories of psyche/soma that were outlined in Chapter 6 which lead individuals to their self-symbols in a manner that initiates transformation. However, symbols are never imposed. Rather, the process of engaging symbols in the theoretical manner that has been described stimulates the internal creative nature of the psyche. As a result, symbols spontaneously arise through the choices the person makes because
of the questions that are posed to them in the SIP. Furthermore, the SIP has been specifically developed to teach participants how to engage their own symbols for the purpose of self-expansion; therefore, this directional procedure and theoretical base is necessary for them to learn self-regulation.

P: I think I’ll stay here in the cave.
N: Why?
P: It is comfortable.
N: Describe it.
P: It is dark and a bit cold – isolating.
N: How do you feel?
P: Alone.
N: What does that tell you?
P: Maybe it’s not so good here after all. I’d like company.

Self-challenge: Focusing on the tension

In order for growth to occur in the SIP, the unbalanced self-symbols are challenged and transformed. This idea is the key to the entire process and forms the cornerstone for psyche/soma interaction. In fact, it is learnt during the sessions, as participants always move into their symbols of tension, which is part of the purpose of the SIP as a whole. Tension, it may be recalled, exists because the complements/opposites are separated; thus, the ability to confront and transcend self-symbols, something that is implicitly taught in the SIP, replaces any tendencies to avoid and/or wallow in the symbols that are in need of their complements/opposites.

Thus, attending to the tension, be it physiological and/or psychological, is the basis of the process, because avoidance, according to the SIP theory, is self-abandonment and prevents the self from harmonizing the complement/opposite. That is, the tension remains, but the self hides out elsewhere preventing the complement/opposite from “marrying” each other due to the fact that avoidance perpetuates the either/or dialectical tension that is the inherent nature of the self. Wallowing, on the other hand, which is the opposite of avoidance, is also rejected in the SIP as it
is the state of being stuck in one place and offers no opportunity for choice -- hopelessness and powerlessness become irrefragable as there is no possibility of finding the complement or opposite which would allow for transformation. It is usually the case that individuals have a preference for one response -- either avoidance or wallowing -- over the other. Avoidance is typically the more active process, whereas wallowing is more passive. It may also be noted that, as is true for all complements/opposites, the two are not at all dissimilar. As one continues to avoid the tension, one invariably remains stuck in it; thus wallowing. Conversely, as one stays stuck in the tension, one is invariably avoiding the whole situation. In the SIP, this process would be as follows:

P: I am in the desert. It is dry and hot. I am isolated.
N: What do you want to do?
P: Leave it [avoidance].
N: But this is where you are. What do you want to do here?
P: Nothing. I can't do anything.
N: How do you feel about that?
P: Sad, but I am O.K. I'll just sit here [wallow].

Thus, in the SIP, it is the attention to the present moment that leads to transcendence, and the process teaches the participants how to move inwards, as many lack both the proclivity and knowledge to do so. The participants are, thus, taught to stay and confront their present self-symbols. So rather than move into other scenes of self (avoidance), or remain stuck (wallowing), choices that are considered poor in the SIP, participants are taught to move through the state. Consequently, everything begins in the present point, and by remaining where they are (present), the individuals are taught via the process how to transcend the tension. Indeed, in the SIP, it is only through acknowledging and learning about the self-symbols that one can understand what one needs for growth:

N: You are here. What can you do beside leaving it or just sitting there?
P: I am not sure.
N: Look around. Touch it. What is this place like? What does it need?
P: Let's see. The sand is very dry and hard. It seems that something happened here -- maybe no one has cared about it for a long time. It feels very desolate. But I can feel
that there is good soil underneath as I keep putting my hand into it. In fact, the more I touch it, the more it yields to me, and I realize that it wants me to be here, that it is not as empty as it had at first seemed. There is more to it. That makes me feel relieved. There is hope. I need to water it so that the earth can be nourished and come up. That's what it needs - water.

N: O.K. Try that. What does that do?

P: The desert is beginning to change. Grass is growing. It is a lot of work though because it is such a large place. It's a little overwhelming, but I like the changes. Flowers are beginning to grow. It is becoming healthy.

This idea of self-confrontation and challenge means that all feelings or observations are not assumed to be “correct” or “real”, although they are always honored. In fact, these feelings and perspectives demonstrate how the self is interpreting its internal/external situations and where the dominant self-symbols are creating tension between the parts, thereby grid-locking psyche/soma in one place. The purpose of the SIP is to confront these interpretations. For example,

P: My lungs are like concrete, which is protecting the lungs.
N: But you just told me that the problem was that oxygen was not circulating in your body.

P: Yes, I know that, but my lungs are afraid. They need the walls to keep them safe.
N: But you just said that your body was completely toxic because there was no air circulating. Is this not the problem?

P: Yes, it is.
N: Remember these are your lungs. Should your lungs be made out of concrete?

P: No, this is unnatural.
N: What do you want to do then?

P: I want my body to be healthy again. It needs oxygen and the lungs need to be lungs again, not concrete blocks. I am going to break the concrete.

N: As you do this, take the concrete out of your body and burn it. How does this feel?

P: Tiring, but good.

N: What is good?

P: Freeing. My lungs are coming back to life.

N: Touch them. What are they like?

P: They are soft. The muscles are weak from disuse.

N: What is needed?

P: They need to be strengthened. They need to know it is all right, that they are safe. I am caring for them.

N: How will you strengthen them?

P: I will touch them and massage them and get them working again. They need to be used. They have atrophied from disuse.

N: O.K. Let's put them to work. Feel the oxygen moving through your body - into your stomach, liver, kidneys . . . legs, etc.
**Supercession and repetition**

In the SIP, the participants are taught to continually reorient themselves to this "new" place (e.g., the garden or the working lungs). However, they do not usurp space; that is, they do not leave a dark place and go to light or paint something over the dark. Instead, they stay and expand the self-symbols. In the work, this is done by letting go of one space to allow another to appear (e.g., breaking the rock and burning it), and/or by attending to the needs of the space (e.g., cultivating the earth; nurturing the lungs). The process of letting go of and/or caring for the self-symbols allows the creative side of psyche/soma to emerge and manifest the complements/opposites. Because the production of balancing images and metaphors is organic to the nature of self, psyche/soma will invariably manifest these symbols once it is given the opportunity, and this method of letting go and/or nurturing allows the self to exercise these tendencies.

Symbols are *never superimposed* in the SIP. That is, one does not make a rock into a flower, which is referred to as superimposing a flower over a rock, because one does not like the rock. This is theoretically considered denial: one is not acknowledging who or what one is. Rather one is pretending to be something else (a flower rather than a rock). Instead, in the SIP, the process of acknowledging, learning about and understanding the presently occurring self-symbols leads to their confrontation and challenge which then allows for the spontaneous eruption of creative or new balancing symbols. In this way, symbols are *superceded* rather than superimposed.

Oscillation between the old and the newly emerging parts is the natural way that learning is brought to bear as psyche/soma adjusts to the new but unfamiliar states of self, and in the SIP, the nascent states are imaginistically reinforced through the repetition of the metaphor to allow psyche/soma the chance to acclimatize. Through repetition, the person learns to balance the
dominant self-symbols with their complements/opposites so that equilibrium and health can be restored. The degree to which this can occur is dependent upon how consistently one chooses to engage the newly existing symbols as well as how much one wants to expand the self-identity. The challenge, repetition and depth of the symbols permit the boundaries that separate the parts to soften. Through time and constancy, psyche/soma learns to trust the benefit of the new state and to accept and embrace it as part of self.

In the SIP, attachment to the self-symbols is the main factor that prevents growth. Attachment occurs for many reasons, the most common of which are: (a) self-identification -- the symbols are closely attached to what the person feels to be the self; (b) positive association -- the person positively associates, rather than negatively associates, symbols that are causing tension; (c) fear of the future -- the past is known, the future is unknown; (d) complacency -- recognizing the problem, but comfortable in it; and (e) the combination factor -- non-complementary/oppositional symbols combine in unhealthy ways. In the sessions, these five would appear as follows:

Self-identification

Because individuals define themselves based on their experiences of self, it is very important when expanding personal metaphors to bond with the newly emerging images. Elements such as trust, understanding and self-commitment are essential parts of this development. The participant below, for instance, has just confronted familiar parts of the self that were sabotaging her. Here she describes the transformation process:

P: They are evolving -- turning into the Archie's [of the comic strip], which represents innocence to me. I need them to know that it is okay to be happy, be yourself, your own personality. I see confusion in their eyes though. They do not know why they are there or who they are. There is no sense of personality with G. and H. [the familiar parts of self] gone. They are formless, losing their identity. They do not know who they are supposed to be if they are not confused or unhappy or lost.

N: Describe their present personality and characteristics. What are they like? Get to know them.

- 150 -
P: Betty [of the Archie's] is pretty, popular, good girl; so is Archie. They are the boy and girl next door. They get in trouble when they are influenced by others.
N: What do they need?
P: They need to be true to themselves, who they are now. They understand and they are excited, starting a new life for me — fresh, clear, young. A new life means a new beginning. I can feel their mentality and innocence through my body. Something new is being born — a new mentality. They are nice. I have to learn from them. They feel better now that they know what to be.

*Positive association*

This is probably one of the most fascinating symbolic connections that arise in the process. It occurs without exception in participants: individuals imbue problematic symbols with attractive qualities that keep them attached to the very thing that causes the problem and that they want to change:

P: I feel the hurt in my heart.
N: What is it like?
P: It is like knives in my heart.
N: Touch them.
P: No, it hurts too much.
N: Try.
P: Oh, it's not knives when I touch it. It's pink cotton candy.
N: What does that mean to you?
P: I love cotton candy. It tastes good. It always means fun. I only have it when I am out doing fun things. Pink means love [remember she is describing her pain and hurt].
N: What do you want to do?
P: Keep it. It's so nice here.
N: Might I remind you that you are talking about your pain.
P: Oh!! I guess this is not good then.

*Fear of the future*

Individuals do not fear the past; instead they fear the future because it is unknown. The future in this context is the parts of the self that have not been brought to bear and thus, are unfamiliar. Through the SIP, this fear diminishes by learning about these unknown parts of self. The past, where it is evoked, is viewed as a symbolic self-context. The process of re-symbolizing means that the past or future is real only in terms that it is symbolically alive within the self:
P: I want to leave, but I am scared. I've been there so long. It is familiar. I am accustomed to it. I don't know what is out there. Although I am unhappy here, at least it is safe.
N: Do you want to try to see what is outside?
P: O. K. If I don't, I know it will never change. I'm going to leave.
N: What's it like outside.
P: Free, full of sunshine.
N: What are you going to do with the house now that you've left it?
P: I guess I'll break it down.
N: How does that make you feel?
P: Like I have lost something.
N: Be specific. What have you lost?
P: I'm seeing a rope and a chain. It makes me feel like a puppet. I've lost not being my own person, following others. But I don't want to be like that either. I want to be strong. It's just that I don't know where to start. My emotions are mixed with fear and feelings of being lost. I don't know what else lies out there.
N: Look around you. What do you see?
P: It's a field, but I don't know this place.
N: Let's learn about it.

Complacency

Participants will often hold onto self-metaphors because, although they recognize that the place it represents is not ideal, once again, it is familiar, and thus they are willing to leave it the way it is. This type of response is found most frequently amongst those who are inclined to wallow in their self-symbols:

P: It is dark and muddy, kind of dreary.
N: How does that make you feel?
P: I am okay with it. It doesn't bother me really. Doesn't matter.
N: What do you want to do?
P: Nothing. Like I said, it doesn't bother me.
N: Touch it. What is it like?
P: Well, it is kind of disgusting. It is squishy gelatin. It repels me.
N: What do you want to do?
P: Well, I know I need to clean it up, but it's so much work.
N: Do you want to try?
P: O. K. It's done.
N: That was fast.
P: I know.
N: What does that show you?
P: That it really isn't difficult at all.

The combination factor

This is another classic SIP scenario. It is the vicious cycle where unhealthy parts interact and blame each other for the problem:
P: I feel sad because I am alone and lonely.
N: Go into the sadness.
P: I am in a closet by myself. I am hiding. It is a hospital. It's sad out there.
N: What do you want to do?
P: Stay here by myself. I don't want to go out there. It's too sad.

Thus, he is blaming the sadness on the loneliness, but when he goes into the sadness, he justifies the loneliness in terms of the sadness. The way out of this cycle is to confront the metaphor:

N: If you stay there you will always be lonely, and thus remain sad.
P: I see that now. But I don't like the sadness. People out there are not well. I don't want to face that.
N: Then you will remain lonely.
P: I realize that. I don't want that either. O. K. I'm coming out.
N: What is it like?
P: I see an old man. He is smiling at me. He's happy I came. He's lonely too. He just wants company, someone to talk to him. He's not really very sick. He's only here for a short stay. He just needs company. I'm glad I'm there. He's nice to talk to, very wise.

**Desire towards movement**

Because self-expansion comes about because of self-challenge, effort and commitment in the SIP, the starting point for the process is to want the growth and learning, which usually begins by not knowing what is wanted. So the answer is not as relevant as the question.

P: I know that I don't want to feel sad, but as I look at her [a self-metaphor], she's telling me that this is the way she is because she learnt to be that way and thinks it is smart, but how could I think it is smart to produce sadness?

