Full-Length Article

Guided Imagery and Music and the Visually Impaired. *Help me stay with the light!*

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Abstract

This study explores the possibility and the potential of using GIM as a therapeutic medium with a visually impaired population. Visually impaired populations can be considered in two broad categories. The congenitally blind, who are sightless from birth and the adventitiously blind, who have lost their sight at a later stage of their life. G.I.M, according to its founder Helen Bonny, is a model which involves listening to music in a relaxed state to elicit visual imagery as well as imagery for other sensory modalities and emotions. An image is an activated sensory memory, or a combination of many sensory memories that are evoked by the music. Given the fact that especially congenitally blind people, do not experience visual mental images, but experience life, mostly, via gustatory, olfactory, auditory and tactual sensory references, the presentation, will focus on how "visual" or "aesthetic" the GIM experience can be and the challenges, both the client and the therapist will face; the significance and the role of music, as an "external stimulus"; the construction of visual as well as spatial representation of the imagery; the adaptations (if needed), according to the special needs of the population, the major therapeutic issues to be addressed and the boundaries that they face. The possibility of the GIM experience offering visually impaired clients a new potential for external reality will be explored.

"One does not become enlightened by imaging figures of light, but by making the darkness conscious" Jung

Keywords: ***visual impairment, GIM, imagery***

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Introduction

The Bonny Method of Guided Imagery and Music, as defined by the Association for Music and Imagery (AMI), is a music-centered transformational therapy, which utilize specifically programmed classical music to stimulate and sustain a dynamic unfolding of inner experiences, in support of physical, psychological and spiritual wholeness [1]. It is a holistic process, where the music interacts with the mind to evoke memories, affects/emotions, feelings, fantasies, imagery for all senses (visual, auditory, tactile, kinesthetic, and olfactory), as well as, thoughts and physical sensations. [2,3,5]. The images within the GIM experience, in whatever form they take (in any of the senses, body sensations, kinesthetic or vascular) are manifestations of the inner emotional life, providing a bridge between internal and external feeling and thinking, the self and the collective unconscious [3]. Stern [4] believed that the unconscious of the client seems to learn to speak in the symbol language of the therapist. In GIM, images are spontaneously created by listening to selected classical music in an altered state of consciousness, facilitated and safe guarded by a trained guide [5]. Imagery varies from multilayered symbols to unprocessed sensory, bodily and affective memories [5].

Goldberg wrote that GIM as a music-centered psychotherapeutic approach has been used for the treatment of a variety of somatic and psychiatric conditions as well as for personal actualization on a deep psychological and existential level [6]. As a music therapist, I have been working for many years with different populations and age groups and specifically with the visually impaired. I have a personal (with a visually impaired family member) and professional experience of how powerful music can be for this population, providing them with a safe and creative space to be, to overcome the limitations of their pathology and explore, express, reveal and unfold their hidden musicality and selves. Currently, as a GIM trainee, and with the knowledge and experience of both the GIM method and the limitations of the specific population, I have come to wonder: Can it be possible that GIM is applied to the visually impaired; and if so, in what form? What can the GIM experience mean and bring into

PRODUCTION NOTES: Address correspondence to:

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their lives? These were a few of the questions, which led me to select this topic as a Final Project in the completion of my GIM training.

The research is divided in two parts; The "Secondary Qualitative Research" and the "Primary Qualitative Research. In the "Secondary Qualitative Research", available bibliography on relevant topics is viewed and in the "Primary Qualitative Research", we find an outline of the therapeutic work with five adult clients. Three congenitally blind and two dventitiously blind, at a circle of six essions each, as well as their affiliated Personal Interviews via questionnaires, which were relevant to the topic of the project. This article gives a brief overview of this research.

Insight on Visual Impairment and Visual Perception

The function of the eye is to collect visual information from the environment and transmit it to the brain where sensory stimuli is perceived and interpreted. Common causes of blindness are those that interfere with the reception and transmission of the sensory information. These can include genetics, prenatal infection, perinatal trauma, or accidents and injury following birth. Visual disorders occur in the protective, refractive, directive, or receptive structures of the eye. Protective structures are those that prevent injury to include the orbit or bony structure surrounding the eye itself, thee, orbital fat, eyelids and eyelashes, eyebrows and tears. Infections of these structures can lead to blindness. Refractive and receptive components of the eye receive, convert, and transmit visual signals to the brain. Degeneration of retina, cornea, and lens resulting from genetics, tumor, atrophy or trauma to these tissues often leads to loss of vision [7].

