THE EFFECTS OF THE INNER COUNSELOR PROCESS© ON ANXIETY AND DEPRESSION IN SENIORS

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Dissertation
submitted to the Faculty of
Holos University Graduate Seminary
in partial fulfillment of the requirements
for the degree of

DOCTOR OF THEOLOGY
The work reported in this thesis is original and carried out by me solely, except for the acknowledged direction and assistance gratefully received from colleagues and mentors.

Ann L. Osborne
ACKNOWLEDGEMENTS

Teilhard de Chardin once said:

Reach beyond your grasp.
Your goals should be grand enough
to get the best of you.

My quest to do just that led me to Holos University Graduate Seminary, and this dissertation is the culmination of that work. But when you “reach beyond your grasp,” you deeply appreciate the love and support of all those who have walked beside you, believed in you, cheered you on, lifted you up, made you laugh, and helped to sustain you. My thanks and gratitude goes to so many people.

I have had the joy of working with an incredible dissertation committee! Each of you brought your own distinct strengths and wisdom to bear on this project, and the final product shows those touches.

♦ To Ann Nunley, my committee chairperson and so much more, I offer an enormous amount of gratitude! You are a mentor, friend, teacher, and guide. Thank you for creating this wonderful Inner Counselor Process®, and for so generously allowing and trusting me to work with it in a research project. Thank you for opening your home and your heart so that others can learn this healing process in an environment of beauty, music, laughter and yes, even tears. And thanks also to Bob Nunley, who sees the immense potential of every human being, and helps them to see it, too!

♦ It was Karin Cremasco who first introduced me to Holos and the idea that it was possible to do a graduate degree in the field of healing. Experiencing the effectiveness and power of your work, Karin, and studying with you brought me to a watershed moment where it became impossible for me to ignore my yearnings to study at Holos! My life changed as a result, and for that, I am very grateful. Thanks for your support, your enthusiasm, and shining your light!

♦ The first person I met upon arrival at ORP was David Eichler, who made me feel very warmly welcomed! David, you are a true researcher who conveys to others that they, too, can be researchers. Your sense of humour, your attention to detail, your ability to make complex topics clear — and what’s more, fun!— are all ways that you have contributed to my life and learning. I admire your questioning mind, and your gentle spirit. In your class, I remembered how much I like to do research!

♦ Mei-fei Elrick is a Holos professor who lives nearby and whom I had never had the joy of meeting before entering Holos! Mei-fei, you live both the caring and academic aspects of life, as a Therapeutic Touch practitioner and a professor. Thank you for your gentle gifts of wisdom and discernment, challenging me to be the best writer and scholar I can be, and keeping me on the right course in academia!
While my committee was working with me academically, my family were there for me in a myriad of untold ways. It would be impossible to put my love for you on paper, so I trust that each of you knows that you are precious to me, and have your own place in my heart.

♦ Hal, my husband, my friend, and my love, you have supported me in so many ways in this journey through graduate school. You unfailingly picked up all the pieces of our family life that I had to let go of in order to do schoolwork; lovingly encouraged me to find time to relax, play and laugh; patiently allowed me the time and space required for study and writing; willingly volunteered as my first “guinea pig” for each new technique and modality I learned; and helped me to believe that it really was my turn to follow my dream. It will be fascinating to learn what life looks like from here!

♦ Laura, who is the other academic in the family: you rooted for me; taught me the basics of writing excellent papers, and patiently corrected me as I learned; showed me how to search databases online; and were the only other person I knew who got as excited as I did about choosing grad school courses. I hope that doing your PhD brings you as much joy as this ThD brought me!

♦ Beth, my marvellous research assistant: there are not many people in this world that I would trust to be such a significant part of this research, but you, I trusted completely. We were/are a wonderful team! Getting to spend many weeks with you was an unexpected bonus to this research. (Middle girls are special…) Thanks for your support, your love, and your enthusiasm!

♦ David, my scientist/philosopher, you never expressed doubt that I should pursue this degree, even when it challenged so many of your beliefs. We started university/graduate school together, and both learned so much along the way. I am grateful for your bear hugs, our drives to and from camp, and knowing that you love me.

♦ Simon, your timing in completing a degree in editing was perfect! I am so grateful for your dedication, skill and knowledge, and more than a few late nights, as you edited this dissertation! It was wonderful to be able to share this part of my graduate degree with you. You now know more about this research project than you may ever have wanted!

♦ Gillian, you have taught me more than you will ever know, just by being yourself. Thank you for your willingness to experience the things I was learning, for your generous spirit, and for your amazing culinary skills!

Holos is so much more than a university or even a graduate seminary. Holos is a community, and within that community are some truly wise and spiritual people.
Martina Steiger, who facilitated the first IC Process© I ever experienced, and has completed her studies to become Dean of Faculty at Holos. Martina, you have been present and available, and are a natural and gifted teacher. You accomplish more in less time than anyone I know! You understand striving for excellence, and I have appreciated your support, your knowledge, and your unique perspective!

Norm Shealy, who I first heard speak at a conference several years ago, and whose conference address nurtured the seedling of “what if?” that was growing within me. Your enthusiasm, wisdom, willingness to take a stand and to challenge the status quo is incredible. Your amazing memory for dates and events and dosages and study results boggles my mind! Thank you for being at the helm of Holos through the early years of its development, and for helping to create this place of spiritual learning.

One of the great joys of this journey through Holos has been studying with some incredible teachers. As well as those on my committee, I was given the gift of classes with Berney Williams, Norm Shealy, Patricia Norris, Bob Nunley, Bob Matusiak, Paul Thomlinson, Monika Eichler, Vera Borgmeyer, and Carolyn Faivre. Thank you! You offered me your unique perspectives, strengths, and wisdom, and I am a better student and person because of it!

Not only the faculty, but the students at Holos have enriched my life. Emails, conference calls, times together at residential courses, and personal contacts have brought us together across miles and countries and continents. I love the Town Hall Meetings in cyberspace with students and faculty from around the world! As we studied together, you taught me so much. For me, one of the most incredible aspects of Holos is the people I have been honoured to meet. Know that I am very grateful!

Nanci Avitable, statistician and psychologist, you were very patient with me as I worked diligently to understand the statistical aspects of this dissertation! Thanks for your statistical knowledge, your willingness to teach, and your clarity.

The decision to return to graduate school turns your life, and very often, your world, upside down. I have been blessed with wonderful people in my life, who have been there for me throughout this time:

Lynne Hillson, my friend, who believed that I could do this even when I doubted myself. You have shared this journey with me from the day I mailed my application to Holos! Thanks for your friendship, your willingness to be an “astral traveller” even when few others understood, and your uncanny ability to network on my behalf!

Deb Gould, with whom I have shared exploring the wonders of energetic healing, the raising of our children, as well as laughter and tears through many years. Thank you for your treatments when I needed them most and your patience with me when I was so unavailable due to schoolwork! As with all things, that will change!
♦ Evelyn MacKay, who first taught me about Therapeutic Touch and angels, and introduced me to energy healing in a grounded and honouring way. You asked the question that started me on the road to Holos, although I’m sure you don’t remember that! You are a wonderful spirit and energy, shining brightly in my life and the lives of so many in this area!

♦ Lori Wilson, whose courses gave me a firm and respectful grounding in “attending” — being with another human being, and getting myself out of the way. I use so many of the skills you teach in so many areas of my life. Thank you!

♦ Ada Garrison, who has been a gentle and spiritual guide for so many years. You helped me to know my strength and my wisdom, and championed my innate and insatiable desire to learn and grow. Thank you!

♦ Emmy Beauchamp, who has been a touchstone in my life. Emmy, our friendship, faith, and mutual support have meant so much to me! You traversed the path through graduate school to ordination before me, lighting the way, and enriching the lives of so many along that path.

♦ Tom Watson, who believed in me even when he didn’t thoroughly understand what it was that I was pursuing! Years ago, you gave me the opportunity to grow and shine – and the music we create together makes my heart sing!

♦ Lorraine Newton-Comar and Andy Comar, who, as friends and ministers, have fanned the flames of my belief that healing and spirituality can be an integral part of the United Church of Canada. Your enthusiasm and support for the Trinity Therapeutic Touch team have planted a seed that is already blossoming!

♦ My sisters, Mary and Heather, and their families. I give you credit for loving me and not “excommunicating me” from the family even when I was studying things that you did not understand. I think it is interesting that out of all the illness we experienced in our family as we grew up, each of us found a career in helping others!

♦ My gratitude goes out to all of the incredible seniors who participated in my study. I am thankful for your willingness to sign up for something very new to you, with someone whom many of you did not know very well or at all! I learned so very much more from you than just what I gathered for this study. You are an inspiring group, and I feel honoured to have spent this time with you.

♦ And, as always, there are so many others. I am very aware of the care and support of friends and church and community, all those people who have expressed their interest and offered their good wishes as I completed this degree. Know that I am grateful!
Daily I am reminded of the abundant blessings in my life. I do not earn them; they are mine only by grace. My task is to live so that those blessings can grow and be shared with others. The Divine presence infuses this world and my life with spirit, love, support, and wisdom. I am grateful, humbled, and honoured.
This study examined whether a guided self-awareness process called the *Inner Counselor Process*® (*IC Process®*) produced statistically significant reductions in depression and anxiety among seniors 65 years of age or older. The approach of the *IC Process®* is that our greatest asset for healing comes from the “healer within” each of us. This process provides a way for people to access this wisdom in order to address a range of concerns, from ordinary worries to major life issues. Eighty-five seniors were assigned to the experimental group (n = 43) that received two *IC Processes®* one week apart, or the waiting-list control group (n = 42) that received post-research processes, using quota sampling and random group allocation. The Geriatric Depression Scale (GDS), the Beck Anxiety Inventory® (BAI®), and anecdotal reports were used to measure the levels of anxiety and depression. A pretest-posttest waiting-list control group design was used. Five testing times occurred. Three pre-tests were completed at weekly intervals: two weeks, one week, and the day before the first *IC Process®*, and two post-tests were completed: the day after and two weeks after the second *IC Process®*. Results show no conclusive evidence of the impact of the *IC Process®* on depression, but a possible effect on anxiety. Anecdotal reports strongly suggest that changes did occur. Implications and future research recommendations are included.

Key Words: *Inner Counselor Process®*, seniors, anxiety, depression, inner wisdom, guided self-awareness, transpersonal psychology, higher self, late-life issues, spirituality, Geriatric Depression Scale (GDS), Beck Anxiety Inventory® (BAI®), Friedman test, Mann-Whitney U test.
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INTRODUCTION

Background of the Problem

We’ve put more effort into helping folks reach old age than into helping them enjoy it.

Frank A. Clark

Our society is being reshaped by a rising demographic tide. Seniors constitute a large portion of society; currently about 12.5% of Americans and Canadians are 65 years of age or older, and the senior population is the only demographic group expected to increase steadily for the next 45 years. At the crest of the aging of the baby boom generation (those born between 1946 and 1964), 20% of the population of the United States and 25% of the Canadian population will be 65 years old or older. The mental health of this growing portion of the population is vitally important.

United States Government Statistics paint a clearer picture of the anticipated population changes. They indicate that in the year 2000, 12.4% of the U.S. population was over 65 years of age; by 2010, that percentage will have risen to 13.0; and by 2020, fully 16.3% of the population of the United States will be over 65 years old, an increase of about one third from the year 2000. This translates into approximately 54,632,000 Americans over 65 years of age by 2020. The U.S. Census Bureau recently predicted that the 65-and-older population will grow at a rate 3.5 times greater than that of the general population. Moreover, the number of adults over the age of 85 will more than double in that time.
Canadian statistics reflect a similar story. Statistics Canada reports that in the year 2001, 12.7% of the population was 65 years of age and older. By 2011, they predict that number will rise to 14.5%; by 2021, an increase to 18.9%; and by 2026, they expect that 21.4% of Canadians will be over 65. The proportion of Canadian seniors is increasing more rapidly than all other age groups, and the fastest growth is occurring among the oldest Canadians. In 2001, there were twice as many Canadians over 85 than there were in 1981; by 2041, it is predicted that 4% of the overall Canadian population will be 85 or over.

The president of the American Psychological Association, Norman Abeles, discussed age and aging in a 1998 report:

Who is old? Specific chronological markers for old age are arbitrary. The definition of “older adult” varies, depending on different perspectives and purposes. For example, gerontologists traditionally focus on persons aged 60 years and older. The federal government uses age 65 as a marker for full Social Security and Medicare benefits. Researchers identify subgroups of “older adults” as “younger old” (ages 65-75), “older-old” (ages 75-85), and “oldest old” (ages 85+). Age ranges vary across studies. Subjectively, though, many older adults don’t label themselves as “old,” even at advanced ages…. Unfortunately, there are numerous negative stereotypes about older people. The reality is that most older people live independently and maintain close relationships with family and friends. Personality remains relatively stable throughout the lifespan.

Seniors can have a great deal to offer society, and can do so most effectively when they experience wellness in their own lives. Supporting seniors so that they can continue to be a vital part of society is important not only individually and socially, but economically as well. Currently, one third of American seniors work for pay, and one third work as volunteers in churches, hospitals, and other organizations; many provide much-needed assistance to family members, friends, and neighbours. It would take three
million paid caregivers, working full time, to provide that assistance to sick and disabled people! Of Canadian seniors, 23% participate in volunteer activities and contribute 44% more time as volunteers than do volunteers aged 25 to 44. The value of the unpaid assistance provided by Canadian seniors is quite substantial. In 1992, it was estimated that seniors contributed unpaid help worth $5.5 billion, or $1650 per senior. A 2005 study has shown that volunteering slows the increase in depression levels for seniors who do so. In effect, these volunteering seniors are helping themselves as well as others!

Is there a “normal” pattern of aging? The American Psychological Association identifies two types of “normal” aging: “optimal” or “healthy” aging of individuals who have no identified physical illnesses; and “typical” aging of individuals who have one or more medical conditions that become prevalent in later life. Those in the “optimal” or “healthy” category are rising — for the first time in history. Although estimates vary, the proportion of older adults needing personal assistance with everyday activities increases with age (e.g., 9% of those aged 65 to 69 and up to 50% of those aged 85 or older). After age 65, a greater proportion of women than men become disabled.

While studies indicate that many seniors experience wellness, there are some who do not. Among those who do not are the seniors living with anxiety and depression. Statistics indicate that a large number of seniors experience anxiety and depression. Between 10% and 15% of seniors living in the community show signs of clinical or subclinical depression, with the number rising to about 50% of those in retirement or seniors’ homes, according to the International Psychogeriatric Association. For purposes of comparison, depression rates in the general adult population are
approximately 8\%.^{16} Reports of prevalence of anxiety in seniors vary from 11.4%\(^{17}\) to 15%,\(^{18}\) as compared to about 6\% to 8\% in the general adult population.\(^{19}\)

Demographic projections indicate that, with the aging of the U.S. population, there will be an unprecedented increase in the burden of mental illness among aging persons, especially among the baby boomers. This growth in the proportion of older adults and the prevalence of mental illness are expected to have major direct and indirect impacts on general health service use and costs.\(^{20}\) A recent study examined the extent and cost of informal caregiving for older Americans with symptoms of depression. The results were staggering. In multivariate regression analyses that adjusted for sociodemographics, caregiver network, and co-existing chronic health conditions, it was determined that seniors with no depressive symptoms received an average of 2.9 hours per week of informal care, compared with 4.3 hours per week for those with one to three depressive symptoms, and 6.0 hours per week for those with four to eight symptoms. Caregiving associated with depressive symptoms in elderly Americans represents a yearly cost of about nine billion dollars!\(^{21}\) The U.S. Surgeon General has recognized disability due to late-life mental illness as a major public health concern for the 21\(^{st}\) century.\(^{22}\)

Depression appears to be a growing concern globally. The World Health Organization (WHO), in their Global Burden of Disease study, projects that depressive disorders alone will increase at least 50\% by 2020, and identifies depressive disorders as one of the most important targets for intervention in the 21\(^{st}\) century.\(^{23}\) The rapidly rising numbers of seniors, compounded with the rapidly rising incidence of depression, argue forcefully for immediate attention and intervention in this area. Dr. C. Norman Shealy
affirms the impact of mental and emotional wellness, and identifies the subtle and menacing dangers of negative emotions, including anxiety and depression: “Fear, anxiety, guilt, anger and depression are the major negative emotions [italics added]. Each of them evokes a stress reaction, more difficult to evaluate than the effects of nicotine, caffeine or alcohol, and ultimately more insidiously pervasive.”

The three most common ways to treat anxiety and depression in seniors are with the use of prescription medications, psychotherapy, and electroconvulsive therapy. All three have had some success in treating seniors for anxiety and depression, and all have limitations, as well. These will be explored further in the Literature Review (Chapter 2).

In the general population, however, prescription medication is often the first approach to managing anxiety and depression. There are difficulties with this approach when dealing with seniors. Some physicians are reluctant to prescribe medication, and the selection of medications is more complex because of the risk of interactions with medications for concomitant somatic disorders. The risk of adverse effects is greater in the elderly compared with younger adults, and any side effects that do occur may be less well tolerated.

Research indicates that non-medical treatments may be safer for many older adults and the elderly. Indeed, the Merck Manual of Diagnosis and Therapy asserts, “Safe, effective pharmacotherapy remains one of the greatest challenges in clinical geriatrics.” Geriatric psychiatrist Dan Blazer echoes this when he states that the time has come to emphasize health-related quality of life and a comprehensive, interdisciplinary approach to the assessment and management of psychiatric disorders in the aged.
Advocates for older adults, including Nobel laureate Elie Wiesel, feel that older adults, as the guardians of the world’s vital memories, should be appreciated and respected — yet they are often neglected. Attention to the mental health and well-being of seniors (defined in this study as being those 65 years of age or older) could represent a benefit not only to many valued individual seniors, but also to society as a whole.

Statement of the Problem

Anxiety and depression levels in the senior population have been shown to be high, and the documented consequences of these illnesses are severe — to individuals, their families, their caregivers, and to society as a whole. There are considerable difficulties associated with the use of pharmacological treatments for anxiety and depression with the senior population. The identification and testing of non-pharmacological ways to support seniors, reduce their anxiety and depression, and contribute to their overall sense of peace of mind and well-being is essential.

Purpose of the Study

The purpose of this study is to explore the effects of the Inner Counselor on anxiety and depression in seniors. This study investigates a previously untested intervention — the Inner Counselor Process© — for use as a way to decrease levels of anxiety and depression in seniors (see note following). The Inner Counselor is a low-cost, non-pharmacological intervention that does not involve a long time commitment or
a complicated apparatus. If it can be shown to be helpful in decreasing anxiety and depression, it can offer a valuable option with benefits for individuals and society.

Note: This study is an initial study using the Inner Counselor Process© (IC Process©) as the sole intervention. The Inner Counselor Seminar© has been tested by Ann Nunley, PhD. Although the setting differed from the current study because the experience was offered as a workshop rather than as a one-on-one experience, significant aspects were similar to those used in this study, in that the workshop included both an introduction to the conceptual material of the Inner Counselor and several opportunities to experience an IC Process©. Her study showed decreases in both the State and Trait anxiety levels, as measured by the State Trait Anxiety Inventory© (STAI©), although the decreases in Trait anxiety were greater.

The IC Process© has also been used as a portion of two other research projects. Martina Steiger used the IC Process© as one of several modalities in her doctoral dissertation research using Getting Unstressed™ (GUSTM)35, a wholistic, multi-modal programme for adolescent well-being. Barbara Birsinger used the IC Process© as part of a research study for her doctoral dissertation regarding weight management. In both of these cases, the intervention involved several other modalities as well as the IC Process©. This study represents the first time this process has been studied as a one-on-one experience offered by the principal investigator, with participants experiencing the IC Process© as the focus of the intervention.
Research Questions

Does the intervention, the Inner Counselor Process© (IC Process©), reduce anxiety and depression among seniors?

Hypotheses

**H1**: Participation in two IC Processes© will result in significant reductions in anxiety in seniors.

**H2**: Participation in two IC Processes© will result in significant reductions in depression in seniors.

The null hypothesis is that there will be no change in the anxiety and depression levels of seniors after they experience two IC Processes© compared to their pre-intervention levels, and that there will be no difference between the levels of anxiety and depression of seniors who experience two IC Processes© and seniors who do not experience those processes.

Definition of Terms

Definitions of terms used in this dissertation can be found in Appendix A.1.
Limitations and Delimitations

Limitations

The lack of self-report tests for anxiety and depression that have normative data for seniors is a limitation for this study. As recently as this year (2006), research is still indicating that “one important limitation is the lack of a widely accepted instrument to measure dimensional anxiety in both normal older people and older people with mental health problems seen in various settings.” The same is true of depression.

The sample in this study was limited to older adults who were primarily recruited from the community. It is possible that the underlying structures of late-life anxiety and depression may differ for seniors who are active and out in the community compared to those who are less active. As a result, the results cannot be generalized to an entire age group of seniors.

The measurement instruments in this study were self-report instruments. This was a necessity due to the number of times that the tests were completed (5) and the number of participants; it would not have been feasible for the principal investigator to personally administer all the tests. However, there is speculation that individuals often respond to self-report measures in a socially desirable way, which may have been a factor in the study. This could have affected test results by indicating lower levels of anxiety and depression.

This study had limited randomization. The study population was a volunteer sample, and participants were assigned to groups in a random fashion after the quota sampling requirements were met. This limits the generalization to other groups of seniors.
Delimitations

This study was limited to seniors 65 to 85 years of age, inclusive. Studies indicate that there are unique risk factors contributing to depression in the “oldest old” (those 85 years of age or older). Including both age groups could make any outcomes in either group more difficult to detect, as those test items that would identify depression in one age group, would not in the other.

The study design of the experience of two IC Processes© means that any results are not generalizable to seniors who experience only one IC Process©.

The decision was made to have only one facilitator conduct all the processes. This introduces the possibility that the results of the study are due to the ability (or lack thereof) of the facilitator. With neither a sufficient pool of expert facilitators from which to draw nor the possibility of paying such facilitators for their time, this study was conducted with only the principal investigator acting as facilitator.
REVIEW OF THE LITERATURE

Introduction

In this review of the literature, several areas related to the research topic are investigated. In order to clearly understand the dependent variables, definitions of depression and anxiety are given and the particular manifestations of these illnesses in the senior population are discussed. Conventional treatments for depression and anxiety are presented, and then complementary treatments and therapies used to deal with those same illnesses are explored. Because the Inner Counselor Process© (IC Process©) has not been used as the sole intervention in other studies to date, there are no related research projects to examine. (For clarification regarding the distinction between the terms “the Inner Counselor” and “the Inner Counselor Process©”, please refer to the Definition of Terms, Appendix A.1.) In lieu, a clear understanding of the concepts, aspects, and basis of the IC Process© will be offered, including the Integration Chart©; the High Self; thoughtforms; symbols, imagery and visualization; and the healing potential of this process. An exploration of seniors and spirituality will place the IC Process© in the context of other spiritual approaches to addressing anxiety and depression.
Depression and Anxiety: Definitions

Depression

There are several definitions and types of depression. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revised (DSM-IV-TR) of the American Psychiatric Association defines “major depression” as a period of at least two weeks during which the individual experiences either depressed mood or loss of interest or pleasure in nearly all activities. The DSM-IV-TR lists other symptoms, of which at least four must be present for a diagnosis of depression. These include: changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; and recurrent thoughts of death or suicidal ideation, plans, or attempts. More subtle symptoms of major depression are listed as well.

A second category of depression identified in the DSM-IV-TR is called Dysthymic Disorder. The essential feature of this category is a chronically depressed mood that occurs for most of the day more days than not for at least two years. During periods of depressed mood, at least two of the following additional symptoms are present: poor appetite or overeating; insomnia or hypersomnia; low energy or fatigue; low self-esteem; poor concentration or difficulty making decisions; and feelings of hopelessness. Again, other subtle symptoms are listed in the DSM-IV-TR. The Surgeon General of the United States identifies this as “minor depression,” a subsyndromal form of depression.
Anxiety

Anxiety is defined as an unpleasant emotional and physical state of overwhelming apprehension and fear. The DSM-IV-TR states that the essential feature of Generalized Anxiety Disorder is excessive anxiety and worry (apprehension, expectation) about a number of events or activities, occurring more days than not for a period of at least six months. The individual finds it difficult to control these feelings. Along with anxiety and worry, the individual shows three of the following symptoms: restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and disturbed sleep. The symptoms are not due to side effects of a substance or a general medical condition. The intensity, duration, or frequency of the anxiety and worry is far out of proportion to the actual likelihood or impact of the feared events.

In general, symptoms of anxiety disorders include intense and prolonged feelings of fear and distress that are out of proportion to the actual threat or danger, and that interfere with daily functioning. Anxiety disorders are categorized as Generalized Anxiety Disorder (GAD), Obsessive-Compulsive Disorder (OCD), Panic Disorder, Post-Traumatic Stress Disorder (PTSD), Social Anxiety Disorder (or Social Phobia) and Specific Phobias. Each category has its own distinctive features, but they are all bound together by the common theme of excessive, irrational fear and dread.
Depression and Anxiety in Seniors

Seniors and Depression

The National Institute of Mental Health (NIMH) indicates that while depression is very common among seniors, it is not a normal part of aging.\(^47\) The International Psychogeriatric Association estimates that between 10% and 15% of seniors living in the community show signs of clinical or subclinical depression; that proportion increases to about 50% for those who live in retirement or seniors’ homes.\(^48\) It seems that depressive illnesses are common, but only one third of affected senior patients seek medical help.\(^49\) This can occur for several reasons: seniors may feel shame admitting depression, attribute their depressive symptoms to “normal aging,” feel unwilling to report their depressive symptoms to their caregivers, or place more emphasis on their physical symptoms so that their doctors miss the underlying depression.\(^50\) Of depressed seniors who do consult a physician, up to 60% are misdiagnosed or incorrectly treated, or receive inadequate pharmacological care.\(^51\)

When depression does occur in later life, it is associated with significant functional decline, family stress, greater risk of medical illness, less complete recovery from illness in general, and premature death from suicide or other causes.\(^52\) One recent study suggests that depression affects elderly people’s lives more than physical illness, and concludes that treatment for depression can lead to more dramatic improvements in functional status, disability, and quality of life than interventions for other chronic illnesses in this age group.\(^53\) On a positive note, depression is “the most treatable of the mental disorders of late life.”\(^54\)
The course of depression among the elderly is not well understood, according to the Clinical Practice Guideline for the Detection, Diagnosis, and Treatment of Depression in Primary Care.\textsuperscript{55} Depression in older adults may present as somatic and behavioural manifestations rather than depressed mood. Depressed individuals often develop low self-esteem and exhibit negative interpretations of everyday perceptions.\textsuperscript{56} Clinical and epidemiologic studies using symptoms scales (such as the Geriatric Depression Scale or the Zung Self-Rating Depression Scale) show that the prevalence of depression increases with age; however, epidemiologic studies using the standard criteria (DSM-IV-TR) show a decrease in prevalence of depression with age.\textsuperscript{57} A possible explanation for this is that elderly people may feel more comfortable admitting to physical symptoms, viewing this as less embarrassing than admitting to the standard criteria, which they may perceive as indicating that they are weak or “crazy,” and hence may be ashamed to discuss.\textsuperscript{58}

Depressed seniors are more likely than depressed younger persons to present with decreased attention span, irritability, lack of motivation and concentration, weight loss, headaches, fatigue, gastrointestinal symptoms, pain, and multiple vague somatic complaints. Depressed seniors, however, are less likely to exhibit the sadness associated with depression in younger people.\textsuperscript{59} Thus, the presentation of depression may be quite different in older adults than in younger persons.\textsuperscript{60} As a result, both doctors and the general public heavily under-recognize depression and depressive symptoms.\textsuperscript{61} Often, people do not seek treatment because they feel that they can handle their depression themselves, do not consider it serious, or do not recognize it as an illness for which treatment is available.\textsuperscript{62} It is also common for isolated, depressed older patients to put
their best faces forward when given the opportunity for positive social encounters with their doctors. As a result, they may not appear depressed during office visits. Other clinical clues for the identification of depression include unexplained somatic complaints, hopelessness, worries, loss of feeling (anhedonia), slowed movements, and lack of interest in personal care. Feelings of hopelessness in particular have been linked strongly with depression in seniors, and seem to increase with age; they have also been shown to indicate tendencies toward suicidal thoughts and suicide.

Older persons may not exhibit the typical symptoms of depression, such as sadness. In fact, some investigators have suggested a syndrome of “depression without sadness” thought to be more common in older adults. A 13-year study of 1650 adults revealed that older adults are less likely to report sadness than younger persons; they may use such terms as feeling “bad,” “lousy,” “crummy,” or “blah,” rather than feeling “sad,” “blue,” or “depressed.” The study authors believe that their results suggest (but do not conclusively prove) that the observed age difference in reporting depression does not reflect a cohort effect. This reinforces the belief that older adults are likely to suffer less typical forms of depression and therefore are less likely to be correctly diagnosed and treated, placing the elderly at greater risk for adverse outcomes.

Risk factors for depression in elderly persons include a history of depression, chronic medical illness, brain disease, alcohol abuse, use of certain medications, female gender, single or divorced marital status, death of a partner, and stressful life events. Unlike younger persons with depression, elderly persons with depression usually have a medical comorbidity; this is particularly true for the “oldest old,” who in this case are
defined as being 80 years old or older. Minor depression, which is more common than major depression in elderly patients, may follow a major depressive episode. The most serious consequence of depression in later life, especially untreated or inadequately treated depression, is increased mortality from suicide or somatic illness. Older persons (65 years and above) have the highest suicide rates of any demographic group, and since national statistics do not often account for more veiled forms of suicide (such as nursing home residents who stop eating), estimates are likely to be conservative. One study found that among suicides 75 years of age or older, 60% to 75% had diagnosable depression. A 1997 study reported that 40% of depressed elderly patients who committed suicide had visited a primary care physician within a week of their deaths. Depression can also lead to increased mortality from other diseases, such as heart disease and cancer. In nursing home residents, major depression increases the likelihood of mortality by 59%, independent of physical health measures. Depression elevates the incidence of myocardial infarction five times. Research has also shown that chronic depression, lasting an average of about four years, raises the risk of cancer by 88% in older people. These statistics give clear evidence that greater understanding of and appropriate treatment for depression in seniors may be, without exaggeration, a matter of life and death.

The literature from about 2000 onward shows a greatly increased level of interest and research in the area of seniors and depression. An encouraging illustration of this is the Fall 2005 issue of the journal Clinical Psychology: Science and Practice (Volume 12, number 3), dedicated entirely to the topic of seniors and depression. The stated purpose of that issue is to “inspire and empower more individuals to work with older adults and
address the challenges presented by those who may suffer from complex medical and psychological comorbidities…. Much has been accomplished … yet there is still much work to be done.”

**Seniors and Anxiety**

Anxiety is one of the most common psychiatric symptoms in older adults, yet it has been studied less than depression or dementia. Anxiety disorders affect approximately 19 million American adults, and reports of their prevalence in seniors vary from 11.4% to 15%. Canadian seniors had the highest rate of all demographic categories for hospitalization for anxiety disorders. GAD is identified as the most common of the pervasive anxiety disorders among older adults, with lifetime prevalence estimates of 6%.

Until recently, anxiety disorders were believed to decline with age. Now, experts are beginning to recognize that aging and anxiety are not mutually exclusive: anxiety is as common in the old as it is in the young, although, as mentioned above, how and when it appears is distinctly different in older adults. Although clinically diagnosable anxiety disorders are not always present, anxiety symptoms affect a substantial number of older adults. In fact, anxiety symptoms that do not fulfill the criteria for specific syndromes are reported in up to 17% of older men and 21% of older women. Some explanations for this lack of identification of anxiety in the elderly include their lack of participation in community surveys, their unwillingness to report anxiety problems, migration of the elderly to rural areas, institutionalization (e.g., nursing homes), mortality, misattribution of symptoms to physical illness, and cohort effects.
The complexity and fluidity of the anxiety response and its relationship to the internal and external environment tend to create difficulties for medical models of assessment. One such difficulty is the use of hierarchies of disorders in the diagnosis of anxiety. If the existence of disorders higher in the hierarchy, such as depression, precludes diagnosing anxiety disorders, the resulting prevalence rates for anxiety will appear much lower. Women report and are diagnosed with some anxiety disorders more frequently than men; however, this may reflect the differences between men and women in their health service–seeking behaviours, rather than true differences in prevalence. What “brings out” the anxiety in older adults are the stresses and vulnerabilities unique to the aging process: chronic physical problems, cognitive impairment, and significant emotional losses. Separating a medical condition from physical symptoms of anxiety can often be more complicated in seniors.

Risk factors for anxiety in the older adult include being female, having less formal education, chronic physical problems, cognitive impairment, and emotional stress. Some factors affecting anxiety in younger persons, such as family and personal history of mood and anxiety disorders, appear to play only a nominal role in seniors’ anxiety risks. Another possible contributing factor to anxiety in seniors could be the use of medications that cause symptoms of anxiety. Many medications can cause anxiety or make pre-existing conditions worse, such as high blood pressure medications, steroids, respiratory medications, and some antidepressants, among others. Like depression, anxiety in seniors is still somewhat lacking in clarity for health professionals. A National Institute of Mental Health (NIMH) workshop that focused on anxiety in older persons concluded that the topic has not been well studied and is not well understood.
The treatment outcome literature regarding anxious older adults is considered to be at an early stage, with randomized, controlled trials largely absent for both pharmacologic and psychosocial treatments. An increase in studies and reports regarding anxiety and seniors has been observed since about 2000, although the increase is not as great as that for depression and seniors.

**Comorbidity of Depression and Anxiety in Seniors**

It is well known that depression often accompanies anxiety disorders. Nevertheless, anxiety and depression are two distinct entities, though they are highly correlated. Anxiety symptoms in older patients frequently coexist with depression, medical illness, and dementia. In the Longitudinal Aging Study Amsterdam (LASA), 47.5% of those with major depressive disorder met criteria for an anxiety disorder as well, and 26.1% of those with anxiety disorders also met criteria for major depressive disorder. Another study has suggested that up to 70% of those with GAD also have major depression. Even more alarming are the findings of yet another study: that of the patients with a depressive disorder, approximately 75% also have significant symptoms of anxiety, and that comorbid anxiety is particularly common among elderly patients.

Controversy has existed as to whether anxiety symptoms in depressed elderly persons represent a separate anxiety diagnosis or are merely an element of the depression diagnosis. A 2005 study showed that GAD was indeed able to be distinguished from major depressive disorder in elderly patients.
Senior patients with anxiety and depression may focus on somatic complaints, leading to misdiagnosis of medical conditions. Many physical conditions can mimic, exacerbate, antedate, or accompany symptoms of anxiety, such as cardiovascular disease, cerebrovascular accidents, hyperthyroidism, sensory impairments, and dementia. Alternatively, symptoms of a medical condition may be misinterpreted as anxiety; for example, symptoms of panic overlap considerably with those of angina or chronic obstructive pulmonary disease.

Flint and Rifat studied the effectiveness of treatments in elderly persons experiencing both anxiety and depression, and concluded that these people were less responsive to treatment and more likely to discontinue treatment. For these reasons, they suggest that concurrent symptoms of anxiety have prognostic importance in geriatric depression.

An illuminating factor in the mental health care of the elderly is that they may feel they have lived a sufficiently long time, and thus be less interested in disease prevention or in prolonging their lives. At the same time, they are more invested in their emotional health and well-being — they want to enjoy whatever time they have left! This reinforces the value of reducing anxiety and depression in seniors with the aim of increasing levels of emotional health and well-being.

Although depression and anxiety are closely associated, they have distinct causes and consequences. Hence experiments studying both variables will be more valuable than those studying one or the other in isolation.
Conventional Treatments of Depression and Anxiety in Seniors

Mood disorders are treatable. Many people with a mood disorder fail to seek treatment, often because of stigma, lack of knowledge, lack of human resources, or inaccessibility of services. Conventional treatment generally falls into one of three categories — pharmacotherapy, psychotherapy, electroconvulsive therapy — or a combination of these three.

Pharmacotherapy

Prescription medication is often the first approach to treating depression and anxiety; it is what many family doctors are aware of and trained to use. The Food and Drug Administration (FDA) has approved many medications to treat depression and anxiety, and these are divided into various classes, each one having a distinct chemical structure that acts on different chemicals in the brain. According to the World Health Organization, there are basically three classes of psychotropic drugs that target specific symptoms of mental disorders: antipsychotics for psychotic symptoms; antidepressants for depression; anti-epileptics for epilepsy, and anxiolytics or tranquillizers for anxiety…. It is important to remember that these medicinal drugs address the symptoms of diseases, not the diseases themselves or their causes. The drugs are therefore not meant to cure the diseases, but rather to reduce or control their symptoms or to prevent relapse.

There is some evidence that older patients, even the very old, respond to antidepressant medication. About 60% to 80% of older patients respond to treatment, compared to the placebo rate of 30% to 40%. Whereas some medications appear to be clearly beneficial (e.g., venlafaxine for GAD) or potentially effective (e.g., nefazodone
for PTSD), others seem less promising (e.g., abercarnil for GAD) or not effective (e.g., CI-998 for Panic Disorder). Treatment responses can take an average of four to six weeks, and often it cannot be determined if the drug is, in fact, working before that time. The recurrence risks after the first three episodes of major depression, treated pharmacologically, are 50%, 70%, and 90% respectively. Some physicians are reluctant to prescribe medication to seniors, and the selection of medication for them is more complex, because of the danger of interaction with medications prescribed for concomitant somatic disorders.

Compared with younger adults, seniors face an increased risk of adverse side effects to medications, and any side effects that do occur may be less well tolerated by them. While side effects from medication can be merely annoying to younger adults, they can lead to severe problems in older adults: constipation can lead to bowel impaction requiring medical attention, for example, and dry mouth can prevent the wearing of dentures, thus affecting seniors’ ability to get proper nutrition. Dan Benor, a holistic psychiatrist who has done considerable research on alternative therapies in health and medicine, states:

Many people think that because antidepressant medications are readily available we can deal effectively with depressive disorders. This is far from the truth. Numbers of people cannot find an effective antidepressant. Others suffer from unpleasant, sometimes severe side effects. They are faced with the horrible choice of living with a markedly diminished quality of life because of such problems as dizziness, drowsiness, blurred vision, diminished sexual drive, and constipation — or discontinuing medication and suffering from the depression.

The efficacy of antidepressants has been examined mostly through clinical trials with the general population, but the effectiveness of these medications in reducing depressive symptoms among older adults specifically has not been solidly verified. As
one researcher states, “Effectiveness studies are critical lest we falsely equate use of medications with adequate treatment of depressed elders.”

The most common drugs prescribed for anxiety in the elderly are antidepressants and benzodiazepines, which are prescribed based on their suitability and, for a patient who is taking other drugs, on the likelihood of drug interactions. Buspirone, an alternative to antidepressants and benzodiazepines with fewer adverse effects, is also effective. Patients are less likely to become dependent on buspirone than on benzodiazepines and, perhaps because of the sedative effect, buspirone may be tolerated by elderly people who cannot tolerate benzodiazepines. However, buspirone does not affect subjective improvement as quickly as the benzodiazepines do; its anxiolytic effect usually occurs after two to four weeks of continuous therapy. People who have responded to benzodiazepines in the past often do not respond to buspirone. In general, elderly patients respond satisfactorily but not exceptionally to antianxiety drugs. Most patients experience relief, but not elimination, of tension and agitation, and many symptoms persist.

Although use of drugs is sometimes indicated for quick or short-term relief of anxiety, research indicates that non-medical treatments may be safer for many older adults and the elderly. The Merck Manual of Diagnosis and Therapy asserts, “Safe, effective pharmacotherapy remains one of the greatest challenges in clinical geriatrics.” It goes on to stress that “aging alters pharmacodynamics and pharmacokinetics, affecting the choice, dose, and frequency of many drugs. In addition, pharmacotherapy may be complicated by an elderly patient’s inability to purchase or obtain drugs or to comply with drug regimens.” Indeed, the suggestion has been made
that from 1970 to 2000, as psychiatry moved toward a medical model and emphasized pharmacological therapies, it thereby moved away from the mainstream of geriatric practice, and that the time has come to emphasize health-related quality of life and a comprehensive, interdisciplinary approach to the assessment and management of psychiatric disorders in the aged.\textsuperscript{128}

**Psychotherapy**

The World Health Organization defines psychotherapy in this way:

Psychotherapy refers to planned and structured interventions aimed at influencing behavior, mood and emotional patterns of reaction to different stimuli through verbal and non-verbal psychological means. Psychotherapy does not comprise the use of any biochemical or biological means. Several techniques and approaches derived from different theoretical foundations have shown their effectiveness in relation to various mental and behavioural disorders. Among these are behavior therapy, cognitive therapy, interpersonal therapy, relaxation techniques, and supportive therapy (counselling) techniques.\textsuperscript{129}

Psychologic therapies are recommended for elderly patients with depression because of this group’s high rates of medical problems and medication use and their vulnerability to adverse effects.\textsuperscript{130} The effectiveness of psychotherapy used to treat depression in late life ranges from 50\% to 86\%, whereas effectiveness for medication ranges from 50\% to 60\%.\textsuperscript{131} Stressful life events, family conflicts, and the reduction or absence of social support likely will not be affected by medication and other somatic treatment approaches, but patients with these problems are responsive to psychologic intervention.\textsuperscript{132} Effective therapy helps people turn their anxious thoughts into more rational and less anxiety-producing ideas. Support groups for individuals and families can also help develop tools for minimizing and coping with symptoms.
Although elderly patients may not be referred for psychotherapy on the (largely incorrect) assumption that they are too set in their ways to benefit from attempts to change their attitudes, the potential benefits of psychotherapy are not diminished by increasing age. Studies show that counselling has not been found to be any less effective in older patients than in younger adult patients. In fact, older adults often have better treatment compliance, lower dropout rates, and more positive responses to psychotherapy than do younger patients. Group and individual formats have been used successfully. One drawback of the psychotherapeutic approach is the length of time needed to see results, which can be up to 10 weeks; this can feel like a very long time to a depressed senior. Combining antidepressant medications and education with various forms of psychotherapy, such as cognitive-behavioural therapy, has demonstrated its effectiveness.

**Interpersonal Therapy (IPT)** is a newly adapted intervention for older primary-care patients. The theory behind IPT is that depression is driven by irresolution of four conflict areas: grief (loss of significant people); interpersonal conflict (disputes and difficulties with others); role transition (changes in one’s societal and personal roles); and interpersonal difficulties (difficulty in interacting with people in general). The aim of treatment is to overcome these conflict areas through active discussion with a therapist. The treatment has been adapted specifically for older adults. Because it is a recent development, its efficacy has not been well established.

“Controlled research on the efficacy and effectiveness of psychotherapy for depression experienced by older adults has a relatively brief history,” reports one review. “Studies began to appear in the late 1980s and have continued at a steady … rate.”
Electroconvulsive Therapy (ECT)

The National Institutes of Health (NIH) Consensus Development Panel on Depression in Late Life explains that ECT entails the electrical induction of seizures in the brain, administered during a series of six to twelve treatment sessions on an inpatient or outpatient basis. It is regarded as an effective intervention for some forms of treatment-resistant depression and is rarely used as a first approach to treatment. NIH Practice Guidelines recommend that ECT should be reserved for severe cases of depression, particularly patients with active suicidal risk or psychosis, those unresponsive to medications, and those who cannot tolerate medications. While used less frequently than pharmacotherapy or psychotherapy, the annual population rate of individuals receiving ECT was about 12.5% in 2004. The population rates of ECT were about threefold higher among older adults, relative to the younger population. ECT is sometimes considered earlier in the treatment timeframe for older adults who respond more slowly and less favourably to medications, and for whom the side effects of medications pose a greater risk than that of ECT. In fact, a British study indicates that old age may be associated with a better response to ECT than responses of younger groups, and maintains that the additional risk of ECT is not great when compared with the risks involved with continuing depression or the side effects of other treatments. ECT must not be used in cases of recent myocardial infarction, brain tumour, cerebral aneurysm, and uncontrolled heart failure, all of which are more prevalent in the elderly.