It is the question, then, that directs the desire for growth. So whereas this person may not know exactly what it is to feel the joy, she does know that she wants to change the sadness and the multi-tiered effect that this base has on her life. Moving from the dominance of sadness to embrace and include its complement/opposite, joy, is both a physiological and psychological transformation: it is a foundation of self from which balanced choices can be made. That is, by learning the complement/opposite, one comes to know how to make a variety of choices rather than relying upon the one dominant theme, which in this case is sadness.
P: When I take the rock [sadness] out of my stomach, it is empty. There is a longing in each organ to remain the same, to be distracted, to not be present. There is a fear of failure, maybe fear of success. And I don't know what to do. When I have had the emptiness my brain has always filled it with the material on hand that isn't good for me — rubber, steel, rock. So the sadness will just come back. I don't know what else to fill it with or what else to do. I don't know how to get what it is I want, which is freedom. I only know how to do this [create sadness in the form of rock, etc.]. I realize though that I can make everything comfortable — good or bad. It is what I want that makes the difference, and I know that I don't want this [sadness/rock] anymore, even if I do not know how to be other than this.

In the SIP, it is assumed that participants are making choices out of ignorance; that is, they are choosing based on their knowledge of self. This woman, for instance, needs to be taught how to know joy, which would be identified as “not self”. The purpose of the SIP is to allow the emerging symbols to teach her this state, which, as has been noted, occurs spontaneously through the letting go and/or nurturing process. Thus, in the SIP it is essential that letting go of self-symbols always be followed by the creation of something else, which is the complement/opposite. This is, again, an organic occurrence because although letting go often provides participants with relief, they also invariably describe it as emptiness. If they are not, therefore, taught how to make other choices, they will inevitably return to what they know — the dominant theme — which prevents them from creating a state of healthy balance and gaining what it is they want.

P: Everything that I choose to want is because I want to change something. It is not about being wrong. It is about what I want from life. I am thinking about when I tried before, but I couldn't do it. I always failed or it didn't work. But not this time. I have new ways now.

Finally, it should be noted that I cannot make anyone do anything that they do not want to do at any point in the work because psyche/soma would not allow it. The participants would simply resist the process or refuse to allow room for the complement/opposite by stating that they liked their present symbolic state and wanted to maintain it.
The source: How not why

In the SIP, the reason for the manifestation of self-symbols, which is traditionally located in the past, is not held to be as significant as the source. Instead, the reason or cause is seen more as a context for the images, and participants are encouraged to focus on how self-symbols come into being rather than why they came to be because knowing how provides concrete ways to work with the symbols and create the desired changes. The difference between why and how in the SIP can be understood quite simply: why is the intangible and how is the tangible description. For example, the intangible descriptions such as “Because I feel insecure” or “It is because I am afraid”, which explain why, cannot create transformation because the depiction is amorphous; that is, they cannot be touched. Thus, intangible descriptions are directed towards tangible descriptions such as “It is a machine that is creating rubber”, which not only explain how the symbols come to bear, but also provide the means to teach the participants how to redirect their images. Learning how to process self-symbols is a very important part of the SIP, although participants will frequently find this aspect of the work most arduous. The following example demonstrates the challenge of one such journey:

P: I feel stagnation, stifling. My spine feels like it is stuck somewhere. It feels like it is not supposed to open up because it would mean that I would have to get involved in the world. It is too much work.
N: Where do you feel this stagnation and stifling in your body?
P: In my heart.
N: Touch it. What is it like?
P: It is like gum.
N: What does that imply to you?
P: Something that sticks.
N: Where is it coming from?
P: It leads to my heart and navel.
N: Go there. How is the gum produced?
P: By tension.
N: But how does tension create gum?
P: Something in my mind. It is a thought.
N: What thought?
P: Laziness.
N: How does that create gum?
P: Thoughts create tension, and the tension creates gum.
N: But how can tension produce the material substance of gum? How does the body physiologically produce gum?
P: I am seeing the spine now.
N: What are you seeing?
P: The gum continues to the spine.
N: How does the spine produce gum?
P: The blood.
N: How does the blood produce gum?
P: It is too much in one place.
N: What is too much in one place?
P: The fear and tension.
N: How does the fear and tension and blood produce gum?
P: My spine is getting hollow. The gum is moving in one circle. The hollowness is in the spine, and the blood is separated from the spine.
N: What does that imply?
P: There is no blood in the spine.
N: What happened? What stops the blood from going in?
P: My mind. It does not want to be there.
N: Tell me physically, not descriptively.
P: There is no blood in the brain.
N: Why not? Tell me physiologically. Make contact with yourself.
P: I am in my heart. It is really tight, really thick and it is suffocating. It feels like that is what is creating the circle [of gum]. When I go into the gum, it is sticky blood. It needs to be cleaned out. I am getting rid of the sticky blood. My heart needs to stretch to allow the blood to circulate because it is totally shut down. As I do this [circulate the now fluid, rather than sticky, gummy blood], I can feel the expansion in my whole body.

Although the SIP orients the participants in the direction of how the symbols are being created in order to learn to process metaphors independently, it should be noted that the journey of why can also serve such a function but only when it is non-deterministic. In general, there are two schools of symbolic representations that describe the cause (or why) of the symbolic presentation: deterministic or non-deterministic explanations. The former is obvious – the participant locates the reason in something situational, whether past or present. Far more interesting, however, are the non-deterministic descriptions that locate the cause in beingness; that is, there is no specific cause that leads to an effect. Rather it is the question of the chicken or egg:

P: I see a group of workers creating the rubber that is causing the blockage.
N: Why are they doing that?
P: They say they don’t know. It is what they do.
N: How did they start doing it?
They say that a long time ago they thought it was a smart thing to do, and then they never stopped. Something happened, and they did this, and now it is just what they do.

Do you know what it is that happened? Ask them.

They can't remember anymore. It happened so long ago — maybe something or somebody scared them — and they covered it up with rubber. It seemed to work and now it's just their job. They don't know any other way. They don't remember being anything else.

What do you want to do?

Get rid of them.

What about educating them? Tell them that they are causing harm. Let them know.

Oh! O.K., I want them to know that it is not working to do this. Producing rubber like this is creating blockages in my body. I need them to stop.

What is their response?

They are surprised. They thought they were doing something good, but they are listening. They want to help, but they don't know how. They are so used to doing this. They did not know that they could do something else.

How do you feel?

Really good, they're very caring and interested. They want to help. They are a little reticent but excited. They're very willing though because they don't want to cause harm anymore. As long as they can be shown how to do something else, given another job, and be useful in another way.

Let's teach them.

The foundation: Wholeness

The general direction that the SIP takes is to move between the macrocosm to the microcosm and back again, with the conclusion always being wholeness through the integration of the parts.

The initializing process begins with the macrocosm of self — wherever the person is situated — and then reduces this to its parts, usually in the context of the body, in order to examine, challenge, let go, nurture and reorient this metaphor, before building it back to wholeness through the integration of the complement/opposite:

Where do you find yourself?

I am in a fog. I feel lost and confused [initializing state — macrocosm].

Where do you feel this in your body? [the part — microcosm].

In my spine.

Go into it. What is it like?

It is heavy. It is metal.

What does that mean to you?

Something very rigid and solid, inflexible [examination].

Why is it there?

I guess to hold up my spine, but that doesn't make sense. My spine shouldn't need
metal to keep it up. This is holding me back because it is rigid and unbending [challenge].
N: What do you want to do?
P: I don't want this in my spine. It is constraining me, and I want to have movement. I'm going to take it out my body and burn it [letting go].
N: What is your spine like without the metal?
P: Better, but weak. It hasn't been used. It needs to be strengthened.
N: How can you do this?
P: First I need to take care of it by touching it. The bones need to be fortified -- they are brittle. So I'm giving them water. They are getting stronger [nurture].
N: Touch the strength. What is it like?
P: Light [reorientation].
N: Let's take this through your whole body, and then circulate it as your blood. What does this do to your body? What is your mental and emotional state as a result?
P: My body is calm, energized. I feel tingles. Emotionally I feel calm, stable, connected, clear. Mentally, I am clear. I feel like I have a direction, I know where I'm going [wholeness and integration – the macrocosm].

Through this process, wholeness is founded on a consciousness that is expanded from its initial stage, which is a debilitating state. Thus, the foundation of the self or homeostasis shifts from one place to another, which, through the process of the SIP, moves towards a healthy structure. Over time and by going deeper into the symbolic realm, more of self emerges that allows for the foundation to revolve around a stable state. This is beautifully summed up in the words of one participant:

P: The whole thing is greater than positive or negative. It does not need to have black because it is not white. It is out of the dualism because it is including the dualism; so it knows about change and differences and extremes and remains calm. There are all of these differences in the castle, and it has all of its value -- some more, some less. I now understand the size of myself, the tolerance of myself and my life, and through that strength I am including all the parts of me, giving them care. I trust that I am doing that now, that I have always had this in me, and that I can count on this. That gives me safety.

Summary

The purpose of the SIP is not only to create a healthy state of homeostasis but also to teach the participants how to work with their symbols to achieve their desired results. In the SIP, therefore, patience is required, and time is a comrade. Clearly, then, this is not a quick fix procedure; the benefits are created to be long term, and the process is implicitly designed and taught so that participants can learn self-regulation. The general idea is that growth is ongoing,
thus, the SIP is not so much about being transformed, because we do not function in absolutes, but more about how to transform. That is, the participants are taught the process so that they can self-regulate. In behavioural terms, this may be understood as learning how to diminish both physiological and psychological responses to stimuli, and then, through self-expansion, the participants learn entirely different ways to respond to the very same stimuli. The result is that the foundational self -- one's personal metaphors -- supports psyche/soma in constructive and productive ways.
CHAPTER 8 - DAVID: METHODOLOGY AND CASE STUDY

We find another type of history whose essential meaning does not necessarily emerge from what happened first and what happened afterwards. It is a history that reaches the conscious not as history but as a current drama, because it is still alive in each action and is ongoing in an eternal present (Chiozza, 1998, 1).

I had been about four years into developing the SIP when I became interested in exploring how the process could be used to create transformation in both the mind and body. Many people reported somatic changes alongside their personal development. As a result of these experiences, I wanted to examine how the SIP could be used to benefit the immune system in the case of an HIV seropositive person who was not using antiretroviral drugs. The research that is conducted in this chapter is a case study of such a person.

HIV

There are approximately 30.6 million people living with HIV/AIDS globally (Eller, 1999), of which 22.3 million are in sub-Saharan Africa (Laurence, 2000). In the USA, 40,000 new cases are reported each year, and those in lower socioeconomic positions are the most vulnerable. For instance, Hispanics and African Americans have the fastest growing numbers. In the case of the latter, there has been a 45 per cent increase in new AIDS cases in 1998 among African-Americans, and it is the leading cause of death amongst men (Laurence, 1999) and women (Bennett et al., 1999) from the ages of 25 to 44 in this group.

The human immune deficiency virus (HIV) is a chronic infection that leads to the continual depletion of CD4+ T-lymphocyte cells (CD4 cells) (Iida et al., 2000). As the CD4
cells are the principal location for the HIV infection, their numbers serve as the main signifier of immune competence and predict the course of the disease (Mulder and Antoni, 1994a). The virus infects the memory CD4 cells and replicates, thereby destroying the cells. At the same time, the immune system attempts to equalize this viral replication by replacing its dying CD4 cells (Schouten, 1995). Hence, there is an intense immune responsiveness at the beginning of the disease to the large numbers of the virus that are being continually replicated. As the disease progresses, however, immunocompetence eventually fails — an average of one billion HIV particles are produced daily (Autran, 1999) — and the organism is no longer capable of producing enough CD4 cells to override the viral replication. In this way, the immune system is depleted. The reduction of the CD4 cells and the growth of the viral load eventually lead to the onset of AIDS (Hennessey et al., 2000).

The progression from the asymptomatic period to clinical AIDS is highly varied: some remain asymptomatic for a long duration whereas others progress to AIDS more rapidly. In general, the chance of accelerating to full-blown AIDS amplifies with time, although plateaus and declines usually mark the development of the disease. Studies have shown that it takes about five years for 15 to 30 percent of those who are infected to develop AIDS (Solomon et al., 1991) and 8 to 10 years for 50 to 75 percent of the cases to develop the disease after the infection (Mulder and Antoni, 1994a). For instance, at the 10-year point, 50 percent of gay and bisexual men in San Francisco who were HIV+ developed AIDS (Rayner-Brosnan, 1993, 87). Once frank AIDS develops, however, the disease progresses quickly (Mulder and Antoni, 1994a), and survival is usually one to two years (Mulder and Antoni, 1994b) — only 15 percent are still alive after five years (Solomon et al., 1991). This figure, however, is different for women, whose survival time is shorter, which is particularly so for African American women (Antoni and Goodkin, 1991).
AIDS occurs when the CD4 cell count of the infected person has fallen to 200 or less, or when there is 14 per cent or less of the total lymphocyte count, or when opportunistic infections such as *Pneumocystis carinii* pneumonia, cryptococcal meningitis, or neoplasma such as Kaposi’s sarcoma occur (Ironson et al., 1997). The use of antiretroviral medications assist in delaying the onset of AIDS by, amongst other things, reducing HIV replication and increasing CD4 and CD8 cell numbers (Vento et al., 1998). Those living with HIV have greater life expectancies due to the use of drug therapies such as protease inhibitors and combination treatments, although the drugs can produce adverse side effects (Eller, 1999). There is no cure for HIV and neither is there a vaccine.