From a medical standpoint**,** visual impairment also known as vision impairment is a severe reduction in vision that cannot be corrected with standard glasses. Technically it encompasses all degrees of vision loss, including total blindness that affects the person's ability to perform the visual tasks of daily life [8]. Total blindness is the inability to tell light from dark, or the total inability to see. Eye disorders and visually impaired populations can be considered in two broad categories. The congenitally blind, who are sightless from birth and the adventitiously blind, who suffer a progressive and changing eye disorder and lost their sight at some later stage of their lives. Subcategories of the adventitiously blind would be the people who lost their vision at an early stage of their life, (until the 7^{th} year of age), or the ones who lost it later on in life.

The congenitally blind never had the visual perception of their environment, while the adventitiously blind had that perception for a few or more years of their life but both of them experience life, mostly, through the other senses, namely gustatory, olfactory, auditory and tactual sensory references. These other senses are the ones that will provide the brain with the necessary information from the environment. They are the intact sensory systems that carry the information to the brain. Brain on the other hand, due to its plasticity, has the ability to adapt and modify its own structural organization and functioning upon to a functional demand [9]. It has the ability of sensory substitution. The idea of sensory substitution was introduced in the 1960s by Paul Bach-y-Rita and it can be defined as the use of one human sense, to receive information normally received by another sense [10]. In an intact visual system, the optical image goes to the retina, where it is turned into electrical impulses in the optic nerve; the perceived image is recreated in the brain [9]. Because the brain is responsible for the final perception, sensory substitution is possible. Visually impaired people do not lose the capacity to see. Usually they lose the peripheral sensory system (the retina), but retain central visual mechanisms. The input from a sensory substitution system can reach many brain structures, including those related to the lost sensory modality [9]. Sensory substitution can occur across sensory systems, such as touch-to-sight or within a sensory system such as touch-to-touch. The most successful sensory substitution systems for the visually impaired are Braille, where information usually acquired visually, is instead, acquired through the fingertips and the long cane for blind mobility. Both systems share common factors like high reliability and appropriate transduction of one type of sensory information into another, but, each one of them is capable of transmitting to the brain only a limited range of environmental information [11] This cross modal plasticity may also explain the typically described tendency of blind people to show enhanced ability in the other senses.

At this point it will be essential to distinguish the meanings of sensing and perceiving. This will be of an importance as our search moves on. Do blind people see or perceive to see by putting together different sensory data? While sensations come in one modality –visual, auditory, tactile- perception due to sensory substitution is not only one modality but a result of cross-modal interactions. That is why we can say that while sensory substitution for vision induces visual-like perception in sighted subjects, it includes mainly auditory or tactile perception in blind individuals [12]. That is, blind people *perceive* to see through touch and audition through sensory substitution.

So how do the visually impaired *perceive* the world around them and consequently, how do they picture it? How do they imagine it? How do they picture the world they live into? Can it be visual imagery without visual perception? A lot of articles and researches have been published through the years [13-21], some of them even controversial [22-23] as well as books [24-25], focusing on the task of visual imagery and visual perception for the blind population. In which extent, visual experience, contributes to people's ability to represent objects or subjects? What were the differences in performance, between blind and sighted subjects? Quite few yet most interesting are the outcomes and results of these

researches that provide me with fruitful information that informed this project.

1. When asked to represent a human figure, congenitally blind children, did internalize a representation of the human body, but compared to that of sighted, it was impoverished and systematically distorted. This findings suggests that tactile-kinesthetic information cannot fully compensate for visual experience in the formation of an internalized representation of the human body [20].

2. After memorizing the locations of several figures on a board, subjects were asked to form an image of the board and mentally "scan" from one figure to another. Overall recall scores did not differ for blind and sighted Ss, but sighted, reported forming the images significantly faster than did the blind [14].

3. Researchers studying waking imagery in blind and sighted individuals have generally concluded that congenitally blind individuals' imagery has characteristics that are functionally equivalent in many ways to the characteristics of the visual imagery reported by sighted individuals. The images of totally congenitally blind individuals, however, lack the unique visual characteristics such as color and brightness and result in slight differences from the performance of sighted individuals on several imagery tasks [23,*p231*].

4. In another study, subjects were asked to name a common object which the imaged pattern resembled. It was found that the greater the proportion of life without sight, the less their pictorial scores, expressed as a proportion of total imagery score. This suggests that the natures of mental imagery slowly changes following the loss of sight [18].