Confusion and temporary loss of memory are the most common side effects of ECT; these may not appear to be serious, but can be enormously distressing to seniors for whom memory is already an issue. Sometimes the loss of memory persists, and that is
much more severe.\textsuperscript{148} ECT does not address the cause of the illness; it merely tries to reduce the symptoms of the illness. It appears to be an effective short-term therapy, but has a higher relapse rate over six to twelve months than those patients taking medications, and patients with a history of medication resistance have higher relapse rates following ECT than those with no history of medication resistance.\textsuperscript{149,150} There may be longer-term memory losses for the time period surrounding the use of ECT.\textsuperscript{151} Often, ECT is followed by a course of antidepressant or mood-stabilizing medication, or even less frequent ECT to prevent relapse.\textsuperscript{152}

A report released in 2005 by the Cochrane Database of Systematic Reviews indicates that there is a lack of firm, randomized evidence and methodological shortcomings in ECT studies. The report advises caution in the interpretation of ECT study results and recommends that “given the specific problems in the treatment of depressed elderly, a well designed, randomized controlled trial should be conducted in which the efficacy of ECT is compared to one or more antidepressants.”\textsuperscript{153}

As well as conventional treatments for anxiety and depression, a number of complementary approaches are used as well. The next section will explore complementary approaches used in the treatment of anxiety and depression.

**Complementary Approaches to the Treatment of Depression and Anxiety**

A recent study found that 73\% of American seniors 66 to 100 years of age use some form of complementary and alternative medicine (CAM). The most prevalent
motivations for using CAM therapies were pain relief (54.8%), improved quality of life (45.2%), and maintenance of health and fitness (40.5%). The CAM therapies most commonly used were chiropractic (61.9%), herbal medicine (54.8%), massage therapy (35.7%), and acupuncture (33.3%).\textsuperscript{154} The seniors studied found CAM therapies to be “extremely beneficial.”\textsuperscript{155}

In his recent literature overview of “who is doing what” regarding depressive disorder in late life, Robert Baldwin, a geriatric psychiatrist and member of the International Psychogeriatric Association’s board of directors, notes that there is “an emerging interest in the benefits of non-specific interventions, often labelled as psychosocial interventions or simply ‘support.’”\textsuperscript{156} He found a response rate to these non-specific interventions of 33% to 66% when used for minor depression, and indicates that this is a “powerful effect.” He recommends future research in this area.\textsuperscript{157} Other researchers believe that non-pharmacologic and behavioural approaches — treatments not frequently proposed to the elderly — should be considered, especially when patients are capable and motivated, and asking what they can do to assume some responsibility for their care.\textsuperscript{158} A study of nurse practitioners who work with the aged states that those nurses could benefit from a theoretically-based, holistic assessment guide, and that treatment plans that include natural, alternative, and complementary therapies and healing strategies should be considered.\textsuperscript{159}

An Italian study found that elders with psychological and/or psychiatric problems are more likely to use CAM therapies than are those with somatic complaints, and that those who tested above the cut-off levels for depressive symptoms were as likely to use
CAM therapies only as they were to use a combination of CAM and conventional therapies.  

Complementary and alternative therapies are used more than conventional therapies by people with self-defined anxiety attacks and severe depression, according to a 2001 survey. It is suggested that use of these therapies will likely increase as insurance coverage expands.  

Following (in alphabetical order) are some of the CAM therapies that have been used to reduce anxiety and depression: acupuncture, Autogenic Training (AT), biofeedback, Body Harmonization™, botanical treatments, electrotherapy (including transcranial magnetic stimulation (TMS), exercise, light therapy, massage, music therapy, Reiki, Therapeutic Touch™, and visualization and imagery.

**Acupuncture**

“Acupuncture is based on ancient Chinese observations of subtle energy lines called meridians that run from the head to the fingers and toes,” writes Benor. He continues, “This energy is called qi…. Each meridian is related to one or more of the organ systems, and diseases are caused by excess or deficits of energy, or blockage of the energy flow in the meridians.” Acupuncture is a traditional Chinese treatment in which needles are inserted at specific points on the body and either manipulated or electrically stimulated (electroacupuncture). Yin and yang disharmonies are the most general, all-inclusive patterns in Chinese medicine. The traditional Chinese theory is
that health depends on the balance of yin and yang forces that circulate along the meridians in the body. Anxiety and nervous agitation result from an imbalance in yin energy, while blocked yang energy contributes to feelings of hopelessness and depression.\textsuperscript{165} Acupuncture attempts to correct imbalances in these forces along the meridians.

Western scientific research with animals has indicated that acupuncture can stimulate the synthesis and release of norepinephrine and serotonin,\textsuperscript{166} neurochemicals that affect mood. Jorm et al. state that acupuncture appears promising as a treatment for depression, but that it requires further research.\textsuperscript{167} A meta-analysis of several databases by the Cochrane Database of Systematic Reviews concurs; it states, “There is insufficient evidence to determine the efficacy of acupuncture compared to medication, or to wait list control or sham acupuncture, in the management of depression. Scientific study design was poor and the number of people studied was small.”\textsuperscript{168} Most researchers in this area identify the complexity of studying acupuncture for depression.\textsuperscript{169}

Studies have indicated that the therapeutic efficacy of electroacupuncture (EA) is equal to that of amitriptyline (a tricyclic antidepressant) for depressive disorders, and that EA has a better therapeutic effect than amitriptyline for anxiety somatization of depressed patients, while having fewer side effects. This suggests that EA could be a treatment of choice for depressed patients.\textsuperscript{170} Other research shows that using acupuncture in addition to pharmacological treatment with mianserin (a tetracyclic antidepressant) created better results than treatment with mianserin alone.\textsuperscript{171}

In cases of unipolar depression where the symptoms are not severe, acupuncture can be a helpful first approach in treatment. The most common points used in
acupuncture for depression treatment are the governor vessel points and the liver points. Gradual improvements in symptoms would be expected in two to four weeks, similar to medication treatment.\(^{172}\)

Anxiety disorders can also be addressed with acupuncture. In Chinese medicine, disorders of the kidney and heart systems are the most frequent dysfunctional patterns observed, and the points for heart and kidney are used to treat anxiety. The treatment and improvement rate is similar to that for depression.\(^{173}\)

A difficulty that occurs in trying to study acupuncture is identified by Rudolph Ballentine. “Today, though acupuncture is practiced throughout the Western world,” he says, “medical scientists continue to search for a physical explanation of its efficacy, rejecting the concept it’s based on — that the movement of the \textit{ch‘i} or energy determines how much of the body works,” he says, “Our culture has an intense resistance to accepting the power of the nonmaterial.”\(^{174}\)

**Autogenic Training**

Autogenic Training (AT) is a technique of medical therapy pioneered by Dr. Johannes Schultz, a psychiatrist and neurologist, which elicits the relaxation response. Schultz found a way to elicit the same beneficial effects that he noticed in hypnotized clients from clients who were \textit{not} hypnotized. He taught simple verbal exercises to patients who were in a relaxed state of mind, and found that they could lessen both physical and mental symptoms. “Schultz’s idea of self instruction during a relaxed, receptive state was a simple, brilliant insight, the significance of which can hardly be overestimated,” according to Elmer and Alyce Green. “Our bodies usually do not ‘listen’
to our instructions because we do not put them in the listening mode, so to speak." AT puts the body into the listening mode. There are several exercises to be practiced daily, which focus on heaviness in the limbs; sensation of warmth in the limbs; slower heart rate; the breath; warmth in abdomen; and coolness in forehead. All of these exercises are done with passive concentration. AT has been shown to be helpful in reducing generalized anxiety when practiced regularly. Therefore, motivation is necessary for its success.

AT was studied extensively in Europe (without control groups), and results suggested significant effects on psychological stress and depression. Few studies have been done using only AT to reduce depression and anxiety. However, a meta-analysis of 73 controlled-outcome studies showed positive effects of AT and of AT versus control in at least three studies each for anxiety and mild to moderate depression/dysthymia.

A 2001 study done in Puerto Rico looked at relaxation training as a treatment for the elderly and found very positive results. The participants were taught a variety of relaxation techniques — including AT, progressive muscle relaxation, and breathing relaxation — and found that this training appears to reduce depression and worry.

An interesting added benefit was noticed in a Japanese research program that included the use of AT, which identified reductions in anxiety and depression for family caregivers of the elderly at home. This opens intriguing possibilities for the use of AT with elderly and caregivers together, with advantages for all!

Biofeedback
Biofeedback brings together the values of the complementary and alternative medicine movement with the sophisticated biotechnology of modern medicine.\(^{182}\) Biofeedback, also referred to as applied psychophysiological feedback, is the process of displaying involuntary or subthreshold physiological processes, usually by electronic instrumentation, and learning to voluntarily influence those processes by making changes in cognition. It provides a visible and experiential demonstration of the mind-body connection. Biofeedback is also a therapeutic tool to facilitate learning self-regulation of autonomic functions for improving health.\(^{183}\)

To illustrate, if you have ever taken your temperature or stepped on a scale to see how much you weigh, you have used biofeedback. The temperature and weight readings from these devices give “feedback” about your body to tell you whether you have a fever or have gained weight. This information will help you make decisions about what to do next. In a similar way, biofeedback therapists use specialized equipment to train patients to improve their health by using signals from their own bodies. Biofeedback is a non-invasive form of treatment, and thermal biofeedback is particularly low-cost. The therapist attaches sensors or electrodes to the body and these sensors provide a variety of readings — feedback — that are displayed on the equipment for the patient to see. The signals typically measure skin temperature, heart rate, muscle tension, and/or brainwave function.\(^{184}\) “The unique value of feedback instrumentation is that it gives the subject an immediate indication of his progress,” writes Elmer Green. “Through external feedback, the subject is enabled to filter out from the welter of internal existential cues, those particular ones which he must learn to manipulate. Voluntary control moves toward increased inner freedom.”\(^{185}\)
All of the anxiety disorders are defined by the dual characteristics of physiologic hyperarousal and excessive emotional fear. Biofeedback has demonstrated value for hyperarousal reduction training in GAD and exposure desensitization in Panic Disorder and PTSD. Biofeedback can be used alone or as an adjunct to other therapies for anxiety. Many forms of psychotherapy (including dynamic, behavioural and brief) appear to have enhanced efficacy when assisted by biofeedback.

**Body Harmonization©**

Body Harmonization (© 2003 Karin Cremasco), is described and explained by Dr. Karin Cremasco:

It [Body Harmonization©] is an integration of two subtle body energy-balancing techniques, Biocomputer Operating System™ (BOS™), and Biocomputer Emotional Spiritual™ (BES™) technique.... Using the model of a computer, Body Harmonization© works as if one were “keying in” data in a computer program, to clear the body’s control system of errors, disturbances and interferences, so that its inborn healing potential can be fully expressed. The techniques of BOS™ and BES™ move the energy towards balance at specific body locations, using the practitioner’s hands to program by “keying in,” “holding,” or “tapping” on specific points on the body. The actual procedure for an individual “balance” is determined by challenging an intact muscle in the arm (called muscle testing or kinesiology188), while asking which one of the above energetic interventions is congruent with the body’s needs in that present moment. This dictates which energy rebalancing intervention should be used by the practitioner…. In utilizing this technique, it is the body that is the authority and not the practitioner. (This could also be called accessing the body’s wisdom, the higher self, the wise self, or the ever-conscious.)189 The body chooses the modalities that would serve it best to restore it to “energetic balance.”190

Although a relatively new modality, preliminary results show that Body Harmonization© may be effective in reducing anxiety and depression. “A single 45-minute energy balancing session had a measurable effect on depression that lasted for at
least six months,"¹⁹¹ states Cremasco. "Body Harmonization© energy balancing seemed to improve State and Trait anxiety."¹⁹² More research is needed; no studies have yet been done that specifically focus on the use of Body Harmonization© for reduction of anxiety and depression in seniors.

**Botanical Treatments**

Herbs have long been used in the treatment of anxiety and depression, and some research trials have been conducted to validate their use.

**Passionflower** (*Passiflora incarnata*) showed very promising results in a recent study. A double-blind, randomized controlled study compared the use of passionflower and Oxazepam (a benzodiazepine drug used to treat anxiety) for treating GAD. Passionflower is a woody, hairy, climbing vine reputed to have sedative and anxiolytic properties; it has been used widely as an herbal remedy, chiefly in the form of a liquid tincture. The results suggest that *Passiflora* extract is an effective drug for the management of GAD, and the low incidence of impairment of job performance with *Passiflora* extract compared with Oxazepam is an advantage. A large-scale trial is justified.¹⁹³

**Immature oat seed** is one of the safest and most popular nervine herbs.¹⁹⁴ It is prescribed for both acute and chronic anxiety, and many Western herbalists choose to use for those purposes.

**Hawthorn and California poppy** (*Crataegus oxyacantha* and *Eschscholzia Californica*) in a mixture was tested against a placebo in a 2004 French study. Both tested and self-reported anxiety levels were significantly reduced in the experimental
group, but not in the control group.\textsuperscript{195} Interestingly, while California poppy is often used as a nervine herb for treating anxiety, hawthorn is not; however, the latter has a calming quality to it that merits further investigation.

**Lemon balm** (*Melissa officinalis*) leaves have a long history of use as anxiolytics, and clinicians often prescribe this calming and mood-elevating herb. There have been a few randomized controlled trials using lemon balm, and the lowest doses (300 mg per day) have been found to produce a sustained improvement in calmness with no reduction of alertness or memory.\textsuperscript{196}

**St. John’s Wort** (*Hypericum perforatum*) is an herb that is available in capsule form in many health stores. It is a traditional herbal remedy in Europe because of its potency and relative freedom from side effects.\textsuperscript{197} It has been shown that the major effects of *Hypericum* in biochemical models of antidepressant activity can be explained by the major constituent hyperforin.\textsuperscript{198} Hyperforin’s mode of action is not fully understood, but it appears to inhibit the synaptic reuptake of serotonin, norepinephrine, and dopamine.\textsuperscript{199} St. John’s Wort is unique in that it displays the pharmacology of many different classes of antidepressants.\textsuperscript{200} Benor cites a number of studies showing the efficacy of St. John’s Wort in reducing depression.\textsuperscript{201} These studies suggest that St. John’s Wort showed excellent results in treating short-term depression, but that further studies would be required to determine the long-term effects. A 2005 review of the literature regarding St. John’s Wort by the Cochrane Database of Systematic Reviews agrees with these conclusions, stating, “The 17 available placebo-controlled trials have demonstrated beneficial effects in mild and moderate depressive disorders. Whether St. John’s Wort is equally as effective as standard antidepressants and in more severe
depression has not yet been established. St. John’s Wort extracts have fewer short-term side effects than older antidepressants, but there are no comparisons with new antidepressants (selective serotonin reuptake inhibitors) and little knowledge on long-term side effects. The preparations available on the market might vary considerably in their pharmaceutical quality.”

**Motherwort** (*Leonurus cardiaca*) is recognized today as a “heart herb” that also increases blood circulation in the brain, and was recommended by the 17th-century herbalist Nicholas Culpeper to prevent melancholy. In modern times it has been studied in Germany, where it is recognized as a mild sedative effective for treating anxiety and sleep disorders, particularly for women. Modern herbalists report that both lemon balm and motherwort help to alleviate depression, especially when combined with other antidepressant herbs. In an Australian report, motherwort is identified as being used for depression, but it is acknowledged that no research was found on its effect on depression specifically in older people (age greater than 60 years).

**Electrotherapy**

Electrotherapy involves the use of devices that emit an electric current at specific frequencies, applied to specific points on the body. Electrotherapy has intrigued naturalist physicians for almost 2,000 years; in 46 CE, Scribonius Largus described how an electric ray was used to treat both headaches and painful gout. Since that time, a wide variety of devices, including the Electret and Transcutaneous Electrical Nerve Stimulation (TENS) units such as the Liss Stimulator, Neuromoc, and SheLi TENS, can be classified as electrotherapy. TENS units “have been most successful in transcranial
applications, which increase beta endorphin and serotonin significantly and are helpful when treating depression,” according to Dr. C. Norman Shealy, creator of the SheLi TENS. “Indeed, this approach alone is more effective than any antidepressant.” He goes on to state, “Our experience with the Liss in well over 25,000 patients reveals that it addresses depression successfully in 50% of patients, far better and more safely than does any antidepressant.”

“More recently,” Shealy adds, “we have found that photostimulation, education, and vibratory music also relieve depression in 48% of chronically depressed patients. But when we combine the two approaches, using cranial electrical stimulation (CES) along with photostimulation, education, and vibratory music, a striking 85% of patients come out of depression. With no further therapy, 70% remain free of depression six months later.”

**Transcranial Magnetic Stimulation (TMS)** is a newer option for treating depression with electrotherapy. TMS involves placing an electromagnetic coil on the scalp. High-intensity current is rapidly turned on and off in the coil through the discharge of capacitors; this produces a time-varying magnetic field that lasts for about 100 to 200 microseconds. The magnetic field typically has a strength of about two Tesla (which is about 40,000 times the Earth’s magnetic field, or about the same intensity as the static magnetic field used in clinical magnetic resonance imaging). The proximity of the brain to the time-varying magnetic field results in current flow in neural tissue. The technological advances made in the last 15 years have led to the development of magnetic stimulators that produce sufficient current in the brain to result in neuronal depolarization. TMS is usually performed in outpatient settings and, unlike ECT, does
not require anaesthesia or analgesics. Subjects usually notice no adverse effects, except for occasional mild headache and discomfort at the point of stimulation.

The literature is divided on the effectiveness of TMS. Some studies claim beneficial effects on depressive symptoms,\textsuperscript{210} and suggest that TMS can accelerate the onset of action and augment the response to amitriptyline.\textsuperscript{211} However, a 2005 meta-analysis of the literature pertaining to repetitive TMS (rTMS) suggests that rTMS is no different from sham treatment in major depression.\textsuperscript{212} Another investigation revealed results using TMS to be “clinically and biochemically indistinguishable from that seen in the placebo arm of the study.”\textsuperscript{213} Nevertheless, there is considerable interest in repetitive transcranial magnetic stimulation (rTMS) as a less invasive alternative to ECT. Optimal treatment parameters have yet to be defined for the geriatric patient population.\textsuperscript{214} Insurance coverage issues remain something of a barrier to widespread adoption of rTMS at this time.\textsuperscript{215} One of the recommendations that appears to be standard across the literature is the need for further research and substantiation.

**Exercise**

Dr. Daniel Landers, a leading authority on exercise and mental health, writes, “The research literature suggests that there is now ample evidence that a definite relationship exists between exercise and improved mental health. This is particularly evident in the case of a reduction of anxiety and depression. For these topics, there is now considerable evidence derived from over hundreds of studies with thousands of subjects to support the claim that ‘exercise is related to a relief in symptoms of depression and anxiety.’”\textsuperscript{216}
An aerobic exercise program has been shown to be an alternative to antidepressants in the treatment of depression in older persons. This study indicates that, while antidepressants may facilitate a more rapid initial response, after 16 weeks of treatment, exercise was equally as effective in reducing depression. Another source reports, “Gentle exercise, such as stretching and weightlifting from a seated or supported position, can benefit both pain and depressive symptoms.” Some researchers have found that aerobic exercise, but not resistance exercise, significantly lowered depression scores during an 18-month follow-up. The antidepressive effect of aerobic exercise was found for both persons with initially high depressive symptomatology and those with low symptomatology; not surprisingly, the effect was strongest for those who were most compliant.

Other studies, however, have shown that resistance exercise is a safe and feasible method to maintain an antidepressant effect over the long term in depressed elderly outpatients. The benefits of treatment were more pronounced in seniors with more severe depression and in those who continued exercising over time. One randomized controlled study began with supervised weightlifting exercises, and then progressed to unsupervised weightlifting exercises; the depression rating for the exercising group was significantly reduced at both 20 weeks and 26 months, compared with a control group who did not exercise.

It is likely that exercise buffers non-depressed elders for events in life that may trigger depressive symptomatology. The results of a pilot study evaluating the effects of aerobic exercise on major depression were positive enough to merit a long-term, randomized controlled study of the same issue. The Mood Disorders Society of
Canada indicates that “moderate exercise and active weightlifting has a remarkable ability to treat depression in the elderly. In fact moderate exercise has been found to be as effective in treating mild depression as medication.”

Patients with anxiety also respond positively to exercise. Exercise helps to improve symptoms and may help to prevent a relapse after treatment for anxiety. Studies have shown that exercise is significantly related to a reduction in anxiety. Greater effects are seen when the exercise is aerobic, as opposed to non-aerobic; the length of the aerobic training program is at least 10 weeks; and subjects have initially lower levels of fitness or higher levels of anxiety.

**T’ai Chi** is a centuries-old form of exercise that has been studied recently with respect to seniors and mental health. Ruth Taylor-Piliae, who has studied this form of movement therapy in depth, reports:

T’ai Chi has been practiced widely in China for thousands of years as a method of meditation, exercise, and self-defence. The art and philosophy of T’ai Chi is based on the collective philosophies of Taoism, Confucianism, Buddhism, and the study of nature. The various forms of the exercise, called movements, come from animals and birds. The function of these movements is to guide breathing and circulation as a means of helping vital energy flow through the body and have beneficial effects.

T’ai Chi is characterized as a form of moderate exercise and, while possibly not suitable for achieving aerobic fitness, may enhance flexibility and overall psychological well-being. There are indications that T’ai Chi may lead to improvements in mood. Some of the reported benefits from both beginners and seasoned T’ai Chi practitioners are reductions in stress, tension, depression, anger, fatigue, confusion, and anxiety. A 2003 study also showed a significant reduction in anxiety levels.
A new form of T’ai Chi, T’ai Chi Fundamentals (TCF), has been developed to benefit the frail elderly. Gerontologist Dr. David Demko explains that TCF is a simplified form of traditional T’ai Chi that emphasizes moving the body mindfully and slowly, and facilitates both strength and endurance through slow and relaxed movements. It appears to be beneficial for reducing stress and anxiety.231

Light Therapy

Light therapy has been studied for the treatment of Seasonal Affective Disorder (SAD), which is characterized by recurring episodes of depression during the fall and winter months; however, its efficacy in nonseasonal depression has not been well established. It is believed that light therapy works to reduce depressive symptomatology by countering the negative effects of light deficiency on brain chemistry and circadian rhythms.232 While research regarding light therapy and nonseasonal depression in seniors is limited, some recent studies have demonstrated usefulness with older adults, and the results are promising. Many older patients, as a result of physical decline and immobility, are confined to their rooms, experiencing little natural sunlight; thus, institutionalized older adults are often at risk for chronic light deprivation. The results of one study suggest that bright light treatment may be effective among institutionalized older adults, providing nonpharmacological intervention in the treatment of depression. Interestingly, participants with the highest depression scores at baseline showed the greatest improvement, with 50% of them no longer scoring in the depressed range.233
Massage

Massage therapy involves the manipulation of soft tissue by trained therapists for therapeutic purposes. Researchers have proposed two possible ways that massage may influence depression. Massage may shift electroencephalogram activation from a right frontal pattern (associated with sad affect) to a left frontal or symmetrical pattern (associated with happy affect). Also, massage increases vagal activity, which stimulates facial expressions and vocalizations that contribute to less depressed affect. Both of these effects would help to decrease depression.

The components of massage therapy that contribute to its efficacy are touch (non-verbal communication conveying caring, facilitating rapport, and building trust), relaxation (which may relieve trigger points for emotional issues), aromatic oils (with medicinal benefits based on the qualities of the substances used in preparing the oils), and spiritual healing.

Most publications relating to massage and depression were found to consist of anecdotal accounts and case studies; a recent review uncovered only a few controlled trials. Jorm et al. indicate that from the limited evidence available, massage therapy appears to have short-term benefits, but that its long-term benefits have not been evaluated. Decreases in depression and anxiety have been noted as common side effects of massage for other initial purposes, such as pain reduction and increased flexibility. Benor believes that the use of massage for physical issues has become accepted by the medical profession, even though there is little scientific data to support this general agreement in the profession, and that, regardless of studies, massage appears
to be one of the most appreciated modalities. Positive testimonials to the effects of massage are in abundance, but few if any truly reliable controlled studies have been done.

**Music Therapy**

“Music Therapy is an established healthcare profession that uses music to address physical, emotional, cognitive, and social needs of individuals of all ages,” states the American Music Therapy Association. “Music therapy improves the quality of life for persons who are well and meets the needs of … adults with disabilities or illnesses. Music therapy interventions can be designed to promote wellness, manage stress, alleviate pain, express feelings, enhance memory, improve communication, and promote physical rehabilitation. Research in music therapy supports its effectiveness in a wide variety of healthcare and educational settings.”

Music therapy involves the active or passive use of music to promote health and well-being. During treatment, patients perform music or listen to music carefully chosen and supervised by a trained music therapist. The type of music will depend on the personality and condition of the patient. “Music therapy … restores[s] emotional and spiritual balance, and stir[s] healing energies,” says Benor. “Music can be soothing or energizing, commonly attributed to the associations and moods that it evokes emotionally…. Participating in music adds to its healing potentials.”

Before 1995, there was a limited amount of published work relating to the effects of music therapy on depression. The results of an observational study using psychodynamic music therapy methods with depressed inpatients suggest that there may be a beneficial effect. One randomized controlled trial involved 30 elderly patients...
(aged 61 to 86) with depression. Participants were randomly allocated to a home-based
music therapy program, a self-administered music therapy program, or a non-intervention
waiting list (control group). After eight weeks, the Geriatric Depression Scale scores of
the two music groups were significantly better than those of the control group. Further
trials with larger numbers are needed to determine whether this result can be replicated.244

A more recent study examined the benefit of music therapy in the form of harp
music on depression rates of seniors. The findings revealed that seniors who received the
harp music had significantly lower depression rates than those who did not; further study
in this area is recommended.245

Steven Halpern is a leading composer and recording artist of music specifically
designed for relaxation, wellness, and what he calls “sound health.” He believes that the
human body is a self-healing instrument (if given the chance), that the body heals itself
most effectively in a state of deep relaxation, and that one of the simplest and most
effective ways to evoke deep relaxation is through the use of appropriately chosen music.
Halpern suggests two ways in which music influences us: rhythm entrainment (an
external rhythmic stimulus, such as a ticking clock or musical beat, causes your heart to
match its speed involuntarily) and the anticipation response (cultural conditioning to
follow melodic, harmonic and rhythmic patterns in music, getting “hooked into” and
following their structure). Although he admits that we do not have a complete
understanding of how music helps us heal, he states with certainty that our response to
music is far more complex, subtle, and far-reaching than previously imagined.246

An innovative approach to music therapy involves brain wave audio technology
that sends pure, precisely tuned sound waves of different frequencies to the brain via
stereo headphones. Dr. Gerald Oster of Mount Sinai Hospital in New York has discovered through EEG research that “when different vibrations or sound frequencies are delivered to the brain separately through each ear (as with stereo headphones), the two hemispheres of the brain function together to ‘hear’ not the external sound signals, but a third phantom signal. This signal is called a binaural beat, and it pulses at the exact mathematical difference between the two actual tones.”²⁴⁷ So, for example, if the left ear hears music at 100 Hz and the right ear hears music at 107 Hz, the brain “hears” a frequency of 7 Hz; as a result, large areas of the brain begin to resonate with the binaural beat.

A series of musical audio tapes and compact discs (CDs) called Brain Sync™ have been developed and then tested at the Harvard Body Mind Medical School, and used at Memorial Sloan Kettering and Dana Farber hospitals. The music on these tapes and CDs accurately corresponds to the various states of consciousness associated with the frequencies of human brainwaves. Beta frequencies (13 to 40 Hz) are associated with heightened awareness. The alpha state (frequencies of 7 to 12 Hz) is a place of deep relaxation (but not meditation) where there is a sense of well-being; the alpha state is the one used to combat anxiety and depression. Theta waves (4 to 7 Hz) are experienced as the “twilight” state as we drift off to sleep, and also experienced in meditation. Delta waves (0 to 4 Hz) are the frequencies of the unconscious mind and are associated with deep, restorative sleep, and the healing that occurs during sleep. The Monroe Institute has also done research using their equivalent product, Hemi Sync® Tapes and CDs.²⁴⁸
Reiki

“Reiki is a Japanese word that means ‘universal life energy,’” writes Dr. Richard Gerber in his book *Vibrational Medicine: Energy Healing and Spiritual Transformation*. "In Reiki therapy, a trained Reiki healer acts as a channel for ‘universal life energy’ that is taken into the healer’s body from the surrounding environment and then directed to a patient in need of healing.”249 One of the basic premises of Reiki is that there is a universal source of energy that impacts the physical, mental, emotional, and spiritual dimensions of human existence.250 Reiki healers hold the intent that whatever energy exchanges or transformations are needed should occur under the direction of a higher intelligence.251

A study was completed that compared four groups: one group received Reiki, a second group received Progressive Muscle Relaxation, a third received mimic or false Reiki, and a fourth came to the same office and read any material of their choosing. Depression and both State and Trait anxiety (as measured by Spielberger’s State-Trait Anxiety Inventory™) were all significantly improved in the group receiving Reiki for the duration of the research. There was no significance difference in the groups at the three month follow-up, which indicates that the effects of the Reiki treatments in this study might lack longevity.252 However, a more recent study of the long-term effects of Reiki on symptoms of psychological depression and perceived stress showed a significant reduction in psychological distress in the treatment groups as compared with controls. These differences continued to be present one year later.253

Reiki, while a “hands-on” type of treatment, differs from massage in that it is accomplished through light touch. Reiki can also be administered using no physical
contact; no rubbing, pushing or massaging is used in Reiki treatments, which can be an advantage in treating the more frail and sensitive elderly.254

**Therapeutic Touch™**

Therapeutic Touch (TT) is the use of hands and intention to balance body, mind, and spirit.255 It was developed by Dolores Krieger and Dora van Gelder Kunz. Thousands of nurses, other health practitioners, and laypersons have learned the process,256 and TT is currently being taught in more than 90 nursing schools in America.257 It is based on the fundamental assumption that there is a universal life energy that sustains all living organisms.258 The human energy field extends beyond the skin, and the practitioner can use the hands as sensors to locate problems in the field that correspond with problems in the physical body. Disease is seen as a condition of energy imbalance or disorder or of blocked energy.259 During a treatment, practitioners move their hands in sweeping motions about two to four inches above the surface of the fully clothed client, to balance the energy.

Richard Gerber addresses the question, “What are the actual mechanisms behind the laying-on-of-hands healing process?” Gerber posits that there are two possible explanations, exploring “whether a healer’s stimulating effects are related to a simple ‘life-energy transfusion’ or possibly some kind of ‘energetic restructuring’ of the patient’s bioenergy field.”260 Another explanation comes from Larry Dossey, who has studied the healing effects of the nonlocal mind. Dossey raises the possibility that “since our nonlocal minds may be able to affect healing changes in another human being at a
distance through an act of prayer, they could also be the true mechanism behind the laying-on-of-hands healing as well.”  

Yet another possible explanation for how TT works is the bioinformational model, which does not necessarily involve the direct transfer of energy from healer to patient. It suggests that “healing may be brought about by supplying appropriate bioinformational instructions to the human body in an effort to stimulate an individual’s own inner mechanisms of healing.” The “earthfield” connection offers another potential mechanism for the process of TT, related to the balancing energies of the Earth’s magnetic field. It proposes that a process of resonance occurs between the healer, the patient, and the Earth’s magnetic field, synchronizing, harmonizing and balancing the energy fields. Although there are many possible explanations, no one theory is clearly dominant at this time.

TT clients often experience relaxation and reduction of pain, and this relaxation response has been shown to reduce anxiety. Several studies have been conducted using TT to alleviate anxiety and have shown significant decreases. In fact, a decrease in state anxiety, as measured by the Spielberger State-Trait Anxiety Inventory™, has been the outcome most consistently reported in the research literature. Because TT helps to reduce anxiety, it has been found to be helpful for those experiencing stress-related physical disorders and those undergoing an emotional crisis. “TT is the most thoroughly researched of the spiritual healing methods,” says Benor, “and has been shown in controlled studies to help in treatment of pain, anxiety, depression, enhanced arthritis, immune function, hypertension, well-being in palliative care, and disruptive behavior in Alzheimer’s disease.”
Visualization and Imagery

In her book *Staying Well with Guided Imagery*, Belleruth Naparstek explains guided imagery in this way: “Guided imagery is a kind of directed daydreaming, a way of using the imagination very specifically to help mind and body heal, stay strong, and even perform as needed…. By ‘images,’ I don’t mean strictly visual images, but any sensory impressions: sights, sounds, smells, taste, or touch.” 270 She continues, “These sensory images are the true language of the body, the only language it understands immediately and without question… Our bodies don’t discriminate between sensory images in the mind and what we call reality.” 271

Dr. Jeanne Achterberg and Dr. Frank Lawlis researched and practiced imagery in a variety of health care settings for many years. They see imagery as combining modern understanding of health and disease with ancient shamanic techniques. They have validated their “body-mind imagery” on patients with a wide variety of disorders: chronic pain, rheumatoid arthritis, cancer, diabetes, severe orthopaedic trauma, burn injury, alcoholism, and stress-related disorders such as migraine headaches and hypertension, as well as during childbirth. 272 Interestingly, one of the most observable effects with the use of imagery for cancer patients is the reduction of anxiety. 273

There are many kinds of imagery that work well, says Naparstek. Cellular imagery, physiological imagery, metaphoric imagery, psychological imagery, end-state imagery, feeling-state imagery, and energy imagery all have useful purposes. 274 “Imagery is a nonverbal, non-invasive intervention that can be implemented by patients alone or with guidance,” states Lynn Keegan. “Imagery uses the internal experiences of memories, dreams, fantasies, and visions to serve as the bridge for connecting body,
mind, and spirit. Guided imagery plus relaxation is being used with increasing frequency to help people improve their performance and control their responses to stressful situations.”

Anxiety symptoms may be decreased with guided imagery. One study done with new mothers showed a substantially greater decline in anxiety and depression for mothers who used guided imagery than those who did not. Most studies seem to deal with imagery and visualization for physical healing, and fewer deal solely with the reduction of anxiety and depression, which often get measured only as a possible factor in the physical healing process. Although many studies indicate beneficial reduction in anxiety and depression in conjunction with a physical illness, no studies were found that use guided imagery solely for the purpose of reducing depression and anxiety in seniors.

The Inner Counselor Process© is the intervention used in this research study. The next section will explore the theoretical basis of this process, with a corresponding review of the literature.
The Inner Counselor Process©

Introduction to the Inner Counselor

“If I had a gift to offer you, I would give you, you. 
If I had a song to sing to you, it would not be sad or blue 
I would somehow help you realize that you’re beautiful and wise 
and within you lies the knowledge of all the Sages’ best advice…”

Ann Nunley

The Inner Counselor Process© (See Appendix A.2) is a creative way to address a range of concerns from ordinary worries to major life issues in order to bring about increased peace of mind and an enhanced sense of well-being. The Inner Counselor Process© (IC Process©) is not therapy, and the facilitator does not offer solutions to the issues raised. The approach of the IC Process© is that our greatest asset for healing comes from the “healer within” each of us; it provides people with a way to access their own inner wisdom regarding issues that are important to them, and includes both psychological and spiritual aspects. This process is respectful of all faith traditions. Seniors experiencing the IC Process© could find a reduction of anxiety and depression that might result in an increased peace of mind, and an enhanced sense of well-being.

Dr. Ann Nunley, creator of the IC Process©, describes it as

an experiential spiritual process that engages the symbolic wisdom of a person’s higher mind in order to access and resolve behavioral and emotional issues. During the fifteen-step process (about 30 minutes long), one’s higher mind is engaged; key emotions are felt in the body; an incident of origin is revisited; basic needs and their corresponding essential qualities are identified; and a highly satisfactory level of mental, emotional and physical resolution is achieved. Old behavior patterns are transformed and transcended as new response patterns are integrated within the personality. Results are profound and lasting.280

At the base of the Inner Counselor is the belief that all people have within themselves the wisdom to address issues that are important to them, and that healing
involves body, mind and spirit. People often rely on their thinking mind to solve their difficulties, but the logical, thinking mind is only one part of human consciousness. The IC Process© offers a way to access the creative aspects of the mind and benefit from this inner wisdom. The facilitator of the process does not offer solutions to the participant’s issues; rather, they offer themselves as a skilled guide to move the person through the specific process steps.

James Gordon, the founder and director of the Center for Mind-Body Medicine, has written extensively on the wise use of alternative therapies, and is quoted as saying, “Removing symptoms is like taking the lid off the pot, so it is no longer boiling over. Finding the emotional causes is like taking the pot off the stove.” The IC Process© would be consistent with “taking the pot off the stove”!

Dr. C. Norman Shealy and Dawson Church, in their 2006 book Soul Medicine: Awakening Your Inner Blueprint for Abundant Health and Energy, refer to the Inner Counselor Process© as “an immensely powerful technique for holistic inquiry … which we believe may be the pinnacle of transpersonal healing.”

In order to understand more fully how the Inner Counselor creates change in our lives, it is important to understand some of the basic concepts involved: the Integration Chart©; the High Self; thoughtforms; symbols, imagery and visualization; and an explanation of the healing potential of the Inner Counselor.

The Integration Chart©

The Lexicon Webster Dictionary defines integration in this way: “The act of integrating; the act of combining into an integral whole; unification of diverse elements
into a complex whole or a harmonious relation; harmonization.” 283 This description can be aptly applied to the Inner Counselor Integration Chart© (see Appendix A.3) of life’s journey.

The term “psychology” comes from two Latin words: psyche, meaning “soul,” and logos, meaning “logic.” Thus, psychology is “soul logic.” The Integration Chart© sets forth the soul logic of the Inner Counselor. 284 While at first glance the chart may look somewhat complex and daunting, it exemplifies a very basic premise: that as we journey through life, our choices and our paths will be affected by our intrinsic needs, whether or not those needs have been met, and our ability to embody the soul qualities we seek. The concepts set forth in this chart coincide with “the pioneering work in self-actualization of persons such as Abraham Maslow, the spiritual concepts of [Sri] Aurobindo and [Roberto] Assagioli, and the holographic, philosophical concepts of David Bohm and Ken Wilber.” 285 The Integration Chart© was developed by Dr. Ann Nunley over a period of 15 years. Beginning concepts were taken from a chart set forth by V. Vernon Woolf in his book Holodynamics. 286

Choice, one of the major themes of the Integration Chart©, runs across the centre of it between the updrafts and the downdrafts, and each column represents a different choice. The chart offers possible options for an individual as they consciously choose a response to whatever life brings at any and every moment. The Integration Chart© sets out — clearly, concisely, and cogently — the choices to be made and possible outcomes for each choice. More importantly, the chart makes it evident that deciding not to choose is not an option: as illustrated in the Flow Chart at the top of the Integration Chart©, it is a journey through life, and all human beings are, without exception, on the chart. Fear of
judgment or of making the wrong choice can drive people to try to avoid choosing. The layout of the chart indicates that in opting not to make a choice (e.g., not choosing an updraft), there is, in fact, still a choice being made (the choice of the downdraft by default). This option to choose between the updraft and downdraft responses empowers individuals and encourages them to make positive, conscious choices.

Offering choices without judgment reduces the likelihood of feeling shame, blame, or guilt. There is great value in this, because “when we react with fear, anger, shame, blame, guilt, and judgment, we are no longer able to choose a creative response to our circumstances.”²⁸⁷ It is comforting and affirming for people to understand that there is no shame attached to finding themselves in disharmony (it can be seen as “only a downdraft”), and that they have the option to make different choices. The lack of external judgment accompanying the choices shown in the chart makes it possible for them to assess the usefulness of these choices in their lives. Abraham Maslow writes, “Seen from the dynamic point of view, ultimately all choices are in fact wise, if only we grant two kinds of wisdom, defensive-wisdom and growth-wisdom.”²⁸⁸ This understanding allows one to look at and appreciate the purposes served by the choices that have previously been made, to evaluate their current appropriateness, and to make different choices if desired. Knowledge of the effects of the choice gives information, and having more information increases the ability to choose wisely. The choice remains the prerogative of the individual, and this maintains the respect for each individual path that is inherent in the Integration Chart©.

One of the reasons stated most often by seniors who do not seek help for anxiety and depression is that they feel ashamed to admit how they are feeling.²⁸⁹ A study of the
role of self-forgiveness as a component of mental health in later life showed that self-forgiveness may play an important role in diminishing guilt and enhancing self-acceptance, resulting in a more congruent view of the self. The lack of judgment as well as the support of choices, both of which are clearly set forth in the Integration Chart©, could help to reduce shame, encourage self-forgiveness, and enhance possibilities for healing.

Chakras are a concept of human energy based on ancient Hindu beliefs. They are spinning vortices of energy that comprise focal points and an interface for information moving in, out, and through the subtle energy bodies. Each of the six columns in the Integration Chart© is associated with one or two of the chakras (indicated along the bottom of the chart), and there is excellent correlation between the qualities listed in a column of the chart and the qualities associated with the related chakra. Neil Cohen, in his Chakra Awareness Guide, states, “The main purpose in working with and understanding the chakras is to create integration and wholeness within ourselves…. We must be able to acknowledge, accept and integrate all levels of our being.” Cohen stresses that it is most important to understand that the chakras are “doorways” for consciousness, through which emotional, mental, spiritual, and physical energies exchange information. Nunley echoes this when she says, “The emotional body interfaces with the etheric energy body and with the physical body through a series of energy vortices called chakras.” The same concept is reiterated by Donna Eden, who states, “Each chakra influences … all other systems within its energy field. Chakras also influence the endocrine system, and are strongly involved with your moods, personality,
and overall health. Your physical and psychological evolution, as well as your spiritual journey, are all reflected in your chakras.”

Eden elaborates on the multidimensionality of the chakras. She explains that each chakra is a conduit for a particular form of energy within the universe, and that they resonate with the principles of survival (root chakra), creativity (sacral or womb chakra), power (solar plexus chakra), love (heart chakra), expression (throat chakra), transcendence (third eye chakra), and unity (crown chakra). “The chakras also feed off both the positive and negative energies of the cosmos — archetypal forces such as those for bonding and for separation, for growth and for atrophy. They spiral these energetic prototypes into your body, feeding your entire physical structure and linking your body to the subtle energies that surround you…. Each developmental stage is as sacred as the next. Each chakra connects with a universal force, has a soul-deep task, and holds a transcendent beauty.” Eden’s description, while coming from the perspective of the chakras, is clearly supportive of the spiritual and psychological premises of the Integration Chart©.

The Whole-Self Model II© (see Appendix A.4) addresses the task of integrating levels of consciousness. It teaches that our spiritual, emotional, mental, and physical bodies are interconnected through three major aspects of the mind — the super-conscious, the self-conscious, and the subconscious — and that “healing requires us to open doors between the three levels.” The Integration Chart© is a tool that can be used to promote this understanding and, in conjunction with the Inner Counselor Process©, open the doorways to greater awareness and healing. “Our level of self-integration is measured by how comprehensively we approach our human experience,” says Nunley.
“Healing modalities that are based on a very limited, partial picture of the whole person have difficulty achieving comprehensive results.” The Inner Counselor offers a way to access the insight and the integrative power of the super-conscious Higher Self, so that it can act upon the attitudes of the conscious mind and the perceptions and beliefs locked within the subconscious mind. This could be an important aspect when working with seniors; researchers are clear that depressed and anxious seniors sometimes present first with somatic concerns and, as a result, their emotional needs can be missed. The Inner Counselor approach is multidimensional; it includes and addresses aspects from all areas of self, so there would be an increased probability that the emotional issues would be included.