**Psychoneuroimmunologic Research and HIV**

Psychoneuroimmunologic research demonstrates that there is triadic connection among the immune, endocrine and nervous systems. This data raises a variety of psychosocial questions about HIV/AIDS. For instance, do stress and other affective states negatively impact the immune competence of an HIV+ person? If so, does this increase the rate of the disease progression? And can psychological interventions positively affect the immune system of HIV+ individuals? The majority of PNI studies that have been conducted with these questions in mind focus on the effect of life stress, coping styles and psychological factors on the immune system of HIV+ individuals. There have been fewer studies on psychosocial intervention and HIV.

*Life stress and coping styles*

Goodkin and colleagues (1992) found that an active coping style was positively associated with higher levels of natural killer cell activity in 62 HIV+ gay men. A study done by Mulder and colleagues (1994c) over the period of one year also found that active confrontation as a coping style was related to a slower progression of the disease. Ironson and colleagues
(1994) found lowered CD4 cell counts and PHA responsiveness in a one-year study on denial as a coping style, findings that are also supported by Mulder and colleagues (1994b). Mulder's group, who studied the relationship between the coping style and the progression of the HIV infection over a seven year period in 181 gay men, found that those who used a distraction coping style had a smaller decrease in CD4 cell counts. Comparatively, Kessler et al. (1991) conducted a three-year prospective study to investigate the relationship between life stress and HIV progression, and they did not find a correlation between the experience of stress and the reduction of CD4 cell counts of 25 per cent or more over the six month period or the onset of thrush or fever for two weeks.

**Psychological factors**

Other studies have focused on the effect of psychological states, such as depression, anxiety and bereavement, on the immune system of HIV+ individuals. Perry and colleagues' (1992) study of male and female seropositive individuals found that there was an association between a variety (22 in total) of psychosocial factors and the CD4 cell count. They were, however, unable to substantiate this correlation 12 months following the entry-level immune counts. Rabkin and colleagues (1991) also found no correlation between a variety of psychosocial factors and CD4 and CD8 cell numbers and HIV related illness both in a concurrent and cross-sectional six-month study of 124 gay men.

A variety of studies have been conducted by Kemeny (1994) and colleagues, and although they were unable to find a correlation between depression and CD4 cell counts, they were able to find a relationship between bereavement and lowered immune responsiveness (lower proliferative response to mitogen and PHA) in a longitudinal study of HIV+ gay men. They also found that fatalistic attitudes had a negative impact on the survival time of gay men with AIDS. Another study conducted by Theorell and colleagues (1995), which was a five-year
prospective study, found that those who had a high level of social support had CD4 counts that were nearly double that of the low support group in the fifth year of the study, although at the outset of the investigation there was little immune differences between the two groups.

**Intervention**

There have been fewer studies measuring the impact of intervention techniques on the immune system of HIV+ individuals. Antoni and colleagues (1990; 1991) examined two separate groups to see how either a 10-week cognitive-behavioral stress management (CBSM) or aerobic exercise intervention would act to buffer the impact of HIV antibody status notification. These interventions were administered five weeks before and five weeks after notification of HIV status, and the results showed that the participants in the intervention groups had lower depression scores and significant increases in CD4 cells when compared to the control groups. However, the two-year follow-up demonstrated that the intervention did not create long-term benefits in terms of the disease progression (Ironson et al., 1994).

In a study conducted by Mulder and colleagues (1994a; 1994d) on the effectiveness of a cognitive-behavioral group therapy and experiential group therapy over a 15-week period, they found that while both therapies reduced the degree of distress when compared to the waiting list control group, there was no change in CD4 cell counts after the intervention. Although there was a lower rate of T-cell responsiveness decline after the intervention, similar findings were also found in another HIV cohort without the intervention. However, in the two-year follow-up, those who displayed the greatest decreases in distress up to six months following the intervention also had a smaller decline in CD4 cells two years preceding the initial intervention.

Auberbach and colleagues (1992) also found no significant change in CD4 cell counts in their eight-week study of the effect of hypnosis, guided imagery and thermal biofeedback on 20 symptomatic gay men. There was, however, a decrease in the experience of symptoms and
distress. These findings were supported by another eight-week study conducted by Coates and colleagues (1989). The asymptomatic participants were given relaxation management group intervention, but they, too, found no change in immune responsiveness (CD4 and CD8 counts, NK cytotoxicity, lymphocyte proliferative responsiveness and serum immunoglobulin A levels).

**Research Objectives and Hypothesis**

Without any form of intervention, studies show that there is a continual depletion of CD4 cells and an increase of viral load as the disease progresses (Bouscarat et al., 1999; Lyles et al., 2000; Giorgi and Detels, 1989). Giorgi and Detels (1989) studied the progression of CD4 cells in 1637 homosexual seronegative and seropositive men. The average number of CD4 cells of the seronegative men was 1000 CD4 T lymphocytes per mm³ of blood. In those men who serconverted (became HIV positive), their CD4 absolute number dropped to approximately 715 cells/mm³, that is, about 70 percent within six months of seroconversion, and to 626 cells/mm³ or about 60 per cent decline within one year. However, by 15 to 18 months after conversion, most of the group plateaued at about 530 cells/mm³. This level usually lasts for several years until another wave of rapid CD4 declines, which usually precedes frank AIDS.

A later study by this group (Lyles et al., 2000) at the Multicenter of AIDS Cohort Study confirmed the findings. They studied the progression of HIV in 218 newly converted antiretroviral drug naive subjects for three years. Prior to seroconversion, the average CD4 cell counts were 988 cells/mm³. At the first visit after seroconversion, which was a three-month interval, the CD4 numbers had dropped by 221 cells/mm³. The CD4 cells dropped to 599 cells/mm³ at six months, 503 cells/mm³ at 18 months, and 429 cells/mm³ three years thereafter. The HIV RNA or viral load was at 33, 759 copies/mL at 6 months, 30,550 copies/mL at 18 months and 43, 498 copies/mL at 3 years after initial seroconversion.
A study done by another group (Bouscarat et al., 1999) with 33 antiretroviral drug naive individuals (only six received more than six months of drug therapy) with a CD4 count of 400 cells/mm$^3$ or greater over a three year time span also indicates that the disease progressed with a continual drop in CD4 cell numbers. Of this group, who had been diagnosed for approximately 14 months, 10 had a rapid decline of more than 100 cells/mm$^3$ per year, four who were long-term survivors (diagnosed for nine years) remained stable with a decrease or increase of less than five cells/mm$^3$, and the remaining 15 had a linear decline in CD4 cells.

Despite some of the conflicting findings of the psychoneurological research, the data does suggest that psychosocial factors can provide both an affective and a physiological buffering effect against the progression of HIV, particularly over time. However, there is a paucity of research on psychosocial intervention processes and their effects on those with HIV/AIDS. I wanted to test out the SIP as a method of intervention, hypothesizing that positive psychological and physiological changes would occur over the period of at least one year, although I could not determine what exactly these would be. Based on my previous observation with psyche/soma transformations (some of which were described in Chapter 7), I expected that psychological benefits would occur initially which would later be accompanied by measurable physiological changes. I could not predict, however, what the degree of change would be or the time frame that it would take this for this change to occur.

**Methods**

**Participant**

I found the participant in this case study, David, through word of mouth. I had also placed a 25-word advertisement in a biweekly newspaper and talked with three long-term antiretroviral-naive HIV survivors who, for various reasons, were uninterested in participating in
a research project of this kind. David is a 32-year old gay male who has been co-habitating with
his present partner for the past two years. At the outset of the research, David reported an
overall satisfaction with his life: He was accomplished at work and his intimate and other
relationships were stable. David smoked about a half to three-quarters a pack of cigarettes daily,
did not use recreational drugs and limited his alcoholic consumption to an occasional glass of
wine. He listed his emotional battles as being low self-esteem and over-eating. He was having
difficulty in coming to terms with his new HIV status, but he wanted to delay using antiretroviral
drugs despite his doctor's strong advice to take them. His main reason for choosing to participate
in this research project was his personal opposition to the use of antiretroviral drug therapy. He
was hopeful that the SIP would be beneficial, and he was taking vitamin supplements.

David and I began this research process during the second week of August 1998, 10
weeks after the HIV RNA testing which showed that he was HIV seropositive. We agreed to
work together for about one year, and we completed the study at the beginning of 2000 — about
one and one half years later. It would be more accurate to say, however, that we worked
together for just over one year, from August 1998 to October 1999. At no time throughout the
process did David want to inform his physician about the work with me, and I did not obtain the
hard copy of his HIV RNA assay tests and CD4 cell counts until we had finished the study. As a
result, I had to rely on David's verbal reporting, which was often vague and inaccurate, although
he was able to relay that change was occurring. At the outset of the project, David was unsure of
his viral load and CD4 cell counts (which were actually 52,650 copies/mL and 330 cells/mm³
respectively); thus, we began with the very basic knowledge that he was HIV+. 

- 167 -
Measures

Changes were to be measured by David's verbal reporting of his psychological states and through the results of the HIV RNA assay tests and CD4 cell counts that he received from his physician. He would usually receive these results three weeks after his blood tests.

Procedure

At the beginning of the study, David and I agreed to work together once a week. The sessions would be for about one hour, and he was asked to do work on his own as a follow-up to our process. This personal work would be developmental: the purpose was for him to learn the process in order to control various psyche/soma responses. He was free to do this in a variety of ways, such as in the morning, evening, throughout the day or a combination of all three, the latter being the optimal approach. I suggest simple exercises like focusing on the emerging symbol for a moment at various intervals during the day in to acclimatize to the new states.

Each session was transcribed manually, and David and I would discuss the process after he had gone through his SIP journey. The interpretations and associations that are described in this chapter are the results of those discussions.

Methodology

I have presented the research as a process-oriented analysis of the SIP with David. This framework of choosing and engaging vignettes to illustrate my perspective is similar to Melanie Klein's methodological style in her book, Narrative of a Child Analysis (1961/1975). Although I am not comparing my work to psychoanalysis, like Klein, I examine my participant's (David's) process with illustrations of a variety of our sessions and the interpretations that we (David and I) have drawn from them.
David: The Case Study

David participated in the study for just over one year. During this time we worked together 38 times -- an average of every two weeks -- until the last 11 weeks when our interactions tapered off. I have divided the research process into three phases based upon when the viral load and CD4 test results were reported to me. This was four weeks after the first test, seven weeks after the second, and 10 weeks after the final one. Phase one is the first 16 weeks of the process where we worked in person nearly every week -- 14 sessions -- for about one hour and fifteen minutes. This phase is presented very descriptively and detailed in order to provide the reader with a sense of how the SIP progresses. Phase two proceeded for 26 weeks, in which time we worked together 14 times, initially person to person, although this quickly evolved into bi-monthly phone sessions. These and the latter sessions are presented with much less detail. The emphasis is, instead, on the personal metamorphosis. By phase three, which covered a 30-week span, David and I worked exclusively over the phone about every two weeks for the first 19 weeks -- 11 sessions. During the final 11 weeks, however, we held only two sessions.

Phase 1 (16 weeks)

Phase one took place over a 16-week span, in which we held 14 sessions that lasted for about one hour and fifteen minutes each. I began each one as described in the previous chapter: I asked David to describe the symbolic place in which he found himself. This is referred to as the initializing space. All symbols are viewed as representing the self. I have extensively described the first sessions so that the reader can gain an understanding of their nature, but I have left out the sessions that are repetitive. Thus, sessions 2, 5, 7, 10, 11, 13 and 14 of the first segment (general sessions) are not presented because they are similar to the ones that I have described here. Sessions 1, 3, 5, 9, 10 and 12 of the second segment (HIV) are not provided.
because either David did not go into this area or again because it was redundant to the ones presented.

*General sessions*

*Session one*

In the first session, David's initializing symbolic space is a hard, cold place where he is claustrophobic and from which there is no escape. This is embodied in his chest, symbolized as a dead, dark, heavy cold body of water, a symbol that means life for him. He is scared to touch or go into this because water evokes feelings of panic, fear and anxiety. Although David chooses to avoid the body of water, I invite him to do otherwise. This is a challenge to the self. He enters the water and experiences it as “empty, endless, dark, cold”, which makes him feel alone. His response to this place is to wallow in it by “hanging out at the bottom”. David does not want to explore the water because he “cannot see anything . . . nothing is there. It doesn’t end.”

I suggest that he touch the bottom in order to learn about the space. He symbolizes this as concrete, which is something he views as hard to break. This means, then, that the emptiness is difficult for him to break through. I suggest that he try to break it so that he can learn that it is possible. Although this is very challenging for him, and he is easily defeated -- he thinks that it is impossible and he is not capable -- his efforts pay off and he discovers that it is “not that hard” to break. As a result, David “doesn’t feel as claustrophobic” and the cement itself is perceived as “softer a little bit, almost like mud.” He also realizes that “this isn’t a permanent thing that I am in. It is man made.” David has mixed feelings about letting go of the walls, which represent his aloneness and emptiness. However, once David lets go of the cement through the SIP burning process (footnote 5, pg. 141), he feels “accomplished”, the environment is “soft”. He also realizes that he is in the water, but his perception of it is different after having gone through the letting-go process. “I don’t feel so claustrophobic. It’s all right, the bottom is soft, and it is
nice to walk on.” He is surprised to find that he is comfortable in the thing that he just feared. This is the complement/opposite manifesting itself.