5. Blind people sometimes do employ visual language, to describe walking experiences that clearly do not include "seeing" things. They talk about "watching TV"-"keeping an eye on things, "seeing what you mean", "taking a look at something"-"see you tomorrow", although these visual terms do not imply a visual component. These expressions are simply the most convenient phrases to communicate their experience. They use the term *visual* to describe imagery experiences that do not fit neatly into any other category of sensory experience. Blind people, who know for example that a star appears as a small spot in the night sky, may include stars in an image of a nighttime scene. Although the blind person's conception of a star may derive only from descriptions, he/she understands it as a visual phenomenon and labels it accordingly [23].

6. It is of a great importance to note that, congenitally blind people may be using the same imagery terminology as sighted people, but with different meaning. Landau and Gleitman have persuasively argued that in language learning, blind children, develop their own meanings that are consistent with both their sensory experience and with the concepts associated with the visual terminology. For example "look" to a congenitally blind person links thee concept "explore with the dominant modality for the blind individual used for apprehending object", with the modality of touch because touch happens to be the dominant modality for the blind individuals object perception [26,*p.1*].

7. Blinds' people imagery lacks information about perspective, a specifically visual-and not amodal- property [26,*p.10*].

Imagery, Dreams and GIM.

In GIM, the imagery experience is core to the clients' therapy [27]. In GIM experiences, the client is asked to allow the music "to take you where you need to go" - a suggestion that the ego be receptive to the areas which need to be explored [28]. The evoked imagery reflects aspects of the self and is used by the client, with the aid of the GIM-trained music therapist, to effectuate meaningful growth towards the aforementioned purpose [29]. Each of us has an inner script, with a scenario that is ready to unfold. When we allow it this script brings us closer to wholeness with each sense of the process. Dreams are a way in which we can participate in this story of our inner experience, but normally we do not consciously navigate the course of our dreams. GIM elicits an altered state of consciousness, not as deep as a sleep state, yet which does reveal our inner scripts. In this waking dream state, we can access the deep, inner reaches of the mind and at the same time, consciously navigate our own drama [30]. Dreams, seen as the "royal way to the unconscious" (Freud) in psychoanalysis are fairly easily related to GIM [6,*p.37*].

Similarities between the dream processes and GIM did not escape the attention of Helen Bonny herself, as well as GIM fellows after her. Helen Bonny believes that dreams are an outlet of emotions and feeling and that is why dreaming relates to GIM work. Holligan, as Iicheva [31] wrote, traces the similarities between dreaming and the GIM experience. Both dreams and GIM are experienced in the inner world, in an altered state of consciousness; both are accessing the psyche; both are presented most frequently in symbolic language; both are inviting us on a spiritual journey towards greater consciousness. Furthermore, both processes transcend the conscious/unconscious mind boundary; that is, they activate the transcending function of the psyche; both allow the conscious and unconscious parts of the psyche to meet and interact; both facilitate and sometimes are the only

possible venues for the confrontation with, working through and integration of repressed material. Bush briefly discussed the dream and GIM imagery in the therapeutic process in terms of the levels of consciousness that generated them and writes that dreams are subject to the deeper influences of the id and superego as well as ego and physical condition. He feels spiritual or soul influences are also reflected in both dreams and GIM. He finds that the difference between GIM imagery and dreams was the active involvement of the will [31].

Freud was very clear about the nature of dreams. A dream represents a wish as fulfilled. Every dream represents the fulfillment of a repressed wish, of desires that are repressed because of their painful character [32]. Our dream material, corresponds to the secret thoughts. As Wollheim wrote, the purpose of Freud's dream analysis was to uncover the patient's wish, which he felt was always hidden [27,*p.65*]. GIM is similar to Freud's dream interpretation in its emphasis on images as an expression of the unconscious. Like Freud, Helen Bonny felt that these images were a way for the psyche to communicate, and contained valuable information about the client's condition. However, Freud focused almost exclusively in verbal processing within his own interpretational system, whereas Bonny focused more on helping the client to understand the meaning of the image within the client's own framework. In fact, Freud was primarily concerned with the content implications of the images, whereas Bonny was at least as concerned with the lived experiences of the images. Freud felt that dreams were always about "wish fulfillment"- interpreting these according to his own analytic system, whereas Bonny uses a range of theories to understand the clients' experience. This was the fundamental difference of the two methods [27,*p.65*].