Nunley describes the columns of the chart as the developmental stages through which specific ideal qualities are experienced and expressed. She echoes Ken Wilber, a creative, spiritual contemporary thinker and philosopher, and states that “in this model, each developmental stage both transcends and includes the previous stages.” In his book Integral Psychology, Wilber refers to “the idea of levels or dimensions of reality and consciousness, reaching from matter to body to mind to soul to spirit, with Spirit fully and equally present at all of these levels as the Ground of the entire display. Each senior level transcends and includes its juniors.”

The Integration Chart© is well supported by the work of Ken Wilber and Abraham Maslow. The updrafts and downdrafts of the chart are a depiction of Maslow’s growth needs and deficiency needs. Maslow defines growth as “the various processes which bring the person toward self-actualization.” The updrafts of the Integration Chart© describe just those processes. The downdrafts correspond to the deficiency needs
which Maslow says are “essentially deficits in the organism, empty holes so to speak, which must be filled up for the health’s sake.” It is these “needs” that are outlined on the chart and encountered and addressed during an Inner Counselor Process©.

Maslow continues his thoughts on the fulfilling of deficiency needs:

“Furthermore, [they] must be filled from without by human beings other than the subject.” Here, the Inner Counselor Process© differs. It is true that participants often identify that someone did not meet a need for them at an earlier time, at a time in their development when it would have been appropriate, and even necessary for others to be meeting their needs. However, the Inner Counselor Process© urges participants in adulthood to take responsibility for meeting their own needs from within, by establishing a meaningful connection with a spiritual and mature inner self. When individuals do this, then their relationships can be founded upon a balanced reciprocity rather than upon the sort of neediness that can never be addressed or fulfilled by an outside source. An historical illustration of the inner fulfillment of an intrinsic need can be seen in Nelson Mandela, who was imprisoned and had his physical freedom taken away. Yet he maintained his sense of inner freedom, and that quality within him gave him the strength to lead an entire people’s movement toward freedom.

Wilber suggests, “For an integral psychology … we should attempt to honor the entire spectrum of consciousness, matter to body to mind to soul to spirit.” This statement is supportive of the Inner Counselor Process© and is reflected in the Integration Chart©. The columns of the chart cover much of this spectrum, from the physical and personal qualities of columns one and two through the mental/emotional qualities of columns three and four to the soul qualities of columns five and six.
The spirit to which Wilber refers would be represented in the Inner Counselor by the card of Grace, grace being “a state in which we are no longer separate from Spirit.” Grace does not appear within the Integration Chart©, because grace is in no way limited: it operates in all aspects of life and “defies all logic and reason by spontaneously bestowing the gift of unconditional acceptance, love, and freedom.” Grace does, however, appear just above the chart, in the three stages of Self Actualization, Self Realization, and Enlightenment, which can be seen as three stages of grace. Hence, the Integration Chart© meets Wilber’s requirements for an integral psychology. These requirements are an intrinsic part of the Inner Counselor, where physical sensations, emotional issues, and mental images are connected by the soul and guided by spirit. Wilber elegantly lends credence to the concepts outlined in the Integration Chart© and the journey it describes. He says, “For an integral psychology, … a person’s deepest drive … is the drive to actualize … through the vehicle of one’s own being, so that one becomes, in full realization, a vehicle of Spirit shining radiantly into the world.”

The High Self

The High Self has been referred to as the “Essence, Heart, Core, Soul, the Life hidden deep within,” according to Dr. Guy Pettit. “It is the invisible, intangible organizing center of energy, the controlling core, the source of the pattern of potential unfolding in mental and physical development … the inner space-time blueprint, with the knowledge of the whole pattern, and thus of any healing process. The storehouse of our not-yet-conscious potentials and higher qualities awaiting expression in the world.” Deepak Chopra uses the term “Higher Self” and explains it this way: “The higher self is
the ‘you’ inside of you — the living force that grows and changes in your body throughout your time on earth. It is the ‘you’ behind all of the defenses and images you have created for yourself … the you that really knows why you are here, what it is you need, and how you can get it.”

Roberto Assagioli, who has worked to develop the concepts of various aspects of will and psychosynthesis, traces human connection with the High Self throughout history. Assagioli offers the illumination of Gautama Buddha as an example of connection with the High Self; he states that the search for connection with the High Self can come about as a result of dissatisfaction with what is experienced as the meaninglessness of the present way of living — both personal and social. Humans often respond to this dissatisfaction in one of two ways: regression (evading the connection) or transcendence (reaching beyond the limitations of ordinary consciousness to attain more expanded and intense states of awareness). The state of transcendence is similar to Abraham Maslow’s term “high nirvana.” Assagioli acknowledges that these connections can be sought (through meditation or other means) or can be made spontaneously, which he understands as a “pull” from the High Self. These spontaneous connections have been detailed in such works as Maurice Bucke’s *Cosmic Consciousness* and William James’s *The Varieties of Religious Experience*. Carl Jung identifies the experiences of the Old Testament prophets, Goethe, and Napoleon as instances of “calling,” of human connection with the inner voice and wisdom. Jung is clear that this type of experience “is not perchance the prerogative of great personalities, but also belongs to the small ones.”
The High Self is central to the *Inner Counselor Process©*. Connection with the High Self helps participants to access inner information and wisdom of which they had not previously been consciously aware. Nunley states, “The High Self is present at birth, and contains the enfolded potential and true essence of each person.”\(^{316}\) It can be considered the idealized organizing pattern through which Spirit expresses at a subtle energy level.\(^{317}\) There are many names that have been used to describe this Self, including (but not limited to): Soul, Essential Self, Ever-Conscious Self, Higher Self, Super Ego, Divine Self, True Self, Eternal Face, Observer Self, Christ Self, Lotus Self, Healer Within, Wise Self, Wise Advisor, the Inner Sacred, Inner Self-Helper, or Full-Potential Self. This illustrates one of the very inclusive aspects of the Inner Counselor.

The High Self has been acknowledged in many different belief systems, though the names used differ. Christians might use the term “Christ Self,” or “Glorified Self,” Buddhists might choose “Lotus Self,” and in the Indian philosophy of Samkhya, the term used might be “Purusa.”\(^{318}\) The thoughts of Sri Aurobindo, a major Indian philosopher, represent more the theosophical-gnostic stream in Indian guise, rather than a specifically Indian (Advaitan or Tantric) approach.\(^{319}\) Sri Aurobindo used the term Jivatma, or “the Central Being,” to refer to the High Self. He understood Jivatma as being “superior to birth and death, always the same, the individual Self or Atman; the eternal true being of the individual.” Those persons who espouse no religious tradition could feel comfortable with the terms “healer within” or “wise self.” Those in the military might find the term “All-that-you-can-be-Self” compatible with their approach to life. The label given to this part of self is not critical; the understanding of what part of self it represents is much more important.
The Inner Counselor, by virtue of connecting participants with their High Selves (or whatever term each feels comfortable using to refer to it), avoids possible religious constrictions and stays in the realm of spirituality. (For a distinction between the terms “religion” and “spirituality,” see the section below on Seniors and Spirituality.) An Inner Counselor facilitator is taught to discuss the concept of the High Self with the participant, determine which term feels most appropriate to the participant, and then use that term throughout the process wherever the words “High Self” appear. Thus, it can be a valuable tool for persons of all faiths, as well as for those who do not identify with any particular faith tradition.

The High Self is available to us at all times. Benor writes, “We have only to call upon our inner self-helper to discover the reasons for our woes and problems, and to learn the steps we may take to alleviate and correct them.”

This describes the way that the High Self functions in the Inner Counselor Process©. The High Self (or inner self-helper) gives the New Symbol (thoughtform) that can embody all the intrinsic needs of the participant’s issue, and that can offer wise advice to the client regarding that issue.

Elmer Green, often referred to as “the father of biofeedback,” states:

Human bodies, emotions, minds, souls, spirits, from densest physical to subtlest spiritual, have both a substance aspect and a consciousness aspect. There is no spirit without substance and no substance without spirit. This may seem paradoxical, but as often mentioned, Sri Aurobindo once said that if you are embarrassed by the word spirit, then think of spirit as the subtlest form of “matter.” If, however, you are not embarrassed by the word, then think of matter as the densest form of “spirit.”

Quantum physics explores the concept that the consciousness of the observer determines that which is observed. Consciousness therefore appears to shape matter. In the Inner
Counselor, the participant is both spirit and matter, both High Self and Personality. “The High Self contains the record and wisdom of our total experience, using that information to evolve and express various idealized patterns in form-life,” teaches Nunley. “The experience of form-life, in turn, enhances the wisdom and awareness of High Self.”

In the *Inner Counselor Process©*, both participant and facilitator commit to working from the perspective of the High Self in the very first step of the process (see Appendix A.2). The purpose of this is to set the intent that both parties will be in contact with their High Selves. In the case of the facilitator, this means that any personal downdrafts (as indicated on the Integration Chart©) they might be experiencing will be less likely to influence the process. For participants, the intent to work with their High Selves helps them to connect with the wisdom they are choosing to access.

**Thoughtforms**

During the 15-step *Inner Counselor Process©* (see Appendix A.2), the participant accesses personal symbols, or thoughtforms, the main organizing components of the mental body and the emotional body (as shown in the Whole Self Model II© in Appendix A.4). Thoughtforms are composed of perceptions, their resonant emotions, and their organizational “conclusions.” Nunley offers this explanation:

Thoughtforms are stored at subconscious and ever-conscious levels and directly influence a person’s mental, emotional, subtle-energy, and physical well-being. Thoughtforms create, direct, shape, and influence (as subtle attractors and selectors) consciousness at all levels. Thoughtforms influence ego-states, engrams, frames of thought, inner dialogues, personality characteristics, and behavior patterns. They are formed from sensory input, modeling, experience, imprinting, genetic inheritance, imagination…. They form the basis of the personality’s substructure.
Gerber contributes a vibrational medicine perspective:

The effects of human thought and emotions often go far beyond the influence of brainwave patterns and neurochemical interactions with the glands and organs of the body. The human mind is not just a hardwired, patterned, chemical organ. The astral and mental bodies also operate in concert with our brain’s inherent processes, and thus contribute additional influences to our thoughts and feelings. Many … believe that our thoughts possess a distinct energy and form. In fact, at the astral and mental levels, it has been suggested that our thoughts can actually exist as individualized thoughtforms or patterns of subtle energy.\textsuperscript{327}

Benor puts forward another view: that the mind exists outside the brain, or overlaps several dimensions to include the brain, which acts as a transducer for mind across the boundaries between dimensions.\textsuperscript{328}

One theory regarding thoughtforms states that strong thoughtforms are created from strong thoughts or emotional charges.\textsuperscript{329} This is consistent with the Inner Counselor practice of assisting participants to gently ride their feelings back through time to an earlier time when the emotions and sensations were very intense. These powerful emotions and sensations help to access a strong and effective thoughtform as the Old Symbol, and provide the catalytic energy for transformational change. If there are no powerful emotions present, then transformational change is not likely.

Healer and teacher Dael Walker believes from his observations and experience that “the strongest thoughtform wins.”\textsuperscript{330} This means that the stronger the thought or the emotional charge behind a thought (negative or positive), the stronger the thoughtform will be, and the strongest thoughtform has the power to influence behaviours and reactions more than weaker ones do. Again, this is consistent with the Inner Counselor. The participant’s High Self shows him or her a New Symbol, or thoughtform, that embodies the qualities that can fulfill all the intrinsic needs related to the identified issue.
The Old Symbol arose in response to an unmet intrinsic need of the participant in the past and, at the time, its purpose was to provide a response pattern that would meet the participant’s need for safety and protection. The Old Symbol was strong enough to endure within the subconscious mind through time and provide protection for some aspect of the participant’s inner and outer self. The New Symbol comes in response to the true intrinsic needs that are identified in the process, as well as the need for protection. The New Symbol is a gestalt that must be powerful enough to embody the fulfillment of all of the identified needs, including the needs for safety and protection.

That New Symbol is asked to show its qualities, energy, and its power to the Old Symbol, before asking the Old Symbol to be completely absorbed (transcended and included) by the New Symbol; this allows the Old Symbol to trust that the participant will be protected and safe once the absorption takes place. Without that trust, the process of “transcending and including” might not occur. While the strength of both symbols is essential to the process, the ability of the New Symbol to provide the qualities and the mature response pattern that meet all of the identified needs is paramount. Without that, the Old Symbol, which represents an immature coping pattern, will persist. Interestingly, while this coping pattern may help the person survive an early abusive situation, its energy often blocks the eventual fulfillment of the identified intrinsic needs. For instance, closing the heart in anger is emotionally protective when one doesn’t get the love one needs. However, this very closing may continue to be re-triggered, blocking the ability to give and receive love in the future.

Another proposed theoretical aspect of thoughtforms is that they are made of subtle magnetic energy generated by our astral (emotional) and mental bodies. This
poses an interesting possibility that is relevant to the Inner Counselor: if these thoughtforms are made of magnetic energy, it is possible that they could interact with the etheric body; it is even possible that they could “produce [changes] at the level of the physical body.” The Energy Exercise at the end of the Inner Counselor Process© is designed to do just that: to take the energy of the special qualities of the New Symbol (thoughtform) into the body so that, as it says in that Energy Exercise, “every cell is changed by the golden light and the qualities of the New Symbol.” Inner Counselor participants have reported changes in physical symptoms because of participating in a process. Further investigation of this aspect of the Inner Counselor Process© would be valuable.

Symbols, Imagery, and Visualization in the Inner Counselor

Symbolic imagery is the language used by our minds to translate transpersonal perceptions into awareness that we can begin to appreciate, although we may not comprehend the imagery in its entirety. We use symbols on a daily basis, although we may not be consciously aware of it. Roberto Assagioli reminds us that the effects and unavoidability of symbols are brought vividly to our consciousness by the direct recognition that all words are, in fact, stenographic, condensed symbols. He further states that we would do well to “utilize the enormous and by far not yet realized potency of symbols in the dynamics of psychological life.”

Mircea Eliade, who pioneered academic studies of shamanism, offers this understanding: “The symbol reveals certain aspects of reality — the deepest aspects — that defy any other means of knowledge. Images, symbols and myths are not
irresponsible creations of the psyche; they respond to a need and fulfill a function, that of bringing to light the most hidden modalities of being.” Symbols are stored as thoughtforms in the subconscious and super-conscious minds. Wilber states that imagery provides modes for transition through the existential and into the transpersonal; in other words, imagery offers a way to move beyond the knowledge of our personal, local self and access transpersonal, nonlocal wisdom.

Assagioli identifies three ways in which symbols function in our lives:

Their primitive and basic dynamic function is that of being accumulators, in the electrical sense, as containers and preservers of a dynamic psychological charge or voltage. Their second function, a most important one, is that of transformers of psychological energies. A third function is that of conductors or channels of psychological energies…. Symbols … have most important and useful therapeutic and educational functions. And this can be considered also in reference to psychodynamics because integration is really a function of energy, specifically the function of what has been called syntropy as contrasted with entropy. Syntropy means a heightening of the tension of the voltage of psychological and also biological energy.

He goes on to explain that there is a normal succession of the psychodynamic efficiency of the symbol: attracting psychological energies, storing them, subsequently transforming them, and then utilizing them for various purposes — particularly for the important purpose of integration. The Inner Counselor helps to access the stored symbols, provides a process for transformation, and allows the participant to move toward integration.

Dr. Patricia Norris is a psychologist who has worked for many years with biofeedback and wellness. She makes a distinction between imagery and visualization. “Visualization is the consciously chosen, intentional instruction to the body,” says Norris. “Imagery is the spontaneously occurring ‘answer,’ qualifier and modifier from the
Thus, images are messages from the subconscious or super-conscious to the conscious mind. In the Inner Counselor, imagery occurs several times (phrases in parentheses are taken from the Inner Counselor Process©, Appendix A.2): when participants initiate access to the feeling (Old) symbol (Let the feelings take a form. Describe the form…); when participants ask their High Selves to show them an ideal (New) symbol; and when participants visit earlier times when they experienced the same feelings (Let the feelings carry you to an earlier time…). Visualization happens throughout, especially during the absorption process of the two symbols (Experience the New Symbol completely absorbing the Old Symbol…) and during the Energy Exercise, as participants visualize the gold light with the energy and qualities of the New Symbol moving through their bodies.

Nunley believes that, in the Inner Counselor, the Old Symbol is connected to all nuances and aspects of the original reactive response (physical and emotional) associated with a situation. The original intent of those responses (and the Old Symbol) was protection for the participant in a situation where intrinsic needs were not met. During the process, participants give this feeling symbol a shape and a form, acknowledge the subconscious protective intent, and thank the symbol for that protection, thus consciously recognizing its protective intention in their lives. Participants ask their High Selves for a New Symbol in step nine of the process, and this New Symbol embodies a new and superconscious way of meeting all of the identified intrinsic needs, creating wiser and more mature responses for the participant in the future.

It has been asserted by Gough and Shaklett that “symbols in the physical dimension are based in archetypes that are beyond space-time, and therefore, every
symbol is available and potentially meaningful to every individual. Meaning in the physical realm is ... energy that is stored within the body."³⁴⁴ Factors that influence the depth of meaning and the potential stored energy of a symbol are unique to each of us and our particular life experiences. In order to release the stored potential energy, we must focus on and fully experience the emotions that are connected to the symbols. Nunley elaborates: "When a symbol is brought to conscious awareness at the physical level, the connection to the related higher-level archetype is also activated. The higher-level archetype [has] a greater degree of 'wholeness.' This wholeness manifests as feedback into the physical world. This feedback is experienced in the individual’s body as emotions and thoughts to which the individual ascribes meaning."³⁴⁵ Participants in the Inner Counselor come to an understanding of their symbols without direction from the facilitator. In this way, the meaning for the participant is directly connected to the archetypal wisdom of the symbol.

Lama Govinda spent over twenty years as a member of the Kargyupta Order, studying Tibetan mysticism and esoteric principles. In his book *Foundations of Tibetan Mysticism*, Govinda discusses symbols:

"The subjectivity of inner vision does not diminish its reality-value. Such visions are not hallucinations, because their reality is that of the human psyche. They are symbols, in which the highest knowledge and the noblest endeavour of the human mind are embodied. Their visualization is the creative process of spiritual projection, through which inner experience is translated into visible form, comparable to the creative act of an artist, whose subjective idea, emotion, or vision is transformed into an objective work of art, which now takes on a reality of its own, independent of its creator."³⁴⁶

Govinda’s description clearly sets forth that symbols can be multidimensional. Multidimensionality allows us to make use of our sixth sense — intuition — to relay
messages and meaning via our more familiar five senses. The multidimensionality of the symbols is evident in the Inner Counselor. The Mental body identifies the issue. The Emotional body expresses the feelings associated with the issue. The Physical body determines where those feelings are felt in the body. The Subconscious mind accesses a feeling (Old) symbol. The Super-conscious mind contributes to an ideal (New) symbol. The Conscious mind receives advice from the New Symbol, and gives the symbol an assignment to help the client. Many aspects of the body and mind are involved in the symbols of the Inner Counselor Process©.

The Healing Potential of the Inner Counselor

“Healing is not about ‘fixing’ what is ‘wrong,’ ” says Nunley. “By its very nature, the intention to fix things is often based on judgments that fragment and divide. True healing is always part of a comprehensive movement towards wholeness.” The Inner Counselor Process© has transpersonal underpinnings that emphasize interconnectedness and wholeness.

Jorge Ferrer defines transpersonal psychology in this way:

Transpersonal psychology is a modern academic discipline concerned with the psychological study of the transpersonal and spiritual dimensions of human nature and existence … as well as with the spiritual and transpersonal study of human psychology. While focusing on the interface of psychology and spirituality, transpersonal psychology strives to understand and nurture the wholeness of human nature — body, instincts, heart, mind, and consciousness — and explores ancient and modern practical tools that foster an integrative spiritual life that is embodied, socially engaged, and ecologically sensitive.
Benor observes:

Transpersonal awareness suggests that each of us is a part of a vast whole — an intricate network of which we are usually but dimly aware. At the very least, transpersonal approaches can provide an expanded perspective from which to view our own problems. Anxiety or depression may not appear so onerous when they are placed in these temporal, spiritual or priority frameworks. These dimensions of therapy can also provide discipline, inspiration, courage, hope, and community with other people or higher powers.\(^{349}\)

Recall Benor’s earlier statement that “we have only to call upon our inner self-helper to discover the reasons for our woes and problems, and to learn the steps we may take to alleviate and correct them.”\(^{350}\) It is evident that Benor sees the possibility of using methods of contacting the inner self-helper and transpersonal approaches (as with Inner Counselor) to address anxiety and depression. Hopelessness has been identified as one of the strong indicators of depression in seniors.\(^{351}\) If transpersonal approaches truly can provide hope, as Benor suggests, then this could be an important factor in alleviating depression.

A fascinating longitudinal study of the antecedents and effects of wisdom in old age sought to explore whether wise individuals (this study was for women only) age more successfully than those with less wisdom (defined as a combination of cognitive, reflective, and affective personality qualities). The findings of the 40-year study indicate that this is indeed the case: on average, wise women were not only more satisfied during their later years of life, but they also tended to be healthier and have better family relationships than women with a lower degree of wisdom. Furthermore, wisdom had a higher impact on life satisfaction than did social relations or objective life conditions.\(^{352}\) The Inner Counselor helps participants to access their wisdom. To whatever extent that happens, it could contribute to a greater sense of well-being for the seniors in this study.
From the experience of both facilitating and participating in the Inner Counselor, the relief of physical symptoms has been observed. Benor was quoted previously as acknowledging the possibility that thoughtforms could “produce [changes] at the level of the physical body.”

James Oschman, a world authority on energy and complementary medicine, offers an explanation for what may be occurring in the body. Oschman believes that each human embodies a tensegrous living matrix, which has the ability to generate and conduct vibrations. (See the Definitions in Appendix A.1 for an explanation of tensegrity.) He says, “The vibrations occur as mechanical waves or sounds, called *phonons*, electrical signals, magnetic fields, electromagnetic fields, heat, light, and *solitons* (a solitary electromechanical wave [as in a gaseous plasma] that propagates with little loss of energy and retains its shape and speed after colliding with another such wave).”

The living matrix retains a record or memory of the influences that have been exerted upon it. When vibrations pass through tissues, they are altered by the signatures of the stored information. In this way, our consciousness and our choices are influenced by memories stored in soft tissues. Oschman indicates that biologists now know that all cells in the body have the capacity to store information in their cytoskeletons, and because the cytoskeleton is continuous with all the other molecular networks in the body, memories stored within any individual cell are accessed and communicated within the living matrix. Consciousness and choice influenced by cell memories communicated within a living matrix can be seen as analogous to the *Inner Counselor Process©*, where consciousness and choice are influenced by accessing inner wisdom from several parts of the living matrix (including the cells) and communicating it to the conscious self.
“Cumulative structural problems … can arise from long-standing emotional attitudes,” writes Oschman. “A skilled therapist reads these structural/emotional patterns and has methods of resolving or freeing us from them. A number of sessions may be required, but when the job is done the tissue and the mental attitude toward life can be completely rearranged…. This has structural and emotional consequences that can bring about the release of toxic materials that have been stored in the tissues for many years.”

Oschman refers primarily to bodywork such as massage, chiropractic, and craniosacral as the forms of therapy that access this information. It is also very plausible that, because of its multidimensionality, the Inner Counselor acts in the same way. The sensations associated with the participant’s issue are felt in the physical body, and could certainly be stored in the cell cytoskeleton, which would the offer the same access to the rest of the body. One significant difference between Inner Counselor and bodywork would be the role of the therapist. Rather than “reading the patterns,” as is done in many bodywork approaches, an Inner Counselor facilitator would assist clients in uncovering their own patterns.

One aspect of the Inner Counselor that contributes to the efficacy of its healing is the immediacy of results. Unlike some other modalities, where the process is the beginning of the work and the participant must further reinforce it with affirmations or other activities, when the Inner Counselor is complete, the participant notices immediate changes. Nunley explains: “The old reactionary pattern worked loyally and automatically. For example, the person never needed to ‘think about’ or ‘call on’ the old reactionary pattern; in fact, prior to the process they have most usually been unaware that their response IS part of a pattern. The New Symbol, once in place, works just as loyally
and automatically. There is no need to use it as an affirmation and, if the process is complete, one’s needs relating to the issue will no longer be triggered.”

This immediacy contrasts with other approaches to treating anxiety and depression, such as pharmacotherapy, psychotherapy, botanical treatments, and even exercise, which generally take several weeks to show results. Experiencing results right away could certainly be seen as a positive aspect in the healing process.

The Inner Counselor Process© includes both psychological and spiritual aspects. Many of the psychological (particularly transpersonal psychology) aspects have already been examined. The following section reviews the literature and current thinking regarding seniors and spirituality.

**Seniors and Spirituality**

*With age comes the inner, the higher life.*
*Who would be forever young, to dwell always in externals?*

*Elizabeth Cady Stanton*

Any contemporary discussion about the psychology of religion and spirituality immediately enters the current fray regarding terminology. Although the terms are sometimes used interchangeably, religion and spirituality have differentiating characteristics. Usually, the term “religion” embodies beliefs or rituals that are associated with a specific institutionalized group or belief system organized around some sacred dimension. In contrast, “spirituality” tends to be thought of in more amorphous terms: that is, one can be spiritual in both belief and behaviour, yet have no ties to an
institutionalized system. In this sense, spirituality can be seen much more as an individual connection with a greater power, a personal search for the sacred, a sense of interconnectedness of all living creatures, and an awareness of the purpose and meaning of life. As noted earlier, the Inner Counselor Process© is a spiritual practice, and respectful of all faith traditions.

More so than younger adults, adults aged 65 or older report that spirituality and religion are important in their lives. The idea that spirituality increases in the second half of adult life dates back at least to Confucius, who in 479 BCE is thought to have said, “At 50, I understood the Decree of Heaven.” Longitudinal data spanning early (30s) and later (late 60s to mid-70s) adulthood were used to study spiritual development across the course of an adult life in a sample of men and women belonging to a younger (born in 1928 and 1929) and an older (born in 1920 and 1921) age cohort. All participants, irrespective of gender and cohort, increased significantly in spirituality between late middle life (mid-50s to early 60s) and older adulthood.

A study on spirituality and aging shows that 88.7% of adults aged 55 or older describe themselves as having moderate to high levels of both religiosity and spirituality. The same study asserts that about two decades ago a researcher would have been hard pressed to find a significant body of high-quality research that critically examines the role religion and spirituality play in people’s lives. Today, there is no such dearth of research: scholars from many fields, including but not limited to medicine, psychiatry, sociology, psychology, public health, and nursing, are increasingly examining religion and spirituality as factors that pattern the health and well-being of adults. The belief that religion and spirituality may play an important part in individual health and well-being has gained enough ground such that nearly 30 U.S. medical schools offer courses on the subject. In addition to these programs, conferences and funding mechanisms that support this area of research are on the rise.
Specifically for older adults, spirituality and religion are associated with a myriad of mental health benefits. For example, spirituality has been described as a buffer against depression.\textsuperscript{364} Also, increased happiness and life satisfaction have been linked empirically with spirituality for older adults.\textsuperscript{365 366} Finally, spirituality and religion have been related to higher levels of adjustment for older adults.\textsuperscript{367} The University of Maryland Medical Centre states that “spiritual practices tend to improve coping skills and social support, foster feelings of optimism and hope … reduce feelings of depression and anxiety. Results from several studies indicate that people with strong religious and spiritual beliefs heal faster from surgery, and are less anxious and depressed.”\textsuperscript{368}

Until recently, the accepted model of successful aging was that proposed by Rowe and Kahn. It is a three-factor model, citing avoidance of disease and disability, maintenance of physical and cognitive function, and engagement in social and productive activities as the defining factors.\textsuperscript{369} More recently, however, a paper has been published that proposes that there is a fourth factor to successful aging: positive spirituality. The authors, Crowther, Parker et al, offer an enhanced model of Rowe and Kahn’s theoretical framework. Their evidence suggests that the addition of spirituality to interventions focused on health promotion has been positively received by older adults.\textsuperscript{370} In their study, positive spirituality is defined in this way: “Positive spirituality involves a developing and internalized personal relation with the sacred or transcendent that is not bound by race, ethnicity, economics, or class, and promotes the wellness and welfare of the self and others. Positive spirituality uses aspects of both religion and spirituality.”\textsuperscript{371} Using those criteria, the Inner Counselor could easily be seen as supportive of positive spirituality, and hence as supportive of successful aging.
The study’s authors further submit that “any intervention using positive spirituality should be patient- and not caregiver-centered, and that the health care provider must honour the patient’s autonomy, follow the patient’s lead and needs, and use permission, respect, wisdom, and sensitivity.” The fact that the Inner Counselor facilitator does not offer solutions, but acts as a guide to assist participants in accessing their own wisdom, certainly addresses the concepts of honouring the participant’s autonomy and following his or her lead. The process is intended to follow the participant’s needs; in fact, determining intrinsic needs is an integral step (step 7). The process notes for the guide, shown in the Inner Counselor Manual, underline the importance of staying in a mode of inquiry and resisting the urge to add words, analyze, or interpret. This demonstrates an approach of sensitivity and respect. The Inner Counselor clearly appears to meet the requirements of an intervention to enhance positive spirituality!

In their book New Directions in the Study of Late Life Religiousness and Spirituality, Susan McFadden, Mark Brennan, and Julie Hicks Patrick state that scientific studies should be balanced by approaches that permit the personal meanings of religion and spirituality to surface. They assert: “Researchers and practitioners need to continue to be in conversation about their quest for deeper understanding and appreciation of the ways that aging motivates people to seek significance that transcends the exigencies of material existence.”

From all of the preceding information, it is clear that spirituality is finally becoming recognized as an important aspect related to seniors and gerontology. A positive indication of this is a three-issue series (2001 to 2002) in the Journal of Adult
Development that focused on spirituality and adult development. The editor sets out the purpose of creating these three issues in an introduction to the series: “Developing adults express the belief that spirituality plays a key role in their development. Yet life span developmental psychologists have given comparatively little attention to the spirituality factor in the past…. The purpose of this Special Issue is to begin to remedy this neglect.”

A few studies have been done in this area, mostly using intercessory prayer as the intervention. One particularly interesting study used the Prayer Wheel as a spiritually-based intervention to alleviate subsyndromal anxiety and minor depression among older adults. Subsyndromal anxiety is an anxiety level that would not meet the criteria of the DSM-IV-TR for a diagnosis of anxiety, but is significant in the life of the person experiencing it; it is similar in severity level to “minor” or subsyndromal depression. The authors acknowledge that, while numerous studies indicate that religion and/or spirituality may be linked to psychological well-being among older adults, less is known about the therapeutic potential of spiritually-based interventions with regard to anxiety and depression among older adults. They found a significant decrease in anxiety and a trend toward decreased depression in their experimental group participants. In addition, those participants who continued to use the Prayer Wheel had a decrease in depression scores, while those who did not had an increase in depression scores. This study is an early indication that spiritually-based interventions can have a positive effect on reducing anxiety and depression in seniors.

A study examining elderly patients’ perceptions of their spiritual needs and care asked an interesting question: what did these people find unsatisfactory about their
spiritual care? The answer was just as interesting: they felt dissatisfied when they perceived that they were being “jollied along,” not allowed to speak about serious issues, or not assisted to make sense of or find meaning in life events. It is possible that the Inner Counselor would be an effective intervention for any of these areas of dissatisfaction. Serious issues are very manageable with the Inner Counselor, and in no case are participants “jollied along,” since they choose the issues they wish to address, participate in the process, and access their own wisdom. The Inner Counselor is a spiritual intervention; it could be an excellent way to address spiritual needs such as the ones expressed in this study.

Recently, concern has been expressed that failure of health service providers to attend adequately to the spiritual component of patient care may be symptomatic of a medical culture in which the more readily observable and measurable elements in care practice have assumed a prominence over the more subjective, deeply personal components. Greasley, Chiu, and Gartland, who studied spiritual care in mental health nursing, propose that a more holistic approach to care should be adopted, which would entail multidisciplinary education in spiritual care. The Inner Counselor could have a great deal to offer to assist in this process. Due to its spiritual, rather than religious nature, it can be used successfully with people of all faiths, including those who espouse no religious tradition. The Inner Counselor is holistic (addressing body, mind, emotions and spirit) and multidisciplinary, since it contains aspects of traditional psychology, transpersonal psychology, energy medicine, and spiritual healing. The *Inner Counselor Process*© is easily facilitated in a wide variety of settings, from the bedside of an ill and immobile patient to more comfortable surroundings for those who are mobile. It allows
the participant to process the subjective, personal emotional and spiritual aspects of their being, as well as the physical, observable ones. The *Inner Counselor Process©* does not take a long time to complete (half an hour to an hour), making it easily incorporated into a care program.

A relatively recent contribution to the gerontological literature is the concept of gerotranscendence. “Gerotranscendence is a shift in meta-perspective from a materialistic and pragmatic view of the world to a more cosmic and transcendent one,” says Lars Tornstam, originator of the concept. “As in Jung’s theory of the individuation process, the theory of gerotranscendence assumes a predisposition to a progression toward maturation and wisdom, a stage of gerotranscendence.” The theory of gerotranscendence states that human aging is a process continuing into old age, and that this process, when optimized, ends in a new and qualitatively different perspective on life. This concept has been created and studied by a group of gerontology and sociology professors at a Swedish university. Many of the concepts of the Inner Counselor appear to resonate with concepts of gerotranscendence. Aspects such as connection with the cosmic (Higher Self), the predisposition toward maturation and wisdom, seeking coherence in self, and accessing inner wisdom are found in both the Inner Counselor and the theory of gerotranscendence.

In some ways, gerotranscendence would have similarities with a version of the *Inner Counselor Integration Chart©* created specifically to focus on the life journey through the senior years. A project designed to derive guidelines from the theory of gerotranscendence for the care of older people found that encouraging and supporting older people in their process towards gerotranscendence involved “putting the main focus
on facilitating and furthering personal growth.” The *IC Process©* could be a valuable tool to accomplish this.

Gerontologist David Moberg offers a positive and hopeful summation of the value of spiritual approaches to the difficulties of aging:

The negative aspect of biological aging is overwhelming for many persons, but … people can transcend it with spiritual approaches toward meaning-making, affirming personhood, enriching insights, increasing wisdom, and continuing growth toward spiritual maturity throughout the later years of life. More research into the effectiveness of spiritually-based interventions is warranted.

**Conclusion**

Dr. Ann Nunley reiterates the healing potential of the Inner Counselor:

When the energy of the High Self is free to move through an unobstructed, balanced personality, we transform our physical and psychological reality, and ultimately, transcend restrictive limitations. Thus, the transformation of the personality helps to heal the body and mind dysfunction and also forms the basis for a lifetime spiritual journey.

The Inner Counselor has been used with many seniors by the PI in her private practice, and their feedback was important as this study was planned. They spoke of heavy burdens being lifted, burdens they had been carrying for a very long time. They remarked that, for the first time in years, they felt they had *released* their grief, not simply managed to *contain* it. Their descriptions of how they felt after an *Inner Counselor Process©* included “euphoric,” “more like the me I know and love,” “connected,” “back in touch with God,” and “returning to a sense of well-being that I haven’t felt in years.” Those phrases could be seen as describing a relief of anxiety and
depression. It is highly possible that through the experience of the IC Process©, seniors may have greater opportunities to increase their personal sense of well-being through reducing symptoms of anxiety and depression.
Chapter 1 Endnotes:


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8 Ibid.

9 Norman Abeles, “What Practitioners Should Know about Working with Older Adults.”


11 Health Canada, Division of Aging and Seniors, “Canada’s Aging Population.”


14 Abeles, “What Practitioners Should Know about Working with Older Adults.”


30 Abeles, “What Practitioners Should Know about Working with Older Adults.”
31 Baldwin and Heeren, “Mood Disorders in Late Life: A New IPA Task Force.”
32 Mehta et al., “Prevalence and Correlates of Anxiety Symptoms in Well-Functioning Older Adults.”
33 Langa et al., “Extent and Cost of Informal Caregiving for Older Americans with Symptoms of Depression.”
34 The Merck Manual of Diagnosis and Therapy, “Drug Therapy in the Elderly.”
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44 Ibid.
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CHAPTER 2: RESEARCH METHODS

Research Design

This study used a pre-test/post-test waiting-list control group design with repeated measure of the dependent variables (depression and anxiety). Because of the stigma seniors sometimes attach to the words anxiety and depression, those words were not used in recruiting letters or flyers, or in communication with potential participants. Instead, the terms “peace of mind” and “well-being” were used, since peace of mind and well-being have been shown to be indicative of an absence or reduction of depression and anxiety.

Participants were not told whether they were in the experimental group or the control group, to which they were assigned using quota sampling. Rather, they were told that they were in the group of people who would experience their Inner Counselor Processes© (“in the next two months,” or in the group of people who would experience their IC Processes© “a few months from now.”) The Principal Investigator (PI), however, was aware of which participants were assigned to each group.

Experimental group participants completed three pre-tests at weekly intervals: two weeks, one week, and the day before the first IC Process© (test forms “A,” “B,” and “C”). They experienced two IC Processes© one week apart, and then completed two post-tests: the day after the second IC Process© (test forms “D”), and two weeks after the final IC Process© (test forms “E”). Participants completed five tests in total.

Control group participants completed the five tests on exactly the same schedule as did the experimental group, but with no IC Processes© between them. Their
processes were scheduled once all of their testing was complete. C group participants had one extra form to complete, an anecdotal reporting form (“F”) that gave them the opportunity for feedback and comments after they had experienced their *IC Processes*.

The study design is depicted in table 1:

<table>
<thead>
<tr>
<th>Form Completion Date</th>
<th>1st Test “A” Forms</th>
<th>2nd Test “B” Forms</th>
<th>3rd Test “C” Forms</th>
<th>IC 1</th>
<th>IC 2</th>
<th>4th Test “D” Forms</th>
<th>5th Test “E” Forms</th>
<th>IC 3</th>
<th>IC 4</th>
<th>“F” Form</th>
</tr>
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<tbody>
<tr>
<td>Experimental Group</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>Control Group</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

In this table *IC* stands for the times when participants experienced an *IC Process*.

Experimental group participants experienced *IC Processes* on Dates 1 and 2, Control group participants on Dates 3 and 4.

**The Researcher’s Role**

The PI had full responsibility for all aspects of this study.
For three months (April, May and June), the PI had the help of a research assistant (RA), who was a university graduate. The RA assisted in the early administrative aspects of the study: preparing the Inner Counselor Office, typing, creating Participant Packages, mailing and/or delivering the Participant Packages, recruiting, enrolling participants, making reminder calls, and inputting the early data.

As well as completing the administrative aspects of the study, the PI also facilitated all of the *Inner Counselor Processes* done for the study. The PI had completed both Inner Counselor courses offered at Holos University Graduate Seminary (831: Inner Counselor — A Spiritual Discipline, and 833: Inner Counselor Advanced Practicum). In addition, the PI had attended the residential portion of the Inner Counselor course as a helper three times, and had been co-facilitator at two Inner Counselor Canada weekend workshops. She received supervision while working with clients for approximately one year (during coursework) and had been using the *IC Processes* with clients in her private practice for three years. She received the *IC Processes* certificate for 100 hours of training using the *IC Process* and its Concepts.

A single facilitator was used for two reasons. First, there were not enough trained facilitators (stipulated as those who had completed both Holos courses on Inner Counselor and had assisted at the residential portion of the Inner Counselor course at least twice) who would be available for the large number of volunteer hours required, and funds were not available to pay facilitators. Second, having a single facilitator eliminated the possibility that any difference in results was due to the differing abilities of the various facilitators. All facilitators are likely to vary slightly in their effectiveness from day to day, and while it is acknowledged that this could also be true for the PI, having
only one facilitator reduced to one the number of facilitators who vary slightly in their effectiveness.

The PI did have an interest in the outcome of the study. The PI uses the IC Process© as one healing modality in her personal practice. The PI was interested to see if statistically significant changes would be observed using the intervention with seniors.

Due to the study design, the PI was clearly aware of which participants were in the Experimental and Control groups. As stated, she also had an interest in the outcome of the study, and wondered if her role as facilitator of the processes might be affected by assessing the data as it came in. If the data did not look promising, would she start “trying too hard”? If the data looked very positive, would she “slack off”? The best approach seemed to be to avoid either of those possibilities; thus, the PI chose not to look at any of the data until the entire Experimental group had completed their processes and all of the test data had been received from both groups. The PI did read the anecdotal information from the Experimental group prior to their processes (from data sets “A,” “B,” and “C”), since participants often gave information they wanted to cover during the processes (and expected the PI would know, since they had written about it!).

A statistician was hired to do the statistical analysis, although the PI duplicated some of the statistical tests as well, since both statistician and PI were using SPSS (the Statistical Package for Social Sciences), a computer statistical package, and data could be transferred easily between computers.
Recruiting

Participants between the ages of 65 and 85 (inclusive) were recruited from a city in Southwestern Ontario, Canada, and the surrounding area. Recruiting was done by the PI and the RA.

Information packages on the research study (the number in parentheses indicates how many information packages were sent to each category) were sent to: local faith communities (38), seniors’ centres (3), retirement homes (15), doctors’ offices (122), geriatrician (1), chiropractors (35), hearing assistance specialists (6), denture clinics (6), golf courses (8), lawn bowling club (1), tennis organizations (2), seniors’ golf group (1), holistic health practitioners (38), osteopaths (3), friends and acquaintances (17), Therapeutic Touch team (1), drug stores (24), natural health stores (5), seniors’ groups (8), local newspapers (2), community care organization (1), church clergy group (1), support groups (6) (Stroke Recovery, Lung Association, Multiple Sclerosis Society, Diabetes Association, Prostate Cancer, Seniors Offering Support), foot care centre (1), healing meals organization (1), and the Royal Canadian Legion (1). Each package included a cover letter for the recipient, a flyer (see Appendix B.1) to be posted in a location where it would be seen by seniors, and at least two letters that could be given to any other seniors who expressed interest. All packages contained contact information for the PI.

Cover letters were adapted slightly to reflect the intended recipients; different letters were sent to administrators (doctors, health care professionals, and those in charge of seniors’ groups, sports organizations, seniors’ homes, businesses, or support groups) (see Appendix B.2), friends and acquaintances (see Appendix B.3), the Therapeutic
Touch™ team (see Appendix B.4), the Clergy Group (see Appendix B.5), and seniors
who expressed interest in the study (see Appendix B.6). All letters, flyers, or
communication intended for seniors used 12-point Arial font with text bolded for ease of
reading.

An informational insert (see Appendix B.7) ran for several weeks in the church
bulletin at the PI’s church, and the PI made announcements (see Appendix B.8) before
church services for four consecutive weeks. The recruiting letter to be given to interested
seniors ran in the church newsletter once. Bulletin inserts were made available at a table
in the church hallway, where they could be accessed by interested seniors. The PI and
her RA set up a table at coffee time after church for five weeks to answer questions, hand
out information on the study, and offer seniors a chance to sign up.

Presentations were made to several groups: the stroke recovery group, two
seniors’ groups at local churches, a seniors’ group at the local YM/YWCA, the
osteoporosis support group, and a local retired men’s group. These presentations
consisted of orally presenting the information in the Recruiting Letter for Interested
Seniors (see Appendix B.6), handing out copies of the letter, and offering those present
an opportunity to sign up for the study if they chose. The announcement made to the
local men’s club is found in Appendix B.9.