However, David does not trust that it will remain this way. I direct him into his body to symbolize where this feeling state (distrust) exists. It is in his chest; its material is rubber, which means for him something that bounces back, so that he can do nothing to change this state. I ask him to go to the source of the rubber. It is in the stomach, but he has difficulty understanding how his body produces it, which is common for most participants:

Nicola (N): How does the stomach produce rubber?
David (D): Through the cells.
N: How?
D: I don’t know.
N: Go into the cells.
D: It is a by-product, the cell’s waste. Every time that they reproduce, a little bit of rubber stuff comes out.
N: What does that tell you?
D: It keeps being produced.
N: How?
D: Every time the cells split, they produce rubber.
N: How?
D: It looks like when the cells divide, a little gets out.
N: How do they get out?
D: A little tear on the side of the cell surrounding its nucleus. There is stuff around it.
N: But how does the cell produce the rubber. You are telling me that it does this but how does it do this? What mechanism is at work?
D: It is what I am giving it. All that I am giving it is bad stuff.
N: David, try and tell me the physiological process that makes the cells produce the material rubber.
D: I don’t know if it’s — it is what I am thinking.
N: Go there.

David and I keep this exchange going until he is finally able to construct the rubber production as electrical impulses of an overly stimulated brain that gets contained in a room in his brain. It then, bounces around, hitting the walls, which thus forms rubber through the impact. What he chooses to do with this information in order to create change is to tear down and burn the rubber walls that contain these over-stimulated thoughts. Without the wall, the space is now open and as he makes contact with the new ground, he discovers it to be beautiful, cool grass; his emotional space is “relaxed and at ease.” It is symbolized as a down comforter,
meaning relaxation for him. We finalize the work with him merging this throughout his body.

The result is a sense of overall sense of ease, which compares to the initializing state where David was in a hard, cold place with feelings of panic, fear and anxiety.

**Session three**

David begins in empty space. "There is no light of any kind any where." This does not bother him, however. "It is neither here nor there to me. I am settling down in it." In the SIP, this suggests that David is complacent in an unhealthy state, and the way to help break from this is to encourage him to explore this space to learn about it. I ask him to look into the eyes of the self that is symbolically present. They are "blank, no life in them." Now, instead of being comfortable in the emptiness, he is "scared" because there is "no life in there". As David engages in conversation with the self about the emptiness, the eyes "look like there might be a light right where pupil is. It is the life force. It is me.” However, David has difficulty accepting this state:

D: It is very soft, bright and warm. It feels really good. It is very bright, but *it doesn’t hurt me to look at it.* It is welcoming. I’m there all around. It is good, comfortable, what I’d like to feel inside.

N: But David, it *is* there inside of you right now.

D: It is hard to get used to. Something gets in the way, covers it. It is a haziness that stops the light from getting through.

David finds the source of the haze to be a cracked pool that is responsible for making the water dirty. He resists the idea of breaking it down. "No way," he says, "it is so nice." I urge him to try, and as before, he finds that it falls away very easily, something he finds to be "really interesting." He burns the rubble, and the ground is now green grass and sunshine. It is "really beautiful." Next to this is a beach, and he now wants to jump into the water, which in session one was a symbol of fear. This shows him that "he has come a long way." The water is clear and beautiful, contrary to his expectation of dark and cold.
D: I expect darkness, but it is not that way. There is constant light all around. I can see the bottom. The sand is white, and there is a whole joyous feeling. I can do what I want to do, and I don't need air. I can stay down here or go up. I am basking in the light, doing whatever I want. It feels free. It is really good to feel that free.

**Session four**

David goes directly into his state of insecurity, which is located in his chest. He represents it as a weight with a rough texture. It is a cold, heavy metal that just sits there. He wants to tear it down, but when he tries to and it does not come down easily, he gets frustrated. As is the nature of the SIP, I take David into the frustration: the frustration and insecurity are being viewed as combined elements. It is like rubber; therefore, he feels that no matter what he does, “it springs back.” However, he is aware from previous sessions that he can change it. “Rubber is easier to tear down. I’ve done it before. If I try hard enough, I break it and it crumbles; then I burn it and it’s gone.” Thus, the result of David’s learning in the past four sessions is evident here: he can do something to change his feeling states, which is what the SIP implicitly teaches. Without the rubber, his chest does not feel as heavy. This gives him the sense of accomplishment and happiness. In the SIP, the goal is to teach the participant how to reorient towards these healthy states, and this state (accomplishment and happiness) is located in his chest. It is like a “warm, warm bath” that is “taking the weight away.” It makes his body tingle, and he feels emotionally strong. He has no problem moving it rapidly through his body.

I return him to the metal, which represents the state of insecurity, and it is now no longer big. As a result David can take it in his hand and crush it. It crumbles easily, and he burns it. He now feels strong. In the SIP, this emerging strength needs to be built into his body for learning and reorientation. I start by asking him to locate where this new state is in his body. He finds it located in his chest again, and it is smooth and warm to touch. At first he has a problem identifying what this condition of strength is texturally like — it is clearly something he needs to
learn. However, he has difficulty grasping this aspect of self. He experiences it as “smooth, red, glowing”, but when asked what form it takes he states, “I can't make out a shape.” Conversely, he had demonstrated how real the insecurity was — it took the form of metal — but the strength is something intangible. That is, it is not real to him as self. He, therefore, needs to be taught to know it; so I direct David to stay in this space of strength that he has located in his chest and to describe and explore it:

D: It is sort of fluid but solid. I can embrace it. It feels good to put my arms around it and to squeeze it.
N: What does this tell you?
D: I am holding it as mine. It is like a baby; he smells good and feels good.
N: Do you understand it?
D: I don’t quite understand it as tangible.
N: What do you want to do with it?
D: I can shape it.
N: What does that tell you about it?
D: That I am controlling it.
N: How does that make you feel?
D: Strong.
N: Keep interacting with it.
D: It does whatever I want it to do.
N: What feeling does that give you?
D: A good one.
N: Specifically. What is good? That is, define good.
D: I control this.
N: What do you want to do with it?
D: I want to go into it.

The space that David enters opens up for him so that it is easy to get into it. This not only tells him that it wants him, but that because it is accessible, he should be there. This makes him feel calm and relaxed. The space, which represents strength, is full of a myriad of colors, and as he interacts with it, it grows bigger, responding to the attention he is feeding it. "The more I interact with it," he states, "the bigger it gets." It makes him happy to touch it because "it is mine." As he merges it into his body, it strengthens it and provides him with a sense of ease because nothing can bother him. He feels confident, standing straight, “like a new body almost.”
Session 6

David starts off this session much more self-aware than before. He is on cobblestone streets, which he associates to mean something old. This is a place that he likes because it is familiar, "feels like home, like I belong there." The place is a small village, not a city, with nice fresh air and breeze. His eyes appear really bright. In the SIP, a person's partiality to a symbolic space does not necessarily imply that it is constructive or healthy for him/her, which becomes evident as David remains there. As he walks around, he depicts the place favorably. "I like it here," he claims "but there are no people. All that is around in this place are buildings, the ground and me. The houses are lined up row after row." When I suggest that he explore the interior, David is unable to do so because there are no doors. With persistence, he eventually finds an entry that links all of the units. When he gets inside, he finds the "whole house completely empty", and no one lives there. Despite his initial, and now familiar complacent response -- "it is fine, doesn't bother me" -- he nonetheless wants to keep exploring. This proves difficult and frustrating for each one is very much like the first one. With persistence, he eventually finds a different house at the end of the street but he can't open the door because it is locked. His frustration increases.

Because this emotional state is getting in the way, I take him into his frustration, which is in his chest as very dense air, and then to the source so that he can address it. After letting go, his psyche organically reorients itself towards the state of strength and power, which he feels embodied in his muscles, and he circulates this through his system as blood. David returns to the scene at the house. With the inner change, the door opens easily, but the house is "funny looking" to David because it is

Different to the rest and stands out. It has a nice shape; the others are boxy. This one has more angles. Inside there is nice furniture, stuff that I like -- a fireplace, big bright kitchen, tons of daylight. The house is filled with warm, wonderful daylight. It entices me to go upstairs. Up here is nice, very shiny and clean. The skylight is
letting in the lights. It feels really good being in this place. I can tell it is mine, but it feels almost like I shouldn't be here. It is a stranger's house. I can't believe that it could be mine because the former me, the old me, shouldn't have this; yet, I know I deserve it. It is the weirdest thing walking around this place. I know my things, I know that it is mine, but I can't believe it.

Once again, I direct David into the emotional state that is restricting him. Here it is disbelief, which is located in his shoulders. He symbolizes it as a stringy, twisted, tense wire cable, which implies strength to him; he is amazed at how thick and twisted it is. "I can't believe it is there. Where did it come from? It shouldn't be there." This reflects growth on David's part: he is disturbed, rather than complacent about symbolic spaces that are unhealthy:

Nothing of the wire is left with my burning it. It's so funny. I'm laughing. I feel good, better in the house now. I feel that I can lie in the bed and get comfortable. It is mine; it smells like mine — my pillow, my room. I feel really happy and alive.

Session 8

David is in a room that is round with windows all the way around it. It is a prison, and he does not like it here. Because he sees no door through which he can escape, he feels hopeless. This state of hopelessness is familiar. Here it is in his chest as a green substance with a sand-like texture. Sand implies something that is hard to pick up because it gets under everything. When he goes into that space, it is constricted, and he is in the sand up to his neck. I direct him to the bottom, which in the SIP is the way to get the participants to connect with their self-symbols, and he finds that it is solid and smooth, like a great big jar. This is very much the same symbol that David was so attached to in week seven, but then, he did not want to crack the glass, so no change was made. As a result, he returns to the same place again, and this time, he does not like it. Thus, he wants to break it down and finds that it does so easily and the sand disappears. The pressure in his chest is gone, replaced by a sense of relief.
Session 9

David is outside. It is nice, a “perfect day, blue skies, white fluffy clouds, warm breeze.” This makes David feel carefree. This is juxtaposed to the previous session (8) when David was encapsulated. He feels happy because it is so beautiful there. I direct him into his body to make contact with this state. It is a tingling sensation running through his body causing his skin to form goose bumps because of the electrical force moving through his cells. It is a static electricity that gives him a little shock when he touches it. The electricity means energy to him, and he is joyous in making it. It is emanating from the center of his heart, which implies for him the center of the whole, and as it beats, energy is produced. I direct him into the beats. It comes from all around, and he is aware that the beat is very powerful because it is a strong heart. In this way, he is assured that it is strong; that nothing is wrong with it, and that it could go on forever. It is soft to the touch, but firm, warm and flexible. The electricity is now shooting through his body, and every time his heart beats another pulse comes through the heart. This provides him with a sense of confidence and energy. Furthermore, because he is able to control his nervous energy; that is, be free of anxiety in his body due to the blood circulation that he is directing from his heart, which is tingling throughout his body, he feels strong.

Session 12

David is on a beach. It is sunny, the ocean is smooth and warm, and the sand is soft and warm. This means for him a vacation. He feels peaceful there and wants to go swimming. The water is very warm and clear. This is a stark contrast to David’s experience of water and subsequent choices. In the early sessions, it was dark, cold and threatening, and he never wanted to go near to it. Now, however, “it doesn’t feel like I am under water. The water is so clear, and I am not afraid of it.” As he goes into the depths of the water, he is amazed at the landscape.
because he has never seen anything like it before. He discovers coral, which is soft to touch although it looks hard, but it is also fragile and breaks easily.

N: Why does it break easily?
D: Because it is made that way.
N: Ask the coral.
D: They say it is my perception of them.
N: What does that show you?
D: That deep inside I feel fragile. I believe that I will break easily, and that this is just the way I am made.

As David continues to explore the space, it is hard for him to believe that nature creates such perfection. Nothing is muted. The colors are bright and sharp, and they do not run into each other, like a rainbow. The water is clear, not polluted, and he is grateful that this place has not been destroyed. David has a hard time labeling his emotions in this state. When David merges this space into his body, he warms up, and his emotions are calm. As it flows through, it acts as a filter through his body, cleaning and strengthening his bones. It is good for calcium, filling in the bits of damage that happened over the years, something really good.

**HIV**

Session 2

In the second week of working with David, I invite him to move into where he feels the HIV virus exists in his body, and he is drawn into his head where he feels that the majority of it exists. This implies to him that he has control, and this provides him with a sense of relief. Upon touching this place, he discovers that it is concrete, but as he connects with it more, it becomes malleable with the consistency of a water bubble. He “can squeeze it, put it in different shapes, flatten it out, and yet nothing comes out of it. It is impenetrable so that I can’t get at the inside where the stuff is. I can hold it in my hands, and it can change shape. But it is still the same.” However, as David remains with it, he finds that it is “not liquid, not solid, but in
between. It hasn’t hardened. It is easy to move, and there is not a lot of it. It is the size of a
basket ball.”

When David goes inside of the basketball, he finds it very hot, which makes him feel
tired, and it is taking all of his energy. He is unable to make contact with the walls of this ball
because he is floating around in it, and as he tries to push on the walls in an attempt to get out,
they “bounce back into shape like rubber.” He is frustrated. David makes contact with the
frustration, which is in his chest as solid marble, and burns it. When he returns to the space
(ball), he is still floating in it but attempts to ground despite the difficulty that it poses for him to
do so. “Its own force is pretty strong.” However, instead of being frustrated as before, he feels
“challenged. I want to get to the bottom.” So he grabs the sides to try to pull him down but finds
that the force pulls him back because it is “coming from all around, is all encompassing and all
around me.” He remains motivated, but the more he fights it, the more energy it takes from him
and that is how the heat is generated. He recognizes, then, that he is feeding it by struggling with
it, and concludes that he needs to slow down his thoughts, which are like the “stock exchange,
flashing by. There is an order to them.” The walls of this space are again hard and cool, “nice to
touch, but hard nonetheless”. They fall apart easily though, and he is in open space where he
feels relaxed and really happy, “nice to be away from all the clutter.” As he merges this into him
and circulates it through his body via his blood, he feels comforted and relaxed.