Jung regarded imagery as a creative process integral to the psyche, to be employed for attaining greater individual, interpersonal and spiritual integration. He stated that "the psyche consists essentially of images. It is a series of images in the truest sense, not an accidental juxtaposition or sequence but a structure that is throughout full of meaning and purpose" [27,*p.66*]. A dream is a psychic product [32]. The purest images of the psyche. GIM is similar to Jung's dream interpretation, in its value on the clients' imagery and imagery experiences. Both theories are interested in understanding all aspects of the human experience (psychological, physical, social, spiritual), along with experiences of the collective unconscious. They both valued the lived experience of the images, rather than verbal processing of the imagery alone.

A diverse range of imagery methods have been developed through the years. Freud's Free Association and Dream Analysis; Jung's Dream Analysis and Active Imagination; Leuner's Guided Affective Imagery; Grof's Holotropic Breathwork; Assagioli's Psychosynthesis; and more. They are clear similarities and differences between GIM and those other imagery methods [27,*p.63*]. The first and perhaps most important commonality of all, is that imagery experiences have layers of meaning. Imagery can be interpreted in a number of ways and from a number of different theoretical perspectives (e.g. Freudian or Jungian) [27,*p.79*], they have a specific meaning (e.g., Leuner and Assagioli) [27,*p.80*], or the same images can be understood in a variety of ways (e.g., Bonny, Grof) [27,*p.80*]. Second, imagery experiences allow access to both conscious and unconscious material and each of these methods place a different emphasis on the imagery experience within the therapeutic method. For Helen Bonny and GIM, the imagery experience was core. Third, each use techniques for moving in and out of the imagery experience, with focusing techniques, relaxation techniques, or combination of both. Forth, in each method the therapist take a role in relationship to the client, and the clients' imagery experience, by suggesting images to clients to work with, engaging in the imagery experience with the client and/or interpreting the clients' imagery. Finally, each method has embraced music in a different way, and this is perhaps the most important distinguishing feature of GIM in relation to the other methods [27,*p.80*].

Visually Impaired Individual's Experience of Imagery and Dreams.

The author, keeping in mind everything that was discussed before both about the visually impaired, their pathology and its limitations in the way they perceive the world, as well as the connection between dreams and imagery and the core role imagery holds for the GIM experience, came to the next topic of research. Do visually impaired dream? Do they actually experience dreams the way all sighted people do? What type of information can that give us as for how possible is it that they can experience GIM the way other sighted clients do? How "vivid" or "aesthetic" would that experience be?

Dreaming is an overwhelmingly visual experience for sighted people. Kerr suggests that the extremely visual nature of dreams may be why many people wonder if blind people even dream. This wonderment may explain why the presence or absence of visual imagery in the dreams of the blind has been of scientific interest since the early nineteenth century [33]. Many researches and surveys' have been performed on that matter some of them even controversial [22,23]. Most of them have shown that congenitally blind dreamers and those who become blind in infancy do not have visual imagery in their dreams, whereas those blinded in adolescence or young adulthood life often retain visual mental imagery in their walking life as well as in their dreams. Kirtley [34] concluded on the basis of his extensive appraisal that, individuals blinded before the age of about 5, report no visual imagery in dreams as adults, whereas those blinded after about the age of 7 are likely to retain visual imagery in dreaming. These studies have theoretical implications beyond the issue of blindness because they suggest that the mental imagery necessary for dreaming

develops between the ages of 4 and 7. Dream reports of congenitally blind individuals conclude that visual images in their dreams appear to them as they would in walking life. They can see things in dreams with no more clarity or detail than they could see in wakefulness, yet they know the details of the dream environment through the integration of information from other sensory systems [23].

On the other hand, according to Bertolo, [22,*p.183*] it has been established by several authors that congenitally blind, use the visual cortex to process different kinds of information, namely auditory, tactile, and somatosensitive during the encoding and transformation of haptic images. That means that auditory and tactile inputs can create virtual images in the brains of congenitally blind, which can be revealed in their dreams. That can also lead us to the fact that experience is considered to be essential both for visual imagery and visualization [22].

Although there is a general belief that visually impaired people dream as they live in waking life and represent situations to themselves and others in pretty much the same way, Wilkerson [35], cites a study performed by Kerr, on the notion that the narrative elaboration in dreams of the sighted and blind remains constant even though specific visual imagery may vary. The study showed that, in neither group did lack of visual imagery adversely affect the richness or narrative continuity of dreaming. Maybe rather than saying that visually impaired individuals have limited dream imagery, it would be a more useful and sophisticated position to say that imagery is inspired and carried by visual components, but is not particularly dependent upon visual elements. Rather, imagery is a cognitive conveyance, a way of seeing rather than of something seen [35].