The local seniors’ centre allowed the PI and her RA to set up a table in their main
lobby to distribute information on the study. Since the majority of the centre’s activities
take place during the morning, the PI and her RA were at the table for several hours every
morning for one week. Interested seniors could take a recruiting letter to read later, ask
questions, and/or sign up for the study. The letter was also available on the table at times
when the PI and her RA were not present. In addition, a flyer was posted on the information board at the seniors’ centre.

A short notice ran for two weeks in two local newspapers (see Appendix B.10).

Permission was sought and granted for the PI to post an invitation to participate in the study on the Web site of a local seniors’ residential community (see Appendix B.11). In keeping with the policy of that community and their Web masters, the invitation was posted for five days.

Seniors had three options for signing up for the study. All interested seniors were given a copy of the Recruiting Letter for Interested Seniors (see Appendix B.6). They could sign up directly, which consisted of giving the PI or her RA their contact information (name and telephone number) so they could be called later and enrolled in the study; they could take printed information with them and call the PI or her RA to enrol in the study at a convenient time; or they could email the PI or her RA to request participation in the study, and the PI or her RA would then call to enrol them. It was found to be beneficial to call seniors who expressed interest and gave their contact information, since many indicated that they had intended to call and sign up but had not gotten around to it, and so were grateful for the call. Most participants either gave the PI their contact information or called to inquire about the study. Only five participants of the 105 who initially enrolled (4.8%) made contact through email.

Information regarding how and where participants heard about the research study was collected as part of the Participant Information Form, and is displayed in table 2. The data in the table represents the information given by the participant on the Participant Information Form. Many participants indicated several sources of information about the
study; for example, seniors may have heard about it from a friend, and then seen the information at the seniors’ centre as well. Many of the participants from the PI’s home church mentioned seeing the posters for the study at the seniors’ centre or at the YM/YWCA; some indicated that they had read about the study on their community Web site and also heard about it at the various groups of which they were members.

Table 2. Participant recruiting information

<table>
<thead>
<tr>
<th>Where Participants Heard about this Research Study</th>
<th>Total Population</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency (number of participants)</td>
<td>Percent (of population)</td>
<td>Frequency (number of participants)</td>
<td>Percent (of group)</td>
<td>Frequency (number of participants)</td>
<td>Percent (of group)</td>
</tr>
<tr>
<td>From the Principal Investigator</td>
<td>10</td>
<td>11.8</td>
<td>4</td>
<td>9.3</td>
<td>6</td>
<td>14.3</td>
</tr>
<tr>
<td>From a Friend</td>
<td>16</td>
<td>18.8</td>
<td>9</td>
<td>20.9</td>
<td>7</td>
<td>16.7</td>
</tr>
<tr>
<td>At the Seniors' Centre</td>
<td>14</td>
<td>16.5</td>
<td>7</td>
<td>16.3</td>
<td>7</td>
<td>16.7</td>
</tr>
<tr>
<td>At the PI's Home Church</td>
<td>18</td>
<td>21.2</td>
<td>10</td>
<td>23.3</td>
<td>8</td>
<td>19.0</td>
</tr>
<tr>
<td>From a Mail Out or Saw a Flyer Posted</td>
<td>5</td>
<td>5.9</td>
<td>3</td>
<td>7.0</td>
<td>2</td>
<td>4.8</td>
</tr>
<tr>
<td>At the Stroke Recovery Group</td>
<td>5</td>
<td>5.9</td>
<td>2</td>
<td>4.7</td>
<td>3</td>
<td>7.1</td>
</tr>
<tr>
<td>At the YM/YWCA</td>
<td>6</td>
<td>7.1</td>
<td>2</td>
<td>4.7</td>
<td>4</td>
<td>9.5</td>
</tr>
<tr>
<td>Newspaper Notice</td>
<td>1</td>
<td>1.2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>At the Men's Group</td>
<td>10</td>
<td>11.8</td>
<td>6</td>
<td>14.0</td>
<td>4</td>
<td>9.5</td>
</tr>
<tr>
<td>Total</td>
<td>85</td>
<td>100.0</td>
<td>43</td>
<td>100.0</td>
<td>42</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Inclusionary Criteria

Participants were 65 to 85 years of age, inclusive. Participants had no previous experience of the Inner Counselor© or the IC Process©. Participants were not taking medication for anxiety and/or depression, or, if they were, their dosage had been stable for at least six months and was likely to remain unchanged during the study. Participants showed willingness to participate by signing a voluntary informed consent form.

Exclusionary Criteria

Prospective participants excluded from the study were: those who were younger than 65 or older than 85 years of age; those who had previous experience of the Inner Counselor© or the IC Process©; those taking medication for anxiety and/or depression whose dosage had not been stable for at least six months, or was expected to change over the course of the study (see the Information Regarding Medication Prescribed for Anxiety and Depression section below); and those who had been diagnosed with schizophrenia, bipolar disorder, dementia, legal blindness, or post-traumatic stress disorder. (The purpose of the addition of several possibilities other than the exclusion criteria on the Participant Information Form was to assist in not identifying the dependent variables of the study to participants.)
Enrolment Procedure

Participants were taken through an enrolment procedure on the telephone to

- determine their eligibility for the study according to the inclusion/exclusion criteria noted above;
- if eligible, be assigned to a group and be given participant numbers through a process of quota sampling;
- obtain their addresses so that participant packages could be sent or delivered to them; and
- determine the dates of the IC Processes© for those in the experimental group.

A copy of the telephone script for the enrolment procedure can be found in Appendix C.1. Three areas of the enrolment procedure require further explanation for clarity: the method of quota sampling used; the ascertaining of information regarding medications for anxiety and depression; and information regarding screening for exclusionary illnesses.

Quota Sampling Procedure

Participants were assigned to groups using quota sampling. Research indicates that education levels, age and gender can influence both depression and anxiety levels. The age factor was addressed by the age limits on the study. This left gender and education level (post-secondary versus no post-secondary education) to be managed using quota sampling.
The study consisted of four participant categories, each divided into an Experimental (E) and Control (C) group, creating eight participant groups numbered as follows:

1. E group  Men  Post-Secondary Education  
2. C group  Men  Post-Secondary Education  
3. E group  Men  No Post-Secondary Education  
4. C group  Men  No Post-Secondary Education  
5. E group  Women Post-Secondary Education  
6. C group  Women Post-Secondary Education  
7. E group  Women No Post-Secondary Education  
8. C group  Women No Post-Secondary Education  

Participants were assigned to these groups in the order in which they enrolled in the study. This contributed to the randomization of participants into E and C groups, since the PI had no control over the order in which potential participants contacted her. In all cases, the participant was assigned to a group after going through the enrolment procedure. Thus, if the PI called a prospective participant but did not make contact, that person was not assigned to a group at that time. This factor also contributed to the randomization of participants, since the PI could not reliably have contacted prospective participants in the order she might have liked each to be assigned to a particular group (even if she had had that intent, which she did not).
The first participant in each category (e.g., men with post-secondary education) was always assigned to the E group, the second in the same category to the C group, the third to the E group, and so on, alternating assignation between E and C groups. Participant numbers consisted of the category number first, then the number of the participant within the group; thus, the first man with post-secondary education was participant 1-1; the second one was 1-2, and so on. The even groups were the controls for the odd groups preceding them (e.g., group 2 was the control for group 1; group 4 was the control for group 3, etc.). This also helped to keep the number of participants in the E and C groups evenly matched.

Because the PI conducted the IC Process© with all of the study participants herself, the processes took place over the course of about six months. In order to ensure that C group participants were completing their forms at roughly the same time that their corresponding E group participants completed their forms, form completion dates were synchronized as closely as possible during the quota sampling process. When a participant was assigned to an E group, the dates for his or her form completion and Inner Counselor Processes© were established. When the participant with the same number in the corresponding C group was enrolled, he or she was given the same form completion dates (but not IC Process© dates) as the corresponding E group participant. So, for example, participants 1-1 and 2-1 would complete forms at the same time, as would participants 5-6 and 6-6, or 7-3 and 8-3. If time elapsed between enrolling the E group and the C group participants, such that the form completion dates of the E group participant would not be viable for the corresponding C group participant, completion
dates as close as possible to those of the E group participant were chosen for the C group participant.

**Information Regarding Medication Prescribed for Anxiety and Depression**

Changes in medications prescribed for anxiety and depression could potentially have an effect on the depression and anxiety test results and, accordingly, measures were taken to minimize that effect. The PI contacted a local geriatrician, who suggested that if dosages of medications for anxiety and depression had been stable for six months, medication was not likely to be a factor in any changes seen in the study. The time frame of six months was longer than that used in other studies of interventions for anxiety and depression with seniors, whose requirement was a three month stability of medication dosage.9

Potential participants were asked, “Are you currently taking medication?” If they answered “no,” the enrolment proceeded to the next step. If they answered “yes,” they were asked: “Have any of the dosages changed in the past six months?” If none of the medication dosages had changed in the past six months and were not expected to change through their involvement in this study (until the day of the last post-test for that participant), enrolment proceeded to the next step. If the dosages for any medications had changed in the past six months, the prospective participant was asked the name of those medications for which dosages had changed. The PI or her RA did an initial identification of the medications for which dosages had changed, ascertaining which ones are prescribed for anxiety and depression. This was done by checking the medication names against a list compiled from the Mayo Clinic Web site, which lists common
medications and their trade names for depression
(http://www.mayoclinic.com/health/antidepressants/HQ01069) and anxiety
(http://www.mayoclinic.com/health/generalized-anxiety-disorder/DS00502/DSECTION=8). The lists that were compiled are found in Appendix C.2.

As indicated above, prospective participants whose dosage for medications taken for anxiety and/or depression had changed in the six months prior to the study were not eligible for the study. Prospective participants whose dosage for medications taken for reasons other than anxiety and/or depression had changed in the past six months remained eligible.

There was no intention to change any of the medication or dosage levels for participants; the only purpose of obtaining medication information was to observe if there were changes in anxiety and depression medication from pre- to post-intervention.

More information on the tracking of medication levels can be found in the Information Regarding Medication Prescribed for Anxiety and Depression section below.

**Screening for Exclusionary Illnesses**

Prospective participants who had been diagnosed with schizophrenia, bipolar disorder, dementia, legal blindness, or PTSD were not eligible for this study. The purpose of the addition of several possibilities other than the exclusion criteria on the Participant Information Form was to assist in not identifying the dependent variables of the study to participants.
A local geriatrician recommended the use of the question “Have you seen your doctor for difficulties with memory?” as a self-report on dementia (one that she uses in her own practice). Based on her medical experience, her opinion was that people with even moderate dementia would be unlikely to read the study flyer or recruitment letter, decide that this was a good thing for them, and then actually follow through with it — so she felt that the self-report in this area would be sufficient.

**Participant Packages**

As part of the telephone enrolment, the participant’s home address was obtained and a participant package was either mailed or delivered to the participant. In some cases, particularly early in the study, there was not sufficient time between enrolment and the date of the first form completion to be certain that a mailed package would arrive in time, so those packages were delivered by the PI or her RA.

Participant packages were sent in 22.9 cm x 30.5 cm (9” x 12”) manila envelopes, and contained:

- A Cover Letter for the Participant Package (see Appendix D.1) that stated the participant number for that participant, described the contents of the package, and explained the various components.
- The Participant Information Form (see Appendix D.2), which was to be completed and returned to the PI.
• Two copies of the Consent Form for Research Participants (see Appendix D.3), one of which was to be filled in and returned to the PI, and the other to be kept by the participant for future reference.

• One stamped, self-addressed 14.9 cm x 24.4 cm (5 7/8” x 9 5/8”) manila envelope in which to return the completed Participant Information Form and one copy (signed and dated) of the Consent Form for Research Participants.

• A bright yellow Reminder Card (see Appendix D.4 [E Group] and Appendix D.5 [C Group]) that listed the dates for form completion for that participant and the dates of the Inner Counselor Process© for those in the experimental group. The reminder card was attached to a magnetic backing so that it could be attached to the participant’s refrigerator or prominently displayed somewhere to help remind him or her of those dates.

• A Map giving directions to the Inner Counselor Office.

• Five stamped, self-addressed, white, legal-sized security envelopes (see Appendix D.6), each of which held:
  o One Sheet titled “Instructions for Completing the Questionnaires for the ‘Effects of the Inner Counselor Process© on Peace of Mind and Well-Being of Seniors’ Study” (see Appendix D.7)
  o One copy of the Beck Anxiety Inventory® (BAI®) (see Appendix D.8)
  o One copy of the Geriatric Depression Scale (GDS), titled “Mood Assessment Scale” (see Appendix D.9)
One sheet titled “Other Information,” used for anecdotal reporting in the participants’ own words their experience of the Inner Counselor (see Appendix D.10)

These five envelopes had the participant number and date to complete the forms contained within marked on the lower left of the front of the envelope, and the letter representing which of the five sets of pre-tests or post-tests this was (“A”, “B”, “C”, “D”, or “E”) marked on the lower right of the front of the envelope.

All envelopes that were to be returned to the PI had the PI’s name and address pre-stamped as both the sender and receiver on the outside of the envelope. This helped to ensure the anonymity of the participant within the study, as his or her return address would not appear on the envelope.

All forms and envelopes that were to be returned to the PI were pre-marked with the participant’s participant number, and participants were asked not to write their names on the forms. The exceptions to this were the Participant Information Form and the Consent Form for Research Participants, which, for obvious reasons, were required to be identified by name.

**Participants**

One hundred and five seniors between the ages of 65 and 85 were recruited from a city in Southwestern Ontario, Canada, and the surrounding area. In order to be included as participants in this study, individuals needed to meet the inclusionary criteria noted earlier. Eighty-five participants met these criteria.
Twenty people enrolled but did not complete the study for the following reasons: health issues (6 people), unexpected travel/visitors (6 people), incomplete paperwork (1 person), family emergencies (1 person), diagnosed dementia (1 person), being prescribed antidepressant medication after starting the study (1 person), feeling too happy to see the need for the Inner Counselor (1 person), hearing about the study from a friend and then finding that it was not what was expected upon receipt of the participant package (1 person), feeling that all the past was forgiven and removed so there was no need for the Inner Counselor (1 person), feeling too spiritually evolved to benefit from the Inner Counselor (1 person).

**Demographic Information**

A considerable amount of demographic information was collected on the 85 participants who enrolled in and completed the study, which helps to give a clearer picture of the study population. This information is best conveyed in table form, for ease of comprehension. All tables give information for the total population (N = 85) as well as for the Experimental (n = 43) and Control (n = 42) groups. As well as the frequencies of responses (n values), the information is also displayed as percentages (%).

Chi-square tests were performed to determine if there were significant differences between the E group participants and the C group participants on each of the pieces of demographic information. In each case, there was no significant difference found — the groups are relatively equivalent.

**Age distribution** ranged from 64 years to 84 years, with a mean age of 73.42 years (standard deviation 5.32). Women ranged in age from 65 to 82 years, with a mean
of 73.00 years (standard deviation 5.04). Men ranged in age from 65 to 84 years, with a mean age of 74.33 years (standard deviation 5.88). A more detailed age distribution can be found in table 3.

Table 3. Participant sample by age of participants

<table>
<thead>
<tr>
<th>Age of Participants (years)</th>
<th>Total Population</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
<td>Frequency</td>
</tr>
<tr>
<td></td>
<td>(number of</td>
<td>(of population)</td>
<td>(number of</td>
</tr>
<tr>
<td></td>
<td>participants)</td>
<td></td>
<td>participants)</td>
</tr>
<tr>
<td>65</td>
<td>3</td>
<td>3.5</td>
<td>2</td>
</tr>
<tr>
<td>66</td>
<td>3</td>
<td>3.5</td>
<td>6</td>
</tr>
<tr>
<td>67</td>
<td>7</td>
<td>8.2</td>
<td>2</td>
</tr>
<tr>
<td>68</td>
<td>6</td>
<td>7.1</td>
<td>2</td>
</tr>
<tr>
<td>69</td>
<td>3</td>
<td>3.5</td>
<td>3</td>
</tr>
<tr>
<td>70</td>
<td>7</td>
<td>8.2</td>
<td>6</td>
</tr>
<tr>
<td>71</td>
<td>10</td>
<td>11.8</td>
<td>1</td>
</tr>
<tr>
<td>72</td>
<td>6</td>
<td>7.1</td>
<td>2</td>
</tr>
<tr>
<td>73</td>
<td>2</td>
<td>2.4</td>
<td>0</td>
</tr>
<tr>
<td>74</td>
<td>3</td>
<td>3.5</td>
<td>2</td>
</tr>
<tr>
<td>75</td>
<td>4</td>
<td>4.7</td>
<td>4</td>
</tr>
<tr>
<td>76</td>
<td>5</td>
<td>5.9</td>
<td>0</td>
</tr>
<tr>
<td>77</td>
<td>4</td>
<td>4.7</td>
<td>1</td>
</tr>
<tr>
<td>78</td>
<td>2</td>
<td>2.4</td>
<td>1</td>
</tr>
<tr>
<td>79</td>
<td>3</td>
<td>3.5</td>
<td>3</td>
</tr>
<tr>
<td>80</td>
<td>4</td>
<td>4.7</td>
<td>2</td>
</tr>
<tr>
<td>81</td>
<td>7</td>
<td>8.2</td>
<td>5</td>
</tr>
<tr>
<td>82</td>
<td>3</td>
<td>3.5</td>
<td>1</td>
</tr>
<tr>
<td>83</td>
<td>2</td>
<td>2.4</td>
<td>1</td>
</tr>
<tr>
<td>84</td>
<td>1</td>
<td>1.2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>85</td>
<td>100.0</td>
<td>43</td>
</tr>
</tbody>
</table>

**Gender distribution** shows that approximately two thirds of the participants were female, and one third male. In the E Group, there were 43 participants, of which 34.9% (n = 15) were male and 65.1% (n = 28) were female. The C group consisted of 42
participants, of which 28.6% (n = 12) were male and 71.4% (n = 30) were female. Quota sampling helped to assure that there were roughly equivalent numbers of males and females in the E and C groups. The slight differences are due to differing numbers of participants who enrolled but did not complete the study in different groups. The gender distribution of the groups is found in table 4.

Table 4. Participant sample by gender of participants

<table>
<thead>
<tr>
<th>Gender</th>
<th>Total Population</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency (number of participants)</td>
<td>Percent (of population)</td>
<td>Frequency (number of participants)</td>
</tr>
<tr>
<td>Male</td>
<td>27</td>
<td>31.8</td>
<td>15</td>
</tr>
<tr>
<td>Female</td>
<td>58</td>
<td>68.2</td>
<td>28</td>
</tr>
<tr>
<td>Total</td>
<td>85</td>
<td>100.0</td>
<td>43</td>
</tr>
</tbody>
</table>

Marital status for the vast majority of participants in the total population was “married.” The E group had more widows or widowers than did the C group, while the C group had more participants who were divorced. Table 5 gives the complete data regarding marital status of this population.

Table 5. Participant sample by marital status of participants

<table>
<thead>
<tr>
<th>Marital Status of Participants</th>
<th>Total Population</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency (number of participants)</td>
<td>Percent (of population)</td>
<td>Frequency (number of participants)</td>
</tr>
<tr>
<td>Living with Partner</td>
<td>1</td>
<td>1.2</td>
<td>1</td>
</tr>
<tr>
<td>Divorced</td>
<td>9</td>
<td>10.6</td>
<td>3</td>
</tr>
<tr>
<td>Married</td>
<td>57</td>
<td>67.1</td>
<td>32</td>
</tr>
<tr>
<td>Widow or Widower</td>
<td>18</td>
<td>21.2</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>85</td>
<td>100.0</td>
<td>43</td>
</tr>
</tbody>
</table>
Education levels for this population were quite standard across the groups. Slightly more C group participants were college graduates than university graduates, and the reverse was true for the E group. The total number of participants who completed graduate school was the same in the two groups, although distribution between Master’s degrees and Doctorates was somewhat different. The figures are shown in table 6.

Table 6. Participant sample by education level of participants

<table>
<thead>
<tr>
<th>Highest Level of Education Completed</th>
<th>Total Population</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency (number of participants)</td>
<td>Percent (of population)</td>
<td>Frequency (number of participants)</td>
</tr>
<tr>
<td>Elementary School</td>
<td>1</td>
<td>1.2</td>
<td>1</td>
</tr>
<tr>
<td>Secondary School</td>
<td>17</td>
<td>20.0</td>
<td>8</td>
</tr>
<tr>
<td>Some Post-Secondary Education</td>
<td>18</td>
<td>21.2</td>
<td>7</td>
</tr>
<tr>
<td>College</td>
<td>12</td>
<td>14.1</td>
<td>6</td>
</tr>
<tr>
<td>University</td>
<td>21</td>
<td>24.7</td>
<td>13</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>11</td>
<td>12.9</td>
<td>4</td>
</tr>
<tr>
<td>Doctorate</td>
<td>5</td>
<td>5.9</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>85</td>
<td>100.0</td>
<td>43</td>
</tr>
</tbody>
</table>

Accommodation information for the study sample showed that most of the study participants (approximately 88%) lived in their own homes. None of the C group lived in a seniors’ facility, and a small number in each group lived with (one of) their children. Exact figures are given in table 7.
Table 7. Participant sample by accommodation of participants

<table>
<thead>
<tr>
<th>Accommodation (where participants live)</th>
<th>Total Population</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency (number of participants)</td>
<td>Percent (of population)</td>
<td>Frequency (number of participants)</td>
<td>Percent (of group)</td>
<td>Frequency (number of participants)</td>
</tr>
<tr>
<td>In my own home</td>
<td>75</td>
<td>88.2</td>
<td>38</td>
<td>88.4</td>
<td>37</td>
</tr>
<tr>
<td>In a Seniors' facility</td>
<td>2</td>
<td>2.4</td>
<td>2</td>
<td>4.7</td>
<td>0</td>
</tr>
<tr>
<td>With (one of) my children</td>
<td>8</td>
<td>9.4</td>
<td>3</td>
<td>7.0</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>85</td>
<td>100.0</td>
<td>43</td>
<td>100.0</td>
<td>42</td>
</tr>
</tbody>
</table>

Diagnosed illnesses and disorders for this group of seniors, when tabulated, showed that hypertension was the most common, followed by heart disease and diabetes. A very small percentage of the population had been diagnosed with either anxiety or depression, and those who had were quite evenly distributed between the E and C groups. One participant was blind, but not legally blind (as she described it, she had an “atypical form of blindness”). (The PI did not know about her blindness until she came for her sessions, as it did not stop her from completing any of the study requirements.) More detailed information about diagnosed illnesses and disorders is found in table 8.
Table 8. Participant sample by diagnosed illnesses/disorders of participants

<table>
<thead>
<tr>
<th>Diagnosed Illnesses or Disorders of Participants</th>
<th>Total Population</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency (number of participants)</td>
<td>Percent (of population)</td>
<td>Frequency (number of participants)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>27</td>
<td>31.8</td>
<td>15</td>
</tr>
<tr>
<td>Bipolar</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Diabetes</td>
<td>5</td>
<td>5.9</td>
<td>4</td>
</tr>
<tr>
<td>Post-traumatic Stress Disorder</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Heart disease</td>
<td>10</td>
<td>11.8</td>
<td>4</td>
</tr>
<tr>
<td>Depression</td>
<td>4</td>
<td>4.7</td>
<td>1</td>
</tr>
<tr>
<td>Blindness</td>
<td>1</td>
<td>1.2</td>
<td>0</td>
</tr>
<tr>
<td>Anxiety</td>
<td>3</td>
<td>3.5</td>
<td>1</td>
</tr>
<tr>
<td>Dementia</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Obsessive/Compulsive Disorder</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Medication prescribed for anxiety and/or depression** was also tabulated.

Although only 4.7% of the population was diagnosed as having had depression, and 3.5% as having anxiety in the past 10 years, a total of 16.5% of the population indicated that they were taking medication prescribed for anxiety and/or depression. This can be seen as consistent with the literature review statements that more seniors experience subsyndromal (minor) anxiety and depression than major instances of either illness. The number of participants who were taking medications for anxiety and/or depression was quite even between groups, as can be seen in table 9.
Table 9. Participants taking medications for anxiety and/or depression

<table>
<thead>
<tr>
<th>Currently Taking Medication for Anxiety and/or Depression?</th>
<th>Total Population</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency (number of participants)</td>
<td>Percent (of population)</td>
<td>Frequency (number of participants)</td>
</tr>
<tr>
<td>Yes</td>
<td>14</td>
<td>16.5</td>
<td>6</td>
</tr>
<tr>
<td>No</td>
<td>71</td>
<td>83.5</td>
<td>37</td>
</tr>
<tr>
<td>Total</td>
<td>85</td>
<td>100.0</td>
<td>43</td>
</tr>
</tbody>
</table>

Tracking of Medication Information

Medication levels were monitored in several ways throughout the study, in addition to the initial assessment during enrolment. When the Participant Information Form was received by the PI, the written medication information was checked to verify the information received verbally during the enrolment phone call. All medications listed on the Participant Information Form for which dosages had changed in the past six months were compared to the lists of anxiety and depression medications from the Mayo Clinic Web site (Appendix C.2) to ensure that they were not medications prescribed for anxiety or depression. The medication information on the Participant Information Form accurately reflected the information given during the enrolment procedure for all participants. The dosage levels on the Participant Information Form were taken as the levels expected to remain stable throughout the study.

To check that medication levels had indeed remained stable throughout the study, participants were given a photocopy of the medication information from their Participant Information Form, which they were asked to assess for accuracy at the time of their fifth
set of tests (“E” forms). They were instructed to look at the medications listed and note any changes in dosages of these medications, or any new medications that may have been added during the course of the study. If there were any changes in dosages or any new medications, they were to record this on the photocopied sheet and return it with their “E” forms, or call the PI to give her the information. If there were no changes, no action was required on the part of the participant. If no information was received from participants, dosages were deemed to have been stable throughout the course of the study. One participant called the PI to let her know of a medication she had been prescribed since she enrolled; it was an antidepressant medication, so that participant did not complete the study. Several medications changed for participants, but none of these was for an anxiolytic or antidepressant medication.

As a second check to ensure that the PI had correctly identified all medications associated with anxiety and depression taken by study participants, a list of all medications listed by every participant in the study was compiled. The Mayo Clinic Web site (http://www.mayoclinic.com/health/drug-information/DrugHerbIndex) which allows users to search by drug name, gives Canadian and American brand names as well as generic names, indicates what the drug is used for, and gives a great deal of other information as well and the Medbroadcast.com website (http://www.medbroadcast.com/drug_info.asp) were used to determine what each medication would be prescribed for, and to obtain a short description of the medication and its uses. A copy of this list is found in Appendix C.3. Any medications indicated for use with anxiety and depression were marked with three asterisks (**). The list was sent to Dr. C. Norman Shealy, who had agreed to act as medication consultant for the
study. Dr. Shealy confirmed that the medications indicated for use with anxiety and depression had been correctly identified from the total list of medications.

Setting

All IC Processes\textregistered were conducted in the same location: a bright, spacious office decorated in warm earth tones, located on the ground level of a house in the city in which the research took place, in Southwestern Ontario, Canada. Requirements for the choice of location were:

- Within the city limits where the study was to take place
- Free parking available
- Bus stop nearby
- Level access — no stairs to get to the office
- Comfortable surroundings
- Easily accessible washroom close by (no stairs to get to it)
- Quiet — no loud interfering noises
- Waiting area with comfortable chairs for those arriving early, waiting for a ride, or preferring to sit until the bus arrived

Office Description

In order that all participants experienced a welcoming and comfortable environment, free from possible irritants or elements that could negatively influence the
experience of the Inner Counselor, several criteria were met by the PI in her choice of the
study location.

Free parking was available, either in the driveway (just a few steps from the
waiting room) or on the street.

A sign was placed outside the house, welcoming participants and indicating which
door they should use (see Appendix E.1). Once inside the waiting room, further signs
were posted beside the door, again welcoming participants and directing them into the
session (see Appendix E.2).

No pictures or decorations that had religious associations (e.g., angels or
Buddhas), or that had sayings, quotations, or writing on them, were placed in the room or
in the waiting area, since the study was open to persons of all (or no) faith traditions. All
pictures were limited to pictures of flowers, landscapes or nature, and the only
decorations in the room were a variety of foliage plants. No flowering plants were used
due to the possibility of sensitivities to them. The PI felt that nature was an experience
common to all, and as innocuous an aesthetic contribution to the setting as could be
chosen.

In the office, three chairs were arranged in a grouping. One chair was for the PI,
with a small table beside it to hold a clipboard, Inner Counselor information to be shared
with participants, a box of facial tissues, bottled water, and pens. A choice of two chairs
was offered to participants. One chair was a soft, comfortable recliner, which had a
footrest that could be elevated, and the other was a firmer wingback chair for those who
preferred more support. Participants were encouraged to choose the chair that would be
most comfortable for them. The PI’s chair swivelled so it could directly face whichever chair the participant chose.

A table and a chair sat in one corner of the room. This table was used by participants to journal (make notes to themselves) after their processes. A lamp, a pad of lined paper, several pens, a box of facial tissues, and a sheet titled “Possible Topics for Personal Notes” (see Appendix E.3) were placed on the table.

A desk was located along one wall, and the PI’s Certificate of Ordination and Certificate of Completion of 100 hours of Inner Counselor Process© Training were displayed above it. At no time were participant files left on the desk. All files were kept in a closed briefcase, set on the opposite side of the desk from the participants’ chairs.

A digital clock with large numbers, which made no ticking noise, was placed in a location where it could easily be seen by the PI during processes, but could not be seen easily by participants. This assisted the PI in staying within the time allotted for processes.

The only books displayed in the room were the Inner Counselor Seminar Manual©, and Inner Counselor: An Intuitive Guide for Life’s Journey. The only other printed material on display was the current Holos University Graduate Seminary Catalog and the Holos University Graduate Seminary brochure (see Appendix E.4). The Holos information was made available because Holos is not located near to the location of the study, and the PI thought participants might have questions or want further information about the university associated with the study. Several participants took flyers to read more about the university.
No fragrances, scents, or scented candles were used in the room, and the PI did not wear perfume of any kind. Part of the guidance in the *IC Process©* is to smell any fragrances in the Place of Peace, and fragrances in the room could interfere with this step. No candles were burned in the room.

The temperature of the room was monitored and kept at comfortable room temperature. The office was air-conditioned, and a fan operated in the room at all times. The fan served two purposes: to circulate the air and cool the office during the summer months, and to provide unobtrusive background noise to reduce participants’ awareness of outside noises, such as traffic on the street. At no time was the fan blowing directly toward a participant or the PI. If any participant had requested the fan be turned off, it would have been (no participant made this request). An electric heater was available for use on days when the room seemed too cool.

The only telephone in the room was the PI’s cell phone, which was turned off during sessions to avoid any interruption. An “In Session” notice was posted on the door to the Inner Counselor Office during sessions to avoid inadvertent interruptions.

The room had large glass patio doors looking out on a garden and a large window, both of which had vertical blinds on them. During all processes, the blinds were closed to eliminate distraction from outside, to allow for privacy, to prevent bright sunlight from shining in the participants’ eyes, and to keep the room the same for all participants.

Bottled water was offered to participants at each of their sessions. It was available refrigerated or at room temperature and participants had their choice.

Photographs of the Inner Counselor Office can be found in Appendix E.5.
Procedure

Inner Counselor Sessions

Inner Counselor sessions for the 43 Experimental (E) Group participants were scheduled beginning on May 30, 2006, and were complete by August 31, 2006. The 42 participants in the Control (C) group began processes on July 10, 2006, and processes were completed on October 20, 2006. Appointments were scheduled for C group participants only after they had completed and returned all five sets of tests. There were five possible session times daily from Monday to Friday: 8:30 -10.00 a.m., 10:30 a.m. – 12:00 p.m., 1:00 – 2:30 p.m., 3:00 – 4:30 p.m., and 7:00 – 8:30 p.m. Each session was 1 ½ hours long. Only one participant chose an evening session; all others were daytime sessions. Session times were chosen to accommodate a wide variety of availabilities and timetables for the participants. No processes were scheduled on statutory holidays or weekends.

Allowing ½ hour between the sessions in the morning and afternoon was helpful in avoiding scheduling difficulties. (Participants arrived up to 20 minutes early, and up to 20 minutes late.) If a participant arrived late, there was still enough time to complete the session in an unhurried manner, without encroaching on the scheduled time of another participant. The session schedule offered privacy, increasing the likelihood that one participant would be gone before another one arrived. It also offered the PI personal time to use the bathroom, make notes, put away files, set out water, and prepare for the next participant.
First Inner Counselor Sessions

Before each participant session, the PI did what she called “Personal Preparation,” which consisted of grounding and centering herself, making contact with her High Self, and offering this prayer: “Lord, be with me as I do this, your work.”

The participant’s file was checked before he or she arrived to make sure that the Participant Information Form and the Consent Form were signed and received. If one or both were missing, the PI had extra copies at the office, and the participant completed them before the session started. Two participants completed the Consent Form before their sessions. All Participant Information Forms had been completed before participants came for their sessions.

Sessions began with the PI welcoming the participant and making introductions, if the PI had not previously met the participant. A few moments of easy chatting (often about the weather, which was unusual for Ontario this year) often occurred as coats were hung up (if necessary) and the participant decided which of the two chairs he or she preferred to use. The participant was offered a bottle of water, either chilled or at room temperature. When the participant was seated and comfortable, the PI began the Participant Introduction to the First Inner Counselor Process© (see Appendix F.1).

As stated in that introduction, participants were asked if they could hear the PI clearly. If a participant had difficulty in hearing, a hearing assistance device was offered. The device used was the Pocketalker Pro™ Personal Amplifier, model PKT C1. This device was suggested to the PI by a geriatrician, who uses it in her practice to assist those with hearing difficulties and make communication easier. Specifications for this hearing assistance device are found in Appendix F.2. The sole counter-indication for use of the
Pocketalker Pro is the concurrent use of a pacemaker. Only one participant requested the use of the Pocketalker Pro. This participant was asked if she had a pacemaker, and when she stated that she did not, the hearing assistance device was used.

When the introduction was complete and participants had identified an issue or feeling they wished to address with their IC Process®, they were asked if they were comfortable and ready to begin.

The IC Process® was then facilitated in the way the PI had been trained, using the most recent version of the steps provided by Dr. Ann Nunley, creator of the IC Process® (see Appendix A.1).

The PI made notes during each IC Process®, using the Facilitator Inner Counselor Process® Notes sheet she had created (See Appendix F.3). This was done for several reasons. In order to follow up on the previous week’s process, it was helpful to have a record of the issue, the symbols, and the advice; with the possibility of 210 processes to do, the PI was concerned that she might not clearly remember every process. Furthermore, though the PI was participating in a large number of IC Processes®, participants themselves were experiencing only their own two processes, which were very significant to them, so it seemed very important to them that the PI remember what had happened. Notes would also have been valuable had a concern or difficulty arisen after a session; the PI would have been able to bring the session to memory much more easily by looking at the notes. This did not occur, but nevertheless, the precaution was in place. Taking notes proved to be a good decision. An unexpected benefit of the PI’s notes was that the PI wrote down the advice of the New Symbol in the notes, and several
times was asked by participants to help them remember the advice so that they could write it down for themselves and have it to keep.

When the process was complete, the PI waited until the participant opened his or her eyes and seemed ready to talk. The PI then asked the participant, “How do you feel?” which opened up a brief discussion of the participant’s experience of the IC Process®.

Participants were then invited to move to a nearby table, on which were located a pad of lined paper, several pens, and a sheet titled “Possible Topics for Personal Notes” (see Appendix E.3). They were encouraged to take their water bottles with them to the table. At the table, they were invited to make some notes about the process for themselves. The PI mentioned that sometimes it is easy to remember the process while experiencing it, or immediately afterwards, but harder to remember later on, and that making notes at this time could make it easier to recall the process at a later time. It was emphasized that the PI would not read those notes — they were strictly for the use of the participant. The purpose of the “Possible Topics for Personal Notes” sheet was to offer suggestions of parts of the process that participants might like to jot down and remember. Participants were told that they did not have to make notes of all the items if they did not choose to — the sheet was only there as a guide. A few participants chose not to make notes. Some participants asked the PI to remind them of specifics of their process, so that they could include them in their notes. Most participants made notes.

When their notes were complete, participants were asked how they felt, to ensure that they were not feeling unsettled or still too meditative to be able to drive or walk safely. All participants reported feeling able to function well enough. They were thanked for their participation that day, helped into jackets if needed, offered their water
bottles to take with them, and walked to the door by the PI, who said goodbye and reminded them of their processes the next week on the same day and time.

The PI then made notes of what the participants has said: about their processes, about what they learned, and about how they felt, as well as any other comments they’d had — whatever participants had shared. The PI made a note of the participant’s chosen way of referring to his or her High Self on that participant’s Facilitator *Inner Counselor Process*© Notes sheet for the following week, put both sheets in the participant’s file, and put the file in the PI’s briefcase, where it would be out of sight.

Between sessions, the PI got out fresh bottles of water and the Facilitator *Inner Counselor Process*© Notes sheet for the next participant, straightened any papers that needed straightening, did her Personal Preparation as described previously, and was ready for the next participant.

**Second Inner Counselor Sessions**

As with the first processes, before each participant session, the PI did her Personal Preparation.

Sessions began again with welcoming the participant and a few moments of easy chatting. The participant was offered a bottle of water, either chilled or at room temperature. When the participant was seated and comfortable, the PI began the Participant Introduction to Second *IC Process*© Session (see Appendix F.4).

When the introduction was complete, The *IC Process*© was then conducted in the way the PI had been trained, using the most recent version of the steps provided by Dr.
Ann Nunley, creator of the *IC Process*© (see Appendix A.1). Again, the PI made process notes in the same way as during the first *IC Process*© sessions.

When the process was complete, the PI waited until the participant opened his or her eyes and seemed ready to talk. The PI then asked the participant, “How do you feel?” which opened up a brief discussion of the participant’s experience of their second *IC Process*©.

As in the first sessions, participants were invited to make notes for themselves. They were then asked how they felt to ensure that they were not feeling unsettled or still too meditative to be safe driving or walking; again, all participants reported feeling able to function as they needed.

At this time, E group participants were given a copy of the medication sheet that they had completed during the enrolment process, with a note attached that read:

> This is the **medication information** that you filled in at the beginning of the study. When filling in your last set of forms, please look it over to see if any of the dosages have changed since the study began. If the dosages of these medications have changed, or if there are any new medications, please add the information to this sheet and return it with your last set of forms, or notify me at 519-767-0505. Thank you!

This sheet was signed by the PI. The sheet and the note were explained to the participant.

C group participants had already completed the review of the medication information sheets with their last set of forms ("E" forms) by the time they experienced their *IC Processes*©. The sheets had been mailed to them during the week in which they would complete their "E" forms. After their second *IC Process*©, C group participants were given a stamped envelope addressed to the PI, in which was a copy of the same “Other Information” sheet they had filled out with each of their sets of forms (see Appendix D.10). This one was labelled “F” so that the PI would know it was from a C
group participant after the processes were complete. The sheet provided an opportunity for them to offer any feedback or comments they had about their experience of the IC Process© after having completed their sessions.

After being given the appropriate sheets for their group, all participants were thanked for their participation in the study, helped into jackets if needed, offered their water bottles to take with them, and walked to the door by the PI, who said goodbye and thanked them again for their willingness to participate in this research project.

Reminder Calls

Participants were telephoned the day before each of their scheduled IC Processes© to remind them of the appointment. The script for the reminder calls when the person answered the phone was:

Hello! Could I please speak to [participant name]? [Then, when speaking to the participant, continued:] This is Ann Osborne calling — I am the person conducting the research study using the Inner Counselor Process© with seniors for peace of mind and well-being. This is just a quick reminder that you have an Inner Counselor Process© scheduled tomorrow, [day of week, date] at [time]. I look forward to seeing you there! Goodbye!

If another adult in the household answered the phone, a message was left giving the information regarding the day of week, date and time of the appointment. The person taking the message was asked to pass this along to the participant.

If no one answered the telephone, a message was left if an answering machine answered. The script for the reminder calls left as messages was:

Hello! This is a message for [participant name]. This is Ann Osborne calling — I am the person conducting the research study using the Inner Counselor Process© with seniors for peace of mind and well-being. This
is just a quick reminder that you have an *Inner Counselor Process*© scheduled tomorrow, [day of week, date] at [time]. I look forward to seeing you there! Goodbye!

Participants who did not have answering machines were called several times during the day until they were reached. One participant was unable to be reached and did not have an answering machine, but nonetheless remembered the appointment and showed up at the correct time.

For the reminder calls for the second sessions, there was no need to identify the PI as the researcher — by that time, the PI and the participant had met, so that line was omitted.

Reminder calls were made between 9:00 a.m. and 12:00 p.m., between 2:00 and 5:00 p.m., and between 7:00 and 9:00 p.m., so as to reduce the possibility of interference with participants’ sleep or meals.

Participants expressed gratitude for the reminder calls, saying that they found them very helpful, even with the bright yellow reminder card they had been sent in the Participant Package. Even with both the reminder card and the reminder calls, two participants forgot their appointments. In these cases, the PI waited until 15 minutes after the scheduled time and then phoned the participant. Fortunately, in both cases, the participants were still free to come to the session, and the PI had no one scheduled in the next time slot, and so completed the sessions with the participants as soon as they were able to get to the IC office.
No pilot study was done for this research project; thus, the PI believed it would be beneficial to experience a full day of facilitating *Inner Counselor Processes*© before embarking on several months of them. She also wanted to test out the office logistics and set-up before using it with actual participants.

Four people were recruited for this trial run day. In each case, the person had previously expressed interest in participating in the study, but was ineligible for the following reasons: one was too old (88), one was not quite old enough (64), and two had experienced *IC Processes*© before (ages 63 and 72). It was made clear to each by the PI that he or she could experience the process as part of this trial run day, but would not be included in the study.

The day was scheduled in exactly the same way as planned for the study. The four processes were scheduled at 8:30 and 10:30 a.m., and 1:00 and 3:00 p.m. The PI arrived at the office at 8:00 a.m. to prepare and conducted the day exactly as planned for the study.

Many valuable pieces of information were gained from the experience of this trial run.

- The PI was able to do four *IC Processes*© in a day without feeling exhausted by the end. Her energy lasted nicely, and she felt she was doing as good a job with the last process as with the first.
- The spacing of the processes was good and left ample time for unhurried changeovers between participants.
• Each trial run participant was offered a bottle of water (either chilled or at room temperature) and seemed to appreciate it. As well, with all the talking the PI did throughout the four sessions (with long introductions to the Inner Counselor and then the facilitation of the processes), it became clear that she needed water, and it seemed impolite to have water for herself and not for participants!

• Seniors with no previous IC Process© or similar experience could understand and follow the IC Process© using the introduction prepared by the PI.

• A sheet called “Possible Topics for Journaling” had been created to give participants an idea of parts of the process that they might like to make note of for themselves during the time allotted. There was considerable feedback from the trial run participants regarding this sheet: “I don’t know how to journal,” “I don’t like journaling,” “They told me to journal when I had counselling previously, but I never knew what to write, so I hated it.” They were assured that they were just making notes for themselves to help them remember their process, and this seemed to solve the problem. For the study, the name of the sheet was changed to “Possible Topics for Personal Notes,” and no study participants complained.

• The importance of being able to monitor and control the room temperature became clear — it was very chilly on the trial day! The room heated quickly using the electric heater. The PI was reminded to make sure she knew how to run the office air conditioning, and to have a fan to move the air on hot days, as well.