Session 4

David cannot see the HIV, but he can feel it in his head as a “very hard rubber ball. It is
small so I can hold it in my hand.” So he breaks the rubber, and it crumbles easily. The part of
his brain that creates the rubber is cold and damp. It needs warmth and a fire to dry it out. He
takes this through his body, which acts as a cleanser.
Session 6

David is still having trouble finding the HIV in his body; that is, becoming conscious of it. "I can’t locate it although it feels like it is there.” I direct him to where he feels its presence: it is his chest. It is very hot, “too hot”, but I suggest that he make contact despite the fact that “it is uncomfortable.” Although it takes him a while to connect with the space, eventually he constructs a symbol – it is rubber again.

N: Tell me the source of the rubber.
D: Me.
N: How does it occur? How does your body produce rubber?
D: The cells.
N: How do the cells produce rubber?
D: They are not healthy. There is waste. I have to put something better in them.
N: First start with the waste.
D: I’ll clean them out.
N: How will you do that?
D: Pump blood to clean them out.

Session 7

David is drawn into his hands, something that means “everything to me. I use them for work, to make people happy, to bring things closer to me. Without them I’d be lost.” The HIV is “like a burning feeling. It is really hot in there [hands], like being in a very hot room without a reprieve.” The source of the heat is all of the cells in his hand that are “not right”, and they are very noisy and hot. This makes him feel helpless – the cells are screaming. He is aware that it is not right and deduces that the cells are reacting this way because the HIV is invading their center or nucleus, which scares him. Going into the nucleus proves to be “very elusive. It [the virus] doesn’t want me to catch it because I could get rid of it.” He responds with his usual frustration, and goes through the burning process to let go of it. He is now relaxed, and we take that through his body to reorient him. “I can focus better.”
David returns to the nucleus, and this time, he can now grab it although it is slippery. However, he is not dropping it although he feels bewildered holding it because it is so weird looking:

It is fluid but solid. Its shape is changing constantly. The HIV is not hot, but when it invades the cells it creates heat. It is not scary looking at it. It is like a worm. I don’t want to touch it, but I would have to if I go fishing for it (the HIV or worm).

This tells him that

I can manipulate it and hold onto it. Once I get it, it is not hard to hold onto. So I am not so scared of it. When I’m in there with it, it is not doing anything. It stops attacking with my holding onto it. It is like Jell-O. That is different. Usually I get rubber. It is trying to trick me; it goes different places. I know that I can fight back, and this makes me feel strong and hopeful.

The Jell-O, David discovers, is produced separately to the rubber ball. The Jell-O, which is in his hands, enters easily, but it is hard to get out. As he works at this, he is able to gather it up easily with both of his hands and put it in a container. This makes him feel frantic because of all the work. The frantic feeling is addressed and shifted to calm. He returns to his cells. They are weaker for having the HIV there, but they will get stronger as he takes it out of his cells. David is only able to locate the HIV in his hands. “I checked the whole body, and it is fine. It is just here [hands].”

Session 8

David finds the HIV in his finger. It is sitting there, not moving around. When he touches it, he experiences “nothing. I touch it and let go, and it doesn’t do a thing.” He puts it in his basket to burn and sees nothing else there. He dances around the burning basket feeling elated because he “got it all. It made me feel really strong that I was controlling the basket as I pulled it up during the week when I was doing the work.” His hands are tired and need to rest a bit. Although David has had enough, I urge him to keep working on the cells. So he polishes

- 181 -
them, rubbing them with a rag so that the cells shine and sparkle. His hands appear “pink and fleshy. They look healthy.” This healthy state is all over his body as a comforter, which makes his body tingly all over when it is circulated. He feels very peaceful.

**Session 11**

David has been using a garbage can to pick up the HIV, and it does not seem as easy to find. This tells him that he is cleaning it up and that there is not so much there. “The journey is full of hardships, and so I’m finding bits of it here and there. This is not disheartening because I know that it takes time.” He is aware that it is hiding though. “When there is a lot there it is easy to find.” At this point, he is cleaning up the bits and pieces of refuse and garbage that is in his body. It is easy to pick up. He looks under things to find it, but it feels like he is doing something that he is not supposed to do. These are the leftovers. He is being thorough rather than just cleaning the surface with his efforts, and as a result, it is quite clean. He is restoring the sense of order. David runs the cleansing liquid throughout his body: it is like a warm bath or hot shower in the morning. He feels relaxed, calm and happy, rejuvenated and very focused.

**Session 13-14**

He does not see anything anywhere. He feels happy. If it exists it is so miniscule that it does not show. He is too strong for it; it cannot reproduce. Instead the body is producing good healthy blood.

**Results**

Over the last 16 weeks, David reports that he is not as negatively affected by a variety of situations that would usually cause him to react with emotions such as anxiety and nervousness. He states:
I don’t go looking at the bad and negative now. It takes a lot to bring me down. Before I was the opposite. The littlest thing bothered me. Now I’m in the good space most of the time, and I can sleep at night and focus on work better. I just don’t fall into negative thoughts anymore.

There is a noticeable difference as the weeks go on. Even three weeks ago, if my partner and I argued, I would have been upset, questioning everything. Now I’m like, “Whatever.” It is not that I’m brushing it off; it just doesn’t affect me in the same way. Either things don’t bother me in the same way, or they seem trivial, not enough to worry about. What is important are my health, family, relationships. Everything else is secondary. It would take so little to throw me off balance before [doing the SIP work] — a disagreement with my partner or a bad day at work. Then my whole state of mind was negative. But it is different now. I can barely remember what I was like in the beginning. It seems so long ago, so far back, not just three months ago. It is like a long distance memory.

David’s viral load has reduced from 52,650 to 48,604 copies/mL (Appendix B [28 October, 1998] and Tables 2 and 3). The Hepatitis B antibodies have disappeared. Despite these results, David communicates that he doesn’t quite believe that he is HIV positive. He states that he does not think about it, and it has no relevance in his life.

Summary

David has worked at developing his symbols both during the sessions and on his own. He has moved from hopeless, empty, and hard symbolic spaces to soft, fluid and strong, confident states in the general sessions. He has been able to symbolize his virus and work with it so that he now has some sense of control over it. The biggest challenge with him is his denial of his condition, which, in the perspective of the SIP, prevents it from being challenged. David initially finds it difficult to do the symbolic processing on his own, but by the fifth week, he reports that he is able to address disruptive emotional states via the symbol and transform them into stable, productive states.

Phase 2 (26 weeks)

These 14 sessions took place over a 26-week span. We began person-to-person but moved to phone sessions because David felt them to be more convenient. They were usually
every other week. Again, I present only the significant and repetitious parts of the work to
demonstrate David’s growth. In the first segment (general sessions), I describe sessions 1, 3, 6,
7, and 14. In the second segment (HIV), I describe sessions 1-8 and 11.

General sessions

Session 1

David starts off in a bright and warm place with the sun rising. This means a new, good,
clear day. The place is by the ocean on a beach, and he appears very happy with clear eyes. He
wants explore the place because it is such a beautiful and perfect day. He feels excited because
it is a new day, and so he feels as if he is looking forward to something. David cannot wait to get
it started. This state is in his stomach. It is warm and soft, very tangible; it looks and feels like
baby powder which means for him a baby; that is, new life. It fills his body. He can even smell
it. Everything is smooth and soft. It is circulating rapidly, and he is emotionally strong.

Session 3

David is aware of a warm light, which is comfortable and soothing. The ground is wet
grass, which implies the morning dew; thus, a new day — dawn. The scene is very vivid to him.
It is springtime, and the air is fresh, really alive, warm and invigorating. All of the good things
to pull out of the environment are present — the warm sun, grass tickling toes, cool air.
Everything feels really good to touch and experience. He is calm and happy. “I don’t have
feelings though like, ‘If I’m too calm, what’ll go wrong?’ It does not feel like that. It is
peaceful.” This state is

all over my body. It is soft and has a spongy texture. When I lie in it, it coats me all
around, forming to my body. I fit there, belong there; it is molded for me. It is
physiological and has always been there, although I never noticed it before. Because I
have gotten the bad stuff out [of the body], I can now be aware of this other state, but
it has always been there. This is why I am able to function now. The difference is
that I have made room for it so it can work and produce. I know that it is supposed to
be there, that my system is working properly because it can now flow freely. The life force is not being deviated by other things that are not supposed to be there. The life force, which is the blood, is moving so freely and quickly through my body, getting where it is supposed to go. As a result, my body functions better, and I have better visions and thoughts. This all comes from my stomach and moves through all other cells.

Session 6

David is in water. It is very warm, and there are no clouds. It is warm sunshine. This means that everything is calm right now, a perfect day where he is. The sun is up; it is the beginning of a new day; he is on the beach, peaceful. He can see the horizon. He is excited because he has the whole day ahead of him. He wants to walk in the sand and water. The waves tickle his feet. When he goes into the water, it is beautiful and he floats. In the depths, he can see the coral all around him and the fish. The water is very clear and does not burn his eyes. He keeps them wide open and breaths in the water. The water is very blue, like swimming in the sky — this is the most outstanding feature here. It is an amazing blueness. He is immersed in the light of the water. His whole body is tingling. He is floating underneath the water. That tells him that he is very free. To float means to he is buoyant and has absorbed the water into him, circulating the blueness. He has a difficult time describing how he feels: it is happiness; he feels no sorrow, the complete opposite of that.

Session 7

David is on top of a hill looking down upon lush green. It goes out to the ocean. It is a perfect day, sunny and warm. He feels the heat of the sun on his face. He is peaceful, happy, sitting there looking out with a big smile. He can feel the moist dew on the grass. It is crisp on his skin. He feels awake, alive at the bottom of the hill looking up at the sky. Three birds are flying around. They have lost the fourth one somewhere because he could not keep up with them. The fourth one went back to the tree, and he is far away. David feels sad for him. He is too weak. When David goes to him, he finds that he is smaller than the other three. In his eyes
is sadness because he does not feel strong enough to go with them, but he does not want to stay alone. David wants to help him learn to fly and the little one responds favorably and is willing. The little bird is able to do it, and when he falls behind, David encourages him.

Session 14

It is David's regular spot by the ocean. He is looking at the landscape — the water, sun, rolling hills, the trees behind. The hills are lush, soft, rolling. The trees are tall and mighty. It is a perfect scene. The water is very blue. He rolls down the hill because it is fun, like a kid. He is at the bottom now looking up at the sky. He feels very relaxed; it is a red energy in the pit of his stomach that is hot -- hotter than the last weeks. It is a good place, secure. He builds and expands it so that it is everywhere at once. It feels incredibly warm all over. It becomes his entire body. He feels relaxed.

HIV

Session 1

David sees many little amoebas working hard and moving fast to fight the virus. However, it is really hard for him to see them because they are moving too fast. They are fighting because they have work to do. The virus is also hard to find: it is like there is a little bit of it. They are dormant and scattered here and there, not doing anything, but he is able to locate it in his fingers piled up like garbage. He clears the space using the amoebas. It will take a bit of time, and his fingers are a little sensitive as a result of the work, like a cut that heals, tender to touch. David journeys to find the rest of the virus, keeping a can with him to put it in. He is walking through his body feeling bits here and there, a little in his legs — a handful — some in his toes, in his knees, a bit around his heart. It is easy to pick-up because it is not strong at all, not holding on tight. This provides him with a sense of control. He wants to get the T4 cells in there
cleaning up. The garbage of the virus that he has collected burns easily, "in a poof". His body is strong and stable.

Session 2

David has not seen it. He does not see little piles since he emptied the garbage, even in the tips of his fingers. He still has the can for the garbage. He can put other garbage in there. It does not have to be for HIV only.

Session 3

David finds the virus in one spot behind of his ear. He believes that is the rest of it being flushed out of the system. The spot is dead, no activity at all. David does not like being there.

The HIV is not a part of my daily life. When I was diagnosed, I needed this because it forced me to take better care of myself. Now I do not need it anymore. It helped me then, but now I want to get it out. What I see is this little spot with lots of activity behind ears collecting garbage and pushing it out.

Session 4

David has not been able to find it for a long time. As he goes around and looks, he cannot find it. He expects to find it because he was told he has it. He looks intensely but he cannot find it.

Session 5

David has not been able to find it in his body. He used to feel that it was there.

Session 6

"That stuff? Not in me man. It is not there."
Session 7

He has no idea where that is. It is not there. He is almost ready to go to the doctor to get it reaffirmed. Before he felt it, felt the virus. “I felt something invading me. But I feel good for the first time in a long time.”

Session 8

Again, David does not see the HIV, nothing in his whole body. He does not feel drawn to anything. The blood cells and internal organs are healthy.

Session 11

It is not there. He has not seen it in him for a long time.

Results

David is making time to do the work on his own. When he finds the place he is at, it is usually very restful, relaxing and calm. He is not doing images of his cells because he does not see the virus. He believes that the stronger part of him is taking over inside, so he does not feel that he has it.