Music as an "external stimulus" [29]

There exists a wide bibliography on the neurophysiological and neuropsychological affects of music on humans. It is currently widely accepted that music can be a strong multimodal stimulant of brain plasticity. Nevertheless, I will focus on the role of the music as an external stimulus [29,*p.3*], in the GIM and more specifically, in the GIM with the visually impaired population. More detailed research on the neurophysiological aspect of music with the visual impaired population might be compelling for a future research to undertake after and if the results of this research give enough evidence and ground to do so.

According to Helen Bonny [37], one of the characteristic of music which contributes to its therapeutic use, aside from the fact that it evokes emotional and physical responses and that it is a non-verbal means of communication, is that it stimulates symbolic representations for the listener and that fact can make it even more important to be applied to the visually impaired clients. She writes that carefully chosen music can enhance the flow of imagery and fantasy or renewal of memories, where clinical situations dictate these as the treatment of choice. The sensory stimulation of music can create synesthesias of other senses. Touch, taste, vision and smell are enhanced when music is deeply listened to, creating a basis for work with the sensorily handicapped [37,*p.120-121*]

When speaking of music in the GIM process, we refer to music listening in other than the usual mode. It is literally allowing oneself to step into, or to become one with the music. Kenny, refers to this mode as the "musical space" [38]. The music, because of its continuing presence in a nonintrusive manner and the containment provided by its structure, serves to keep the client absorbed and engaged in the presenting psychic material until some completion has been achieved; it serves as a compatible co-therapist in that it is always present and active; it provides a model of movement and change. The symbolic, ambiguous nature of music is always pointing toward something not quite clear. It leaves an opening for the client to create his own clarity and meaning. It can evoke the creative power of the imaginal world to access important memories and permit the client to view them from fresh perspectives [39].

For GIM, music is considered to be an external stimulus [29,*p.3*] and one that will affect the experience to some degree. But, in what way can it affect the GIM experience and the imagery for the visually impaired clients? Can it serve the re-collection of sensory memories of the blind, and help build a fulfilling imagery and experience?

In considering music as an external, auditory stimulus, we give to it an even more important role, when working with the visually impaired population and GIM. This important role of music for this specific population will be explored during the primary qualitative research.

This imaginal world, this imagery, is affected by the external, objective world. Is that the issue with the visually impaired population? The authors research indicates that blind clients are very sensitive to music and they all report having a very intimate and fulfilling relationship with music, using it in their everyday lives to relax and calm themselves and they all report having images at some time when listening to it alone.

The Therapeutic Work

Primary Qualitative Research focuses on the key observations and data from the ongoing therapeutic work with five articipants; Three congenitally blind and two adventitiously blind adults as well as their personal interview material on questionnaire relevant to the topic of the project. The following is a brief overview of the session process, including key components of a typical GIM session and resulting observations of work using GIM with visually impaired clients.

A typical GIM session consists of four main parts; The Pre-Talk, the Relaxation/induction, the Music Listening and the Post-Talk.

a) Pre-Talk

Pre-talk is the part of the GIM session where information is taken, issues of the here- and- now are addressed and the therapeutic goals are set. Since the beginning of therapy, it was clear that people with visual impairments needed more time to connect, in order to feel safe and to build trust with the therapist and with the procedure itself. They seemed to need more details on the procedure, especially on directions related to the main part of the session- the music listening and the travel. I tended to start up with short sessions with some of the clients and give them the time they needed until they felt ready to follow a full session.

A detailed interview with all the specific information on the educational background, social status and of course the pathology and its characteristics have been taken. Different pathologies can bring different elements, and bring forth unique deficiencies and a variety of individual needs into the therapy. At this point, it is of a major importance to know the "when and how" of the loss of vision. If the client is born blind or lost his/her vision at a certain point of his/her life; if he/she is color blind or not; if there exists the day/night sense.

b) Induction

After the pre-talk, comes the Relaxation/Induction part of the session. A guided relaxation that would take away any superficial tension the clients have in their bodies and put them in a receptive mode for the music to come [29,*p.11*].