• The map was well done and easy to follow. No one reported having trouble finding the office, and the person who came on the city bus found the bus schedule to be
workable. This was true for study participants, as well. The two participants who got lost coming to the sessions had forgotten their maps at home.

- The value of having an easily accessible washroom was reinforced. It was used by three of the four trial day participants, one of whom would have had difficulty climbing stairs.

- The need for plenty of facial tissues was evident. Tears are not an uncommon part of an IC Process©, and trial day participants mentioned being grateful for easily accessible tissues.

- The outdoor sign blew over in a strong wind — it needed to be better supported. During the study, it was anchored by a cement block.

**Materials**

The *Inner Counselor Process*© steps (see Appendix A.1) and the Integration Chart© (see Appendix A.2) used in this study were the ones currently being used by Dr. Ann Nunley in her Inner Counselor course at the time of the study. The process was facilitated as taught during the Inner Counselor course. The Facilitator *Inner Counselor Process*© Notes (see Appendix F.3) sheet was created by the PI as a concise way of taking brief notes regarding the process after it was complete and the participant was occupied with reflecting and making his or her own notes on the experience. The PI took these notes so that she would be able to recall the details of any one process from the large number involved in the study, should a memory aid be necessary.
The two quantitative measures used in this study were the Beck Anxiety Inventory® for Adults\textsuperscript{13} (BAI®), (see Appendix D.8), and the Geriatric Depression Scale\textsuperscript{14} (GDS) (see Appendix D.9). These instruments met the criteria of the PI, which were:

- Tests needed to be self-administered. Because of the large number of times (5) the tests were to be completed, it was not feasible for the PI to administer the tests to each participant each time.
- Tests needed to have been tested and used with seniors. As indicated in the Review of the Literature, it is thought that older people exhibit different symptoms of anxiety and depression than do younger people, so tests used in the general population may not be useful with seniors.
- Tests needed to be able to be completed in a fairly short time. Together, these instruments could be completed in about 15 minutes.
- Tests needed to have ease of scoring. There is no training required to score either the BAI® or the GDS. Both come with clear instructions for scoring.

\textbf{The Beck Anxiety Inventory® (BAI®)} is a well-known measure of general anxiety, and has some documented utility for assessing late-life anxiety.\textsuperscript{15} It is a 21-item, self-report questionnaire in which each item is rated on a 4-point Likert scale ranging from 0 (not at all) to 3 (severely, I could barely stand it). The total score ranges from 0 to 63. Scores between 0 and 21 indicate very low anxiety; scores between 22 and 35 indicate moderate anxiety; and scores exceeding 36 indicate more severe anxiety. An article written in 2000 gave an overview of the uses of the BAI®, among other measures for anxiety in the elderly.\textsuperscript{16} The BAI® was developed to distinguish symptoms of anxiety
from depression; it typically produces a 2- or 4-factor structure comprising cognitive and somatic symptoms. In a study of 217 older adult psychiatric outpatients, the BAI® was administered along with the State-Trait Anxiety Inventory® (STAI®) as part of a standard intake battery. Psychometric analyses demonstrated excellent internal consistency for the BAI® and significant differences in scores for patients with and without anxiety disorders diagnosed according to the Structured Clinical Interview for the Diagnostic and Statistical Manual for Mental Disorders (DSM-III-R) (SCID). Factor analyses revealed a clear 2-factor solution suggesting two internally consistent factors assessing cognitive and somatic symptoms. Factor scores correlated moderately with each other ($r = .63$). In another study with 197 low-income, ethnically diverse older primary care patients, the BAI® also demonstrated excellent internal consistency. BAI® scores were found to be generally unrelated to ethnicity, gender, or education, although there was a significant negative correlation of anxiety with age. Confirmatory factor analyses showed a good fit to a 4-factor model comprising cognitive, autonomic, neuromotor, and panic symptoms. Other factor analytic procedures with these data demonstrated that the BAI® measured a distinct construct from depression as assessed by the Beck Depression Inventory® (BDI) or the Geriatric Depression Scale (GDS). This was an excellent factor for this study, since the GDS was used to measure depression, and it was helpful to be certain that the two instruments were measuring different factors. In a more recent study of community-dwelling older adults, the BAI® appeared to have adequate internal consistency and convergent validity, although a 6-factor solution was demonstrated. Overall, these data suggest that the BAI®, despite a
relatively heavy somatic focus, may be particularly useful for the assessment of late-life anxiety.

It was the intent of the PI not to inform participants that the dependent variables were anxiety and depression. However, since the BAI® forms must be ordered from their publisher, and since the term “anxiety” was printed on the form, there was little option but to use it and have the participants see the term being used. “Anxiety” was in very small print, which was the best case if the term could not be avoided altogether.

**The Geriatric Depression Scale (GDS)** has been tested and used extensively with the older population. It was designed to avoid most of the problems associated with the measurement of geriatric depression by developing the scale with the aged in mind (55 years old or older) and selecting items for the scale based on the performance of these items within this population. Joseph Gallo et al. write in their *Handbook of Geriatric Assessment*, “The Geriatric Depression Scale (GDS) has been recommended for clinical use by the Institute of Medicine and is included as a routine part of comprehensive geriatric assessment in *A Core Curriculum in Geriatric Medicine* … [and] is finding increasing use in research on depression in older adults.”24 It was developed by J. A. Yesavage et al. in 1982–3, and labelled the “Mood Assessment Questionnaire.” It is a brief questionnaire in which participants are asked to respond to 30 questions by answering “yes” or “no,” in reference to how they felt over the past week. The GDS screens for seven characteristics of depression in elderly: somatic concern, lower affect, cognitive impairment, feelings of discrimination, impaired motivation, lack of future orientation, and lack of self-esteem. It may to be used with healthy, medically ill, and even mild to moderately cognitively impaired adults.25
The GDS has been extensively used in community, acute, and long-term care settings. This matched the study population well. The GDS is not a substitute for a diagnostic interview by a mental health professional; rather, it is a useful screening tool to facilitate assessment of depression in older adults, especially when baseline measurements are compared to subsequent scores. Again, this matched the purpose of the study. The PI does not purport to be a mental health professional and would not consider diagnosing. The PI was interested, however, in assessing levels of depression in the elderly and comparing baseline scores to subsequent (post-intervention) scores.

The GDS consists of 30 questions, which are answered “yes” or “no,” and takes about 10 minutes to complete. Of the 30 questions selected for inclusion in the GDS, 20 indicate the presence of depression when answered positively, while 10 others (numbers 1, 5, 7, 9, 15, 19, 21, 27, 29 and 30) indicate depression when answered negatively. Each question is valued as one point if answered in the manner indicating depression. This gives a maximum possible score of 30, and a minimum possible score of 0. Scores of 0 to 9 are considered normal, 10 to 19 indicate mild depression, and 20 to 30 indicate more severe depression.

A short form of the GDS (sfGDS) was devised and has been published. Some researchers show a high correlation coefficient for scores on the two instruments (.66), which would indicate very high agreement. Another study compared the two forms of the test and concluded that the sfGDS consistently identified between 94% and 100% of the depressed participants using the long form of the GDS as the standard. However, yet another more recent study assessed the appropriateness of applying the sfGDS to unselected older inpatients, and found that it did not qualify as a unidimensional test.
As the research seems to be somewhat inconsistent, and the GDS long form has been validated in numerous ways, the longer format was selected.

The GDS is published widely on the Internet, and on the official Web site for the scale (http://www.stanford.edu/~yesavage/GDS.html), there is a statement that “the original scale is in the public domain due to it being partly the result of Federal support.”\(^{31}\) Hence, there was no charge to use this rating scale, and it is easily available from J. A. Yesavage’s Web site. There is a wide variety of formats of the GDS available (all have identical questions). Some use yes/no and the participant is to circle the appropriate answer. Some have yes/no boxes or circles that the participant marks with an “x.” Others have yes/no circles that the participant is to fill in with a pencil. For ease of scoring, the version chosen was the one with circles marked with an “x,” and a template was created to go over the questionnaire, such that the circles indicating depression were revealed and the others covered. This made it easy to count the number of “depression indicator” circles on the form. The form used was in the original format devised by Yesavage. One positive feature of this test was that the title of the test as given (“Mood Assessment Questionnaire”) does not indicate that it is a depression scale. This was an asset in this study, since participants were not informed that the dependent variables were anxiety and depression.

The GDS and the BAI\(^{®}\) offered methods for tracking the effects of the Inner Counselor Process\(^{®}\) on anxiety and depression. At the same time, it was felt by the PI that it would be beneficial to offer participants an opportunity to offer their thoughts, feedback, and comments on their experiences of the process. To accomplish this, Qualitative Methods of Feedback were used in this study.
**Anecdotal reporting** was collected on a sheet titled “Other Information” (see Appendix D.10) that was created for this purpose. It consisted of one question: “Is there anything that you have noticed or would like to share that relates to your experience of the Inner Counselor?” The intent was to leave the topic open, so as not to “lead” the participants’ comments. It allowed them to say whatever they chose to say.

Another form of anecdotal information that was collected was comments made to the PI by participants, recorded at the end of the Facilitator *Inner Counselor Process©* Notes (those notes that recorded what participants had to say after they had experienced their *IC Processes©*), taken down by the PI at the conclusion of each *IC Process©*. The importance of these became clear as participants commented that they hadn’t written anything on the Other Information sheet because they had told the PI everything they had to say at the time of their sessions.

Initially, these two data sources were kept separately. However, since some participants responded in one way, but not the other, the decision was made to combine the two kinds of anecdotal information, giving a more complete picture of each participant’s response. Since both scales had content analysis done using the same “response themes,” the data files represented two different ways of accessing the same information. When combined into one information file, in no case was information duplicated – if the participant responded both in writing and vocally, one response was tallied.
Verification

For the test data from the GDS and the BAI®, data were inputted and then checked twice for accuracy by the PI. For the second check of the data, the data numbers were checked in reverse order, as an extra measure of caution. After this, a spot check was done, randomly pulling files and checking the accuracy of the data.

Anecdotal information was transcribed, and then checked twice for accuracy as well. The only changes made were the removal of information that could have identified the participant, as discussed in the Ethical Considerations section below.

The PI’s RA began the transcribing of the anecdotal information, which was completed by the PI after the RA’s departure from the study. The PI checked all of the information the RA had inputted for accuracy.

Data Analysis

The data were analyzed using two non-parametric statistical tests, the Friedman and Mann-Whitney U tests. The PI had originally planned to use a 2-way repeated measures analysis of variance (ANOVA) for each of the dependent variables, anxiety and depression. The data, however, did not meet the assumptions necessary for use of the ANOVA.

Non-parametric statistical tests differ from parametric statistical tests in that the model structure is not specified a priori but is instead determined from data. The term “non-parametric” is not meant to imply that such models completely lack parameters, but
that the number and nature of the parameters are flexible and not fixed in advance.

Nonparametric models are also called distribution-free.

The Friedman test is a non-parametric statistical test developed by the U.S. economist Milton Friedman. A 2-way analysis of variance by ranks, it is useful for testing the null hypothesis that samples have been drawn from the same population. Similar to the parametric repeated measures ANOVA, it is used to detect differences in treatments across multiple test attempts. The procedure involves ranking each row (or group) together, then considering the values of ranks by columns. Unlike the parametric tests, this non-parametric test makes no assumptions about the distribution of the data (e.g., normality).

The Mann-Whitney U test is a non-parametric statistical significance test for assessing whether the difference in medians between two samples of observations is statistically significant (whether the distributions of the samples overlap less than would be expected by chance). The null hypothesis is that the two samples are drawn from a single population, and therefore that the medians are equal. It is one of the most powerful of the non-parametric tests, and it is a most useful alternative to the parametric t-test when the assumptions for the use of the t-test are not met.

Content analysis of the anecdotal information was used to examine the written and vocally reported information. From the written anecdotal information (WAI) and the vocally reported anecdotal information (VRAI) received after participants had experienced their IC Processes©, the recurring themes were identified by the PI. In order for any one piece of information to be identified as a theme, it had to be mentioned by at least five participants in either the WAI or VRAI. Each participant’s anecdotal
information was then assessed to see which of these themes were mentioned in it, and the number of participants who mentioned that theme was tabulated.

**Ethical Considerations**

Because Inner Counselor concepts cannot fully be utilized outside of a spiritual, transpersonal, subtle energy context, the *IC Process*© is considered to be a spiritual intervention. The process also involves many aspects related to self-help, in that the participant has the most prominent role in determining the direction and outcome of each process.

Experience has shown that while some people report feeling euphoric and uplifted immediately following a process, others indicate a feeling of tiredness. Participants had about 15 minutes to make notes quietly at the end of the session, a time that also could be used to rest. The sessions took place in a closed room that ensured the privacy of each participant. A 30-minute break was created between sessions, to allow time for unhurried changeovers. Two comfortable chairs were situated in a waiting area so that participants who were waiting for a session to begin or for a ride home had a comfortable place to sit. The PI checked with participants before they left to make sure they felt they were able to drive or walk, as was needed. All participants stated that they felt fine to do so.

Experience also indicates that some people experience strong emotions during an *IC Process*©. The PI is an ordained minister with training in pastoral care, spiritual direction, and spiritual intuitive counselling; she is trained to deal with situations where unusually strong, unpleasant, or disturbing emotions arise. In order to work effectively
with this process, participants must be able and willing to “feel” the emotions related to
issues, and able to follow the steps of the process even while experiencing those
emotions. The great majority of people are (and all of the study participants were) able to
fulfill these two criteria. In the event that the PI had determined that a study participant
could not fulfill these criteria, a plan was in place. If the PI had determined that it was
not in the best interest of the participant to continue the process (i.e., the participant was
not able to fulfill the two criteria stated above for working with the process), he or she
would have gently been brought out of the process. During the session’s remaining time,
the PI would have discussed the situation with the participant and offered possible
options for professional counselling, if that were of interest to him or her.

In Canada, where the study took place, referrals to other professionals generally
take place through the family doctor; the name and telephone number of each study
participant’s doctor was on the Participant Information Form (which was always at the
Inner Counselor Office during processes). In the unlikely event that the participant
needed follow-up care, the doctor would have been contacted. An ordained minister with
considerable counselling training and certification had agreed to be available to work
with any participants who required or wished further spiritual guidance.

Any participants who were already in a counselling relationship were asked to
inform their counsellors of the study, as a courtesy.

Although the Inner Counselor employs a hypnagogic state, similar to the
experience of daydreaming, throughout the process the participant is empowered to make
conscious choices. Participants were informed that they would experience this state of
reverie in the Informed Consent Form, and again during the Introduction to the First Inner Counselor Process©.

Some participants indicated that there is more exploring they would like to do around the issues they addressed with the two Inner Counselor sessions of the study, or other issues they would like to address with the IC Process©. In this case, they were given options. The PI offered to refer them to other Inner Counselor facilitators in the area for further processes after the completion of their testing, or they were offered the option of waiting until the end of the study (January 2007), after which point the PI would be happy to work further with them. All participants who expressed interest chose to wait until January, probably because they had familiarity with the PI.

Data for the study were gathered by participant number solely; no participant names were on the test sheets or return envelopes, which had been pre-printed with the participant numbers. Data were only reported by participant number when sent to the statistician. In the final recording of anecdotal information in this dissertation, even participant numbers were removed, since they were not a necessary part of that information. Both the “to” and “from” addresses on envelopes given to participants were printed with the PI’s name and address. Participants were informed that this rather unusual situation was to help ensure their anonymity within the study.

The written anecdotal data from the study were initially transcribed exactly as they appeared on the form returned by the participant. In order to respect the privacy of individual participants, the PI then went through all of the written material and removed identifying information, replacing it with generic substitutes and indicating this with the use of square brackets []. For example, if a participant wrote about his wife, Beatrice,
and had used her name, the name would have been replaced by [my wife]. Similarly, symbols from the IC Processes® were replaced with [my New Symbol] or [my Old Symbol].

All identifying information was also removed from the vocally reported anecdotal information in the same manner as described for the written anecdotal information.
Chapter 2 Endnotes

6 Holos University Graduate Seminary Course Catalog (Fair Grove, MO: Self Published, Fall 2004), 36–37.
12 Holos University Graduate Seminary Catalog: Fall 2005-Spring 2006 (Holos University Graduate Seminary, 2005).
16 Ibid.
22 Yesavage et al., “Development and Validation of a Geriatric Depression Screening Scale.”


26 Ibid.

27 Ibid.


34 Siegel, *Nonparametric Statistics for the Behavioral Sciences*.

CHAPTER 3: 
RESULTS

*Not everything that counts can be counted.*
*Not everything that can be counted counts.*

— Albert Einstein

This chapter presents the statistical findings of the study. The first section presents the examination of the normality of the GDS and BAI® data. Normality is one of the three assumptions of the parametric 2-way repeated measures analysis of variance (ANOVA) test. This is a statistical test that allows for the testing of change over time within and between the two study groups in one analysis and is appropriate for use with continuous (i.e., interval or ratio) data. Because the results of this preliminary normality assessment indicated that these data were significantly non-normal, the decision was made to analyze the data using Friedman’s 2-way ANOVA and Mann-Whitney U test. Results from the Friedman and the Mann-Whitney U tests are presented next. Finally, the content analysis of the two forms of anecdotal reporting (written information and vocally reported information) is presented.

The testing schedule for the study, which indicates data collection dates, can be found in the Research Design section of Chapter 2.

**Tests for Normality of Quantitative Data**

*Parametric* inferential statistical methods are mathematical procedures for statistical hypothesis testing that assume the distributions of the variables being assessed
belong to known, parameterized families of probability distributions. In order to use a 2-way repeated measures ANOVA, the data must meet certain assumptions, the first of which is normality: that is, the populations from which the samples were obtained must be normally or approximately normally distributed. Hence, it was important to test the normality of the study data before using the 2-way repeated measures ANOVA.

The data were assessed for normality in three ways. First, skewness and kurtosis were examined, and then two tests of non-normality — the Shapiro Wilks Test and the Kolmogorov-Smirnov (Lilliefors) Test, also known as the K-S (Lilliefors) — were performed. Finally histograms, overlaid with a normal curve, were examined.

Table 10 gives a list of abbreviations that are used in the tables throughout this chapter.

<table>
<thead>
<tr>
<th><strong>Full Name or Term</strong></th>
<th><strong>Abbreviation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental Group</td>
<td>E</td>
</tr>
<tr>
<td>Control Group</td>
<td>C</td>
</tr>
<tr>
<td>Geriatric Depression Scale</td>
<td>GDS</td>
</tr>
<tr>
<td>Beck Anxiety Inventory®®</td>
<td>BAI®®</td>
</tr>
<tr>
<td>“A” Forms (letter indicating time of form completion; forms are lettered “A,” “B,” “C,” “D,” and “E” (with quotation marks))</td>
<td>“A,” “B,” “C,” “D,” and “E”</td>
</tr>
<tr>
<td>Skewness</td>
<td>Skew</td>
</tr>
<tr>
<td>Kurtosis</td>
<td>Kurt</td>
</tr>
<tr>
<td>Standard Error</td>
<td>SE</td>
</tr>
<tr>
<td>Statistic</td>
<td>Stat</td>
</tr>
<tr>
<td>Significance</td>
<td>p</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>SD</td>
</tr>
</tbody>
</table>
Examination of Skewness and Kurtosis of Data

Skewness and Kurtosis were examined by dividing Skewness (Skew) by the standard error of the Skewness (SE Skew), and Kurtosis (Kurt) by the standard error of Kurtosis (SE Kurt) for each group for each test time and comparing the results to 2. If this value was greater than 2, it indicates that non-normality of the data is possible. These results are shown in tables 11 and 12.

Table 11. Comparison of skewness and kurtosis for GDS data

<table>
<thead>
<tr>
<th>Group</th>
<th>Test Time</th>
<th>GDS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Skew</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experimental</td>
<td>“A” test</td>
<td>1.42</td>
</tr>
<tr>
<td>Experimental</td>
<td>“B” test</td>
<td>1.72</td>
</tr>
<tr>
<td>Experimental</td>
<td>“C” test</td>
<td>1.65</td>
</tr>
<tr>
<td>Experimental</td>
<td>“D” test</td>
<td>1.72</td>
</tr>
<tr>
<td>Experimental</td>
<td>“E” test</td>
<td>1.92</td>
</tr>
<tr>
<td>Control</td>
<td>“A” test</td>
<td>0.89</td>
</tr>
<tr>
<td>Control</td>
<td>“B” test</td>
<td>1.40</td>
</tr>
<tr>
<td>Control</td>
<td>“C” test</td>
<td>2.07</td>
</tr>
<tr>
<td>Control</td>
<td>“D” test</td>
<td>1.62</td>
</tr>
<tr>
<td>Control</td>
<td>“E” test</td>
<td>1.25</td>
</tr>
</tbody>
</table>
Table 12. Comparison of skewness and kurtosis for BAI data.

<table>
<thead>
<tr>
<th>Group</th>
<th>Test Time</th>
<th>Skew</th>
<th>SE Skew</th>
<th>Ratio</th>
<th>SE Kurt</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental</td>
<td>“A” test</td>
<td>1.68</td>
<td>0.36</td>
<td>4.67</td>
<td>4.43</td>
<td>6.24</td>
</tr>
<tr>
<td>Experimental</td>
<td>“B” test</td>
<td>1.70</td>
<td>0.36</td>
<td>4.72</td>
<td>3.28</td>
<td>4.62</td>
</tr>
<tr>
<td>Experimental</td>
<td>“C” test</td>
<td>2.47</td>
<td>0.36</td>
<td>6.86</td>
<td>8.17</td>
<td>11.51</td>
</tr>
<tr>
<td>Experimental</td>
<td>“D” test</td>
<td>1.38</td>
<td>0.36</td>
<td>3.83</td>
<td>2.25</td>
<td>3.17</td>
</tr>
<tr>
<td>Experimental</td>
<td>“E” test</td>
<td>1.68</td>
<td>0.36</td>
<td>4.67</td>
<td>3.14</td>
<td>4.46</td>
</tr>
<tr>
<td>Control</td>
<td>“A” test</td>
<td>0.74</td>
<td>0.37</td>
<td>2.00</td>
<td>-0.46</td>
<td>-0.64</td>
</tr>
<tr>
<td>Control</td>
<td>“B” test</td>
<td>1.01</td>
<td>0.37</td>
<td>2.73</td>
<td>0.28</td>
<td>0.39</td>
</tr>
<tr>
<td>Control</td>
<td>“C” test</td>
<td>0.92</td>
<td>0.37</td>
<td>2.49</td>
<td>0.14</td>
<td>0.19</td>
</tr>
<tr>
<td>Control</td>
<td>“D” test</td>
<td>0.76</td>
<td>0.37</td>
<td>2.05</td>
<td>-0.54</td>
<td>-0.75</td>
</tr>
<tr>
<td>Control</td>
<td>“E” test</td>
<td>1.93</td>
<td>0.37</td>
<td>5.22</td>
<td>5.70</td>
<td>7.92</td>
</tr>
</tbody>
</table>

As can be seen, the majority (35 out of 40, or 87.5%) of the ratio values in both tables are > 2, suggesting non-normality of data distribution. In addition, 22 out of 40 ratio values (55%) were greater than 4, indicating considerable non-normality of data distribution.
The Shapiro-Wilks Test and the K-S (Lilliefors) Test

Two tests that are specifically designed to measure the proximity of a dataset to the normal (Gaussian) distribution were performed. These are the Shapiro-Wilks Test and the K-S (Lilliefors) Test.

These statistics and related significance for the study data are found in table 13. When significance is found, the null hypothesis that the data is normally distributed is rejected.

Table 13. Shapiro-Wilks and K-S (Lilliefors) tests for normality

<table>
<thead>
<tr>
<th>Group</th>
<th>Time</th>
<th>GDS</th>
<th>BAI&lt;sup&gt;®&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Shapiro-Wilks</td>
<td>Stat</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shapiro-Wilks</td>
<td>Stat</td>
</tr>
<tr>
<td>E</td>
<td>“A”</td>
<td>0.86</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>E</td>
<td>“B”</td>
<td>0.85</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>E</td>
<td>“C”</td>
<td>0.82</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>E</td>
<td>“D”</td>
<td>0.81</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>E</td>
<td>“E”</td>
<td>0.76</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>C</td>
<td>“A”</td>
<td>0.91</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>C</td>
<td>“B”</td>
<td>0.87</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>C</td>
<td>“C”</td>
<td>0.79</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>C</td>
<td>“D”</td>
<td>0.85</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>C</td>
<td>“E”</td>
<td>0.86</td>
<td>&lt;.01</td>
</tr>
</tbody>
</table>

As is evident, each of the statistics meets the criterion for significance, again indicating non-normality of the data.
Histograms

An examination of the histograms for the GDS and the BAI® at each time and by group gives an excellent visual picture of the non-normality of the distributions. These can be found in Appendix G.1. The normal data curve is also shown on each graph, so that there is a clear visual comparison between the distribution that would be expected in a normally distributed sample, and the distribution that occurred in the study data. Normally distributed data has the shape of a “bell curve,” with a dome in the middle and a slope on either side. In each case for the study data, the data distribution resembles more of a “ski slope” that begins high and then trails off. The histograms support the statistical tests’ indications of non-normality.

It is the informed opinion of the PI and the statistician, having examined all of these normality tests and the histograms, that the data distribution in this study is sufficiently non-normal that proceeding with the 2-way repeated measures ANOVA would likely have resulted in misleading findings.

Friedman Two-Way ANOVA and Mann-Whitney U Tests

Two nonparametric tests were done on the data from the GDS and the BAI®: the Friedman Test and the Mann-Whitney U Test. While using multiple tests (instead of a single test) to address a question is less powerful because it increases the possibility of making a Type I error, this is a more appropriate approach due to the non-normal nature of the data. The PI believed that this loss of power was less damaging to any results than
the loss of integrity would have been, had parametric analysis proceeded despite the
decided non-normality distribution of the data.

**The Friedman Test** is similar to the parametric repeated measures ANOVA in
that it is used to detect differences in treatments across multiple test attempts. The
procedure involves ranking each of the responses in a group from highest to lowest and
determining the mean rank. The mean ranks of different groups are then compared to test
the null hypothesis that the two groups have been drawn from the same population,
meaning that there is no statistical difference between the groups.¹ This test does not
measure the results of the E versus the C Groups together as would the 2-way repeated
measures ANOVA; what the Friedman test measures is the change in the E group over
time and the change in the C group over time. The resulting chi-square statistic is used to
test the question, “Are the mean ranks equal across the five time points of testing?” The
results of this test are shown in table 14.

Table 14. Friedman test results

<table>
<thead>
<tr>
<th></th>
<th>GDS</th>
<th>BAI®</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean Rank</td>
<td>Mean Rank</td>
</tr>
<tr>
<td></td>
<td>E Group</td>
<td>C Group</td>
</tr>
<tr>
<td>“A”</td>
<td>3.58</td>
<td>3.68</td>
</tr>
<tr>
<td>“B”</td>
<td>3.30</td>
<td>2.88</td>
</tr>
<tr>
<td>“C”</td>
<td>2.87</td>
<td>2.68</td>
</tr>
<tr>
<td>“D”</td>
<td>2.70</td>
<td>2.81</td>
</tr>
<tr>
<td>“E”</td>
<td>2.55</td>
<td>2.95</td>
</tr>
<tr>
<td>Chi-Square</td>
<td>12.78</td>
<td>10.36</td>
</tr>
<tr>
<td>Significance</td>
<td>0.01</td>
<td>0.05</td>
</tr>
</tbody>
</table>
Results of the Friedman test indicate significance ($p<0.5$) in all but the test of the C group with the BAI® data. An examination of the mean ranks displayed in Table 14 shows a decrease in the mean ranks from test time one ("A" forms) to test time five ("E" forms), and suggests that there may have been a decrease in the associated BAI® scores across time. What this test does indicate is some difference in the data over time, but it cannot answer the question, “What created the difference?” Since both the E and C groups showed a statistically significant difference on the GDS data, it is not possible to attribute the difference to the *Inner Counselor Process*© intervention.

Before any statements regarding differences can be made, it is important to determine if there were any differences between the study groups at each testing time, and if so, how different they were, and if the observed differences would fall within the range of expected variability. The Mann-Whitney U test was used to answer these questions.

**The Mann-Whitney U test** is a non-parametric statistical significance test for assessing whether the difference between two samples of observations is statistically significant (e.g., whether two independent groups have been drawn from the same population). The null hypothesis is that the two samples are drawn from a single population, and therefore that the medians are equal, meaning that there is no statistical difference between the groups tested. In this study, the Mann-Whitney U test measures the difference in mean ranks of the E versus the C group at each of the five testing points. Significance was tested at $p<.05$. The data are shown in table 15.
Table 15. Mann-Whitney U test results

<table>
<thead>
<tr>
<th></th>
<th>Mann-Whitney U Statistic</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDS “A”</td>
<td>899.5</td>
<td>.98</td>
</tr>
<tr>
<td>GDS “B”</td>
<td>833.5</td>
<td>.54</td>
</tr>
<tr>
<td>GDS “C”</td>
<td>829.5</td>
<td>.51</td>
</tr>
<tr>
<td>GDS “D”</td>
<td>858.0</td>
<td>.69</td>
</tr>
<tr>
<td>GDS “E”</td>
<td>825.0</td>
<td>.49</td>
</tr>
<tr>
<td>BAI® “A”</td>
<td>688.5</td>
<td>.06</td>
</tr>
<tr>
<td>BAI® “B”</td>
<td>728.5</td>
<td>.12</td>
</tr>
<tr>
<td>BAI® “C”</td>
<td>642.0</td>
<td>.02</td>
</tr>
<tr>
<td>BAI® “D”</td>
<td>644.0</td>
<td>.02</td>
</tr>
<tr>
<td>BAI® “E”</td>
<td>646.5</td>
<td>.02</td>
</tr>
</tbody>
</table>

No significant differences were found between the means of the E and C groups at any of the five testing points for the GDS.

Significance was found in the “C,” “D,” and “E” test periods for the BAI®, indicating a statistical difference in the mean ranks. An examination of the mean ranks potentially suggests higher BAI® scores for the C than the E group at those times. This analysis indicates that there is a difference, but it cannot state the cause of the difference.

**Anecdotal Information**

As was described earlier, two kinds of anecdotal information were gathered in this study. The first was the written anecdotal information (see Appendix G.2) that came from the Anecdotal Information Sheet (Appendix D.10) completed after participants had experienced their *Inner Counselor Processes*® (*IC Processes*®). There was only one question on the sheet: “Is there anything that you have noticed or would like to share that relates to your experience of the Inner Counselor?”
Vocally reported anecdotal information (Appendix G.3) was gathered from the process notes that the PI took during and after IC Process© sessions. Again, one question was asked by the PI after each process, which was “How are you feeling?” As noted earlier, both kinds of anecdotal information were combined into one file.

When the content of the anecdotal information was analyzed, the following themes became apparent as those mentioned by a significant number of people (> 5) after their experience of two IC Processes©. They are listed in order from most to least frequently mentioned.

- Feeling calm, relaxed, and peaceful
- Indicating that the IC Process© had a positive effect
- Indicating that the IC Process© was a learning experience
- Indicating that the IC Process© was helpful and beneficial
- Indicating that an issue or problem had been resolved
- Indicating that they would use the IC Process© again
- Indicating that they accessed inner wisdom
- Feeling confident and empowered
- Indicating that the experience of the IC Process© reinforced what they had known before
- Feeling freed of a burden
- Indicating that they had grown spiritually
- Being able to sleep better
- Feeling tired after the process

The percentages of participants who mentioned each of the themes is shown in figure 1.
It is important to note that participants were not asked specifically about any of these themes. It should also be noted that participants may have mentioned more than one of the themes — the content is what participants volunteered or shared. Each theme will be expanded upon, with sample comments from participants that would have fit into that theme.
**Feeling calm, relaxed, and peaceful**

This was the most prevalent comment from study participants, with 90.59% indicating they felt this way. This feeling was expressed with a wide variety of descriptors, such as “serene,” “less tense,” and “more peaceful.” Phrases used by participants included:

- There is a great sense of peace because of my experience of the Inner Counselor.
- I feel very much at peace, calm, not hurried or pressured.
- I am cool, calm, and collected.
- I feel better, more at peace with myself than I have in years.
- I feel very relaxed — if I went to sleep, how long would you leave me???
- I *feel* the calmness and the peace. I’m not sure I ever really felt it before; I just knew it in my head.

**Indicating that the IC Process© had a positive effect**

This theme was mentioned by just over 90% of participants, as indicated by the bar chart. Ways of expressing this included:

- I have really noticed a change in my behaviour. It is really amazing that that simple process makes such a difference!
- I do think I’ve felt somewhat more “upbeat” since the two sessions — more “positive.”
- This process changed my life — it gave my life back to *me*!
- It is a wonderful experience… I feel so much more comfortable about life in general.
I noticed a big change this week. I feel more relaxed, less pressured, more able to cope, less onerously responsible. I am surprised what a difference it made!

**Indicating that the IC Process© was a learning experience**

A large number of participants (about 87%) expressed that their experience of the IC Process© was, for them, a learning experience:

- It was a learning process that I will carry over to everyday happenings.
- A good learning experience.
- I learned to see my own needs, and became aware how I could move past any obstacles to true happiness.
- I have never experienced anything like this before, and find it very helpful. I didn’t know you could work with emotions like this.
- This was new to me — I learned things. I am reminded that I do have a choice.
- This is a BIG discovery and will be of immense help to me.
- This has been a profound learning for me, about me.

**Indicating that the IC Process© was helpful and beneficial**

This comment was also expressed by a substantial number of participants — just over 83% — and was conveyed in such statements as:

- The IC Process© was enlightening and cathartic and beneficial.
- I feel sure that I have benefited from the sessions.
- I am in awe of this process — I am confident that it has helped me [with my issue]. I can do this!
I found it very helpful — can use these images and exercises to relax and to solve problems, and to understand myself and others.

My first appointment of the IC Process© was moving, insightful, and helpful.

**Indicating that an issue or problem had been resolved**

Sixty percent of participants indicated that they had resolved a problem or an issue in their lives:

- I now have a new approach to something that was bothering me. My old approach wasn’t working — this feels hopeful!
- I addressed [the situation] and it went well. I felt better after!
- My [issue] is no longer a concern to me.
- I feel confident now that change has taken place, and I have even had a chance to prove it to myself!
- This has been so hard for so long and now I finally have some peace with it. I wasn’t sure I ever would.
- I had a big success this week — a direct change as a result of what I worked on in my process. It feels so good!

**Indicating that participants would use the IC Process© again**

The desire or willingness to use the IC Process© in the future was conveyed by 36.7% of participants, in statements such as:

- I have a very large issue that I would like to address with this process, once your studies are done.
This is a wonderful process! I would love to do several more!

I could have [an IC Process®] every week!

If it would be possible to explore my inner self some more [using the IC Process®], I would.

I want to use IC Process® to explore my intuition and spirituality more!

If I have other things that bother me, I would like to call you.

I am looking forward to doing this again!

**Indicating that participants accessed inner wisdom**

Those participants who expressed their contact with their inner wisdom (55.29%) used such phrases as:

- It was a good experience for me — a very deep soul searching, I might say.
- The sessions opened more doors to me, emphasizing the power from within a person can experience.
- I feel startled by the depth of wisdom I accessed. I am deeply touched.
- Who knew that I had all that wisdom inside of me? We are not taught that we have it or can accept it.
- The [situation I addressed in my process] no longer had power in my life this week — so my inner wisdom was right!
- I know that [my New Symbol] represents the qualities I needed, but this process makes those very real and personal to me. They make my inner wisdom visible to me!
Feeling confident and empowered

Feelings of being confident and empowered were articulated by 54.12% of participants. These comments clearly convey those sentiments:

- I feel like I am now in control of me, instead of letting my reactions control me — that’s personal power.
- I have a sense of increased access to inner resources. To know it, that’s one thing. To have a renewed sense of access — that’s empowering
- An incredible, empowering process! I gained deep, deep insights, rich with meaning.
- I gained confidence in choosing to do what is best for me.
- I feel like a new person, I feel like I can conquer the world now.
- I am much more confident — I’ll know!

Indicating that the experience of the IC Process© reinforced what participants had known before

Several participants (28.24%) offered comments that indicate they felt the IC Process© reinforced or re-affirmed what they had already known:

- I learned that I have the personal power to effect change in the things I need to change; perhaps I knew this before, but the process re-affirmed it.
- In the week following my first helpful meeting with you, I realized that I have had an “Inner Counselor” for many years!
- Over the years, I believe, I have used these “tools.”
I enjoyed experiencing this process; I have had experience with self-hypnosis, and find this to be similar, so it brought that back to me.

I feel calm and relaxed. This reaffirmed what I already knew.

I might have come to the same conclusions on my own, but I came to them sooner and with more clarity.

**Feeling freed of a burden**

Just over 22% of participants stated that after experiencing the IC Processes®, they felt they were freed of a burden that they had been carrying. The following comments are illustrative of those feelings:

- I’m grateful that I don’t have to go on for the rest of my life dissatisfied for the way I’ve been managing my life. I feel I’m freed of a huge burden.
- I am now rid of some of the burdens that have been drawing me down all these years.
- I can deal with my life in a much better way now that a burden has been lifted from me.
- I feel lighter, as if a heavy weight had suddenly been lifted from my shoulders.
- When I arrived, I was feeling depressed, like everything was too much — I was weighed down. After, I feel lighter, happier, so pleased!

**Indicating that participants had grown spiritually**

Spiritual growth as a result of having experienced the IC Processes® was mentioned by almost 11% of participants:
This feels to me like true spiritual growth.

My ability to work with my spirit has grown.

I now value myself, and deserve to be treated well. My inner spirit is right!

It was hard for me to get in contact with my Spiritual Self — that part of me has not wanted to show up! Now I know how to get in touch with it, and can do it often.

I am back in touch with Spirit Within, reconnected.

**Being able to sleep better**

Some participants (9.41%) commented that they were sleeping better, and several aspects of this theme were expressed:

- I did sleep better!
- I felt better (less stressed) and coped better this week. Maybe that is partly because I also slept better this week!
- I am able to sleep better, or should I say that I go to sleep faster.
- Has helped me relax at night.
- I’m sleeping better, and I often have trouble getting off to sleep. Now I just go to my Place of Peace, relax, and go to sleep.

**Feeling tired after the process**

Participants were made aware of the possibility of feeling tired after an IC Process© both in the informed consent form and during the introduction to the first IC
Most often, comments regarding feeling tired were combined with other information, as the following statements show:

- I feel a bit exhausted, but energized at the same time.
- I am somewhat tired, so will go home and be nice to myself.
- This was draining, but good!
- Last week I felt drained, and went home and had a sleep. This week I feel energized!
- I feel happy and peaceful and have great anticipation of good things! I also feel a little tired, so will go home and rest.

These are only a very few of the participant comments illustrating each of the themes of the anecdotal information. To read more complete compilations of the Written Anecdotal Information, see Appendix G.2, and for the Vocally Reported Anecdotal Information, see Appendix G.3.
Chapter 3 Endnotes

2 Siegel, *Nonparametric Statistics for the Behavioral Sciences*. 

CHAPTER 4: DISCUSSION, SUGGESTIONS, AND CONCLUSION

Discussion

The data do not support the hypothesis that the Inner Counselor Process® (IC Process©) will decrease anxiety and depression in seniors as measured by GDS and BAI® instruments, although a possible effect on anxiety is examined. However, the anecdotal evidence collected shows that over 90% of the population voluntarily reported that the IC Process© had a positive effect on their lives. Participants made reference to feeling calm, relaxed, and peaceful after their processes, which would seem to be in direct contrast to the restlessness, irritability, and muscle tension that are some of the hallmarks of anxiety in seniors. Just over 54% made statements indicating that they felt confident or empowered after experiencing the process, which again would seem to be in opposition to the feelings of hopelessness that are strongly linked with depression in seniors.

To clarify the difference between the data from the Friedman and Mann-Whitney U tests and the anecdotal evidence, the results will be analyzed more closely and the appropriateness of the two tests for this population will be considered in this chapter. In addition, issues of access to a population of seniors will be discussed. As well, other possible instruments will be explored. Finally, because this is the first study using the IC Process© as the sole intervention, some observations regarding the IC Process© as an intervention with the senior population will be discussed.
Information from the Friedman and Mann-Whitney U Measurement Instruments

Results of the Friedman measurement instrument indicate significance ($p < 0.5$) for the E group, but not the C group, with the BAI® data. An examination of the mean ranks of the data shows a decrease in the mean ranks from test time one (“A” forms) to test time five (“E” forms) and suggests that there may have been a decrease in the associated BAI® scores across time. However, that change cannot provide evidence to connect the BAI® scores causally to the experience of the Inner Counselor, because the Friedman test does not test for interactions between the test conditions (E versus C groups).

The Mann-Whitney U results also showed a significant difference between the results on the BAI® for the mean ranks of the E versus the C group at the “C,” “D,” and “E” test points; this suggests that the two groups were significantly different at these times. However, the IC Processes© occurred after the “C” test point. There are several possible explanations for this, although none of them is conclusive. One possibility is that the IC Process© did have the effect of reducing anxiety, and that some other factor was also in play at the “C” test point that contributed to the reduction of mean rank for the E group at that time. What might constitute another factor? Possibly, the “C” test point of the E group improved simply because they knew they would have the opportunity to experience the IC Process© the next day — an anticipatory effect.

Another possibility is that the process did not have the effect of reducing anxiety, and that some other factor was responsible for all changes observed in the mean ranks. Perhaps the C group became more focused on the measurement instruments and the themes and
concepts involved as the measurements were repeated, and therefore they spent more time focusing on those aspects (anxious or depressed aspects) of their lives. Whether their actual feelings changed or not, their focus on those aspects may have affected test results. There is no way to know whether factors such as these had an impact on the outcome of the test results. However, if such factors did have an influence, it might have been expected that this would be seen in both tests (the GDS and the BAI®), which was not the case.

It is noteworthy that both the Friedman and the Mann-Whitney U tests suggest reductions in the levels of anxiety, but not in depression. Thus, if the IC Process© did have an impact on anything, it appears that it might have contributed to a reduction in some characteristics of anxiety. The single-question nature of the anecdotal reporting did not lend itself to inferential statistical testing, but the anecdotal information gathered supports this possibility — over 90% of participants reported feeling calm, relaxed, and peaceful, descriptors that do not indicate anxiety.

**Appropriateness of Measurement Instruments to Population**

It is possible that the measurement instruments used in this study (the GDS and the BAI®) were not appropriate for this population. This population appeared to have been too “well” or “normal” (defined for the purposes of this discussion as non-anxious and non-depressed) for any changes to be seen using these measurements. This introduces a floor effect: “Floor effects,” writes Alan Kazdin in *Research Design in Clinical Psychology*, “refer to the fact that change in the dependent measure may reach a
lower limit, and that further change cannot be demonstrated because of this limit.”³ In this study, the floor effect was obvious; most participants’ scores were normal to begin with, so any changes occurring would not likely produce substantial changes in those scores and would be more difficult to detect. The floor effect was evident in both the results from the GDS and the BAI®.

Recall that for the GDS, scores are rated as “normal,” “mild,” or “severe.” Test results from the very first GDS pretest (“A” forms) show that only 13 (6 in the E group and 7 in the C group) of 85 participants (15.3%) had scores that would have been rated as “mild depression,” and no participants scored in the “severe” category. By the time of the second pretest (“B”), the number in the “mild” category had dropped to eight (three in the E group and 5 in the C group). Literature statistics suggest that these numbers should be much higher. Baldwin and Heeren indicate that “major [severe] depression in late life … [has] prevalence in the community of 10% to 15%, rising to about one-half of residents in nursing and residential homes. Notably among older people, sub-threshold depression (minor depression) outnumbers major cases by a factor of three or four to one.”⁴ If those statistics were true for the population of this study, between 9 and 13 participants would have fallen into the “severe” category, and between 27 and 42 participants would have exhibited “mild” depression. These numbers are considerably higher than the data obtained.