I notice that the images are becoming more real. I have the ability to go inside whenever I want to - at work, in the car. Now when I get there, the images are clear and more vivid, more real. I know it is real, not real, real, but real inside of me. I definitely think that I’m more aware of myself, and it seems like things don’t bug me like they used to. In the last few weeks at work tempers have flared a bit. That would have bugged me for days before, but now I go in and get rid of where it bothers me on a quick conscious level. As soon as a situation arises that would bother me or is negative, I go in and attack it so it doesn’t stay. I’ve changed a lot. I’m positive. I used to be more negative, expecting something to go wrong. Now I expect it to go right. I was never like that. That is the big difference in my life. My expectations and outlook is different.

I’ve been so healthy. Every other person at work has had the flu, and I have not had it. Every aspect of my life has changed. It is amazing. The work is an ongoing thing now. The tiniest little bit of stress — my body attacks it right away. The positive energy goes in and attacks it. This positive energy starts in my chest and travels in my body. I can’t believe how quickly I have retrained my mind. I don’t question it anymore. Something trivial happens and this energy just takes over.
David’s viral load has dropped from 48,604 to 28,412 copies/mL (Appendix C [14 April, 1999]), and his CD4 cells have risen by 45 counts, from 330 cells/mm$^3$ (Appendix A and Appendix C [15 July, 1998]) to 375 cells/mm$^3$ (Appendix D [April 4, 1999]). These changes are shown in Tables 1 to 3.

**Summary**

David’s scenes are consistently positive and upbeat, but in the SIP, this is not necessarily a good thing. A person needs to be willing to enter into “dark” or problematic areas in order to challenge them, but David is on a “feel good” binge. He is always “good”, so there is no route to confront the problems, because according to him, there are none. Except for the very beginning of this phase, he has been unwilling to connect with metaphors of the disease. As a result, I feel that we are proceeding slowly. I keep urging him to go for his blood test, but he delays this, unwilling to confront the obvious. He also prolongs obtaining the results from his physician for seven weeks.

**Phase 3 (30 weeks)**

This phase is the final 30 weeks of the study, and we worked on the phone 11 times, usually every other week, for the first 19 weeks. David went for his blood tests at the end of this time period (19 weeks), and after that, we only worked together twice. When David obtained his results (at the 30 week point), we completed the study. I begin this phase by asking David to seriously address the metaphors of the virus. Once again, I highlight only the most relevant and non-repetitious aspects of the sessions. In the first segment (general sessions), I describe sessions 2, 5, 6 and 10. In the second segment (HIV), I describe sessions 1 to 3 in great detail, and sessions 5, 9 and 11 with less details because the latter are a continuum of the first three.
General sessions

Session 2

David is jogging, running along a well-laid path. This means that there is a destination, and he is going somewhere. Jogging means to him something he would like to do and feels good doing. In his eyes is fire, determination. He is proud of himself for persevering. As he jogs, the scenery changes. For instance, he can see over the horizon. The more he pushes himself, the stronger he gets. He experiences that strength in his stomach, in the rib cage area. It is solid but smooth, like a rock with no determined shape. This means that it is permanent. He looks at it in wonderment.

Whoever knew that this was inside of me? Wow! This has been here all along, and I've just uncovered it underneath all of this crap. It is the solid rock of strength that I have. It is easy to find. I know it is there, and it is confirmed. I knew I had it.

Session 5

David is running. In his eyes is determination to keep going and get stronger. He feels proud of himself. The environment does not change. It is a perfect place, and he wants to keep running. He feels happy, calm, determined, every step makes him want to take another. This feeling is all throughout his body emanating inside of him, coming from everywhere. It is a pure thing. When he touches it, it is very hot. The heat is cleansing, coming right from the oven, so that it is hot but not burning him. When he touches it, it is hard but smooth to feel. It has the texture of feathers but with a solid form, which means to him the softness of down feathers as well as the solid feeling, meaning permanence. It is moving in his body warming it. He feels happy, mentally clear and focused.

Session 6

The place is the same – the ocean setting. He is moving, walking very fast, not stopping. He looks really good and feels very awake, very alive. He expects to find a new environment,
but it is always the same clear day with the ocean on one side. The path he is on has green grass and hills. It is a perfect setting. It is early morning — a new day. He wants to keep walking and see where this goes. The path is endless, could be a lifetime walk, but this does not distress him. It goes on forever, and he is excited to keep going.

This is an excited feeling, the reverse of an anxiety attack that makes him sick, which is what he experienced in the past. He wants to pull the excitement through him. It is in his stomach, and when he goes there, it is bright, very warm like sunshine on a hot day. The lights are energy, his life source, very pure and nothing is filtering through it or in its way. It is bright light, and he wants to immerse himself in it, dive right into it.

N: What creates this? What are its origins?
D: I’m searching for this, and I think that it is something that I’ve always been, that I was born with. Until recently it was not noticeable; it was stifled, not allowed to flourish. I think that what I am understanding is that this is something that we all have — you have it too — you can say this is our soul; this is our existence. It feels so familiar like I have always known it’s been there. It is easy to find, that is why I am not rejecting it. When I put something foreign into my body it gets rejected. But this is not foreign. It is mine. It sounds so hokey, but it is what I feel. I feel all kinds of different emotions with this — smart, knowledgeable. It gives me knowledge because I have understanding. I feel comfort, hope, and peace. There are no ill feelings, no sadness or despair, just good feelings. You will have a hard time pulling me out of this. What a wonderful place this is, the core of my existence. I feel lucky to have found this. All other people have this but do not know it. It moves with every breath. It is how the body distributes oxygen, through breathing. The blood feels so clear and pure.

*Session 10*

David is on his regular trail. The place is a very peaceful, happy place. He is still running, and it is easy. It does not change week to week. The only thing that he notices that is different is how he feels. He is stronger. He should be; he is doing this running. It is almost hard to distinguish inside from outside now. The inside, he realizes, is affected by the outside and vice versa. They both rely on each other. Everything is relative to each other:

I have to keep everything happy by harmonizing both the inside and the outside to maintain the perfect little world. This is great. I have to maintain the work, go in and check everything out. So if obstacles are on the outside, I deal with them inside. If I give into the obstacles, it can affect the whole inside. I feel determination.
**HIV**

**Session 1**

David cannot find the viral load. It is not there or it is just hard to find. He can find the T-cells, but not the virus. He does not know where it is because he does not feel them in his body. If he gets the T-cells strong enough, he believes, the viral load will decrease.

N: Go to the T-cells then. Where are they in your body?
D: Everywhere.
N: What is the source of the T-cells?
D: They come out of the bones.
N: How?
D: They pop out of the bones from their very core, from what gives the body structure. It looks like little construction workers. They are so funny. It feels neat to stand back and look from my own eyes. There are so many of them that it looks like they are chipping away at all of the cells in my body with pick axes. I get a pretty vivid picture of them underground. They come to the cells and are digging out and chipping away above me, chipping at all of the bad stuff until it falls. They are cleaning the little cells very neat, making way for the new stuff.
N: What are they chipping away at?
D: The build up from all of the years of chemicals and bad things in my body. So they are making room for the new cells to come.
N: Ask them about the viral load.
D: The virus is here, and when they get to it — it is lurking in the dead stuff — they will kill it. The more guys they have to help, the more of that they can do. The way I help these guys is to be happy. When I am happy, more guys reproduce.
N: Do they reproduce with the reduction of the junk cells?
D: They work harder and faster when I am happy, which then reduces the junk cells. This leads to the increase of good cells when I am in a good positive state of mind. I encourage them to work faster and the other guys to come out and help. I really understand how my body functions now that I watching them as I stand on a plateau.
N: Go in and help them. Let them teach you what they are doing.
D: It is more exciting to watch them. I don’t like physical labor.
N: Would you like to try?
D: I am looking for a place to start. There is little room for me. They look like Lego to me, little men who are wearing little white outfits and hard hats. I feel silly with this picture.
N: How does it feel to help?
D: It is nice to help. It is easy work. It is not difficult, just time consuming.
N: What do they do with the residue?
D: It disappears as it falls. I see nice pink healthy flesh.
N: What is their response?
D: They are happy
N: What are you feeling?
D: I feel happy, confident. We, the little guys and I, will get rid of the black stuff. We’ll get to the viral load and clear it up. They tell me to take my time, go slow and get it all. Then there will be no room for the bad to grow. It is like algae. It can grow
into tons. So I am to make sure that I get it all. I'll check on the guys everyday. I can see them easily.
N: What is their state of mind?
D: There is no hesitation. They are telling me that we draw upon each other for strength. They are in me, and I am in them. I am the conscious one that helps them by being happy and stress free.
N: Where is it that they are working in your body?
D: They are working from the bone level.
N: What does that mean?
D: They are starting from the core and working out.
N: What is inside of the bone like?
D: It is fleshy and healthy. It is very pink, like rosy cheeks.
N: Where are the crap cells?
D: They are outside of the bones. They have worked inside of the bones. It is already done. They started at the deepest level and accomplished that. That is why it is time consuming. I understand that now. I see the plan of action. Because they are so thorough, they cleaned every micron of the area so no crap can grow back in there. If they don't do that, the only thing that can grow is the crap, which can squeeze out the good. So they have to keep working, got to keep going. If they stop, the black stuff will push the good out. So they can't stop, but they don't get tired. One guy chips out enough room for two and two for four and four for six. They clear another spot and make room for another one. It is a continuum of fighting, attacking and chopping away so the T-cells will increase, and the stuff that is dark can't take over.
N: Circulate the blood through your body. How does that make your body feel?
D: It sort of tingles. It is changing.
N: What is your emotional state?
D: It is good, happy, relaxed, confident.
N: Your mental state?
D: Good, steady. I used to feel on edge, but I don't now.
N: And spiritual state?
D: Peaceful.

Session 2

N: Where are the guys in your body?
D: They are working their way through tunnels and a maze of veins, cleaning them up. They are in the lung area now; that is what it looks like.
N: What about the virus?
D: There is not a lot of it. It is hard to find. If there was more of it, I would see it floating around in space.
N: Grab it.
D: I grab it, and it doesn't put up a fight.
N: What is it like?
D: Jell-O.
N: What does Jell-O mean to you?
D: Things that are solid are permanent; things that are soft aren't strong. It is easy to put away and compact it, get it out of my system. Solid is strength; soft things are useless.
N: Can you talk to it?
D: It doesn't talk. It is like a mold.
N: What does that mean to you?
D: Bacteria.
N: What does that tell you?
D: It is not a part of me. It doesn't belong there.
N: Where is it?
D: It is in the gray areas. It is just tissue. It is not in any vital organs.
N: What does that imply to you?
D: Either it hasn't penetrated or that I have gotten rid of it to the point of it being superficial. I couldn't find it before because I think it was floating around looking for bits to get bigger.
N: How is it manufactured?
D: There is strength in numbers. That is the feeling that I am getting, but they can't find enough to multiply. If they are big, I'll find them. They are so sneaky, but I'm onto it, so there are just little bits floating around in my body. I find it when the little pieces get together. Then I burn it.
N: How are they produced?
D: They are remnants, leftovers. That is the part that I feel. They are not growing or being produced. It invades from the outside in but the mind is too strong to let to let them get in. From the center of the bones is the strongest. With these guys working I will eventually push them right out. It'll be like a cleansing. When I get rid of it, I'll get a fever. I have had a temperature during the nights. When I wake up, I am super sweaty. I haven't felt a cold. My partner told me that he couldn't sleep beside me because I am too hot. I've been tired. I need my rest now.
N: Take out the virus.
D: Yes.
N: What is the area like without it?
D: Pink and bright, light bright.
N: Tell me about the heating process. What is the source of the heat?
D: It is head to toe, deep inside of me. So it reaches the surface, I feel the sweat.
N: Go deep into it.
D: I see a furnace. I see an incinerator.
N: Who is working it?
D: My goodness! It is me shoveling coal into it.
N: What do you see in the eyes?
D: The fire in the furnace.
N: How does that make you feel?
D: I'm taken aback — whoa — neat. I didn't think I was down there. Now there I am. It is amazing what I find when I am working with you. We are shoveling the stuff we put in us, all of the garbage, the stuff we don't need, the years of frustration and pain, what we don't need in the body. A lot of it is easy to burn. Now I know where to put the stuff.
N: What about the workers?
D: They are shoveling away. This is the place that the garbage goes to, and he shovels it in.
N: What does that imply to you?
D: It is neat to know and understand how everything works now. I know exactly what is happening. It is easy to get rid of things. He — me — will get rid of it.
N: How does that make you feel?
D: I feel strength and determination. It is very empowering.
N: Take the fire through your body.
D: It is heating everything up. It is tremendous heat. It warms things up to help purify. It is like keeping the bugs away.
N: What does that do to your body?
D: It warms it up, makes it tingle, takes away any aches and pains. I feel awake, very alive.
N: What is your mental state?
Session 3

Heat is emanating from everywhere in David’s body:

D: Crystal clear, steady.
N: Your spiritual state?
D: Peaceful, but it is weird. I have a strong emotional sense from it.