During the induction with my visually impaired clients, it was essential to keep in mind all of the individual characteristics and limitations of their pathology and use them accordingly. Physically closing their eyes, for some of them was not an option. Focusing more on the body and be more directive and clear in order to help them relax and prepare for the music, using, or avoid using elements they cannot relate to or understand, proved to be essential.

c) Music Listening

Following the guided relaxation/induction, comes the main part of the session. The music listening, where the client, while in a relaxed state, engages in a reflective dialogue with the guide, aimed at facilitating a spontaneous unfolding of images, feelings, senses, thoughts or memories elicited by the music.

Once they gained trust with the therapist and to the procedure, visually impaired clients entered the GIM with enthusiasm. The truth is that all of them admitted during their interviews, having a very intimate relationship with music and the idea of using it in therapy was very challenging. After studying the bibliographic data and the personal information collected during the personal interviews, I was more that eager to explore and see the way the clients would cope with the experience. How "visual" or "aesthetic" their GIM experience would be. The following is a brief outline with the major themes that unfolded across the therapeutic work with the participants.

Visual Imagery: Surprisingly, all of the clients who participated in the research, did have visual imagery in their travels, and did not only travel the same way they experience their waking lives, which was only via their other senses, as expected. That was for some of them even shocking. The only difference that must be underlined was that the congenitally blind clients shared less detailed images, vivid but not detailed. It is well known that auditory skills are crucial for them in the development of spatial orientation, distance assessment, sound source identification and localization, obstacle detection and avoidance [36]. So, it was interesting to see how the participants focused and shared more information evolving their other sensations, (experiencing touching and smelling more), that accompanied their imagery, when the same time, adventitiously blind shared more details and more images. It felt as if they were trying to absorb as much as they could. That made them even more emotional and sensitive during therapy. What is important to say, is that, these same people, during their interviews and before the GIM sessions, have reported not having actual images during their dreams or not dreaming at all (the congenitally blind), having retained visual mental imagery in their dreams, (those blinded in adolescence or young adulthood) or having lost the ability to dream for many years, as they experience the tendency of the visual imagery to fade over time, due to the lack of constant visual reference (the ones blinded after the age of seven). The author can report a case of a client who lost her vision after the age of 20, admitting having lost the ability of dreaming, or visualizing at least for the last 10 years. The same client experienced a vivid travel and of course a very interesting and fulfilling session. We see that although during their interviews, the clients supported the bibliographic data, during the actual GIM experience, the results, gave another perspective, something that came as a total surprise mostly for the clients themselves.

Colors: Clients, who have experienced colors in their life, especially the ones who lost vision at a young age, experienced colors also during their travels, but limited to the amount of colors they had until the time they lost their vision and of course according to their ability to recall or identify the names of these colors. That is why most of them could recall the basic and common colors and not the more complicated and sophisticated ones. The same time, people who lost vision at a later stage of life, had rather vivid and even overwhelming experiences, as far as colors are concerned. I report a client saying during a session: "*It's amazing how many colors I see……..*", "*I want to cry….*" "*Thank you so much for that….*"or on the other hand for the clients who had never

experienced colors in their lives, having the freedom to be creative and make their own choices, was a very fulfilling experience…Another client said: *"I don't want people to tell me what color something is. That way I can imagine it the way I want. I don't want anybody to spoil it for me*".

Another very interesting point is the importance and the meaning of light. It appears to be a vital element in almost all of their travels. "Life giving", "energizing", "healing", "warming", "giving hope", "giving freedom" or "being freedom itself." Considering that most of them don't even experience day vs. night at the time of the research, this fact can provide an interesting and important perspective to the therapeutic process.

Terminology: As it has already been mentioned, visually impaired clients, "see,", "look", 'don't see", and so on during their walking life. They shared their travel experiences with the therapist, in the same way. They use the same imagery terminology as sighted people, but with different meaning sometimes. For example, colors take a different meaning and texture. I report a client mentioning during her travel that she had the "*white of the milk, not the white of the hospital wall*" (!!!!!!!!). So, it is more than clear how they combine collective information from other senses in order to form the world around them and that music can trigger these types of memories and bring them in the form of a collective imagery.

Life Experience: As mentioned before, it seemed to be of a great importance to always know and keep in mind the educational background and social status of the client. It was more than clear during our therapeutic work that there was a difference between the imagery of the educated/trained, social, outgoing clients than the more isolated and less social ones. The more input they have gained from the environment and the richer their experiences of life, the richer their imagery and travels appeared to be.