For the BAI®, there are also three categories into which results may fall: “very low anxiety,” “moderate anxiety,” and “more severe anxiety.” All of the participants in both groups were in the “very low anxiety” category at the first and second testing time (“A” and “B” forms). Again, this is startlingly different from published statistics, which
suggest that 11.4% to 15% of older adults meet the criteria for a major anxiety disorder, and that this number increases when subsyndromal anxiety is included; that would translate into between 10 and 13 participants who would have tested as either “moderately anxious” or “more severely anxious.” In actuality, however, there were no study participants in either of those categories. Since the BAI® does not test for “no anxiety,” it is not possible to differentiate “no anxiety” from “very low anxiety” in the study population. Nonetheless, the differences between statistics on anxiety in seniors found in the literature and the anxiety levels indicated by the study population are clear. Furthermore, it is much more difficult to show differences when no illness appears to be present to begin with!

Why was such a “normal” population accessed for this research study? The answer may lie in the PI’s lack of access to the broadest range of the senior population when recruiting.

**Accessing the Senior Population**

**Lack of Access to Nursing Homes and Retirement Homes**

The research literature is very clear that seniors have high rates of both anxiety and depression. Further, seniors living in nursing homes have been shown to have even higher rates of anxiety and depression than seniors living in the community. Consequently, it would be reasonable to expect that with the high prevalence of these illnesses, it would not be difficult to access depressed and anxious seniors.
Upon conception of the study, the PI contacted 15 retirement and nursing homes in the area and enquired about the participation of their residents in the study; all but one expressed great interest. The owner of that one nursing home informed the PI that his retirement home was primarily for cognitively impaired seniors who would not likely meet the “non-dementia” requirement of the study, which seemed very reasonable. The owner nonetheless expressed his appreciation that research was being conducted in this area. Another interested retirement home indicated that they had a newly formed “research department” at the head office of the company that owns and operates the facility and several other retirement homes in the province, and that this department would need to be consulted regarding the study. All indications were very positive that this retirement home would participate after discussion with their research department. One retirement home operator went so far as to say, “You know, peace of mind and seniors rarely seem to go together, and you see it in rigid hands and stiff joints. I am so glad that someone is looking into this!”

The reality of accessing seniors in retirement and nursing homes was very different from initial indications. All of the homes accepted information about the study. The retirement home with the research department continued to show great interest in the study, asked for the Internal Review Board (IRB) information from Holos, and requested permission to send information about the study to their affiliates at a local university. However, the research department was very new at this facility, and innumerable delays ensued. Meetings were cancelled and re-scheduled at later dates, people who needed to be consulted were on holiday (a common frustration when conducting research over the summer months), and since policies were still being developed, there was no procedure in
place to allow the research to commence at the facility. Just as the study reached the total number of participants needed, the PI was informed that the facility’s approval would come at a meeting the following week. The PI appreciates the value of the care taken by this facility with regards to protecting its residents, since they are entrusted with the care and support of those residents; unfortunately, the newness of the situation and the associated time delays meant that an excellent source of potential participants was not available. Any further or related studies would benefit greatly from allowing several months to complete IRB processes with nursing or retirement homes.

In the end, recruiting was not allowed in any of the nursing or retirement homes contacted. Concerns were expressed regarding possible legal liabilities of the home owners, should something untoward happen to one of the residents while he or she was taking part in the study. While this is understandable, it was a direct contrast to the initial interest and enthusiasm expressed by the nursing and retirement homes, and came as a surprise to the PI.

With no possibility of recruiting from nursing or retirement homes, recruiting in the community was emphasized, and the number of participants required for the study was reached. Research shows it is very probable that seniors who are able to be out in the community are less likely to experience major anxiety\textsuperscript{11} or depression.\textsuperscript{12} Many study participants were recruited from groups or events specifically for seniors (e.g., the seniors’ centre [16.5%], a retired men’s club [11.8%], the seniors’ group at the “Y” [7.1%]), or from groups of which seniors constitute a large part (e.g., churches [21.2%], stroke recovery groups [5.9%]), or from places “out and about” in the community. Thus, it is possible that the study participants would have been among those seniors less likely
to experience major anxiety and depression. This is not to say that there would not have been some anxious and depressed seniors in the study population, only that there may have been a lower percentage of them. The unexpected change in access to nursing homes and retirement homes may have contributed greatly to having recruited a predominantly “well” study population rather than the normal distribution of seniors initially targeted.

**Did Participants Put Their “Best Face Forward”?**

One of the stated reasons that researchers have found it difficult to accurately assess the levels of depression and anxiety in seniors is that it is common for seniors to put their best faces forward when given the opportunity for positive social encounters with their doctors. As a result, they may not appear depressed during office visits. It is also possible that during the time of office visits, seniors are happy to have someone to talk to, and so honestly do not feel as depressed at those times. While the PI is not a doctor, the low levels of anxiety and depression reported by study participants could be attributable to a similar phenomenon. Participants made several comments indicating that they did not want to present a more negative picture of themselves than they believed to be true. Anecdotal remarks were common that carried the message, “I didn’t mark this question ‘yes’ because it says ‘Do you feel this way?’ and I do sometimes, but not often, so I didn’t want it to sound worse than it is.”
The Effects of Using the Terms “Peace of Mind” and “Well-being” Rather Than “Anxiety” and “Depression”

The PI chose not to use the words anxiety and depression on literature given to participants, because of the stigma that has been associated with those words. Peace of mind and well-being were seen as the opposites of being anxious and depressed, so that reducing anxiety and depression would be the equivalent of increasing peace of mind and well-being. Peace of mind and well-being do not typically carry a social stigma, so those terms were chosen. While this use of terms was intended to avoid an emotional aversion on the part of potential participants, it may have inadvertently resulted in recruiting participants who were not experiencing anxiety and depression and who would not, therefore, be as likely to experience change in those areas as a result of experiencing the Inner Counselor. In fact, while it is possible that some of the study participants would not have enrolled if they believed the study was examining anxiety and depression, it is also possible that others, for whom anxiety and depression are issues, would have signed up. Many participants told the PI (and indicated on their Participant Information Form) that friends had told them about the study and suggested that they enrol; the power of word of mouth among potential participants was evident. Would the same have been true if the words anxiety and depression had been used in recruiting information? Would seniors have told their friends whom they knew to be struggling with anxiety and/or depression? There is no way of knowing for sure, but the possibility exists.
Examination of Choice of Measurement Instruments

Different, possibly more sensitive measurement instruments that would pick up smaller differences in subsyndromal disorders could possibly have been used in this study. The difficulty, of course, is in determining what those instruments might be from the tests available.

Recall from Chapter 2 that the criteria for tests in this study were:

- Tests needed to be self-report scales, rather than interviewer-administered.
- The tests needed to have been used and validated with an older population.
- Tests needed to be able to be completed in a fairly short time.
- Tests needed to have ease of scoring.

Anxiety Tests

In order to understand the choice of the BAI®, it is important to know the other choices available. As well as the BAI®, scales considered for use in the study were: the Zung Self-Rating Anxiety Scale (Zung SAS); the Short Anxiety Screening Test (SAST); the State-Trait Anxiety Inventory® (STAI®); the Hospital Anxiety and Depression Scale (HADS); the Adult Manifest Anxiety Scale–Elderly Version© (AMAS–E©); and the Hamilton Anxiety Rating Scale (HARS).

All of the anxiety tests that were assessed met the criteria for completion time and ease of scoring; this left the criteria of being a self-report test and having been used and validated with seniors. Table 16 presents information pertinent to the choice of the BAI® for this study from the group of tests.
Table 16. Comparison of anxiety scales

<table>
<thead>
<tr>
<th></th>
<th>Self Report?</th>
<th>Tested with Seniors?</th>
<th>Sufficient Validation Data with Seniors Available?</th>
<th>Other Information</th>
<th>Information Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BAI</strong>&lt;sup&gt;®&lt;/sup&gt;</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Data has shown usefulness with seniors</td>
<td>15</td>
</tr>
<tr>
<td><strong>Zung SAS</strong></td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Little reported data on this scale</td>
<td>16</td>
</tr>
<tr>
<td><strong>SAST</strong></td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>New (1999) Early indications are good regarding usefulness with seniors, but more data is required.</td>
<td>17</td>
</tr>
<tr>
<td><strong>STAI©</strong></td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Dr. Charles Spielberger stated that, while normative data for seniors was not currently available, he would like to gather that information in the near future.</td>
<td>18, 19</td>
</tr>
<tr>
<td><strong>HADS</strong></td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Designed to be used with medically ill patients, measures both anxiety and depression</td>
<td>20</td>
</tr>
<tr>
<td><strong>AMAS-E©</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>New (2003). Needs more normative data collection</td>
<td>21</td>
</tr>
<tr>
<td><strong>HARS</strong></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Currently being converted to Hamilton Anxiety Scale (HAMA) since it appeared to confound the measurement of anxiety and depression</td>
<td>22</td>
</tr>
</tbody>
</table>

Dr. Gerard Byrne sums it up nicely: “A suitable scale to measure generalized anxiety in older people is yet to be developed.”<sup>23</sup> At least three new tests for anxiety are in the process of being validated at this time, but were not available at the time that this study was conceived. Each has its strengths and weaknesses.
The Geriatric Anxiety Inventory (GAI) is a very new scale. The authors describe it in this way:

In order to overcome the deficiencies of available anxiety self-report scales for older adults, a new instrument was designed specifically for use with an older cohort over a wide range of settings, including inpatient and nursing home settings. The instrument was intended to be kept relatively brief (20 items) to enhance clinical utility, was designed with a simple yes-no response format for ease of use with mildly cognitively impaired older adults, and was designed to maximize differentiation of somatic symptoms of illness and depression, as well as medication side effects, from anxiety symptoms. The instrument was designed to measure common symptoms of anxiety in older adults. It was not designed to diagnose anxiety disorders, but rather to measure symptom severity across a range of anxiety disorders and symptoms. In this way it was hoped the instrument could also be used to measure not only clinical symptoms of anxiety disorders but also subsyndromal expressions of anxiety … which have become a focus of recent research.24

This instrument is designed to detect subsyndromal expressions of anxiety, which, quite likely, would have been more evident in the population of this study. A possible drawback of the GAI is that it is a yes/no format, designed to be useful with seniors who have mild cognitive impairment as well as the general population. The population of the current study indicated that they found yes/no questions too limiting; they would have preferred a range of choices.

The Adult Manifest Anxiety Scale–Elderly Version© (AMAS–E©) is “a new multidimensional self-report measure designed specifically to assess chronic, manifest anxiety in older adults, aged 60 and older.”25 This scale has 44 questions answered in a yes/no format. Because it is a new scale (developed in 2003), limited information is available on the psychometric properties of the AMAS–E© test scores.26 So, while it was not useful to the current study, it could be useful in the future. Testing will indicate if it is sensitive to subsyndromal anxiety or only to diagnosed anxiety disorder, which would
be an important aspect to consider when matching test with population. The yes/no format has the same drawbacks as the GAI with a “well” population.

The Short Anxiety Screening Test (SAST) is a measure developed with specific intention to “standardize the detection of anxiety disorder in the elderly, even, and especially, in the presence of depression.”27 It consists of 10 questions and uses a Likert scale, with five possible answers from which to choose. Early normative data with seniors is promising, but not abundant. The biggest drawback to using this test in a study like the current one is that it is an interviewer-administered test. Communications with the scale’s creator, Dr. Gary Sinoff, indicate that he would very much like to test it in a self-report setting — but to date, this has not been done.28

In personal communication with the PI, Dr. Charles Spielberger, author of the STAI®, said that although the STAI® does not currently have normative data for the senior population, he would like to gather such data.29 If normative data for seniors were available, the STAI® could be a good test choice for a similar study. Anecdotal information from current study participants indicated that they were aware that “how they felt right now” was not “how they always felt”; in other words, that their State levels (levels at a given moment in time and at a particular intensity)30 were different than their Trait levels (relatively stable individual differences in anxiety-proneness).31 Participants seemed hesitant to accurately indicate their current State levels lest they be mistaken for their Trait levels. An excellent example of this comes from anecdotal information received before a particular participant experienced the IC Process® (and so not included in the anecdotal Appendices). The participant said, “This past week, while driving, my car went off the road and into the ditch — on a country road. I was driving and had a
friend in the car. We were both unhurt, but I did feel shaky and nervous for a while. I
felt guilty about not concentrating enough on the driving — I do have a problem with
that. If I filled in the BAI® sheet with a ‘yes’ for ‘hands trembling’ and ‘shaky’ it would
look as if I am always doing this rather than it being there for just a short period of time
three days ago.” It is possible that the use of the STAII™ could be beneficial in helping
participants to feel comfortable reporting how they felt in exactly those kinds of
situations, knowing it could be differentiated from their perceived usual characteristics.

**Depression Tests**

Depression, having been studied more than anxiety, also has more tests with
normative data for seniors. However, most of those tests are intended to measure major
depression in the general population. The GDS is considered to be the best depression
test for seniors at the current time, as was indicated in the Research Methods Chapter.
The depression tests shown in Table 17 were examined for possible use in this study: the
Geriatric Depression Scale (GDS); Zung Self-Rating Depression Scale (SDS); Beck
Depression Inventory (BDI); Hamilton Depression Rating Scale (HDRS); Montgomery
and Asberg Depression Rating Scale (MADRS); the Center for Epidemiological Studies–
Depression Scale (CES–D); the OARS Depressive Scale (ODS); the Carroll Rating Scale
(CRS); and the Mood Scales–Elderly (MS–E). This information is taken from Alistair
Burns, Brian Lawlor, and Sarah Craig’s book *Assessment Scales in Old Age Psychiatry.*
Table 17. Comparison of depression scales

<table>
<thead>
<tr>
<th></th>
<th>Self Report?</th>
<th>Tested with Seniors?</th>
<th>Sufficient Validation Data with Seniors Available?</th>
<th>Other Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDS</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Specifically designed for use with seniors</td>
</tr>
<tr>
<td>SDS</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Designed for use with general population, starting to be used more with seniors now, but more data needed</td>
</tr>
<tr>
<td>BDI</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Not used specifically for older people</td>
</tr>
<tr>
<td>HDRS</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Not specific to the elderly</td>
</tr>
<tr>
<td>MADRS</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Designed to measure changes in depression over time</td>
</tr>
<tr>
<td>CES–D</td>
<td>Yes</td>
<td>Some</td>
<td>No</td>
<td>Originally developed for general population, is now starting to find some usefulness with older adults</td>
</tr>
<tr>
<td>ODS</td>
<td>No</td>
<td>Some</td>
<td>No</td>
<td>Lacks sensitivity compared to other instruments</td>
</tr>
<tr>
<td>CRS</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Not been used specifically in elderly people</td>
</tr>
<tr>
<td>MS–E</td>
<td>Yes</td>
<td>Yes</td>
<td>Some</td>
<td>Designed to measure changes in depression with treatment. It is a longer test, which takes about $\frac{1}{2}$ hour to complete</td>
</tr>
</tbody>
</table>

It does not appear from an overview of the literature that many new scales are in the process of being developed for the measurement of depression in seniors. However, some of the scales that have found a high degree of reliability in the general population are beginning to be tested with seniors, and data is being collected. Several tests that have normative data for seniors are designed for seniors who show signs of dementia, and not for the general senior population.

One new depression test currently under development is the AB Clinician Depression Screen (ABCDS). It is “a short screening instrument for depression for use in
elderly people with normal cognition, mild cognitive impairment or early dementia,” according to its creators, William Malloy, Timothy Standish, Sacha Dubois, and Alwin Cunje. Their belief is that clinicians are busy and that many of the existing instruments that screen for depression are lengthy; due to this, diagnoses of depression may be incomplete or overlooked due to time constraints. The ABCDS is comprised of only five questions, and so takes little time to complete. This test was first developed in 2005 and is in the process of validation at this time.

**Conclusions: Measurement Instruments for Anxiety and Depression in Seniors**

At this time, there do not appear to be proven and reliable tests for measuring anxiety and depression in the senior population that are self-report instruments and that have normative data for seniors. Further, most of the measurement instruments that exist are designed to measure major depressive episodes and major anxiety, rather than the subsyndromal forms of these illnesses; the current literature indicates that the subsyndromal forms may be the most prevalent. While the measurement instruments used in this study appeared to have been the best choice given the alternatives, they may not have been able to detect anxiety and depression, particularly subsyndromal forms, in the population that was accessed for this study.

Interestingly, one of the pieces of anecdotal information that was tallied was the number of participants who expressed frustration with the measurement instruments. These results are shown in Figure 2.
As is evident, more participants expressed frustration with the GDS than the BAI®. Frustration with the GDS (see Appendix D.9) had several themes. Some participants expressed a dislike of the “yes/no” format; many indicated that they preferred a rating scale, or at least a “sometimes” category, which they felt would have been a more accurate assessment of how they were feeling. Some participants stated that they did not mark “yes” because they did not feel that way all the time, even if they were feeling that way at the moment. Some participants indicated that they did not think the questions were specific to seniors.

The question, “Do you prefer to stay at home, rather than going out and doing new things?” irked several participants, one of whom wrote beside the question, “I can stay home and do new things, you know!” Others were very specific: “I am an introvert,
and always have been. My preferring to stay home is a part of my character, not a problem!” Others remarked that with their particular illnesses or disabilities, it was difficult for them to leave the house, but that this was strictly a physical issue, not an emotional one. “Besides,” said one person, “now that I know how to use the Internet, I can do new things every day, and only go out when I need to!”

Participants had great fun with the question, “Is your mind as clear as it used to be?” Responses varied from, “No, but whose is at my age?” to “If it isn’t, how can I be sure that I would know?” Some people were clear that it was the adjectives used in the test questions they found frustrating. In response to the question, “Do you feel full of energy?” participants commented that they had reasonable energy for their age, but were not “full” of it, or that their lack of energy was a result of a physical ailment, but they were used to it now and it did not bother them. The question, “Do you feel happy most of the time?” brought a similar response from many participants. “I can’t say that I exactly feel ‘happy’ most of the time,” said one participant. “I would say that I feel ‘contented’ and at this age, a steady feeling of contentment is more important to me than momentary happiness.” So despite the fact that the GDS was the scale designed specifically for use with older adults, it was the one with which the participants expressed the most frustration.

Study data support the possibility that the measurement instruments used were not a good match for the study population. The differences in anxiety and depression found in the community-based population of this study compared with literature statistics raises questions about the statistics in the literature regarding the prevalence of anxiety and depression in seniors. If it is true that the presentation of depression may be quite
different in older adults than in younger persons,\textsuperscript{34} and if it is also a fact that most current measurement instruments are designed to measure anxiety and depression as they manifest in younger adults, then it is possible that some of the statistics published earlier could be misleading. Another issue that could contribute to differences in statistics concerns what the measurement instruments were designed to measure. If, as the literature states, more seniors experience subsyndromal forms of anxiety and depression, and if most scales are designed to identify major forms of those illnesses, a discrepancy could occur. It is unclear whether this means that more or fewer seniors actually have anxiety and depression than is reported in the literature. The measurement instruments available at different times may have missed the diagnosis in some seniors who do experience anxiety or depression, and may also have incorrectly diagnosed some seniors who were not experiencing those illnesses. What it does mean is that the studies reported in the literature should be read very carefully, taking the identified factors of the measurement instrument designs into account. It will be very interesting to observe if the statistics reported in the literature change as some of the new measurement instruments being developed and tested for normative data with seniors begin to get more widespread use.

Another consideration is that the whole area of anxiety and depression in seniors could be changing rapidly in character as the baby boomers (those born between 1946 and 1964) reach their senior years. As Dr. Norman Abeles, past president of the American Psychological Association, writes, “Never before have so many people lived into the later stages of their lives so healthily and productively.”\textsuperscript{35} As the full contingent of baby boomers moves into later life, representative statistics for this age group could
change dramatically. It is possible that the baby boomer influence is already affecting some of the most recently reported statistics. Some researchers consider “older adults” to be those 55 years of age or over; thus, approximately the first five years of the baby boomers are already included in this group. Testing done more than 10 to 15 years ago may well have reflected the senior population at that time; the current senior population could be quite different.

Other Possibilities for Measurement Scales

It is possible that changes in anxiety and depression levels were not the best indicators of the effects of the IC Process®, despite indications of their prevalence in the senior population and their apparent suitability as assessed by trained Inner Counselor facilitators. Perhaps other measurements would have given a different picture.

It is believed that subsyndromal forms of anxiety and depression are indeed more prevalent in the senior population, particularly in community-dwelling seniors. Current measurement scales tend to more accurately measure major depression and anxiety, which are not the most prevalent forms of these illnesses in the senior population. In light of this, as well as the difficulties experienced in accessing the senior population more likely to suffer from anxiety and depression (i.e., those in nursing or retirement homes), perhaps different evaluation criteria and scales would have had more value in this study.
Well-being Scales

A literature search of the (relatively few) recent CAM studies done with seniors indicates an interest in assessing seniors’ well-being. This turned out to be a more complicated area than might be assumed. A cursory investigation into well-being scales of use with seniors produced some interesting information.

An examination was done of three measures assessing psychological well-being in the elderly: the Positive Affect and Negative Affect of the Affect Balance Scale, the Positive Well-Being Scale, and the Seven Point Satisfaction Rating. It was determined that none of them gave reliable results, and suggested that the difficulty was that none of the studied instruments was based on a clear conceptual model of well-being.37

A published evaluation of subjective well-being measures assessed 11 subjective well-being scales for criterion validity, convergent validity, content validity, and construct validity. However, it intentionally did not include what was referred to as “the geriatric scales,”38 so the results are not helpful to finding a scale for a study with seniors. Further research would be needed to determine if there are studies indicating that subjective well-being is different for seniors than for the general population.

Studies of seniors’ well-being often used Quality of Life (QOL) scales,39 or measured State Affect,40 and many of these were interviewer-assisted.41

The Scale of Subjective Wellbeing for Older Persons (SSWO) is a 30-item questionnaire designed to measure an individual’s health, self-respect, morale, optimism, and relationships. As far as can be determined, it is currently available only in Dutch. No indication is given based on its translated abstracts whether it is a self-report scale or interviewer-assisted. Further information regarding this scale would be useful.
Perhaps the scale with the most potential for use in a population similar to the one in this study is the Well-Being Picture Scale (WPS), developed in 2005 by Sarah Hall Gueldner et al. The WPS is a non-language-based pictorial scale that measures general well-being; it is a shorter, refined version of the Index of Field Energy (IFE). It was designed as an easy-to-administer tool for use with the broadest possible range of adult populations, including persons who have limited formal education; who do not speak English as their first language; who may not be able to see well; or who may be too sick or too frail to respond to lengthier or more complex evaluations. Interestingly, the initial inspiration for the development of the picture tool came when Gueldner encountered difficulty using other well-being scales in a sample of nursing home residents. To date, it has had some testing with seniors, with positive results and good correlation with other measures of well-being.

A participant comment supports the idea that a well-being scale could be appropriate. She wrote, “I feel that the process is well named — Inner Counselor for wellbeing.”

**Outcome Rating Scales**

Another type of measurement scale worth investigating would be the outcome rating scales. These scales are typically designed to track progress with treatment, and several are available.

The Outcome Rating Scale (ORS), created by Scott Miller and Barry Duncan in 2000, could have possibilities for use with seniors, since it was created with an adult population including those up to 83 years old, and age differences proved to be non-
significant. It is a short (4-item) visual analog scale, on which participants are instructed to place a hash mark along the line, with low estimates to the left and high to the right. It measures changes in participants’ functioning in three specific areas — individual (personal well-being), relational (family, close relationships), and social (work, school, friendships) — plus an overall (general sense of well-being) measurement. It is reported to have adequate validity and solid reliability.

Another possible outcomes rating scale might be the 45-item OQ-45.2, which is the longer scale from which the ORS was derived. This test measures functioning in three domains: symptom distress (heavily loaded for depression and anxiety), interpersonal functioning, and social role, enabling the assessment of functional level and change over time. Less information is available on this test without purchasing the manual, so information regarding normative data with seniors is not known. Regardless, it might be worth exploring.

This brief exploration of other options in tests in no way purports to be an exhaustive search of the literature. It does, however, indicate that there are some potentially useful scales with which to measure changes in seniors after having experienced the Inner Counselor. More in-depth information would be needed before selecting a scale, but the expansion of the field of search to include scales other than those for anxiety and depression might produce a scale that would be a good measure for seniors using the Inner Counselor.
Observations Regarding the Inner Counselor as an Intervention

As is evident from the anecdotal data reported in Chapter 3, many study participants offered insightful information after having experienced two IC Processes©. The PI also gained some valuable information from the experience of facilitation the IC Processes© with this population. Because this was an initial study using IC Process© as the sole intervention, some of the information gained may be of use to subsequent researchers.

Can the IC Process© be used successfully with a brief introduction?

It became clear that seniors are very capable of understanding and following the IC Processes© with no previous experience and only a brief introduction. By way of contrast, students in the Holos 731/831 Inner Counselor Seminar usually have an entire evening of introduction to the process and observe a demonstration before participating in it themselves. This raised the question of whether or not people would understand and be able to participate in the process with much less introductory time. Some participants mentioned that they weren’t sure they remembered the entire introduction given by the PI when the introduction was over (which was not necessary), but all participants were able to be facilitated through the process. After experiencing the process, many participants commented that it was easier than they had thought it might be, and that they had been concerned mainly due to their lack of prior experience. Very few participants had any questions or concerns regarding the process before their second IC Processes©; having experienced one, they knew what to expect and felt ready to proceed. The questions that
were asked mostly had to do with what they had learned from the first process, and how they could best use the second process to benefit their lives.

**Choosing an Issue or Feeling to Address**

Choosing an issue or feeling to explore using the *IC Process*© was another area of learning regarding the use of this process in a research environment, rather than a classroom setting or a private practice. When Holos students attend the 731/831 Inner Counselor seminar, they have already read two books (Don Miguel Ruiz’s book *The Four Agreements* and Ann Nunley’s *The Inner Counselor Seminar Manual*) and prepared two short papers. The stated purpose of these assignments is “to become familiar with the IC Manual and some of its concepts prior to the residency,” and “to discuss and become aware of patterns within yourself and your family so that you will have a better idea about issues you may choose to explore during the experiential portion of the residency.” As mentioned, they have also had an in-depth introduction to the process, and have observed a demonstration of the *IC Process*© before participating in a process themselves. In short, students have had ample time and preparation to begin to understand the Inner Counselor, and to identify areas of their lives that they might wish to explore using the *IC Process*© by the time they actually experience it.

Clients of the PI’s private practice often come because they have issues they are working on, so identifying the issue is not often an obstacle. The participants in this study, however, signed up to participate in research. Although the recruiting information gave a brief indication about the process, it was not initially certain that participants would be able to translate that information and their brief introduction into a clear picture
of what issues in their lives might be addressed using the *IC Process*©. This concern proved to be unfounded. Participants were able to identify issues without exception; some participants knew right away what they would like to address and others came to a decision more slowly, but all participants found issues or feelings to explore.

It was interesting that many participants began by saying, “I have a very good life. I’m not sure I have anything to work on.” However, when the idea that the *IC Process*© could be used for everyday concerns as well as major life issues was reiterated, participants became more willing to choose an issue or feeling. It seemed very important to the participants that they express their overall satisfaction with their lives. For some, this may have been a form of denial, of not wanting to acknowledge their life issues; for others, it may have been an accurate assessment of their lives at the time. Several participants commented that they could really have used this process at an earlier time in their lives when they were experiencing challenging situations. These statements of contentment add to the picture of a non-anxious and non-depressed study population that has emerged from the participant information.

**Empowerment of Participants**

The feelings of empowerment reported by many participants were a striking aspect of this study. Just over 54% indicated that they felt empowered and confident after experiencing their *IC Processes*©. As this percentage reflects only those who volunteered this information, it would be very interesting to know what the percentage might have been if all participants had been asked specifically about it. One of the most significant aspects of the *IC Process*© is that the wisdom comes from within, from
“higher powers [and] … self-healing powers or energies latent in the healee,” as Dan Benor says. Those who work with older adults are warned against over-caretaking, solving all the seniors’ problems, and creating “learned helplessness.” The IC Process©, by virtue of the fact that it accesses the High Self of the participant as a guide for the process, leaves the participant in control of the process at all times.

The anecdotal information illustrates that many participants marvelled at the inner wisdom they accessed and the fact that they had it within themselves all along, but were unaware of it or did not know how to access it. Consider the possibilities for the benefit of seniors if, merely through the experience of two IC Processes©, feelings of confidence and empowerment could be increased in more than half of them! Confidence and empowerment are certainly not depressed states; thus the possibility still exists, though the tests were not able to show it, that the IC Process© does have an effect on depression.

**Weaknesses of the Study**

The weaknesses of the study have been identified at different points throughout this work; this section brings them together for scrutiny.

The PI was not granted access to local nursing homes and retirement homes, and therefore failed to reach a potentially large and more representative group of participants for the study; this may have contributed to the recruitment of a predominantly non-anxious and non-depressed group. While finding a group of seniors who are non-anxious and non-depressed can be seen as reflecting positively on those involved, it contributed to the extreme non-normality of data, which precluded the use of the two-way repeated
measures ANOVA, since to use that ANOVA may have created a high possibility of inaccurate results. This, in turn, led to the use of multiple non-parametric tests to address the research question, which may have reduced the power of the test to detect differences between groups, or provide evidence of a causal link between the *IC Process©* and any observed changes.

Having one facilitator for all processes introduced the skill and ability of the facilitator as a possible weakness of the study. It is also possible that the PI increased in her effectiveness to facilitate the process as time progressed, simply due to the added experience gained through the large volume of processes facilitated. This could have had more possible impact had test results been gathered for the C group after the experience of their *IC Processes©*, since the C group would have experienced their processes last and benefited from any increased effectiveness. Counteracting this possibility was the training of the PI before any processes began; she was well trained and had the support and approval of Ann Nunley, PhD, creator of the *IC Process©*. While having one facilitator has been identified as a weakness of the study, there are strengths associated with this factor as well. All participants experienced the same facilitator, so differences between facilitators were not an issue. Differences in the PI’s performance from day to day would be no greater than the differences between each of a group of facilitators’ performances from day to day.

The PI was not blind to information regarding which participants were in the Experimental and Control groups of the study. This was not possible due to study design. Because the PI knew which participants were in which groups, it is possible that she could have tried harder to do more effective processes with the E group than with the C
group, thus contributing to any difference found between the groups. This could have been more of a problem had statistical significance been found in this study; as it was not found, it is not necessary to defend that as one possible cause of the difference. It should be identified, however, for the benefit of future research.

The PI created the study, facilitated the processes, and wanted the results to support the research hypothesis. There is a possibility that her intent created more positive results than might otherwise have been seen. It is difficult to assess those effects in this study due to the lack of statistical information from the measurement instruments.

Due to the number of times that the tests were completed (five) and the number of participants, the measurement instruments in this study needed to be self-report instruments; it would not have been feasible for the PI to personally administer all the tests. However, there is speculation that individuals often respond to self-report measures in a socially desirable way,\(^4\) which may have been a factor in the study. This could have affected test results, producing lower reported levels of anxiety and depression.

Research on seniors and aging indicates that “one important limitation is the lack of a widely accepted instrument to measure dimensional anxiety in both normal older people and older people with mental health problems seen in various settings.”\(^4\) The same is true of depression. The lack of self-report tests for anxiety and depression that have normative data for seniors is a weakness of this study, as it may have affected the ability to accurately reflect the levels of anxiety and depression in the study population.

This study had limited randomization. Quota sampling occurred first, and then participants were assigned to groups in a random fashion. As a result, generalization to other groups of seniors is limited.
Recommendations for Future Research

This study involved several aspects: the Inner Counselor Process©, research with seniors, and appropriate testing measures with seniors, all of which can lead to interesting future research.

Repeating this study using a more diversified population would be an excellent first step. The increased diversity would reduce the possibility that the non-normality of data would recur, allowing for the use of the 2-way repeated measures ANOVA and increasing the power to detect differences that were statistically significant.

With a more diversified population and some modifications to the research design, a repeat of the study could offer new insights. Repeating the measurements of the tests with the Control group after they experience their IC Processes© could be of value. Creating a third group who visited with the researcher but did not experience the IC Process© would help to address the question of whether changes observed were due to the experience of the process itself, or due to time spent with a caring person. It would be interesting to do a three month follow-up as well, to see if any changes that occur are lasting.

Valuable information could be obtained by testing the IC Process© with a population for which there are more reliable tests (e.g., the general adult population). If the process was tested with the general adult population using the same research design and methodology and a significant difference was found, this would support the concept that the IC Process© can have an impact on anxiety and depression. It would also give credence to the possibility that it was not that anxiety and depression had not been
influenced in the current study, but that the changes in the dependent variables were not accurately reflected in the tests.

Another interesting scenario would be to test the Inner Counselor with a known anxious and depressed general adult population. This would probably require collaboration with a medical facility or practice and would need to be carefully supervised, such that the interests of the participants, who would be seen as a high-risk population, would be well protected. Drawing from this population would mean that participants would be more likely to have initial test scores on the GDS and BAI® high enough to detect improvement, if it occurred. The difficulty would be that most people diagnosed with anxiety and/or depression are on medication, which, of course, could interfere with test scores. If the medications for anxiety and depression were working, it could mean that the test scores would not be indicative of anxiety and/or depression. It would be necessary, as well, to find a sufficient number of depressed or anxious participants whose medication dosages were unchanged for at least six months to have a statistically viable study. It is noteworthy that society considers being under medical care, even with all the known possible side effects of medications, to be “safer” than using complementary therapies that often have fewer side effects. There appears to be greater willingness to test new medications than to test a new healing modality. In this case, it would be important to conduct this study with the full awareness and cooperation of a medical doctor who was supportive of CAM therapies. This would provide the safety that is so important when working with at-risk populations, and at the same time, contribute to building a stronger working relationship between allopathic and alternative approaches to wellness. It would also be true that skewness of results could also be
found using this population, except that it could reflect a “too unwell population” rather than a “too well population.” There would be issues to address, but the results could be very helpful. If people knew that they had an alternative to medications, they would have the opportunity to make a choice. As one of the study participants said, “When I experienced depression earlier in my life, they just filled me full of drugs. I really didn’t like it. This process helps without drugs by accessing the wisdom within me.”

It would be of interest to repeat the study using another scale to measure the effects of the *Inner Counselor Process*©. This begs the question, “What should be measured?” One approach to determining the answer to that would be to gather a group of experienced *IC*© facilitators, and ask them to identify those words or phrases that describe changes they have seen in participants with whom they have facilitated the process. A sheet of those words and phrases could be compiled. Students taking Holos University Graduate Seminary course 831, Inner Counselor – A Spiritual Discipline, could be asked at the completion of the residential portion of the course to complete one of these sheets, circling any changes they feel they have experienced as a result of the *Inner Counselor Process*©, as well as adding any others that were not already on the sheet. Over time, those changes which are mentioned most frequently would become apparent, and a scale could be sought that would most aptly measure them, individually or together. The effects of the *IC Process*© could then be tested in a larger population using that scale. This approaches the question of the effects of the *IC Process*© from a slightly different angle. Rather than, “Does the *IC Process*© have an effect on a specific dependent variable?” it works from a clearer initial picture of the effects of the *IC Process*©, and then tests for those.
It would be of value to repeat this study using a different facilitator. Since only one facilitator did all of the processes, her skill level and competence with the process could be a factor. If time and money allowed, it would be interesting to repeat the study having several different facilitators. While this would introduce the difference between facilitators as a possible confound (which would need to be tracked and analyzed), it would lessen the possibility that the outcome of the study was completely dependent on the ability of any one facilitator. Several facilitators would also make possible an increased study population, which would make such a study more rigorous.

It would be interesting to create a study design where the facilitators were blinded to which participants were in the E and C groups. This would require the assistance of a “project manager” who had no vested interest in the outcome of the study, and also had full responsibility for administration and the scheduling of processes. The facilitators’ only task would be to facilitate *IC Processes*© for participants as they showed up at the designated time. This would reduce possible facilitator bias regarding doing a better job with the E group participants. If the “project manager” was not the PI, it would also enhance the randomization, since there would be no intention to influence (consciously or not) the assignment of participants to groups.

More structured anecdotal information could access valuable participant information. The current study is an initial study using the *IC Process*© as the sole intervention. As such, it seemed important during the processes not to “lead” participants regarding the information they wanted to share about their experience by asking directive questions, but rather to allow them the freedom to choose what they wished to say. The open-ended question eliciting anecdotal information certainly accessed a variety of
different responses to the *IC Process*, which is valuable in itself. However, it was difficult to quantify the information for use in statistical analysis, since participants did not address the same topics in their anecdotal reporting. It is also possible that participants did not mention a specific topic merely because they forgot or didn’t think of it at the time they were completing their forms, and not because they had nothing to say. The experiences of the seniors in this study could serve as a beginning point in the development of a questionnaire for future studies. The aversion of the seniors in this study to yes/no questions suggests that a different format would be good, perhaps a scale from 0 to 10 for each question (the meaning of the different numbers would be clearly defined), with a section for comments included. Other formats could be investigated as well.

**Conclusion**

This research project was designed to determine the effects of the *Inner Counselor Process* on anxiety and depression in seniors. Was statistical significance found on the two dependent variables (anxiety and depression) from the data of two measurement instruments (the GDS and the BAI)? Yes and no. Results show no conclusive evidence of the impact of the *IC Process* on depression, but a possible effect on anxiety. Did the experience of the *IC Process* make a difference in the lives of the participants in these areas? Anecdotal information strongly suggests that the answer is “yes.” While it would have been beneficial to have had the statistical verification of the
effects, the information gained anecdotally cannot be ignored. Further research is required to investigate this topic in greater detail.
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**DISCOGRAPHY**


APPENDIX A

A.1 Definition of Terms

**Acupuncture:** A complete system of treatment for physical and psychological problems developed in China thousands of years ago. Acupuncture points are stimulated along bioenergy lines (meridians) that run from toes and fingers to the head. Each meridian corresponds to a bioenergy organ, roughly correlated with physical organs.

**Anxiety:** An unpleasant emotional and physical state of overwhelming apprehension and fear.

**Autogenic Training (AT):** Autogenic Training is a technique of medical therapy, pioneered by Dr. Johannes Schultz (a psychiatrist and neurologist), that elicits the relaxation response. Schultz taught simple verbal exercises to patients who were in a relaxed state of mind and found that they could lessen both physical and mental symptoms.

**Binaural beat:** When different vibrations, or sound frequencies, are delivered to the brain separately through each ear (as with stereo headphones), the two hemispheres of the brain function together to “hear” not the external sound signals, but a third phantom signal. This signal is called a binaural beat and it pulses at the exact mathematical difference between the two actual tones.

**Biofeedback:** Also referred to as *applied psychophysiological feedback*, biofeedback is the process of displaying involuntary or subthreshold physiological processes, usually by electronic instrumentation, and learning to voluntarily influence those processes by making changes in cognition. It provides a visible and experiential demonstration of the mind-body connection.
**Body Harmonization©**: A synthesis of three spiritual healing techniques: BOS©, BES©, and Inner Counselor. It accesses the body’s wisdom using muscle testing (kinesiology) to discover and balance the energetic precursors of physical, emotional, mental, and spiritual imbalances in the body, mind, and spirit. It is a form of spiritual healing that seeks to balance the energy anatomy (the subtle energy fields, the meridian system, and the chakras) as well as the body physically, emotionally, mentally, and spiritually. Its energy-harmonizing techniques are intended to tap into the body’s inborn potential to heal itself.

**Botanical treatments**: Plant extracts and essences, often from herbs, that are used to treat physical, emotional and spiritual issues.

**Chakras**: A concept of human energy based on ancient Hindu beliefs, chakras are spinning vortices of energy that comprise focal points and an interface for information moving in, out, and through the subtle energy bodies.

**Ch’i**: Life energy carried along meridians (see Acupuncture). Ch’i is said to come from three sources: ancestral ch’i inherited from parents, nutritional ch’i absorbed from the foods eaten, and environmental ch’i from the environment. Imbalances in ch’i flow are thought to contribute to illness.

**Comorbidity**: The presence of coexisting or additional diseases with reference to an initial diagnosis or with reference to the index condition that is the subject of study. Comorbidity may affect the ability of affected individuals to function and also their survival; it may be used as a prognostic indicator for length of hospital stay, cost factors, and outcome or survival.

**Complementary and Alternative Medicine (CAM)**: Therapies that are not generally offered within conventional medical care (such as acupuncture, homeopathy, spiritual healing, and many more) are grouped under the term CAM.
**Depression:** The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revised (DSM-IV-TR) of the American Psychiatric Association defines major depression as a period of at least two weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities. For minor depression, see Dysthymic Disorder.

**Dysthymic Disorder:** A term for minor depression, characterized by a chronically depressed mood that occurs for most of the day more days than not for at least two years. During periods of depressed mood, at least two of the following additional symptoms are present: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, and feelings of hopelessness.

**Electroacupuncture:** The use of a source of electricity attached to the needles used for acupuncture treatment.

**Electroconvulsive Therapy (ECT):** ECT entails the electrical induction of seizures in the brain, administered during a series of six to twelve treatment sessions on an inpatient or outpatient basis.

**Electrotherapy:** Electrotherapy involves the use of devices that emit an electric current at specific frequencies, applied to specific points on the body.

**Energy Healing:** The growing number of approaches where an understanding of the body as a system of energies is being applied to promote health, healing, and happiness. Energy medicine is the art and science of fostering physical, psychological, and spiritual health and well-being. It combines a rational knowledge and intuitive understanding of the energies in the body and in the environment.

**Extrinsic Needs:** Needs met from someone or something external to the self, e.g., the need for others to love us, or the need for someone to look after us.
**Friedman Test:** Similar to the parametric repeated measures ANOVA, and used to detect differences in treatments across multiple test attempts. The procedure involves ranking each row (or block) together, then considering the values of ranks by columns.

**Generalized Anxiety Disorder (GAD):** An anxiety disorder characterized by excessive anxiety and worry occurring more days than not about a number of different events or activities. The individual finds it difficult to control the worry.

**High Self:** The High Self has been referred to as the essence, heart, core, soul, or the life hidden deep within. It is the invisible, intangible organizing centre of energy, the controlling core, the source of the pattern of potential unfolding in mental and physical development. It is the inner space-time blueprint, with the knowledge of the whole pattern, and thus of any healing process, and the storehouse of our not-yet-conscious potentials and higher qualities awaiting expression in the world.

**Imagery:** The use of images. Imagery is the thought process that invokes and uses the senses — vision, hearing, smell, taste, the senses of movement, position, and touch — and a communication mechanism between perception, emotion, and bodily change.

**Inner Counselor:** A comprehensive approach that comprises a conceptual framework and an experiential process that includes a way to witness inner change. Aspects of the Inner Counselor include the 15-step *Inner Counselor Process©*, the Integration Chart©, the Whole Self Model II©, and other conceptual components.

**Inner Counselor Process©:** A guided, 15-step, self-awareness process intended to provide people with a way to access their own inner wisdom regarding issues that are important to them. It is not therapy, but rather a spiritual process.
**Integration Chart©:** A chart used in conjunction with the *Inner Counselor Process©* that illustrates the soul’s journey through life and briefly outlines the psychological underpinnings of the Inner Counselor.