D: How is the heat produced?
D: I am looking. It is hard to figure out where it comes from. It is everywhere — coming from everything. Maybe it is coming from my blood. My blood is feeding everything. It is everywhere, a part of me, everything that is nice and constant. It is warm but not burning.
N: What gets it hot like this?
D: It is cleansing.
N: Yes, but what is the source if the heat? Physiologically?
D: I am looking for the physiological explanation. I am not getting one. I am understanding that it is getting its own heat and momentum from me.
N: What part of you is that?
D: O.K., I’m feeling something now. It is almost like there is a furnace inside my stomach. I’m way deep now inside of my stomach.
N: What is it like?
D: It is very warm. I’m a kook.
N: Why?
D: O.K., this is the picture that popped in front of my eyes. There is a conveyor belt and it is moving. There is a furnace at the end of the conveyor belt, and a little control booth that I’m in. There is a panel with a fast or slow button. On the conveyor belt is waste material being fed to the furnace. There is a shoot — this is way down inside — waste comes down the chute and goes into the furnace. I am controlling the speed of things. Oh my word, I’m a freak, eh? It’s neat. I’m going up the shoot. This is where the guys are working. They are everywhere. It looks like the area they are working on. It is like looking through ice when you see the wide water, and you look up and see muted light. They are chipping away, and the light breaks through more so that they are chipping away at the surface, like calcium a little.
N: What does the calcium imply?
D: Impurities, and as they chip away the light gets brighter. I never saw this light before, not like that.
N: How does that make you feel?
D: Wonderment — wow, what’s beyond that?
N: What do you see as you are there?
D: As I look at the light, it is almost like pulling me to it, to keep hacking away too because that light is something that I really want.
N: Why?
D: The light could be my life force.
N: Do you feel it coming in?
D: Yes, it is like lying in the sun and feeling the heat on my face. It feels amazing, relaxing, pure sun. It is really good. I think that it has the same effect on the workers. They all look so determined. It feels so close Nicola.
N: Work away so that the light can break through.
D: It can’t happen so fast. I can’t rush this or get it all through. The way we are chipping away so carefully and methodically, I see it all break away and come through all of that at one time. It is not far off. This is what I get from everyone. What I feel is neat; it’s like ready minds, a group consciousness. I don’t feel in this
space that I can’t have it or can’t know it. I am knowing it and it is mine and it’s coming.
N: Are you still chipping away?
D: Yes, it falls into the conveyor belt to the furnace. The furnace heats everything up.
It now makes sense. It is simple.

Session 5

David feels intense warmth with a solid but fluid texture. It is red, his blood feeding every little part of him, bringing strength through his body:

N: What heats up the blood?
D: The furnace.
N: Let’s go there. What is it like?
D: I can’t describe it. The fire — I expected it to burn but it does not. It wants more fire the more I make. It does not burn. The more I make, the stronger I feel.
N: How does that make you feel?
D: Relief, there is just the real sense that it is the way it should be — that sense of belonging.
N: What pace is it going at?
D: It is like a fireball — fast.
N: Is the fire everywhere all at the same time?
D: Yes, it is, and as it circles around, it gets hotter and hotter and hotter.
N: What does that do to your body?
D: The hotter it gets, the more it can endure. It is adjusting to the heat and it says, “Give me more and more.”
N: Why?
D: It is cleansing.

The system has now changed. David is primarily aware of the heat emanating everywhere, which has replaced the workers; that is, the heating system has taken over.

Session 9

He does not see the virus anymore. The T4 cells are strong, powerful and creating heat.

When they pass through, they are electrical.

Session 11

He cannot see the virus in his body.
Results

David reports feeling more in control of and connected to his body through the images

the working cells and fire. In the first few weeks of this phase, he comments that

with the work that we have done, I have learnt to handle stress and get rid of it, not let things get to me like they used to. In times of stress, I can actually feel my worker guys slowing down. Isn’t that weird? So I get rid of that feeling quickly.

Now that I know what’s inside of me, it is easy to visualize. The virus feels like it is slowing down. I feel great. I’d go on trips inside and wander through myself. I feel really good, warm everyday. I’m working with my little guys everyday. I thought I saw light. I have hot flashes throughout the day. At nighttime I notice that I kick off the covers.

After the fifth session, the worker guys have been superceded by an energy system:

When I first noticed it -- when things started to move with the workers -- I would notice myself heating up in the day, even in air conditioning. I feel hot now even though the workers have finished their job. Whenever anything in my body is changing or things are not right -- I get hot flashes to get rid of it. The hot flashes were a lot more intense before, but since the workers have done their job, the hot flashes are not as intense.

As the weeks progress, David reports an overall decrease of hot energy:

The hots aren’t consistent now but were at the beginning. A few months ago constant.

And,

I am good. Nothing to report, things are great. My hot flashes are not as frequent. They are a lot less often and not so long, now I get hot three or four times a week and they last the duration of a couple of minutes. I don’t really keep track of them. I don’t notice them anymore. It is all through my body — head to toe.

Doing this work is part of my daily routine. I don’t think about it; it just happens. In the last three to four weeks, there are shorter heat phases. The other ones were a lot longer and more intense. I still notice that when I wake up I must have been hot because I kick the covers off of me. I need a lot more rest for repair. My sleep is very restful.

Finally,

I am very good. I had only a couple of noticeable hot flashes, and when I do have them, it feels like maintenance. Nothing is wrong with me. I am so totally different than how I used to feel. I have been good at work, getting along with everyone, at home happy, happy. I went for my blood test last week.
David’s viral load has dropped from 28,412 to 24,699 copies/mL (Appendix D [October 25, 1999]). His CD4 cell counts have jumped from 375 to 450 cells/mm$^3$ (Appendix E [October 25, 1999]). These changes are demonstrated in Tables 1 to 3.

**Summary**

David begins this phase with a renewed intensity. His general symbols of running and being active compare to the previous phase where he is typically lounging in his environment; for instance, basking in the sun. In the initial part of these sessions, David displays a determinism that manifests a whole new system of creativity and concomitant psychological and physiological changes. However, as the weeks progress, he once again returns to denial: the virus does not exist. Furthermore, he prolongs both going for and obtaining the results of his viral load and CD4 count testing, and the final sessions become redundant. When the results are attained, David expresses disappointment despite his incredible achievements – he wanted greater change. When I describe the two main areas that I feel need attention in order to enhance his progress — his need to be “happy” and his denial of the virus’ existence — he is unwilling to explore these ideas. At this point, he decides to complete the study.

**Conclusion**

David has made remarkable progress and has achieved substantial benefits on many levels throughout the year and one half of our working together. Psychologically, David, amongst other things, now has a greater sense of power and control in his life and is capable of reorienting himself from stressful and anxious to calm and relaxed states. On the physiological level, David began with a viral load of 52,650 copies/mL and a CD4 count of 330 cells/mm$^3$, and
this changed to a viral load of 24,699 copies/mL with a CD4 count of 450 cells/mm³. These physiological changes are shown in Tables 1 to 3.
Table 1

CD4+ Cell Count

<table>
<thead>
<tr>
<th>Date</th>
<th>CD4+ Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 72</td>
<td>330</td>
</tr>
<tr>
<td>Apr. 79</td>
<td>376</td>
</tr>
<tr>
<td>Oct. 79</td>
<td>440</td>
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</table>
Table 2

<table>
<thead>
<tr>
<th>Date</th>
<th>HIV RNA load, copies/mL</th>
<th>CD4 cell counts, cells/mm³</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/28/1998</td>
<td>55,012</td>
<td>-</td>
</tr>
<tr>
<td>07/15/1998</td>
<td>52,650</td>
<td>330</td>
</tr>
<tr>
<td>10/28/1998</td>
<td>48,604</td>
<td>-</td>
</tr>
<tr>
<td>04/14/1999</td>
<td>28,412</td>
<td>375</td>
</tr>
<tr>
<td>10/25/1999</td>
<td>24,699</td>
<td>450</td>
</tr>
</tbody>
</table>
CHAPTER 9 - DISCUSSION

If the brain is connected to the immune system, then so is the experiential mind (Bakal, 1999, 131).

We need more sensitive tools for studying emotional and psychological states. The sensitivity of our emotional assessment needs to equal the sophistication of our immunological knowledge and we are not there yet (Hafen et al., 1996, 18).

When I began this study, the SIP had been in development for about five years, and the approach was heuristic. During its inception period, it was actually difficult for me to describe or label what the SIP was because I was working from such a symbolic level. However, even in those embryonic days, I did not want to only cultivate the process from or limit it as simply a phenomenological process, and this propelled me to develop both the theoretical and practical aspects of the work.

**Personal goals**

The creation of the SIP has not only been about providing a process that promotes betterment and self-knowledge. It has also very much been about describing and "explaining" the psyche/soma from the perspective of the symbol. Without this construction, the imagination would have remained an arcane and undefined aspect of myself, which would have meant that I would not have been able to share it. Doing this work has allowed me to grow from being alone in my own surreptitious world of symbols. So despite the possible loss that might occur as a
result of opening up this metaphoric landscape, such as the limitations that definitions impose upon the mystery, to remain hidden means to never be known.

When I came to experience myself in post-pubescence, it meant coming face to face with an inexplicable, intuitive ability to know symbols. I was basically left floundering through this esoteric terrain, attempting not only to grasp its meaning but also to understand my identity in relation to it and what it was that I was supposed to do with it. It was so dark and recondite that I found myself wandering through its vistas struggling to make sense of its meaning. Because I expected that this exploration would only lead me to rejection and isolation, I was as terrified of it as I was compelled towards it. Irrespective of whatever fears accompanied this aspect of myself, I could never escape its existence in my life. When I finally began to lift the veil of mystery surrounding symbolism and started establishing the SIP, it meant that finally I found my home. It is as if the mystery inside of me longs to be explored and known -- it is the way that my soul finds its peace. The challenge, therein, lies in being able to express this work beyond phenomenology without losing or abandoning the mystery. At the same time, I am faced with examining my own thesis, now not only within the context of myself, but through my work with others.

Although I have made claims regarding the interpretation of symbolism in this thesis, I am not suggesting that I have any answers. My ideas are speculations about meaning, never absolutes. The more I come to claim knowledge, the more questions appear. I tread through the mysterious landscape of imagination with the awareness that I am learning about the immediate moment, which will then lead me to the next moment, and so the journey continues. However, that does not mean that a structure cannot be built, that a way, so to speak, cannot be constructed, once it is established that this way, in this case the SIP, is simply one of the many, many possibilities in the journey of life. I do believe that there is a basic need to have a home,
although that dwelling need not be limited; for instance, it can be redecorated and expanded. Furthermore, I have found that the SIP is dramatically more effective with a definition and structure rather than without it, although this is not set in stone and is always malleable. Perhaps this is so because these definitive elements help to balance the recondite nature of symbolism on a human level, and it has not been my experience that this causes it to lose any of its mystery. In fact, it is quite the contrary: juxtaposed against the practical, the mystery is so much more apparent.

**Thesis development**

The development of this thesis occurred in various stages. The first stage was based on the knowledge that I had gained from my five years of working with the SIP. I understood that to create change, the challenge is to know how to evoke the appropriate symbols that will produce the desired results over time. Thus, the temporal aspect of the study is most significant; that is, it takes time for psyche/soma to develop through the symbol. I liken the process to physical exercise — the doing creates results, which can be surprising. It may be important to understand that the SIP is not necessarily a pleasant, relaxing experience, except towards the end of a session. It is diligent work, and it does not appeal to everyone. There needs to be some type of motivational impulse that will compel a person to challenge the self through symbols, which is usually the desire for change, be it affective or somatic. The idea of working with an individual challenged by HIV was compelling to me because I believed that some type of physiological response could be achieved over time, although I had no way of predicting what that would be.

I commenced this study with the intention of stimulating some form of physiological change through the SIP for several reasons. First of all, I had already investigated the psychosocial benefits based upon the verbal reporting of participants, such as a greater sense of
power, control, spiritual peace, and the ability to achieve various goals in life (e.g. intimate partnership, career success, quitting smoking, etc.). As a result, I was confident that the participant would derive psychological benefits. There were also many reports of physiological changes, and I was sometimes asked to address problems that had proven resistant to other forms of treatment; for instance, chronic yeast infections, allergies, and so on. Certainly, doing this imagistic work showed me that the dividing line between psyche and soma is very permeable; however, I had never studied the physiological relationships with measurements, such as blood counts.

Secondly, I felt that developing the somatic aspects of the SIP would allow me to gain a greater understanding of how to utilize symbolism for physiological efficacy, which would also broaden the definition and use of the process. I believed that this would be a greater social contribution because it could then be applied more extensively. Although I had successfully worked with various physiological problems (allergies, migraines, etc.), I had never done so with a life threatening illness and certainly not an HIV+ person. I chose this disease because it is an epidemic without a cure, and the experience of being HIV+ has both personal (e.g., facing illness and eventual death) and social (e.g., alienation) consequences. I also wondered how responsive the immune system would be to change that was elicited through the psyche; because the SIP is so effective in creating behavioral modification, I hypothesized that this could have concomitant physiological benefits. In addition, I felt that achieving positive physiological results in the case of HIV/AIDS would be life supporting for an individual facing a life and death crisis. For instance, studies show that coping styles can affect the progression of disease (Solomon et al., 1991; Ironson et al., 1994; Mulder et al., 1994b and c; Theorell et al., 1995; Kemeny et al., 1994). As the SIP teaches how to elicit healthy coping styles through symbolic transformation, I believed that it could also have a physiological buffering effect.
The second stage was the research process with David for just over one year. The relationship between David and I was unique in that the main focus was the disease. It is less common for the physiological component to be the compelling purpose for doing the work. In addition, in previous work, individuals' sense of betterment had been the only measure of change, such as the verbal reporting of allergies subsiding or disappearing over time. Although there does not seem to be a certain type of personality that engages in the work, there does need to be an intention towards growth accompanied by the willingness to engage in internal processing. David had such an intention, although, like most participants, he had never visualized or explored inner processes, but he had one very strong motivational force: he was HIV+ and he wanted to delay anti-retroviral drug usage despite his physician's strong recommendation that he partake in such therapy. We determined that we would work together for at least one year, and he was very keen about proceeding with me.