It was more that clear that most of them could "create" and "travel" to environments, they are familiar to, during their waking life. I report: "*I can only dream or visualize elements, places, objects, that I have walked, or touched*" (from a personal interview). "*It is impossible for me to create a picture in my head, no matter how well you can describe it for me*", or, "*I don't have the ability to fantasize. So, I cannot just create something up*". Two of the participants, appeared to be able to build up imagery using familiar places, familiar aspects of their "walked" environments and put them together to build a new one. That came as an interesting surprise to both of them and was discussed during the Post-talk.

Of course, once again we need to point out the power that music appears to have in bringing back and re-creating previous memories, memories coming from all sensory modalities.

Sense of Identity: The visually impaired, most of the times, seemed to experience the world as something big, which extended far away from them, and they would see themselves as something small, in relationship to the size. They tend to have issues with their body image. How they perceived it, how they felt about it or how others felt or saw it, in life and of course during their travels.

In general, it seemed that a travel for the visually impaired clients was "a way of seeing" rather than "something seen." It appeared to be their chance to experience something, for some of them, maybe for the first time, or re-experience a leaved or a "seen" experience for one more time.

d) Post – Talk

After the music-listening is finished, the client, with the help of the therapist, is back to the "here and now" and exploration and discussion on the inner meaning and interpretations of the images, senses, feelings that have occurred during the music listening takes place. A mandala or other forms of Art are used to represent the significant parts of the experience and to "externally concretize the client's internal images through a non-verbal medium"[31,*p.xix*].

Exploring our options and/or adaptations that could be done, as mandala or other forms of art were concerned, in order to represent the experience and focus on the most significant parts of the travel, appeared to be a major challenge in this research work with the visible impaired clients. The clients seemed to be very nervous and stressed at that part of the procedure. But, all of them, even though they had the choice of proceeding verbally, chose to take the risk and explore that part too.

Clay was one of the very first options, as it could elaborate the sense of touch into the process and bring them closer to something so familiar and safe; something more concrete and real; their own unique way to connect to the world in that sense. In an attempt to bring it as close as possible to a Mandala, I formed a circle clay plate, where the client had the chance to place parts of his/her image or impressions. The circle plate, and the concrete space it offered, helped them a lot, as it seemed to have eliminated the stress of "*what am I supposed to do now with that"* (the clay). The same time it gave the Mandala quality and it could be read as a painted Mandala. The client put all the impressions on the "plate" and verbally, gave the therapist information on the colors of the elements, which the therapist adds to the session log. (Fig.1).

Figure 1. Clay Mandala made by one of the participants.

Music Making**:** It seemed that making music, expressing and connecting in that way to the experience was indeed a beloved choice. Especially using their voices to a vocal improvisation appeared to be their first option after the clay Mandala. It seemed to be less challenging and less threatening than using an instrument, and that as a music therapist amazed me. They showed less stress using their voice than expected. It seemed that they had a more intimate and direct connection to their voice.

Mandala Painting**:** Even with clients who have lost their vision in an older age and they used to have the ability to draw, painting a Mandala, seemed to be a rather "painful" task to perform, and they chose not to. Using me to "paint" a Mandala for them was also an option. A client gave me the exact location of every element of her image, as well as colors and I did that for her. "*If I could paint, I would paint……..*" she said and I painted that for her.

At all times, the Mandala in any art form, seemed to bring even more light and detail to their travel, and they seemed to have enjoyed it a lot.

Therapeutic Issues

Visually impaired clients, no matter what their status or background, come to therapy with the same issues, with the same anxieties, the same difficulties, the same fears for the here and now, as sighted clients do. In addition to these, the pathology itself, being a congenitally or an adventitiously blind can also bring different issues of denial, anger, envy, the sense of isolation and loneliness, the fact of having limited options in life, issues of trust and of course the anxiety and fear for the future, into therapy. Most, if not all of them, have experienced a form of bulling in their lives and they share a need for acceptance, stability and safety. They share their need to overcome their strong defenses, build due to their lifelong difficulties, depending on their environment, as well as their need for change. During the music listening part of the session, no matter what the therapeutic goals and focus of therapy, overwhelming is their need to move, act and explore in their travels. They have a strong and powerful sense of survival and they appear to be resourceful and fighters.

The Role of the Therapist/Guide

More than obvious was their need for a significant other in their lives, in the role of a helper, a guide or a partner and was more that clear that the music and the therapist/guide played that role, most of the times.