**Interpersonal Therapy (IPT):** A form of psychotherapy that posits that depression is driven by irresolution of four conflict areas, namely grief (loss of significant people), interpersonal conflict (disputes and difficulties with others), role transition (changes in one’s societal and personal roles), and interpersonal difficulties (difficulty in interacting with people in general). The aim of treatment is to overcome these conflict areas through active discussion with a therapist.

**Intrinsic Needs:** Needs met from within the individual, e.g., the need for self-love, or self-respect.

**Kurtosis:** A statistical measure of the “peakedness” of data distribution compared to the normal (Gaussian) distribution, which is often described as a “Bell curve.”

**Light therapy:** The use of photostimulation (lights) to affect mood. It is believed that light therapy works to reduce depressive symptomatology by countering the negative effects of light deficiency on brain chemistry and circadian rhythms.

**Mann-Whitney U Test:** A non-parametric statistical significance test for assessing whether the difference between two samples of observations is statistically significant (i.e., whether two independent groups have been drawn from the same population).

**Massage therapy:** Massage therapy involves the manipulation of soft tissue by trained therapists for therapeutic purposes.

**Music therapy:** Music therapy involves the active or passive use of music to promote health and well-being. During treatment, patients perform music or listen to music carefully chosen and supervised by a trained music therapist.
Non-normal data distribution: Distribution of statistical data that does not meet the requirements for normality (see next definition). The distribution does not approximate a bell-shaped curve.

Normality of data Distribution: The normal or Gaussian distribution is a continuous symmetric distribution that follows the familiar bell-shaped curve. The distribution is uniquely determined by its mean and variance. Many frequently used statistical tests make the assumption that the data comes from a normal distribution.

Obsessive-Compulsive Disorder (OCD): An anxiety disorder characterized by recurrent obsessions or compulsions that are severe enough to be time consuming, or cause marked distress or significant impairment. The obsessions or compulsions are deemed excessive or unreasonable.

Oldest old: Those persons 85 years of age and older.

Panic Disorder: An anxiety disorder characterized by the presence of recurrent, unexpected panic attacks followed by at least one month of persistent concern about having another panic attack, worry about the possible implications of the panic attacks, or a significant behavioural change related to the attacks.

Pharmacotherapy: The use of prescription medications to treat illness and/or disease.

Post-Traumatic Stress Disorder (PTSD): An anxiety disorder characterized by the development of characteristic symptoms following exposure to an extreme traumatic stressor. The individual’s response involves intense fear, helplessness, or horror, and the response involves disorganized or agitated behaviour.

Psychotherapy: Planned and structured interventions aimed at influencing behaviour, mood, and emotional patterns of reaction to different stimuli through verbal and non-
verbal psychological means. Psychotherapy does not comprise the use of any biochemical or biological means.

**Reiki**: A Japanese system of laying-on of hands and distant healing. A trained Reiki healer acts as a channel of universal life energy that is taken into the healer’s body from the surrounding environment and directed to a patient in need of healing.

**Religion**: Beliefs and/or rituals that are associated with a specific institutionalized group or belief system organized around some sacred dimension.

**Seniors**: For the purpose of this study, seniors are defined as those persons between the ages of 65 and 85.

**Skewness**: A statistical measurement indicating the deviation of data distribution from the symmetry of normally distributed data.

**Social Anxiety Disorder (or Social Phobia)**: An abject fear of one or more social situations, such as performing, speaking in public, meeting new people, or attending gatherings. It also manifests as severe anxiety when speaking to authority figures, or publicly disagreeing with others, such as in a meeting.

**Soliton**: A solitary electromechanical wave that propagates with little loss of energy and retains its shape and speed after colliding with another such wave.

**Specific Phobias**: An anxiety disorder characterized by marked and persistent fear of clearly discernable circumscribed objects or situations. Exposure to the phobic stimulus provokes an immediate anxiety response that is deemed excessive or unreasonable.

**Spirituality**: An individual connection with a greater power, a personal search for the sacred, a sense of interconnectedness with all living creatures, and an awareness of the purpose and meaning of life.
**Spiritual Healing:** A systematic, purposeful intervention by one or more persons aiming to help another living being (person, animal, plant, or other living system) to improve their condition by means of focused intention, hand contact, or movements of their hands near the body. Spiritual healing is brought about without the use of conventional energetic, mechanical, or chemical interventions.

**Statistical Testing – Non-parametric:** Non-parametric statistical tests are tests that do not make distributional assumptions about the data. In particular, non-parametric tests usually drop the assumption that the data comes from normally distributed populations.

**Statistical Testing – Parametric:** Parametric inferential statistical methods are mathematical procedures for statistical hypothesis testing that assume the distributions of the variables being assessed belong to known parameterized families of probability distributions.

**Subsyndromal anxiety:** An anxiety level that would not meet the criteria of the DSM-IV-TR for a diagnosis of anxiety, but is significant in the life of the person experiencing it. It is similar in severity level to “minor” or subsyndromal depression.

**Symbol:** A thing that represents or stands for something else, especially a material object representing something abstract.

**Tensegrity:** A term coined by Buckminster Fuller, the inventor of the geodesic dome, which is a tensegrous structure. Tensegrity simply means a system of tension and compression elements.

**Therapeutic:** Having a good effect on the body or mind; contributing to a sense of well-being.
**Therapeutic Touch™ (TT™):** A form of bioenergy healing developed by Delores Krieger and Dora van Gelder Kunz. TT is the use of hands and intention to balance body, mind, and spirit.

**Thoughtforms:** Strong thoughts and emotions create an energy structure known as a thoughtform. Thoughtforms are formed from sensory input, modeling, experience, imprinting, genetic inheritance, and imagination. They are stored at subconscious and super-conscious levels of being and directly influence a person’s mental, emotional, subtle-energy, and physical well-being.

**Transcranial Magnetic Stimulation (TMS):** TMS involves placing an electromagnetic coil on the scalp. High-intensity current is rapidly turned on and off in the coil through the discharge of capacitors. This produces a time-varying magnetic field that lasts for about 100 to 200 microseconds. The proximity of the brain to the time-varying magnetic field results in current flow in neural tissue. Transcranial magnetic stimulation is usually performed in outpatient settings and does not require anaesthesia or analgesics.

**Transpersonal Psychology:** A modern academic discipline concerned with the psychological study of the transpersonal and spiritual dimensions of human nature and existence, as well as with the spiritual and transpersonal study of human psychology. While focusing on the interface of psychology and spirituality, transpersonal psychology strives to understand and nurture the wholeness of human nature — body, instincts, heart, mind, and consciousness.

**Visualization:** Forming a mental image of; imagining.

**Whole Self Model II©:** A model explaining the task of integrating levels of consciousness. It teaches that our spiritual, emotional, mental and physical bodies are interconnected through three major aspects of the mind — the super-conscious, the self-conscious, and the subconscious — and that healing requires us to open doors between the three levels.
A.2 The Inner Counselor Process

1. **Begin in your Place of Peace.** Feel yourself totally there. • **See** the surroundings • **Hear** any sounds • **Smell** any fragrances. • **Describe** this place. • **In this place** you feel calm, safe, grounded and centered in your heart. • From your heart center **invite your (High Self) to be present** and to be the guide for this journey. • I will invite my (High Self) to be present as my guide.

2. **What is the issue and feeling** you wish to explore? (Feeling = emotion and physical sensation)

3. **Ask your self and your (High Self)** if it is safe and advisable to address this issue at this time. • (If not, ask to be shown an appropriate issue to address at this time). • **Are there additional wise and loving guides** who would like to help you with this issue? •

4. **Go to a recent time** when you experienced this issue. • **Where are you?** • What is happening? • **How do you feel?** (emotions/sensations). • Where in your body are the feelings the strongest? (throat, heart, stomach, etc).

5. **Let the feelings carry you to an earlier time** (ride the feelings). • **How old are you?** • **What is happening?** • **How do you feel?** (emotions/sensations)

6. **Let the feelings take a form.** • **Describe the form** (color, shape). • **This (form) is the Old Symbol.** * (Page 1 of 4)
7. **Be in that experience** of *(Describe experience.)* • **What do you really NEED and WANT?** - If you could cry out and say, “I need!” “I want!” what would you ask for? *(Dialog to identify intrinsic qualities).* •

8. **How did the (emotions/sensations) serve you when your needs were not met?**
   • Thank the *(Old Symbol)* for helping you by providing this response. • Ask the *(Old Symbol)* if it is willing for you to find a way to respond that will keep you safe AND fulfill your deep inner need for *(qualities).* •

9. **Fully sense** the qualities that will fulfill your need. • Ask your High Self to show you a New Symbol – someone or something that *truly* embodies those qualities. • **Describe your New Symbol.** • Will the *(New Symbol)* commit to help you with this issue? •

10. Will you commit to the qualities and protection represented by the *(New Symbol)*? •

11. **Bring the two symbols together.** Have the *(New Symbol)* show the *(Old Symbol)* how its qualities will protect you and fulfill your needs. • Is the *(Old Symbol)* willing to be absorbed within the *(New Symbol)* so you can have what you truly need? • *(Re-state needs and address any fears).*

12. **Experience** the *(New Symbol)* completely absorbing the *(Old Symbol).* •

   Is the *(Old Symbol)* completely absorbed and transformed by the *(New Symbol)*? • **How does the (New Symbol) look now?** • *(there may or may not be a change)*
13. What special advice does the (New Symbol) have for you that you need to hear at this time? • Put the advice in words and speak it out loud. • (If there are other guides). Do (other guides) have any advice? •

14. Be aware of your original issue. • Feel the qualities of (New Symbol) in your body. • Describe a specific circumstance in the near future when those qualities, now present within you, will empower you to respond to the issue in a new way. • Feel the new response in your body. •

15. Give the (New Symbol) a place of honor within yourself and in your Place of Peace. • Thank your guide(s) and your (+High Self+). • Thank yourself. •

(COMplete Energy Exercise)

• NOTE: Step #6 and Step #7 can be interchanged in terms of sequence, depending on facilitator’s choice.

• Use of a bullet “•” means that the facilitator should pause and allow the participant to respond.
ENERGY EXERCISE

With our hands joined we form a circuit of energy and we experience that flow….As the energy flows, imagine a golden light with the special qualities of the (New Symbol) entering the crown of your head. Visualize and feel the light and power of this light as it fills your head (Pause) filling every cell. Feel the light as it moves down to fill your throat (Pause) across your shoulders and down your arms to the tips of your fingers. Feel the light filling your heart and lungs (Pause) your solar plexus (Pause) your abdomen (Pause) the golden light with the energy of the (New Symbol) then moves down to the base of your spine filling your lower body full of healing light (Pause) down your legs to the tips of your toes (Pause). As the light fills your body, every cell is full of light (Pause) Every cell is changed by the golden light and the qualities of the (New Symbol). Feel your feet connect with the energy of the earth. (Pause) Feel the strength of that energy and draw it up into your body to become part of the golden light energy (Pause). We will take some cleansing breaths together, breathing in through the nose and blowing out through the mouth. With each cleansing breath, we allow the golden light to move up through our bodies, releasing any residual energies that are not part of the light. (Breathe with the person until you are both calm and full of light)

AFFIRMATION PRAYER:

May every cell in your body forever hold in memory that —

You are created by Divine Light,
You are surrounded by Divine Light,
You are protected by Divine Light,
You are sustained by Divine Light,
You are ever growing into Divine Light.

Swami Radha, Canada

Quietly open your eyes, and be here in this room feeling alert and refreshed, and filled with light.
A.3 The Integration Chart

INTEGRATION CHART
From the INNER COUNSELOR © Ann Nunley

© Ann Nunley
A.4 The Whole Self Model II

*whole self model ii*

Our level of self-integration is measured by how comprehensively we approach our human experiences. Healing modalities that are based on a very limited, partial picture of the whole person, have difficulty achieving comprehensive results. The body does not heal itself selectively, and our healing methods need to acknowledge and utilize a comprehensive approach to human dimensions and potentials. This diagram illustrates ways in which the Inner Counselor Process promotes integral healing of the Whole Self.

*Integration & Healing*

Using the

The Inner Counselor Process™
AN INVITATION FOR PARTICIPATION IN
THE EFFECTS OF THE INNER COUNSELOR PROCESS©
ON THE WELL-BEING OF SENIORS
RESEARCH PROJECT

Are you ... between 65 and 85 years of age?
... interested in increasing your sense of well-being?

If so, please consider participating in this research study!

The Inner Counselor Process© is a creative way to address a range of concerns from ordinary worries to major life issues in order to bring about increased peace of mind and an enhanced sense of well-being. It is not psychotherapy, and the facilitator does not offer solutions to the issue raised. The approach of the Inner Counselor Process© is that our greatest asset for healing comes from the “healer within” each one of us. The Inner Counselor Process© provides you with a way to access your own inner wisdom regarding issues that are important to you.

If you participate, you will receive two Inner Counselor sessions with the researcher, and you will fill in some forms. There is no cost to participate, and only about 6 hours of your time is required over several weeks.

For more information, or to enrol in the study, please contact:

Rev. Ann Osborne
(519) 767-0505
aosborne@earthlink.net
**Note:** This was printed as a full-page flyer on pale green paper.
Dear __________________________,

I am a Doctor of Theology (ThD) student at Holos University Graduate Seminary doing a doctoral dissertation entitled “The Effects of the Inner Counselor Process© on the Peace of Mind and Well-Being of Seniors,” which addresses certain aspects associated with the health and well-being of seniors aged 65 to 85 years of age. I am asking for your help to recruit seniors who might consider participating in this study.

The Inner Counselor Process© (IC Process©) is a creative way to address a range of concerns from ordinary worries to major life issues. The approach of the Inner Counselor is based on the concept that our greatest asset for healing comes from the “healer within” each of us. The IC Process© provides people with a way to access their own inner wisdom regarding issues that are important to them. It is a guided self-awareness process, not psychotherapy, and the facilitator does not analyze or offer solutions to the concerns or issues raised. During the process, volunteers sit relaxed and comfortable with eyes closed, and are guided by the principle investigator through the fifteen steps that make up the IC Process©. A process generally takes between 30 and 45 minutes. This process is respectful of all faith traditions.

I am looking for 100 seniors 65 to 85 years of age who do not show signs of serious dementia, and who have not previously experienced an IC Process© to participate in my study. There is no financial cost to the participants, and the total time commitment will be approximately 6 hours over the course of six weeks. I will work with the seniors in an office in Guelph with excellent accessibility, free parking, and a bus stop nearby. The study will be conducted beginning in May 2006. Interested seniors can contact me directly to indicate their interest.
The enclosed letter can be copied and given to interested seniors, and gives further information regarding what participants in the study could expect. If you would like more printed copies, I will gladly get them to you.

I would be happy to meet with you or speak with you to answer any questions you might have regarding this study or the IC Process© itself. If you would like to experience an IC Process© before suggesting it to others, I would be pleased to facilitate a process with you.

Would you be willing to post the enclosed flyer in a prominent location where it could be seen by many of the seniors with whom you are in contact and/or personally draw their attention to the possibility of participating in this study?

I believe that seniors are a valuable segment of society, and that their health and well-being are vitally important. Please help me find participants so that this research can be conducted to better understand and support our seniors!

I greatly appreciate your assistance, and look forward hearing from you!

Sincerely,

Rev. Ann Osborne,  
ThD Candidate

519-767-0505  
aosborne@earthlink.net
B.3 Recruiting Letter to Friends and Acquaintances

Rev. Ann Osborne,
4796 Nassagaweya-Puslinch Townline,
R.R. #1, Moffat, Ontario.
L0P 1J0
(519) 767-0505
aosborne@earthlink.net

May 8, 2006

Dear __________________________,

As you know, I am a Doctor of Theology (ThD) student at Holos University Graduate Seminary doing a dissertation entitled “The Effects of the Inner Counselor Process© on Peace of Mind and Well-Being of Seniors,” which addresses certain aspects associated with the health and well-being of seniors aged 65 to 85. I am asking for your help to recruit seniors who might be interested in participating in this study.

The Inner Counselor Process© (IC Process©) is a creative way to address a range of concerns from ordinary worries to major life issues. The approach of the Inner Counselor is based on the concept that our greatest asset for healing comes from the “healer within” each of us. The IC Process© provides people with a way to access their own inner wisdom regarding issues that are important to them. It is a guided self-awareness process, not psychotherapy, and the facilitator does not analyze or offer solutions to the concerns or issues raised. During the process, volunteers sit relaxed and comfortable with eyes closed, and are guided by the principle investigator through the fifteen steps that make up the IC Process©. A process generally takes between 30 and 45 minutes. This process is respectful of all faith traditions.

I am looking for 100 seniors 65 to 85 years of age who do not show signs of serious dementia and who have not previously experienced an IC Process© to participate in my study. There is no financial cost to the participants, and the total time commitment will be approximately 6 hours over the course of six weeks. I will work with the seniors in an office in Guelph with excellent accessibility, free parking, and with a bus stop nearby. The study will be conducted beginning in May 2006. Anyone who is interested (you or others!) can contact me directly.
The enclosed letter can be copied and given to interested seniors, and gives further information regarding what participants in the study could expect. If you would like more printed copies, I will gladly get them to you. I would be happy to meet with you or speak with you to answer any questions you might have regarding this study or the IC Process® itself. If you would like to experience an IC Process® before suggesting it to others, I would be pleased to facilitate a process with you.

Would you be willing to give copies of the enclosed flyer and/or letter to seniors you know who might be willing to participate in this study?

I believe that seniors are a valuable segment of society, and that their health and well-being are vitally important. Please help me find participants so that this research can be conducted to better understand and support our seniors!

I greatly appreciate your assistance!

Sincerely,

Rev. Ann Osborne,
ThD Candidate,
Holos University Graduate Seminary

519-767-0505
aosborne@earthlink.net
B.4 Recruiting Letter to Therapeutic Touch™ Team

Rev. Ann Osborne,
4796 Nassagaweya-Puslinch Townline,
R.R. #1, Moffat, Ontario.
L0P 1J0
(519) 767-0505
aosborne@earthlink.net

May 8, 2006

Dear Members of the Therapeutic Touch Team,

Thank you so much for agreeing to receive this information about my study! I am very grateful to be able to send this information to you. Please know that I am not asking you to actively recruit participants for my study. However, having read the information, if you know of seniors – relatives, neighbours, or friends, perhaps – who you think could benefit from this, then please pass the information along to them! Some of you have indicated that you would like to participate yourselves – that would be great!

As most of you will know, I am a Doctor of Theology (ThD) candidate at Holos University Graduate Seminary, doing a dissertation entitled “The Effects of the Inner Counselor Process© on the Peace of Mind and Well-Being of Seniors,” which addresses certain aspects associated with the health and well-being of seniors aged 65 to 85 years of age. I am asking for your help to recruit seniors who might consider participating in this study.

The Inner Counselor Process© (IC Process©) is a creative way to address a range of concerns from ordinary worries to major life issues. It is a guided self-awareness process, not psychotherapy, and the facilitator does not offer solutions to the issue raised. The approach of the Inner Counselor is that our greatest asset for healing comes from the “healer within” each of us. The IC Process© provides people with a way to access their own inner wisdom regarding issues that are important to them. During the process, you sit relaxed and comfortable with your eyes closed, and are guided by the principal investigator through the fifteen steps that make up the IC Process©. A process generally takes between 30 and 45 minutes. This process is respectful of all faith traditions.
I am looking for 100 seniors 65 to 85 years of age who do not show signs of serious dementia, and who have not previously experienced an IC Process© to participate in my study. There is no financial cost to the participants, and the total time commitment will be approximately 6 hours over the course of six weeks. I will work with the seniors in an office in Guelph with excellent accessibility, free parking, and a bus stop nearby. The study will be conducted beginning in May 2006. Interested seniors can contact me directly to indicate their interest.

There are two attachments to this letter. The letter can be printed and given to interested seniors, and gives further information regarding what participants in the study could expect. The flyer can be printed and posted in locations where potential participants might have the opportunity to read it. If you would like printed copies of either of these attachments, I will gladly get them to you.

I would be happy to meet with you or speak with you to answer any questions you might have regarding this study or the IC Process© itself. If you would like to experience an IC Process© before suggesting it to others, I would be pleased to facilitate a process with you.

If there is some place you go regularly where the flyer could be posted (health clubs, golf courses, community centres, for example) where it could be seen by many seniors, that would be great. If not, that is fine, too!

I believe that seniors are a valuable segment of society, and that their health and well-being are vitally important. Please help me find participants so that this research can be conducted to better understand and support our seniors!

I greatly appreciate your assistance, and look forward hearing from you!

Sincerely,

Rev. Ann Osborne
ThD Candidate,
Holos University Graduate Seminary

519-767-0505
aosborne@earthlink.net
B.5 Recruiting Letter to Clergy Group

Rev. Ann Osborne,
4796 Nassagaweya-Puslinch Townline,
R.R. #1, Moffat, Ontario.
L0P 1J0
(519) 767-0505
aosborne@earthlink.net

May 8, 2006

Dear Members of the Cluster,

Thank you so much for having invited me to attend your April cluster meeting to talk about the ministry of the Therapeutic Touch team at Trinity! I am very grateful to be able to send this information to all of you.

As many of you will know, I am a Doctor of Theology (ThD) student at Holos University Graduate Seminary doing a doctoral dissertation entitled “The Effects of the Inner Counselor Process® on the Peace of Mind and Well-Being of Seniors,” which addresses certain aspects associated with the health and well-being of seniors aged 65 to 85 years of age. I am asking for your help to recruit seniors who might consider participating in this study.

The Inner Counselor Process® (IC Process®) is a creative way to address a range of concerns from ordinary worries to major life issues. The approach of the Inner Counselor is based on the concept that our greatest asset for healing comes from the “healer within” each of us. The IC Process® provides people with a way to access their own inner wisdom regarding issues that are important to them. It is a guided self-awareness process, not psychotherapy, and the facilitator does not analyze or offer solutions to the concerns or issues raised. During the process, volunteers sit relaxed and comfortable with eyes closed, and are guided by the principal investigator through the fifteen steps that make up the IC Process®. A process generally takes between 30 and 45 minutes. This process is respectful of all faith traditions.

I am looking for 100 seniors 65 to 85 years of age who do not show signs of serious dementia, and who have not experienced an IC Process® previously to participate in my study. There is no financial cost to the participants, and the total time commitment will be approximately 6 hours over the course of six weeks. I will work with the seniors in an office in Guelph with excellent accessibility, free parking, and a bus stop nearby. The study will be conducted beginning in May 2006. Interested seniors can contact me directly to indicate their interest.
There are three pieces of information accompanying this letter. The letter (Recruiting Letter to Interested Seniors) can be printed and given to interested seniors, and gives further information regarding what participants in the study could expect. The flyer (Recruiting Flyer) can be printed and posted in locations where potential participants might have the opportunity to read it. The bulletin insert (Self-titled!) can be printed and inserted in your bulletin for a few Sundays. If you would like printed copies of any of these attachments, I will gladly get them to you. Please let me know!

I would be happy to meet with you or speak with you to answer any questions you might have regarding this study or the IC Process® itself. If you would like to experience an IC Process® before suggesting it to others, I would be pleased to facilitate a process with you.

Would you be willing to post the flyer in a prominent location where it could be seen by many of the seniors with whom you are in contact and/or personally draw their attention to the possibility of participating in this study?

I believe that seniors are a valuable segment of society, and that their health and well-being are vitally important. Please help me find participants so that this research can be conducted to better understand and support our seniors!

I greatly appreciate your assistance, and look forward hearing from you!

Sincerely,

Rev. Ann Osborne
ThD Candidate

519-767-0505
aosborne@earthlink.net
Hello!

Thank you for your interest in my research project! I am a Doctor of Theology (ThD) candidate at Holos University Graduate Seminary doing a dissertation entitled “The Effects of the Inner Counselor Process© for Peace of Mind and Well-Being of Seniors,” which addresses concerns and life issues encountered by seniors with the intention of possibly bringing about increased peace of mind and an enhanced sense of well-being. In order to participate in my study, you must be 65 to 85 years old, free of serious dementia, and must not have previously experienced an Inner Counselor Process©.

The Inner Counselor is a guided self-awareness process, not psychotherapy, and the facilitator does not analyze or offer solutions to the concerns or issues raised. This approach is based on the idea that our greatest asset for healing comes from the “healer within” each of us. The IC Process© provides you with a way to access your own inner wisdom regarding issues that are important to you. During the process, you sit comfortably and relaxed with your eyes closed, and are guided by the principal investigator (me!) through the fifteen steps that make up the IC Process©. A process generally takes between 30 and 45 minutes.

If you agree to participate in the study, you will experience two IC Processes©. You will meet with me twice. The first visit is expected to take about 1 ½ hours, during which you will be introduced to the concepts and basic ideas of the IC Process©, experience your first process, and have time for follow-up. The second visit will take about the same length of time, during which you will experience a process, and again have time for follow-up.
You will be asked to fill out two short questionnaires five times in total over a six-week time span. It is estimated that these forms will take no more than twenty minutes to fill out each time, and no more than two hours all together. You will mail the completed forms back to me in stamped, pre-addressed envelopes that will be provided for you. There is no financial cost to you to participate in this study.

The study will be conducted beginning in May 2006. We will meet for our Inner Counselor sessions in a home office in Guelph that has excellent accessibility (no stairs involved!), free parking, and a bus stop nearby.

For more information or to enrol in the study, please contact me. If I am not available when you call, please leave me a message, and I will return your call as soon as possible. I look forward to hearing from you!

Sincerely,

Rev. Ann Osborne
ThD Candidate
519-767-0505
B.7 Recruiting Insert in Church Bulletin

An Opportunity for Seniors 65 to 85 Years Old to Participate in a Research Study

As many of you know, I am a Doctor of Theology (ThD) student at Holos University Graduate Seminary doing a doctoral dissertation entitled “The Effects of the Inner Counselor Process© on the Peace of Mind and Well-Being of Seniors,” which addresses certain aspects associated with the health and well-being of seniors aged 65 to 85 years of age.

The Inner Counselor Process© (IC Process©) is a creative way to address a range of concerns from ordinary worries to major life issues. The approach of the Inner Counselor is based on the concept that our greatest asset for healing comes from the “healer within” each of us. The IC Process© provides people with a way to access their own inner wisdom regarding issues that are important to them. It is a guided self-awareness process, not psychotherapy, and the facilitator does not analyze or offer solutions to the concerns or issues raised. During the process, volunteers sit relaxed and comfortable with eyes closed, and are guided by the principal investigator through the fifteen steps that make up the IC Process©. A process generally takes between 30 and 45 minutes. This process is respectful of all faith traditions.

I am looking for 100 seniors 65 to 85 years of age who do not show signs of serious dementia, and who have not experienced an IC Process© previously to participate in my study. There is no financial cost to the participants, and the total time commitment will be approximately 6 hours over the course of six weeks. I will work with the seniors in an office in Guelph with excellent accessibility, free parking, and with a bus stop nearby. The study will be conducted beginning in May 2006. Anyone who is interested (you or others!) can contact me directly. I greatly appreciate your assistance, and look forward hearing from you!

Many thanks to all who have supported my research by helping me to find participants, and especially to those seniors who have agreed to participate. I am very grateful! My numbers are climbing, which is wonderful, but at this time, I still have room for many more participants.

I believe that seniors are a valuable segment of society, and that their health and well-being are vitally important. Please help me find participants so that this research can be conducted to better understand and support our seniors! If you or someone you know would be interested, please contact me.
Rev. Ann Osborne,
519-767-0505
aosborne@earthlink.net
Good morning, everyone!

As many of you know, I have been studying to complete a doctorate in theology for the past three years. I have now completed all of my course work, and am into the research and dissertation phase of my degree. The official title of my dissertation is “The Effects of The Inner Counselor Process© on the Peace of Mind and Well-Being of Seniors,” and it addresses certain aspects associated with the health and well-being of seniors aged 65 to 85. You may already have read the bulletin insert on the _______ (colour) paper, which gives more details about the study.

My research involves a process called the Inner Counselor. The Inner Counselor Process© (IC Process©) is a creative way to address a range of concerns from ordinary worries to major life issues. These can be as minor as “whenever I talk to my sister on the phone, we end up arguing, and I would like to stop that,” or “whenever this happens, I completely overreact,” or bigger issues, such as “I’ve never been able to let go of my grief around a certain person’s death” or “I’ve had a serious medical diagnosis, and am struggling with it,” and everything in between.

The approach of the Inner Counselor is based on the concept that our greatest asset for healing comes from the “healer within” each of us. The IC Process© provides people with a way to access their own inner wisdom regarding issues that are important to them. It is a guided self-awareness process, not psychotherapy, and the facilitator (me!) does not analyze or offer solutions to the concerns or issues raised.

During a process, you sit relaxed and comfortable with your eyes closed, and are guided by me through the fifteen steps that make up the IC Process©. A process generally takes between 30 and 45 minutes.

I am looking for 100 seniors 65 to 85 years of age who do not show signs of serious dementia and who have not previously experienced an IC Process© to participate in my study. There is no financial cost to participate in the study, and the total time commitment will be about 6 hours over the course of six weeks. I will work with the seniors in a home office in Guelph that has excellent accessibility (no stairs!), free parking, and a bus stop nearby.

I believe that seniors are a valuable segment of society, and that their health and well-being are vitally important. Please help me find participants so that this research can be conducted to better understand and support our seniors! If you are interested, or know someone who might be interested, contact me using the information on the insert, or speak to me in the auditorium after church.

I appreciate your support! Thanks!
B.9 Recruiting Announcement to Men’s Group

Good morning, everyone!

I appreciate that I am able to take a few minutes of your time to talk to you about my research project.

For the past three and a half years, I have been studying to complete a doctorate in theology. I have now completed all of my course work, and am into the research and dissertation phase of my degree. The official title of my dissertation is “The Effects of the Inner Counselor Process© on the Peace of Mind and Well-Being of Seniors,” and it addresses certain aspects associated with the health and well-being of seniors aged 65 to 85.

The Inner Counselor Process© (IC Process©) is a creative way to address a range of concerns from ordinary worries to major life issues. These can be as minor as “whenever I talk to my son on the phone, we end up arguing, and I would like that to change,” or “I am a very impatient person, and would like to be more patient” or bigger issues, such as “I’ve never been able to let go of my grief around a certain person’s death” or “I’ve had a serious medical diagnosis, and am struggling with it,” and everything in between. An interesting note: someone who chose to look at becoming more patient discovered that this work has very practical outcomes – instead of being impatient with slower golfers ahead of him on the course, he stayed more relaxed, which vastly improved both his golf swing and his game!

The approach of the Inner Counselor is based on the concept that our greatest asset for healing comes from the “healer within” each of us. The IC Process© provides people with a way to access their own inner wisdom regarding issues that are important to them. It is a guided self-awareness process, not psychotherapy, and the facilitator (me!) does not analyze or offer solutions to the concerns or issues raised.

During a process, you sit relaxed and comfortable with your eyes closed, and are guided by me through the fifteen steps that make up the IC Process©. A process generally takes between 30 and 45 minutes.

I am looking for a total of 100 seniors 65 to 85 years of age who do not show signs of serious dementia and who have not previously experienced an IC Process© to participate in my study. There is no financial cost to participate in the study, and the total time commitment is about 6 hours over the course of six weeks. If you agree to participate, you will fill in questionnaires on 5 different dates (they take about 20 minutes to complete each time) and experience 2 IC Processes© with me. I work with the seniors in a home office in Guelph, which has excellent accessibility (no stairs!), free parking, and a bus stop nearby.
You need to know that all information in the study is treated with the highest degree of confidentiality. When you enrol in the study, you are assigned a participant number, and all forms and questionnaires are identified only by that number. Your personal information is never released. When the research results are published, no names will be used.

Although the date on the top of the letter that you have received is May, that was just the beginning of the study. Because I am facilitating all of the IC Processes©, the study will run for several months, so there is still time to enrol!

I believe that seniors are a valuable segment of society, and that their health and well-being are vitally important. Please help me find participants so that this research can be conducted to better understand and support our seniors! If you are interested, or know someone who might be interested, or have questions regarding the study, you can contact me using the information on the insert, or speak to me after the conclusion of the meeting.

I appreciate your support! Thanks!
B.10 Recruiting Notice in Newspapers

The notice which ran in the local newspapers read:

Research with Seniors

A Research Study titled “The Effects of the Inner Counselor Process on the Peace of Mind and Well-Being of Seniors” is looking for volunteers, 65 – 85 years old. Interested participants please call (519) 767-0505.
B.11 Recruiting Invitation Posted on Seniors’ Community Web site

An invitation for participation in
"THE EFFECTS OF THE INNER COUNSELOR PROCESS ON THE WELL-BEING OF SENIORS RESEARCH PROJECT"

Are you between 65 and 85 years of age?
Interested in increasing your sense of well-being?

If interested, check out the brochure here,
or check out the detailed information letter here.
This project is not endorsed by the VBA Website Committee.
But ... the researcher is Rev. Ann Osborne, who is a daughter-in-law of a VBA resident.
APPENDIX C

C.1 Telephone Script for Enrolment

Thank you for your interest in this study!

Could I please have your name and the correct spelling?
________________________________________

And you are: Male   Female

Because this study is designed for seniors 65-85 years old, I need to ask your age.

_____

Now, there are some questions I need to ask you to make sure that we are able to include you in this study:

1) Have you seen a doctor recently regarding memory difficulties? Yes  No
   If yes: Was the difficulty resolved? Yes   No
   If yes, continue to question 2
   If no, then ask: Do you still have severe memory difficulties? Yes  No
   If yes, say, “Thank you for enquiring about the study, but unfortunately you are not an eligible participant for this research. I appreciate your interest. Thanks again! Goodbye.”
   If no, continue to question 2

If no: continue to question 2.

2) Are you currently taking medication? Yes  No
   If yes: Have any of the dosages changed in the past 6 months? Yes  No
   If yes: For which medications have the dosages changed?
   _______________________________
   _______________________________
   _______________________________
   _______________________________
   _______________________________

Look at the list of common medications for anxiety and depression. If the medications for which dosages have changed are on that list, say, “Thank you for enquiring about the
If no: Continue with information for sign-up.

It sounds like you are someone who is eligible to participate in this study! In order to enrol you, we need to get some further information.

Address: __________________________________________
________________________________________________
________________________________________________
________________________________________________
________________________________________________

Phone Number ______________________________________

Do you have post-secondary education? Yes    No

Slot the participant into the appropriate group in the study.
First, slot by gender.
Second, slot by education level.

The first person in any of these categories automatically goes into the experimental group, and the second person in the same category goes into the control group.

Write the person’s name in the appropriate category on the Participant Sign-Up Sheets.

Calculate the dates for processes and form completion:

Two weeks before the first IC Process© __________________________
Date 1

One week before the first IC Process© __________________________
Date 2: 7 days after date 1

One day before the first IC Process© __________________________
Date 3: 6 days after date 2

Date and time of First IC Process© __________________________
(For Experimental Group)

Date and time of Second IC Process© __________________________
(For Experimental Group)

One day after the second IC Process© __________________________
Date 4: eight days after date 3

Two weeks after the second IC Process© __________________________
Date 5: 13 days after date 4
For the Experimental Group

Tell the participant:

Because all of the Inner Counselor Processes© are being done by one person, they will take place over several months. Participants are being randomly assigned to different time periods, and you are one of the participants whose Inner Counselor Processes© will take place within the next two months. We can choose those times right now, if you have your calendar handy. We need to agree on two dates which are exactly one week apart. We can book times beginning about three weeks from now.

There are 5 possible IC Process© times each day:
- Morning: 8:30 – 10:00
- Afternoon: 1:00 – 2:30
- Evening: 7:00 – 8:30

What days and times would work for you?

Choose times for two Inner Counselor Processes©, exactly one week apart, i.e., if the first process is Tuesday morning at 8:30, the second IC Process© is the next week, Tuesday, at 8:30 a.m. Check to see that the second week time slot is available before you book them. Do not book processes for Statutory Holidays. Mark both times in the planner.

Calculate the dates for form completion:
- Two weeks before the first IC Process© ___________________________
- One week before the first IC Process© ____________________________
- One day before the first IC Process© _____________________________
- Date and time of First IC Process© ______________________________
- Date and time of Second IC Process© ____________________________
- One day after the second IC Process© ____________________________
- Two weeks after the second IC Process© __________________________

Tell the participant:

You will receive a participant package in the next few days. It will either arrive in the mail, or be hand-delivered. It contains all of the information that you need regarding this study. There are two forms to fill in and return immediately, and 5 envelopes with dates on the outside which contain forms to be filled in later.

The dates for each set of forms will be marked on the outside of the envelope containing the forms. On that date, take out the forms, complete them, put them back in the envelope, seal, and mail it.
These dates are also marked on a magnetic card that you will find in the package, which you can put on your fridge or anywhere where it will help to make it easy to remember to fill in the forms on the appropriate days.

You will receive a brief phone call the day before each IC Process© to remind you of the appointment.

A map of the Inner Counselor Office location is included in the participant package.

Do you have any questions? (Answer questions from the information given to participants)

Thanks!

**DO NOT:**

Use the terms anxiety or depression – use the phrases “peace of mind” and “well-being.”

Use the terms “experimental group” or “control group.” Instead, talk about the participants whose Inner Counselor Processes© are in the next few months or several months away.
For the Control Group

Tell the participant:

Because all of the Inner Counselor Processes® are being done by one person, they will take place over several months. Participants are being randomly assigned to different time periods, and you are one of the participants whose Inner Counselor Processes® will take place several months from now. Because it is hard to plan times that far in advance, we’ll give you a phone call closer to that time to choose your Inner Counselor Process® appointment times.

The part of the study that you complete at this time involves filling in 5 sets of forms on specified dates.

You will receive a participant package in the next few days. It will either arrive in the mail, or be hand-delivered. It contains all of the information that you need regarding this study. There are two forms to fill in and return immediately, and 5 envelopes with dates on the outside which contain forms to be filled in later.

If possible, use the same dates for form completion as the person with the same number in the corresponding experimental group. If those dates are past, or too close to be able to reliably get the forms to the participant, schedule dates as soon as reasonably possible, using the same timing of form completion. (Date 1 and date 2 are in place of Inner Counselor dates, and are exactly one week apart):

Two weeks before date 1 __________________________
One week before date 1 __________________________
One day before date 1 __________________________
Date 1 __________________________
Date 2 __________________________
One day after date 2 __________________________
Two weeks after date 2 __________________________

Tell the participant:

The dates for each set of forms will be marked on the outside of the envelope containing the forms. On that date, take out the forms, complete them, put them back in the envelope, seal, and mail it.

These dates are also marked on a magnetic card that you will find in the package, which you can put on your fridge or anywhere where it will help to make it easy to remember to fill in the forms on the appropriate days.

Do you have any questions? (Answer questions from the information given to participants.)

Thanks!
DO NOT:

Use the terms anxiety or depression – use the phrases “peace of mind” and “well-being.”

Use the terms “experimental group” or “control group.” Instead, talk about the participants whose Inner Counselor processes are in the next few months or several months away.
C.2 Mayo Clinic Information on Medications Prescribed for Anxiety and Depression

Medications Commonly Used to Treat Anxiety

- Alprazolam
- Ativan
- Benzodiazepines
- BuSpar
- Buspirone
- Celexa
- Chlordiazepoxide
- Citalopram
- Clonazepam
- Diazepam
- Escitalopram
- Effexor
- Fluoxetine
- Fluvoxamine
- Imipramine
- Inderal LA
- Innopran XL
- Klonopin
- Lorazepam
- Lexapro
- Librium
- Lorazepam
- Luvox
- Nardil
- Parnate
- Paroxetine
- Paxil
- Phenelzine
- Propranolol
- Prozac
- Sarafem
- Sertraline
- Tofranil
- Tranylcypromine
- Valium
- Venlafaxine
- Xanax
- Zoloft

Medications Commonly Used to Treat Depression

- Amitriptyline
- Aventyl
- Bupropion
- Celexa
- Citalopram
- Cymbalta
- Desipramine
- Desyrel
- Doxepin
- Duloxetine
- Escitalopram
- Effexor, Effexor XR
- Fluoxetine
- Imipramine
- Isocarboxazid
- Lexapro
- Maprotiline
- Marplan
- Mirtazapine
- Nardil
- Norpramin
- Nortriptyline
- Nefazodone
- Parnate
- Paroxetine
- Paxil, Paxil CR
- Phenelzine
- Protriptyline
- Prozac, Prozac Weekly
- Remeron, Remeron Soltab
- Sertraline
- Serzone
- Sinequan
- Surmontil
- Tofranil
- Tranylcypromine
- Trazodone
- Trimipramine
- Venlafaxine
- Vivactil
- Wellbutrin, Wellbutrin SR, Wellbutrin XL
- Zoloft
C.3 Medications Prescribed to Study Participants

Following is a list of all of the prescription drugs listed by study participants as part of the Participant Information Form. The name of the drug as given by the participant is first, followed by its pharmaceutical name (if different) and a description of conditions for which it would be prescribed.

The information provided here has been accessed from two locations, the Mayo Clinic Web site http://www.mayoclinic.com/health/drug-information/DrugHerbIndex, and Medbroadcast.com http://www.medbroadcast.com/drug_info.asp

Information was first gathered at the time of receipt of the Participant Information Form, and was re-checked on September 21-23, 2006, to ensure current accuracy. Medications used to treat anxiety and/or depression have been indicated by three stars (***)) preceding the medication name. The list has been checked for accuracy by Dr. C. Norman Shealy, M.D., PhD.

Medications Listed by Participants on the Participant Information Form

Acebutelol (Beta-adrenergic Blocking Agents) (Systemic) This group of medicines is known as beta-blockers and used in the treatment of hypertension (high blood pressure).

Actonel (Risedronate) (Systemic) Risedronate is used to prevent and treat osteoporosis (thinning of bone) in women after menopause. It may also be used in men and women to prevent and treat osteoporosis caused by long-term use of corticosteroids.
**Advair** (Fluticasone and Salmeterol) (Inhalation-Local) Fluticasone and salmeterol is a combination of two medicines that are used to help control the symptoms of asthma and improve lung function.

**Alendronate** (Systemic) Alendronate is used to prevent or treat osteoporosis (thinning of the bone) in women after menopause and to treat osteoporosis in men. It may also be used to treat Paget’s disease of bone and osteoporosis.

**Allopurinol** (Systemic) Allopurinol is used to treat chronic gout (gouty arthritis).

**Alphagan** (Brimonidine) (Ophthalmic) Brimonidine is used to treat glaucoma or ocular hypertension (another condition in which pressure in the eye is too high).

**Altace** (Angiotensin-converting Enzyme [ACE] Inhibitors) (Systemic) ACE inhibitors belong to the class of medicines called antihypertensives (high blood pressure medicines). They are used to treat hypertension (high blood pressure).

***Amitriptyline*** (Antidepressants, Tricyclic) (Systemic) Tricyclic antidepressants are used to relieve mental depression.  (Chlordiazepoxide and Amitriptyline) (Systemic) Chlordiazepoxide and amitriptyline combination is used to treat mental depression that occurs with anxiety or nervous tension.
***Apo-Citalopram (Systemic) Citalopram is used to treat mental depression.

Apo-diltiaz (Calcium Channel Blocking Agents) (Systemic) Apo-diltiaz belongs to the group of medicines called calcium channel blocking agents. Some of the calcium channel blocking agents are used to relieve and control angina pectoris (chest pain). Some are also used to treat hypertension (high blood pressure).

Apo-furosemide (Diuretics, Loop) (Systemic) Loop diuretics are given to help reduce the amount of water in the body.

Apo-hydro (Diuretics, Thiazide) (Systemic) Thiazide or thiazide-like diuretics are commonly used to treat high hypertension (high blood pressure).