Throughout the process, David was reliable and maintained his appointments with me, and he certainly worked hard at developing the ability for himself. Even though we had agreed to work together once a week, David's schedule usually prevented this, and it became more bi-monthly. However, he would do the symbolic work on his own, based on what we had done the previous week. I certainly felt that David was determined to improve his well-being. David chose to complete our work together just after the first year because he felt that he had gained what he needed from the SIP. He did not want to explore other avenues of his symbolism, such as the denial.

Unlike others with whom I worked, David was not interested in the philosophical aspect of the SIP. He constructed what he decided it was and was not particularly interested in many perspectives that I believe would have benefited him. Individuals differ in what they want to gain from the process and personal orientation. One of my main concerns was what I felt to be
his denial of his condition, but he refused to consider this. When David began his work with me, the only other intervention process with which he engaged was taking vitamin supplements to help boost his immune system. He also received chiropractic care. He remained in his intimate relationship throughout the duration, bought a house with his partner and formed a business partnership with two other people. He also reduced some of his working hours.

To date, David remains optimistic and hopeful, and he feels a sense of control in his life. The main goal in doing the SIP was to delay HAART (antiretroviral therapy) drug therapy for as long as possible for several reasons. One of these was that he was afraid that given his constitution, he would not manage the intake of the drugs well, and he desired quality of life. Another was that because he was newly diagnosed at the beginning of the study, he wanted to explore alternative health options, hoping that such approaches would delay the need to take drugs. David believes that HIV/AIDS research will eventually develop drugs therapies that will be more effective (HAART is not an indefinite treatment) or at least less deleterious on the body. However, given that his CD4 cell counts were so low and his viral load so high (Tables 1 to 3) at the onset of the study, David’s physician pressured him to begin drug therapy. (David never informed his doctor of our study for fear of being ostracized.) Because of the improvements that occurred throughout our work together, his doctor no longer insists that he take the drugs, particularly as these changes have been sustained: his most recent blood tests, which were taken in October 2000, one year after the last tests for our study (in October 1999), showed that his counts remained stable: his CD4 cell count was 440 cells/mm³ and his viral load was in the 20,000 copies/mL range. In our follow-up conversation in August 2000, David stated:

The [SIP] work helped to change my life. I am a stronger person because of it, and it has totally changed my outlook. It was an amazing experience. I would recommend it for anybody. I am not letting it [the disease] take over my life. I still return to it [the SIP] in times of stress and other emotions. It is a part of my life now (August 31, 2000).
Despite David's perceived benefits from having engaged in this process with me, there are still areas of my work with him that leave me with questions. Could David have gone further had he been willing to confront the denial? How long will he be able to sustain his physiological and psychological equilibrium? Would there have been a difference had I worked alongside his physician or in a more clinical environment? One of the most striking aspects of the study for me was that David was not an adept at the process, and he represents a very average response. He was neutral in terms of his belief in it; he only did what was comfortable to him; and he did not allow me to stretch him into deeper symbolic places, such as his denial, which many people are willing to explore. This dynamic provides me with a sense of comfort because it suggests to me that the SIP can be beneficial to those who are not particularly skilled in terms of comprehension but who are motivated to learn on their own terms.

The third stage of the thesis was receiving the blood test results and investigating the physiological aspect of the work, which I did through the PNI research. The final stage was putting the research together. The biggest challenge in doing this was figuring out how to blend the nonlinear theories of the imagination with the linear changes. This dilemma was mostly resolved through my research on psychoneuroimmunological findings.

**Discussing the findings**

The practical goal of this case study was to examine how the SIP method of intervention would affect the physiological and the psychological states of an antiretroviral drug-naive 32-year old HIV seropositive gay male, David. I did this by documenting: (a) David's symbolic changes throughout the three stages of the study; (b) his personal account of affective and psychological changes, (c) the pattern of change that occurred to the HIV RNA plasma levels and the CD4 cell counts, and (d) following up one year after the last blood test of the study.
At the beginning of the study, it was hypothesized that the SIP would positively affect both the psychological and physiological states, but it was unknown in what manner, to what degree, or in what time span. David’s verbal reporting indicates that he experienced a variety of psychological benefits, such as a decrease in stress, a greater feeling of personal power and control over his life, and a sense of hope and optimism. The blood sample tests demonstrate that change occurred in both the viral load levels and the CD4 cell counts. The viral load reduced by more than one half, from 52,650 to 24,699 copies/mL, and the CD4 cell count rose by 120 cells/mm³, from 330 to 450 cells/mm³ from the beginning to the end of the process (Tables 1 to 3). The follow-up with David one year after his final blood test for the study revealed that his blood counts have remained constant and his affective state remains positive.

This study has been a preliminary investigation to consider and test out the possible affective and somatic buffering effects of the SIP. While David’s physiological results are not generalisable given that this is a single case study and should therefore be interpreted with caution, they nonetheless suggest that the SIP form of intervention may have provided both a psychological and physiological buffering effect against the disease. These findings are also limited in that they do not show the long-term immunological and psychological effects, and because it is a single case, it is restricted without a control group or comparative case or group (for instance, could the changes have resulted because David had only recently seroconverted?).

The changes in David’s plasma and CD4 levels contrast with the findings of other studies investigating immunologic changes in HIV-infected antiretroviral drug-naïve cases (Bouscarat et al., 1999; Lyles et al., 2000; Giorgi and Detels, 1989). These studies (discussed in Chapter 8) show a pattern of CD4 cell count decrease over time and general stability of HIV RNA levels. David’s low CD4 count and high viral load at the point of seroconversion is also of interest. By his report, David’s previous blood test showing him to be seronegative had been taken only one
year prior to his diagnosis in May 1998. This suggests that David's CD4 cell count was rapidly descending and his viral load rapidly increasing from the point of seroconversion, which was somewhere in that one year time frame (when compared to the average numbers post-seroconversion outlined in the studies of HIV progression, which were in the 700 cells/mm\(^3\) range) (Bouscarat et al., 1999; Lyles et al., 2000; Giorgi and Detels, 1989).

It can be hypothesized from these studies that David was experiencing a rapidly declining immune responsiveness to the virus. However, David has since reversed this cycle — his immune system has shown signs of some recovery and stability. At the beginning of the study, David described himself as an anxious, nervous and easily stressed person who was prone to pessimism, and one of the major benefits that he gained from doing the process was the ability to self-modulate his anxiety and stress as well as his negativism. It could, therefore, be speculated that the affective changes that David made acted as buffers against immunologic deterioration, particularly when one considers the research linking coping styles to disease progression (Solomon et al., 1991; Ironson et al., 1994; Mulder et al., 1994b and c; Theorell et al., 1995; Kemeny et al., 1994).

Despite opinions like that of Kaschka (1997), who, drawing upon several studies, argues that HIV/AIDS is particularly resistant to therapeutic interventions, research on intervention processes and coping styles, particularly those done at the Biopsychosocial Centre for the Study of AIDS at the University of Miami, suggest that psychosocial intervention can provide a buffering effect against disease progression over time. This is particularly true when the behavioural impact of such intervention is considered. That is, positive behavioural changes can affect self-care, which in turn can help to slow down the progression of disease. In David's case, he maintained healthy regiments, such as taking immunoenhancing supplements and consuming a balanced diet.
The case for researching behavioral intervention processes is particularly compelling for HIV/AIDS research, considering that it is an immunological disease without a cure and that HIV/AIDS patients have increased their interest in alternative therapies (Crellin et al., 1997). To date, the only medical treatment is antiretroviral drug therapy, which comes with its own challenges. First of all, the efficacy of antiretroviral drugs is dependent upon taking the drugs. In the USA, compliance rates are below 50 per cent (Autran, 1999). Secondly, drug resistant mutants occur in some of the patients who are receiving anti-reverse transcriptase inhibitors, such as the nucleosides AZT, ddi, and ddc, or peptidic anti-protease inhibitors (Karn, 1995). For example, in Amsterdam, eight per cent of newly infected people have strains of the virus that are AZT-resistant and in San Francisco this is as high as 16 per cent to a variety of drug treatments (Autran, 1999). Drug toxicity is also very high. As a result, certain individuals are unable to cope with the drug regimen. Furthermore, it is costly, which makes it unavailable to those in lower socioeconomic positions, even in the West (Autran, 1999). Finally, although the drugs force the HIV away from the blood stream, the virus still hides in the CD4 cells (Balter, 1999).

Conclusion

Because I conducted a single case study of HIV and the SIP intervention, there are many questions still left unanswered about the potential physiological efficacy of the SIP, although its psychological benefits are evident to me. However, given that the methodology is symbolic processing via the imagination, I certainly do not and did not expect to provide any "answers" about the relationship between the mind and body, and thus, I can only propose ideas about meaning. I have created this philosophy of symbols, the SIP, so that it may be used for positive gain. My intent in designing this process is to provide a window opening towards achieving some forms of physiological and psychological betterment. It is my hope that something
beneficial can emerge from this investigation, and that it will spark greater interest in how intrinsic processing can help buffer the impact and progression of disease.
## Appendix A

<table>
<thead>
<tr>
<th>CD4+</th>
<th>B cells, epitogenic</th>
<th>Percentage</th>
<th>Absolute</th>
<th>%</th>
<th>Absolute</th>
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</thead>
<tbody>
<tr>
<td>74</td>
<td>T cells, epitogenic</td>
<td>1150</td>
<td>60-77</td>
<td>960-1800 /</td>
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<tr>
<td>21</td>
<td>T helper/inducer class II rest.</td>
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<td>535-1125 /</td>
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</tr>
<tr>
<td>51</td>
<td>T suppressor/cytotoxic class I rest.</td>
<td>750</td>
<td>300-810 /w</td>
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</table>

| CD4/CD8 Ratio | 0.41 | 0.8 - 2.8 XEL |

Low CD4 count may be related to HIV infection
### Current Results

<table>
<thead>
<tr>
<th>Date</th>
<th>Test</th>
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</tr>
</thead>
<tbody>
<tr>
<td>31-Oct-1998</td>
<td>Chiron 3.0 HIV RNA Assay</td>
<td>48,604, 4.69</td>
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<td>52,050, 4.72</td>
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<tr>
<td>7-Jul-1999</td>
<td>Chiron 3.0 HIV RNA Assay</td>
<td>55,012, 4.74</td>
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<tr>
<td>25-Nov-98</td>
<td>CHIRON 2.0</td>
<td>19,090, 4.28</td>
</tr>
</tbody>
</table>

**Patient Information:**
- **Date of Birth:** 11-Jun-1968
- **Sex:** M
- **Chart Number:** 7161/BDM
- **HIN:** 3010041685

**PLEASE NOTE:** One or more specimens from this patient may have been tested with either CHIRON 3.0 viral load assay. Please see attached brochure for details on this test.
### Current Results

<table>
<thead>
<tr>
<th>Specimen</th>
<th>Received</th>
<th>Test</th>
<th>HIV Viral Load</th>
<th>CD4 +T Cell Count</th>
<th>AR Therapy</th>
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</thead>
<tbody>
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<td>w002585</td>
<td>14-Apr-1998</td>
<td>Chiron 3.0 HIV RNA Assay</td>
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### Previous Results

<table>
<thead>
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<th>Test</th>
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<th>CD4 +T Cell Count</th>
<th>AR Therapy</th>
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<td>w003510</td>
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## Appendix D

**HIV Viral Load Testing Program**

**Public Health Laboratory Report**

<table>
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<tr>
<th>Test Results</th>
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**Previous Results**

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<th>Test Results</th>
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<th>Count</th>
<th>24</th>
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<th>72</th>
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<td>w0046831</td>
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</table>

**Tests Requested:** HIVVL3

**HD: M**
Appendix E

H1641  COLL: 1999/10/25  UNKNOWN REC: 1999/10/25 10:30

IMMUNOPHENOTYPING

<table>
<thead>
<tr>
<th>ORIGIN OF SAMPLE</th>
<th>PERIPHERAL BLOOD</th>
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</thead>
<tbody>
<tr>
<td>COMMENTS</td>
<td>REVIEWED BY DR. F. PINKERTON</td>
</tr>
<tr>
<td>ABSOLUTE CD4 COUNT</td>
<td>0.45 (0.40-1.42) X10^9/L</td>
</tr>
<tr>
<td>CD4/CD8 RATIO</td>
<td>H 1.30 (0.14-0.80) X10^9/L</td>
</tr>
<tr>
<td>CD4</td>
<td>L 0.4 (0.9-3.1)</td>
</tr>
<tr>
<td>CD8</td>
<td>78.0 (32.0-80.0)</td>
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<tr>
<td>CD3</td>
<td>L 19.0 (27.0-54.0)</td>
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<tr>
<td></td>
<td>H 56.0 (10.0-37.0)</td>
</tr>
</tbody>
</table>

Patient:
Date of Birth: 1966/06/11  Sex: M
HIN: 4919041865  FL
Chart Number: 7181/BDM
Sender Ref #: 7181
Tests Requested: VL3

As recorded on request

CD4+T Cell Count  AR Therapy
Cells/mm³  CD4 Date
450  1999/10/25  NIL

CLAB-4919041865
REFERENCES


Ader, R. (2000). The placebo effect: If it's all in your head, does that mean you only think you feel better? *Advances in Mind-Body Medicine, 16,* 7-11.


- 222 -


- 225 -


- 229 -


Sivic, T. (1998). Since we have both body and mind, we are all psychosomatic. Advances in Mind-Body Medicine, 14, 223-230.