It is really interesting that the word "Guide" is the expression visually impaired people use for the person responsible to show and help them around just like a "Guide" is the therapist in the GIM therapeutic process. It is true that, that made them all smile. "*I felt so safe that you were there to help me decide where to move, take the risk and explore my surroundings*"…… shared one of the clients after the end of the travel and during the post-talk. That can also mean that guiding a visually impaired client, can be a very challenging task for the therapist as it is important to provide a clear and sometimes more directive, as for the environment, guiding than other ways suggested or advised. Having a lifelong experience and training of how to guide my visually impaired sister, I found that to be very helpful when executing this task during guiding a visually impaired client.

Conclusion

This research, since the beginning, had an ultimate goal to fulfill; can GIM be a therapeutic tool for the visually impaired?

GIM appeared to be a striking and powerful experience for all the clients participating in the research, and for myself as well. They all realized the powerful and immediate impact music had on their bodies and even more. They came to realize that new experiences were offered to them; new ways of connecting to the world, and actually a new way of being a part of it.

"*Since I lost my vision, I feel like my life stopped. My development stopped. I feel limited, unable to learn more. I miss everything, I envy people and I have difficulties handling that. It felt so nice being able to "see" again, even that way. I didn't have any dreams for the last 10 years. I feel so much alive again. Music made me see all that. I know*." (C.S, age 40, lost her vision at age 20; she has no sense of day or night now).

"*I only dream when I am calm. I dream nice dreams. I bring back all these nice pictures of the past, all this beautiful sunsets, beaches. All these can keep me going, as my major fear, is not to lose this sense of day and night. Not to lose the light. Can you help me stay with that light?*" (T.D age 42, limited vision until the age of 19, since then, she only has a sense of day and night)

Visually impaired clients, do have dreams, and if we recall what Freud wrote on the nature of dreams, that "a dream is a (disguised) fulfillment of a (supposed or repressed) wish" (Freud, 1935, p. 608, cited in Wellheim, 1991, p. 66), then we can strongly suggest that GIM can give visually impaired

clients, this unique chance to travel, to fulfill their wish; their "dream" to "keep the light."

Roberta Wigle Justice and Roseann Kasayka in their article on GIM with medical patients [40] note that the basis for transpersonal work as seen in GIM is contained in Maslow's exploration of the phenomenon of Peak Experiences. He identified characteristics of what constitutes the highest happiness and fulfillment in one's self and in the people he studied. These characteristics include (among others) the loss of fear, anxiety, inhibition, defense and control. The positive after –effects of peak experiences have been identified as a) the removal of symptoms, b) shifts in the person's way of viewing him or herself from ill to healthy c) changes in the individual's view of the world or aspects of it, and e) feelings that life is worth living, in spite of its adversities and because of the meaningfulness of what has been experienced. That was exactly a part of what all participants reported after the GIM experience that were part of this study.

They share a common experience of being "normal" and not blind during their travels; without being needy, without pulling back. Being able to "be", without the need of touching, searching, hitting on things, of being scared, being hit or blocked; Even if not "normal" but blind, being able and strong to overcome such scrutiny of others or pathology, in order to move forward in life. It can help solve issues and work toward overcoming obstacles that often tend to stay in the way. This can provide the means of a peak experience.

Can it also be that the GIM experience can be as Lisa Summer wrote a "substitute for external reality"[29] for the visually impaired? The impact both the visual imagery and the GIM experience had for the visually impaired clients who participated to this research, providing a more vivid means of being in the "here and now" and the actual long term therapeutic value and meaning for their lives, can strongly support this point.

The research gives strong indications that GIM can offer unique opportunities for self exploration, and growth. It can offer peak experiences and be "the substitute for (an) external reality", in the way that clients have dreamed it to be. It can bring light and maybe color in the blind person's experience of darkness. It can bring hope and help one "stay with the light". Especially for the adventitiously blind clients, GIM can truly play an active role, as it provides the individual with a unique opportunity to integrate their previous sighted life with the ongoing blind experience. Provide opportunities to gain some distance from the trauma of the onset of blindness; help to integrate, in visual terms, experiences acquired since the onset of blindness; as well as reminisce about experiences involved in having been sighted [42].

As it has already been noted, this is an ongoing project. The results and data until now, can positively suggest that GIM can be definitively noted as a therapeutic medium for the visually impaired population. One of the major points that needs to be addressed through further research is the potential role of music to trigger imagery which may provide both client and therapist with an aesthetic and visual GIM experience, which can be especially potent for congenitally blind clients. It would be interesting to look into the reasoning and the neurophysiological aspects that follow this finding, in continued research.

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