Apo-Metopopol (Beta-adrenergic Blocking Agents) (Systemic) This group of medicines is known as beta-blockers, and used in the treatment of hypertension (high blood pressure).

Apo-triazide (Diuretics, Potassium-sparing, and Hydrochlorothiazide) (Systemic) This medicine is a combination of two diuretics (water pills). It is commonly used to help reduce the amount of water in the body.

Arimidex (Anastrozole) (Systemic) Anastrozole is a medicine that is used to treat breast cancer.
**Arthrotec** (Diclofenac and Misoprostol) (Systemic) Diclofenac and misoprostol combination is used for patients with arthritis who may develop stomach ulcers from taking nonsteroidal anti-inflammatory drugs (NSAIDs) alone.

**Atacand** (Candesartan) (Systemic) Candesartan belongs to the class of medicines called angiotensin II inhibitors. It is used to treat hypertension (high blood pressure).

**Atenolol** (Beta-adrenergic Blocking Agents) (Systemic) This group of medicines is known as beta-blockers, and used in the treatment of hypertension (high blood pressure).

***Ativan** (Benzodiazepines) (Systemic) Benzodiazepines belong to the group of medicines called central nervous system (CNS) depressants (medicines that slow down the nervous system). Some benzodiazepines are used to relieve anxiety. Some benzodiazepines are used to treat insomnia.

**Avalide** (Irbesartan-hydrochlorothiazide). This medication is a combination of two drugs that are used to reduce high blood pressure. Irbesartan belongs to a class of medications called angiotensin II blockers and helps to lower blood pressure by relaxing blood vessels. Hydrochlorothiazide is a diuretic or “water pill” that helps control blood pressure by getting rid of excess salt and water. This medication is most often prescribed when other drugs have been found not to be effective or to have side effects, and when a
person’s blood pressure is stabilized on irbesartan and hydrochlorothiazide taken individually.

**Avapro** (Irbesartan) (Systemic) Irbesartan belongs to the class of medicines called angiotensin II inhibitor antihypertensives. It is used to treat hypertension (high blood pressure).

**Avelox** (Fluoroquinolones) (Systemic) Fluoroquinolones are used to treat bacterial infections in many different parts of the body. They work by killing bacteria or preventing their growth.

**Baclophen** (Systemic) Baclofen is used to help relax certain muscles in your body. It relieves the spasms, cramping, and tightness of muscles caused by medical problems such as multiple sclerosis or certain injuries to the spine.

**Betoptic** (Beta-Adrenergic Blocking Agents) (Ophthalmic) Betaxolol, carteolol, levobetaxolol, levobunolol, metipranolol, and timolol are used to treat certain types of glaucoma.

**Bisoprolol** (Beta-adrenergic Blocking Agents) (Systemic) This group of medicines is known as beta-blockers, and used in the treatment of hypertension (high blood pressure).
**Buscopan** (Anticholinergics/Antispasmodics) (Systemic) Buscopan is known as an anticholinergic medicine. It relieves the pain of stomach and bowel cramps by helping the digestive system to relax.

**Casodex** (Antiandrogens, Nonsteroidal) (Systemic) Nonsteroidal antiandrogens are used to treat cancer of the prostate gland.

**Celebrex** (Celecoxib) (Systemic) Celecoxib is used to relieve some symptoms caused by arthritis, such as inflammation, swelling, stiffness, and joint pain.

**Clasteon** (Clodronate) belongs to a family of medications known as bisphosphonates. It is used for the treatment of hypercalcemia (high blood calcium).

***Clonazepam** (Benzodiazepines) (Systemic) Benzodiazepines belong to the group of medicines called central nervous system (CNS) depressants (medicines that slow down the nervous system). Some benzodiazepines are used to relieve anxiety. Some benzodiazepines are used to treat insomnia.

**Colchicine** (Probenecid and Colchicine) (Systemic) Probenecid and colchicine combination is used to treat gout or gouty arthritis.

**Corgard** (Beta-adrenergic Blocking Agents) (Systemic) This group of medicines is known as beta-blockers, and used in the treatment of hypertension (high blood pressure).
Co-Symvastin (Statins): Statins lower cholesterol.

Cozaar (Losartan) (Systemic) Losartan is used to treat hypertension (high blood pressure).

Crestor (Rosuvastatin) (Systemic) Rosuvastatin is used to lower cholesterol and triglyceride (fat-like substances) levels in the blood.

Coumadin (Anticoagulants) (Systemic) Anticoagulants decrease the clotting ability of the blood and therefore help to prevent harmful clots from forming in the blood vessels.

Delatestryl (Androgens) (Systemic) Androgens are male hormones. Some androgens are naturally produced in the body and are necessary for the normal sexual development of males.

Detrol (Tolterodine) (Systemic) Tolterodine is used to treat bladder problems such as frequent need to urinate or loss of control of urinary function.

Diclofenac (Topical) Diclofenac belongs to the family of medicines called antineoplastics. Antineoplastics are used to treat cancer by killing cancer cells.

Digoxin (Digitalis Medicines) (Systemic) Digitalis medicines are used to improve the strength and efficiency of the heart, or to control the rate and rhythm of the heartbeat.
**Domperidone** (Systemic) Domperidone is a medicine that increases the movements or contractions of the stomach and bowel.

**Doxazosin** (Systemic) Doxazosin belongs to the general class of medicines called antihypertensives. It is used to treat hypertension (high blood pressure).

**Dyazide** (triamterene – hydrochlorothiazide) Triamterene and hydrochlorothiazide both belong to the class of medications called diuretics ("water pills"). These two diuretics are used in combination for the treatment of edema (fluid retention) that occurs with congestive heart failure and disorders of the liver and kidney. Dyazide is also used for the treatment of hypertension (high blood pressure).

**Effexor** (Venlafaxine) (Systemic) Venlafaxine is used to treat mental depression. It is also used to treat certain anxiety disorders or to relieve the symptoms of anxiety. However, it usually is not used for anxiety or tension caused by the stress of everyday life.

**Eltroxin** (Thyroid Hormones) (Systemic) Thyroid medicines belong to the general group of medicines called hormones. They are used when the thyroid gland does not produce enough hormone. They are also used to help decrease the size of enlarged thyroid glands.
Estring (Estrogens) (Vaginal) Estrogens are hormones produced by the body. Among other things, estrogens help develop and maintain female organs.

Ezetrol (Ezetimibe) belongs to the group of medicines known as cholesterol absorption inhibitors. It lowers cholesterol levels by decreasing the body’s ability to absorb cholesterol.

Flomax (Tamsulosin) (Systemic) Tamsulosin is used to treat the signs and symptoms of benign prostatic hyperplasia or BPH (benign enlargement of the prostate).

Forteo (Teriparatide) belongs to a family of medications known as bone formation agents. This medication is used for the treatment of severe osteoporosis in postmenopausal women. It is also used for the treatment of osteoporosis for men. Teriparatide is usually used when other treatments for osteoporosis have not worked or have not been tolerated.

Fosomax (Alendronate) (Systemic) Alendronate is used to prevent or treat osteoporosis (thinning of the bone) in women after menopause and to treat osteoporosis in men. It may also be used to treat Paget’s disease of bone and osteoporosis (thinning of the bone).

Hydrazide (Diuretics, Thiazide) (Systemic) Thiazide or thiazide-like diuretics are commonly used to treat hypertension (high blood pressure).
**Hydrochlorothiazide** (Angiotensin-converting Enzyme [ACE] Inhibitors and Hydrochlorothiazide) (Systemic) This combination belongs to the class of medicines called antihypertensives (high blood pressure medicines). It is used to treat hypertension (high blood pressure).

**Indapamide** (Systemic) Indapamide belongs to the group of medicines known as diuretics. It is commonly used to treat hypertension (high blood pressure).

**Ketoprofen** (Anti-inflammatory Drugs, Nonsteroidal) (Systemic) Nonsteroidal anti-inflammatory drugs (also called NSAIDs) are used to relieve some symptoms caused by arthritis (rheumatism), such as inflammation, swelling, stiffness, and joint pain.

**Lactulose** (Laxatives) (Oral) Oral laxatives are medicines taken by mouth to encourage bowel movements to relieve constipation.

**Lanoxin** (Digitalis Medicines) (Systemic) Digitalis medicines are used to improve the strength and efficiency of the heart, or to control the rate and rhythm of the heartbeat.

**Levothyroxine** (Thyroid Hormones) (Systemic) Thyroid medicines belong to the general group of medicines called hormones. They are used when the thyroid gland does not produce enough hormone.
**Lipitor** (Atorvastatin) (Systemic) Atorvastatin is used to lower cholesterol and triglyceride (fat-like substances) levels in the blood.

**Lisinopril** (Angiotensin-converting Enzyme [ACE] Inhibitors) (Systemic) ACE inhibitors belong to the class of medicines called antihypertensives (high blood pressure medicines). They are used to treat hypertension (high blood pressure).

**Lomotil** (Diphenoxylate and Atropine) (Systemic) Diphenoxylate and atropine is a combination medicine used along with other measures to treat severe diarrhea in adults. Diphenoxylate helps stop diarrhea by slowing down the movements of the intestines.

***Lorazepam** (Benzodiazepines) (Systemic) Benzodiazepines belong to the group of medicines called central nervous system (CNS) depressants (medicines that slow down the nervous system). Some benzodiazepines are used to relieve anxiety. Some benzodiazepines are used to treat insomnia.

**Losec** (Omeprazole) (Systemic) Omeprazole is used to treat certain conditions in which there is too much acid in the stomach. It is used to treat gastric and duodenal ulcers and gastroesophageal reflux disease.

**Lovastatin** (HMG-CoA Reductase Inhibitors) (Systemic) Lovastatin is used to lower levels of cholesterol and other fats in the blood.
**Lumigan** (Bimatoprost) (Ophthalmic) Bimatoprost is used to treat certain diseases of the eye, such as glaucoma, which occur in many people as they grow older.

***Luvox** (Fluvoxamine) (Systemic) Fluvoxamine is used to treat obsessive-compulsive disorder. Fluvoxamine belongs to the class of medications called selective serotonin reuptake inhibitors (SSRIs). It is used for the treatment of depression and obsessive-compulsive disorder (OCD). It helps to reduce anxiety and unpleasant thoughts associated with OCD and improves mood by treating depression.

**Meloxicam** (Systemic) Meloxicam is a nonsteroidal anti-inflammatory drug (NSAID) used to relieve some symptoms of arthritis and rheumatoid arthritis, such as inflammation, swelling, stiffness, and joint pain.

**Mestinon** (Antimyasthenics) (Systemic) Antimyasthenics are given by mouth or by injection to treat myasthenia gravis. Neostigmine may also be given by injection as a test for myasthenia gravis.

**Metopoplool** (Beta-adrenergic Blocking Agents) (Systemic) This group of medicines is known as beta-blockers, and are used in the treatment of hypertension (high blood pressure).

**Miacalcin** (Calcitonin) (Nasal-Systemic) Calcitonin is used to treat women with postmenopausal osteoporosis (bone loss). It is used together with calcium and vitamin D.
**Mucillium** (Psyllium hyfrophylc) (Laxatives) (Oral) Oral laxatives are medicines taken by mouth to encourage bowel movements to relieve constipation.

**Naproxen** (Anti-inflammatory Drugs, Nonsteroidal) (Systemic) Nonsteroidal anti-inflammatory drugs (also called NSAIDs) are used to relieve some symptoms caused by arthritis (rheumatism), such as inflammation, swelling, stiffness, and joint pain.

**Nexium** (Esomeprazole) (Systemic) Esomeprazole is used to treat conditions in which there is too much acid in the stomach. It is used to treat duodenal ulcers and gastroesophageal reflux disease (GERD).

***Nortriptyline*** (Antidepressants, Tricyclic) (Systemic) Tricyclic antidepressants are used to relieve mental depression.

**Norvasc** (Amlodipine) (Systemic) Amlodipine is a calcium channel blocker used to treat angina (chest pain) and hypertension (high blood pressure).

**Novasen** (Salicylates) (Systemic) Salicylates are used to relieve pain and reduce fever. Most salicylates are also used to relieve some symptoms caused by arthritis (rheumatism), such as swelling, stiffness, and joint pain.
**Novolin** (Insulin) (Systemic) Insulin is one of many hormones that helps the body turn the food we eat into energy.

**Novo-Metoprol** (Metoprolol) is a beta-blocker that is used to treat high blood pressure and prevent the symptoms of angina (chest pain).

**Novospiroton** (Diuretics, Potassium-sparing) (Systemic) Potassium-sparing diuretics are commonly used to help reduce the amount of water in the body. Unlike some other diuretics, these medicines do not cause your body to lose potassium.

**Pantoloc** (Pantoprazole) (Systemic) Pantoprazole is used to treat certain conditions in which there is too much acid in the stomach. It is used to treat duodenal and gastric ulcers and gastroesophageal reflux disease (GERD)

**Pariet** (Rabeprazole) belongs to the class of medications known as proton pump inhibitors (PPIs) and works by slowing or preventing the production of acid in the stomach. Rabeprazole is used to treat and maintain healing of gastroesophageal reflux disease (GERD). It is also used for short-term treatment in the healing and relief of symptoms associated with duodenal and gastric ulcers. Finally, rabeprazole is used for long-term treatment of conditions associated with constant production of excess acid in the stomach, including Zollinger-Ellison syndrome.
***Paroxetine is used to treat mental depression, obsessive-compulsive disorder, panic disorder, generalized anxiety disorder, social anxiety disorder (also known as social phobia), premenstrual dysphoric disorder (PMDD), and post-traumatic stress disorder. Paroxetine belongs to a group of medicines known as selective serotonin reuptake inhibitors (SSRIs). These medicines are thought to work by increasing the activity of the chemical serotonin in the brain.

***Paxil (Paroxetine) (Systemic) Paroxetine is used to treat mental depression, obsessive-compulsive disorder, panic disorder, generalized anxiety disorder, social anxiety disorder (also known as social phobia), premenstrual dysphoric disorder (PMDD), and post-traumatic stress disorder.

Pennsaid (Diclofenac topical solution) belongs to the class of medications known as nonsteroidal anti-inflammatory drugs (NSAIDs). It works by reducing pain, swelling, and inflammation. The topical solution (a lotion applied to the skin) is used to relieve symptoms such as pain associated with osteoarthritis of the knee.

Plavix (Clopidogrel) (Systemic) Clopidogrel is used to lessen the chance of heart attack or stroke. It is given to people who have already had a heart attack or stroke or to people with other blood circulation problems that could lead to a stroke or heart attack.

Plendil (Calcium Channel Blocking Agents) (Systemic) Plendil belongs to the group of medicines called calcium channel blocking agents. Some of the calcium channel
blocking agents are used to relieve and control angina pectoris (chest pain). Some are also used to treat hypertension (high blood pressure).

**Prenisolone**: (Corticosteroids and Acetic Acid) (Otic) Corticosteroid and acetic acid combinations are used to treat certain problems of the ear canal. They also help relieve the redness, itching, and swelling that may accompany these conditions.

**Premarin** (Estrogens) (Systemic) Estrogens are female hormones. They are produced by the body and are necessary for the normal sexual development of the female and for the regulation of the menstrual cycle during the childbearing years.

**Prevacid** (Lansoprazole) (Systemic) Lansoprazole is used to treat certain conditions in which there is too much acid in the stomach. It is used to treat duodenal and gastric ulcers and gastroesophageal reflux disease (GERD).

**Quinine** (Systemic) Quinine is used to treat malaria. This medicine usually is given with one or more other medicines for malaria.

**Ranitidine** (Histamine H2-receptor Antagonists) (Systemic) Histamine H2-receptor antagonists, also known as H2-blockers, are used to treat duodenal ulcers and prevent their return. They are also used to treat gastric ulcers and for conditions such as Zollinger-Ellison disease.
**Salbutamol** (Bronchodilators, Adrenergic) (Inhalation) Adrenergic bronchodilators are medicines that are breathed in through the mouth to open up the bronchial tubes (air passages) of the lungs. Some of these medicines are used to treat the symptoms of asthma, chronic bronchitis, and emphysema.

**Simvastatin** (Systemic) Simvastatin is used to lower cholesterol and triglyceride (fat-like substances) levels in the blood.

**Soflax** (Laxatives) (Oral) Oral laxatives are medicines taken by mouth to encourage bowel movements to relieve constipation.

**Sotalol** (Beta-adrenergic Blocking Agents) (Systemic) This group of medicines is known as beta-blockers and used in the treatment of hypertension (high blood pressure).

**Spiriva** (Tiotropium) (Inhalation-Local) Tiotropium is a medicine used to treat bronchospasm (wheezing or difficulty in breathing) that is associated with Chronic Obstructive Pulmonary Disease. Chronic obstructive pulmonary disease is a long-term lung disease.

**Symbicort** is a combination inhaler that contains two separate medications, a preventer and a controller/reliever in the same one inhaler. The preventer medicine is an anti-inflammatory medicine called budesonide (Pulmicort). The anti-inflammatory effect of regular treatment with budesonide helps to prevent asthma symptoms. Formoterol (Oxis)
is the controller medicine that relaxes and opens up the small airways, helping you to breathe more easily and avoid an attack. Formoterol works quickly and for a long period of time. Because of its speed, Formoterol can act as both a controller and reliever.

**Synthroid** (Thyroid Hormones) (Systemic) Thyroid medicines belong to the general group of medicines called hormones. They are used when the thyroid gland does not produce enough hormone. They are also used to help decrease the size of enlarged thyroid glands.

**Tapazole** (Antithyroid Agents) (Systemic) Methimazole and propylthiouracil are used to treat conditions in which the thyroid gland produces too much thyroid hormone.

**Tiazac** (Diltiazem) belongs to a family of medicines known as calcium channel blockers. It is used to treat high blood pressure and angina (chest pain). It works by relaxing blood vessels and by reducing the workload of the heart. The injectable form of this medication is sometimes used in the hospital to bring abnormal heart rhythms under control.

**Timoptic** (Beta-Adrenergic Blocking Agents) (Ophthalmic) Timoptic is used to treat certain types of glaucoma.

***Trazodone** (Systemic) Trazodone belongs to the group of medicines known as antidepressants or “mood elevators.” It is used to relieve mental depression and depression that sometimes occurs with anxiety.
**Triamizide** tablets contain the active ingredients hydrochlorothiazide and triamterene. It is a combination of a diuretic and an antihypertensive. Triamizide is used to treat high blood pressure. It can also be used to reduce fluid retention in people with heart, kidney, or liver disease.

**Triamzide** (Diuretics, Potassium-sparing, and Hydrochlorothiazide) (Systemic) This medicine is a combination of two diuretics (water pills). It is commonly used to help reduce the amount of water in the body.

**Vasotec** (Angiotensin-converting Enzyme [ACE] Inhibitors) (Systemic) ACE inhibitors belong to the class of medicines called antihypertensives (high blood pressure medicines). They are used to treat hypertension (high blood pressure).

**Verapamil** (Calcium Channel Blocking Agents) (Systemic) Verapamil belongs to the group of medicines called calcium channel blocking agents. It is used to treat hypertension (high blood pressure).

**Warfarin** (Anticoagulants) (Systemic) Anticoagulants decrease the clotting ability of the blood and therefore help to prevent harmful clots from forming in the blood vessels.

**Xeloda** (Capecitabine) (Systemic) Capecitabine belongs to the group of medicines called antimetabolites. It is used to treat breast cancer and colorectal cancer.
**Zocor** (HMG-CoA Reductase Inhibitors) (Systemic) Zocor is used to lower levels of cholesterol and other fats in the blood.

**Zoladex** (Goserelin) (Systemic) Goserelin is a hormone similar to the one normally released from the hypothalamus gland in the brain. It is used to treat a number of medical problems. These include cancer of the prostate in men.
Dear _____________________,

Thank you very much for agreeing to participate in this research project, which evaluates the effectiveness of the *Inner Counselor Process*©.

You have been assigned a participant number for this research study. Your number is ___________. This number has been pre-printed on the questionnaires that you will fill in during the study, so you do not need to put your name on any of the questionnaires. This contributes to your personal anonymity in the study. Two forms do require your name, however, and they are identified below.

In this package, you will find descriptive information related to your participation and all of the questionnaires that you will need to complete for this research project.

a) *Two copies of the Consent Form for Participants*
   Please sign both copies; keep one copy for yourself, and return one copy to me in the enclosed *manila (tan-coloured)* self-addressed, stamped envelope. (This is one form where your name is required.)

b) *Participant Information Form*
   Please complete and return to me in the same *manila* envelope as the consent form. (This is the other form where your name is required.)
c) A bright yellow magnetic “Reminder Card.” The dates written on it are the dates on which you are to open the corresponding envelope and fill in the questionnaires inside. You can put this card on your refrigerator or anywhere you will see it regularly to help you remember when to fill in the questionnaires. My name and phone number are also on this card, should you want to contact me.

d) Five white envelopes, each with your participant number and a date written on the outside, in the lower left corner. On that date, open the envelope, complete the forms inside, and then put them back in the envelope and mail them to me. Instructions for completing the forms are included in each package. Your participant number has already been marked on the forms — do not put your name on the forms.

e) A map showing how to get to the office where the Inner Counselor Processes will take place. The address is 7 Woodborough Road, Guelph, near Kortright and Ironwood. The office is the ground level of a home. There are no stairs to negotiate, and there is free parking and a bus stop nearby. You will see signs for the study on the house showing you which door to use.

Please do your best to complete each set of forms on the designated date, and then mail each set of forms back to me. Although it might seem unusual for both the “to” and “from” addresses to be mine, this is done, again, to contribute to your anonymity within the study.

If you are presently receiving personal counseling, please tell your counselor about your participation in this study, as a courtesy to them.

I appreciate your willingness to participate in this study!

If you have any questions, please call me or email me. I will do my best to answer all of your questions within the parameters of the study.

Sincerely,

[Signature]

Rev. Ann Osborne,
ThD Candidate,
Holos University Graduate Seminary
PARTICIPANT INFORMATION FORM FOR
“THE EFFECTS OF THE INNER COUNSELOR PROCESS© ON SENIORS’ PEACE OF MIND AND WELL-BEING”

Please print, and complete the following information:

Name _______________________________    Today’s Date ______________

Address______________________________________________________________

______________________________________________________________________

Telephone Number__________________ Date of Birth ____________________
Day    Month      Year

Gender: Male _____     Female _____

Doctor’s Name ____________________ Doctor’s Phone Number__________

How did you hear about this study?
______________________________________________________________________

______________________________________________________________________

In the past ten years (since 1996), have you been diagnosed with:

_____ Hypertension

_____ Bi-polar disorder

_____ Diabetes

_____ Post-traumatic stress disorder

_____ Heart disease

_____ Clinical depression

_____ Legal blindness

_____ Severe anxiety

_____ Dementia

_____ Schizophrenia

_____ Obsessive-Compulsive Disorder

(Please turn over)
Have you ever experienced an Inner Counselor Process® before?
Yes _____   No_____

Marital Status: Living with partner ____________
Divorced  ____________
Married    ____________
Single     ____________
Widow or Widower ________

Where are you currently living?
_____ In my own home
_____ In a Senior’s facility
_____ In a Nursing Home
_____ With (one of) my children
_____ Other, please specify ___________________________________

What is the highest level of education that you have completed?
_____ Elementary School
_____ Secondary School
_____ Some Post-Secondary Education
_____ College
_____ University
_____ Master’s Degree
_____ Doctorate
Medication Information

Are you currently taking medication? Please list with dosages:

___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________

(If more space is needed, please use the back of the page)

Have your medication levels been changed in the past 6 months? If so, indicate which medications have changed and when they changed.

___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
D.3 Consent Form for Participants

CONSENT FORM FOR PARTICIPANTS OF THE RESEARCH STUDY, “THE EFFECTS OF THE INNER COUNSELOR PROCESS© ON THE PEACE OF MIND AND WELL-BEING OF SENIORS”

Holos University Graduate Seminary supports the practice of protection for human subjects participating in research. The following information is provided to help you decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time without penalty.

The principal investigator, Rev. Ann Osborne, is interested in studying the effects of the Inner Counselor Process© (IC Process©) on certain aspects associated with the health and well-being of seniors aged 65 to 85 years. The IC Process© is a creative way to address a range of concerns from ordinary worries to major life issues. The approach of the Inner Counselor is based on the concept that our greatest asset for healing comes from the “healer within” each of us. It is a guided self-awareness process, not psychotherapy, and the facilitator does not analyze or offer solutions to the issue raised. The IC Process© provides you with a way to access your own inner wisdom regarding issues that are important to you. During the process, you sit comfortably and relaxed with your eyes closed, and are guided by the principle investigator through the fifteen steps that make up the IC Process©. An IC Process© usually takes between 30 and 45 minutes.

During the IC Process©, you will experience a state of reverie very much like daydreaming, but you will, at all times, be encouraged to be fully aware of and in control of your choices. Some people report feeling introspective, insightful, thoughtful, relieved, or uplifted. You may experience sadness, strong emotions, or tears. Participants are relaxed but sometimes slightly tired after completing an IC Process©. Sometimes people indicate a desire to explore an issue further by doing another IC Process© at a later date. Participation may be of direct benefit to you in terms of increased peace of mind and enhanced well-being.

If you agree to participate in the study, you will experience two IC Processes©. You will meet with the principal investigator twice. The first visit is expected to take about 1 ½ hours, during which you will be introduced to the concepts and basic ideas of the IC Process©, experience your first process, and have time for follow-up. The second visit will take about the same length of time, during which you will experience a process, and again have time for follow-up. You will be asked to fill out two short questionnaires five times in total. It is estimated that these forms will
take no more than twenty minutes to fill out each time, and no more than two hours all together.

You will mail the completed forms back to the principal investigator in stamped, pre-addressed envelopes that will be provided for you. Your participation in this study and any forms generated will be held in strict confidence. We assure you that your name will not be associated in any way with the research findings. The information will be identified only by a code number. There is no financial cost to you to participate in this study. Your participation is solicited, although strictly voluntary.

Your participation is greatly appreciated. If you would like additional information concerning this study, its procedures or its purpose, before or after it is complete, please feel free to contact Ann Osborne by phone, mail or email.

If you have concerns or questions about your rights as a research participant, you may contact the Holos University Graduate Seminary Dean of Academic Affairs through the University at (888) 272-6109, 5607 South 222nd Road, Fair Grove, Missouri, 65648.

Sincerely,

Rev. Ann Osborne, ThD Candidate

Principal Investigator: Rev. Ann Osborne, BSc
Revised Nassagaweya-Puslinch Townline
4796 Nassagaweya-Puslinch Townline
R.R. #1,
Moffat, ON, Canada. L0P 1J0
(519) 767-0505
aosborne@earthlink.net

Faculty Supervisor: Rev. Ann Nunley, PhD
4221 Nunley Lane,
McLouth,
Kansas, 66054, USA.
(785) 863-2176
ann4847@earthlink.net

________________________________________      ____________________________
Signature of Person Agreeing to Participate  Date

With my signature, I affirm that I agree to take full personal responsibility for my participation in the protocol described above. I am 65 to 85 years of age and have received a copy of this consent form to keep.

Print Your Name Here ______________________________ _____________
D.4 Reminder Card for Experimental Group Participants

Note: This was printed on bright yellow paper and attached to a magnetic backing, so that it could be posted on the refrigerator, for example, or placed in any location where it would be a helpful reminder.

RESEARCH STUDY
FORM COMPLETION DATES

On the following days, please complete the forms in the envelope indicated. Note the dates for your Inner Counselor Sessions.

Envelope A ___________________
Envelope B ___________________
Envelope C___________________
1st Inner Counselor___________
2nd Inner Counselor___________
Envelope D _________________
Envelope E _________________

When completed, please put the forms back in the envelope that they came in, and mail them as soon as possible. Thanks!

Rev. Ann Osborne,
519-767-0505
D.5 Reminder Card for Control Group Participants

Note: This was printed on bright yellow paper and attached to a magnetic backing, so that it could be posted on the refrigerator, for example, or placed in any location where it would be a helpful reminder.

RESEARCH STUDY
FORM COMPLETION DATES

On the following days, please complete the forms in the envelope indicated.

Envelope A __________________
Envelope B __________________
Envelope C __________________
Envelope D __________________
Envelope E __________________

When completed, please put the forms back in the envelope that they came in, and mail them as soon as possible.
Thanks!

Rev. Ann Osborne,
519-767-0505
D.6 Return Envelope in Participant Packages

Rev. Ann Osborne,
4796 Nassagaweya-
Puslinch Townline,
RR 1, Moffat, ON L0P 1J0

Rev. Ann Osborne,
Inner Counselor with Seniors Research Study,
4796 Nassagaweya-Puslinch Townline,
RR 1, Moffat, ON L0P 1J0

Date:
Participant Number:
D.7 Instructions for Completing the Questionnaires

Instructions for Completing the Questionnaires for the “Effects of the Inner Counselor Process© on Peace of Mind and Well-Being of Seniors” Study

Please do your best to follow these instructions closely in order to ensure the accuracy of the data collected for the research project. You have been assigned a participant number in this study, which will be the only means of identification on the forms. This contributes to the privacy of your information within the study. Your participant number has already been printed on each questionnaire. Please do not put your name on any of the questionnaires.

1. Please find enclosed: one page entitled Mood Assessment Scale with questions on front and back.
   : one page entitled BAI® with questions on the front only.
   : one page entitled Other Information with lines on which to write.

2. Choose a time of day and a private location where you will be undisturbed. Use this same time of day and same location each time you fill in questionnaires for this study. It will take approximately 20 minutes to fill in both questionnaires.

   Make sure that you will be undisturbed by such things as telephone calls, visitors, animals, the needs of family members, the radio, or the television. Turn off the television and radio.

3. Filling in the questionnaires:

   MOOD ASSESSMENT SCALE (front and back of sheet)
   Please complete this form by filling in the appropriate circle indicating how you have felt over the past week.

   BAI® (front of sheet only)
   Please complete this form by marking the appropriate box with an X, indicating how you have felt over the past week.

   OTHER INFORMATION
   Please write down anything you have noticed or wish to share that relates to your experience of the Inner Counselor.
4. Mailing the questionnaires:
   Please put the completed questionnaires in the same addressed, stamped envelope that they came in. Seal the envelope, and mail it as soon as possible. Remember, the “to” and “from” address labels are intentionally the same, to contribute to your privacy.

5. Questions?
   If you have any questions, please contact

   Ann Osborne at (519) 767-0505,
   or email me at aosborne@earthlink.net.

   Thank you so much!
   Your participation in this research project is greatly appreciated!
D.8 Information about the Beck Anxiety Inventory®

Harcourt Assessment, Inc., who sell the Beck Anxiety Inventory®, do not permit inclusion of the BAI® in dissertations due to the “secure nature of the instrument,” so it cannot be reproduced here.

The BAI® is a 21-item, self-report questionnaire in which each item is rated on a four-point Likert scale. Each item is a symptom of anxiety.

The instructions for completing the test state: Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

The choices for rating are:

1) NOT AT ALL

2) MILDLY – It did not bother me much.

3) MODERATELY – It was very unpleasant, but I could stand it.

4) SEVERELY – I could barely stand it.
D.9 The Geriatric Depression Scale (Mood Assessment Scale)

MOOD ASSESSMENT SCALE

Please choose the best answer for how you have felt over the past week. 
Fill in the appropriate circle.

1. Are you basically satisfied with your life?
   Yes   No
   O     O

2. Have you dropped many of your activities and interests?
   Yes   No
   O     O

3. Do you feel that your life is empty?
   Yes   No
   O     O

4. Do you often get bored?
   Yes   No
   O     O

5. Are you hopeful about the future?
   Yes   No
   O     O

6. Are you bothered by thoughts you can’t get out of your head?
   Yes   No
   O     O

7. Are you in good spirits most of the time?
   Yes   No
   O     O

8. Are you afraid that something bad is going to happen to you?
   Yes   No
   O     O

9. Do you feel happy most of the time?
   Yes   No
   O     O

10. Do you often feel helpless?
    Yes   No
     O    O

11. Do you often get restless and fidgety?
    Yes   No
     O    O

12. Do you prefer to stay at home, rather than going out and doing new things?
    Yes   No
     O    O

(Please turn over and complete questions on the other side)
13. Do you frequently worry about the future? O O
14. Do you feel you have more problems with memory than most? O O
15. Do you think it is wonderful to be alive now? O O
16. Do you often feel downhearted and blue? O O
17. Do you feel pretty worthless the way you are now? O O
18. Do you worry a lot about the past? O O
19. Do you find life very exciting? O O
20. Is it hard for you to get started on new projects? O O
21. Do you feel full of energy? O O
22. Do you feel that your situation is hopeless? O O
23. Do you think that most people are better off than you are? O O
24. Do you frequently get upset over little things? O O
25. Do you frequently feel like crying? O O
26. Do you have trouble concentrating? O O
27. Do you enjoy getting up in the morning? O O
28. Do you prefer to avoid social gatherings? O O
29. Is it easy for you to make decisions? O O
30. Is your mind as clear as it used to be? O O
D.10 Anecdotal Reporting Sheet

OTHER INFORMATION

Participant Number _____
Date __________________

Is there anything that you have noticed or would like to share that relates to your experience of the Inner Counselor?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
(Please use the other side, too, if required!)
APPENDIX E

E.1 Sign Outside of Inner Counselor Office Building

“The Inner Counselor Process© for Peace of Mind and Well-being of Seniors”

Research Project

Welcome!

Please enter through the garage door.

Please Note: The actual sign was 38 cm. x 50 cm. (15” x 20”). It has been reduced in size here for formatting purposes.
E.2 Sign Beside the Door to the Inner Counselor Office Building

“The Inner Counselor Process© for Peace of Mind and Well-being of Seniors”

Research Project
Welcome!

Please ring the doorbell,

and

watch your step as you enter.
Possible Topics for Personal Notes

Description of my Place of Peace ....

Were there any Additional Guides? If so, describe ....

What was the Issue or Feeling that I explored?

Earlier Times that I experienced this issue ....

Description of my Old Symbol ....

What did I really need and want?

Description of my New Symbol ....

Advice of my New Symbol ..... 

Advice of Guides (if any) ..... 

Situation in the near future when the qualities of the New Symbol that are now present within me will allow me to respond differently ..... 

How do I feel right now?
Student Audience
Degrees and Certificate Programs are designed for professional adults who are committed to integrating energy medicine and spiritual healing into their personal and professional lives. Holos University students and alumni come from such diverse backgrounds as allopathic, osteopathic, naturopathic, and chiropractic medicine, nursing, physical therapy, psychology, education, art, ministry, music, and business. All programs emphasize study and research of the various aspects of spiritually-based, holistic health and well-being. Holos University appeals equally to mystically inclined scientists and scientifically inclined mystics.

Holos University Faculty
Holos University Graduate Seminary (HUGS) offers a superb faculty of leaders in the field of Energy Medicine and Spiritual Healing, including well-known pioneers:

- C. Norman Shealy, MD, PhD, Holos President
- Judith Cornwell, PhD
- Marcia Emery, PhD
- Caroline Myers, PhD
- Werner Neubert, PhD
- Christine Page, MD

International Science of Mind Church
Holos University Graduate Seminary (HUGS) is the official, post-graduate school of the International Science of Mind Church for Spiritual Healing. The primary mission of the Church is to support an encompassing non-denominational healing ministry. The Holos University Chapel pictured above houses this mission by representing the faith and ensuring the spiritual and religious traditions of the world. The Sanctuary operates in compliance with the laws of the State of Missouri.

Contact Information
Holos University Graduate Seminary
5000 South 22nd Road
Dundalk, MD 21226
1-888-272-6199 (Toll-free)
Website: www.hugs-edu.org
register@holosuniversity-edu.org

Master’s, Doctoral & Post-Doctoral Degrees

Specialty Areas of Study & Certificate Programs
Integrative Healthcare
Complementary & Alternative Medicine (CAM)
Medical Intuition
Spiritual Direction
Transpersonal Psychology

www.hugs-edu.org
Commitment to Energy Medicine & Spiritual Healing

Hols University Graduate Seminary (HUGS) embraces a society whose foundation for well-being is based on a holistic, spiritual philosophy. Recognizing the role that stress plays in the manifestation of "disease," HUGS University affirms the inherent holistic and excentrical spiritual principles as the foundation for optimal physical, mental, and spiritual health.

Energy Medicine and Spiritual Healing include all aspects of the human experience: body, emotions, mind, relationships, and spirit. HUGS University students have an opportunity to:

- **STUDY** the broad field of Spiritual Healing and Holistic Theology
- **PRODUCE** significant scientific research, contributing to the evolution of human consciousness, spirituality, and global well-being
- **INTEGRATE** the highest principles of Spiritual Healing in their personal and professional lives
- **BE ENRaptured** by holistically-oriented Pastoral and Spiritual Counseling while honoring the personal religious and cultural traditions of students, faculty, and their communities.

Master's, Doctoral, and Post-Doctoral Degrees in Theology

Hols University Graduate Seminary offers Master's, Doctoral, and Post-Doctoral degrees in Theology with specialty areas of study in Integrative Healthcare/CAM, Medical Intuition, Spiritual Direction, and Transpersonal Psychology. In addition, Post-Doctoral degrees are offered in Energy Medicine.

Easy-Access Certificate Programs

The Easy-Access Certificate Programs offer a choice of four specialty tracks of study:
- Regenerative Healthcare/CAM, Medical Intuition, Spiritual Direction, and Transpersonal Psychology.

Certificates are offered on an easy-access basis, allowing qualified students to apply credits earned toward more advanced degrees.

Course Formats

Many of the courses are offered in an all-distance learning format, while others also require a brief residential component. Additional information about entry requirements and specific coursework for the Master's, Doctoral, and Post-Doctoral degrees is available at the Hols University website: [www.hols.edu](http://www.hols.edu). The Hols University Graduate Seminary Catalog can also be downloaded from this website.

Specialty Areas of Study

Doctoral Emphasis & Certificate Tracks

Integrative Healthcare/CAM

Efforts to integrate CAM, bio-energetic, traditional, holistic, and conventional medicine in an integrative healthcare model are taking place worldwide. In this specialty area of study, students will expand their knowledge of CAM, bio-energetic, traditional, and holistic approaches, and are invited to participate in the creation of innovative, effective, and rapidly evolving healthcare systems and individual programs.

Medical Intuition

Taught by experienced and respected experts in the field of Medical Intuition, this specialty area of study is ideal for those who wish to develop or enhance their intuitive counseling skills in the physical, emotional, mental, and spiritual aspects of well-being on behalf of their clients and in cooperation with their clients' primary care professionals.

Spiritual Direction

As a Seminary, Hols University emphasizes the spiritual components of healing. Focusing on the inner spiritual journey, this specialty area of study enables students to navigate their own spiritual path, and provides effective methods to guide other individuals and communities.

Transpersonal Psychology

Courses based on the work of scholars such as Carl Jung, Abraham Maslow, and Roberto Assagioli constitute an exciting curriculum in this specialty area of study. Included are innovative transpersonal approaches and a comprehensive overview of ways to draw upon ancient mystical traditions that support a psychology based in spirit.
E.5 Pictures of the Inner Counselor Office

Figure 3. Outside of the Inner Counselor office building.

Figure 4. Waiting area.
Figure 5.  *Inner Counselor Process©* area.

Figure 6.  Area for making participant notes.
APPENDIX F

F.1 Participant Introduction to the First *Inner Counselor Process*© Session

- Just to check before we begin — are you able to hear me clearly? You just need to be able to hear me and carry on a conversation. (If yes— then we proceeded to the next item.) (If not,) would you like to try a hearing assist device that I have to see if it is helpful? It is an ordinary pair of headphones, but is attached to a device that amplifies voices, making them easier to hear clearly. We can try it, if you like, to see if it would be beneficial for you. Alternatively, I can just speak more loudly. What works best for you?
- It will be just the two of us here during the session, so as we go along, if you find that you have questions, comments, or thoughts, please go ahead and speak up! Or, if I use words or phrases that you are not familiar with, by all means, feel free to stop me and ask me about them, and I’ll be happy to explain.
- You know from the information that you have already received that the process that you will experience today is called the *Inner Counselor Process*© (*IC Process*©). It is called that because it is based on the idea that we all have great wisdom within ourselves — our own Inner Counselor! The Inner Counselor is not therapy. It is a guided self-awareness process, an educational tool and a way for *you* to assist *yourself* by addressing your issues and concerns. You will not be given answers by me; you will discover those answers in yourself. What we do in this process is to access those answers, that inner wisdom, for your own benefit. When we are trying to sort things out
in our lives, we often have people who would like to tell us “you could, you should, why don’t you, you ought to…” and sometimes that is helpful, but often as we listen to their usually well-meaning advice, we find ourselves saying in our mind, “But you don’t know this part of it” … or, “You don’t understand that aspect of the situation…” The Inner Counselor honours the fact that we do have all those pieces of information about our own issues and the inner wisdom to address those issues — much of which we may not even be aware! So I will not be offering any advice or solutions or suggestions today — this is an opportunity for you to access your own wisdom about issues that are important to you!

• To begin with, let’s “talk through” the IC Process©, so that you will have an idea what the process entails, what the steps are, and will have a chance to ask questions. That means that the process won’t be totally unfamiliar to you when you experience it. You will also have an opportunity to try out some of the aspects of the Inner Counselor as we talk about it, so that they will feel a bit more comfortable when you do your process.

• First, know that this is a creative process, and that you do not have to “think up, figure out, or deduce” the “right” answers to any questions. You only need to be willing to say whatever pops into your mind at the time. Whatever pops in will be exactly right, even though it may not be something that you had expected – that is part of the creative aspect of the IC Process©! Some people who have done this process have admitted afterwards that they were worried that nothing would come into their mind – but I can assure you that it always did! We’ll practice this right now, so that you have some personal experience with it. Close your eyes. Imagine something that makes you happy. What comes to mind? Describe it. Now imagine something that makes you feel afraid. What comes to mind this time? Describe it. Now imagine that you are asking a friend a
question, and that you are hearing their answer. Do you hear what they are saying? You
don’t have to tell me the question or the answer; just nod if you can imagine that you are
doing this. (After they nod:) You can open your eyes now. Those are examples of saying
whatever comes to your mind. You didn’t have to make a list of the top ten things that
make you happy, and then figure out which one would be the most important or the best
one to say – you just said what came into your mind. So now you know that you can do
that!

• We think of the Inner Counselor as a journey to access your own wisdom, and we
begin this journey in your Place of Peace. Your Place of Peace is any place that you go
to in your mind where you feel calm, safe, and peaceful. It can be someplace real that
you have been and enjoyed, it can be someplace that you have seen in a movie or read
about in a book, perhaps, and thought, “Oh, I would really like to be there!” It can be no
place real at all, just a place that you conjure up in your mind when you imagine what a
very peaceful place might look like. What is important is that you know you are safe and
calm in your Place of Peace. So let’s find your place of peace now. Close your eyes,
take a deep breath and let it out, and allow a very peaceful place to surface in your mind.
Feel yourself totally there… See your surroundings… Hear any sounds… Smell any
fragrances… In this place, you feel calm, safe, grounded, and centred in your heart.
Describe this place. (Write down the description of the place of peace.) … You can
open your eyes again. You can visit your place of peace any time that you choose. When
we begin the process, you will once more go to your place of peace, and we’ll begin from
there.
Each of us has within us a part of ourselves that is very wise, connected to infinite wisdom, to the universe, the Divine, however you experience that in your world. It is present with us at birth, and contains the unfolded potential and true essence of each person. It is the “you” that really knows why you are here, what it is you need, and how you can get it. Some people call this part of themselves their “High Self,” but there are many names that have been used to describe this Self, including Wise Advisor, Soul, Essential Self, Higher Self, Divine Self, Healer Within, Wise Self, or Full-Potential Self. (Also: True Self, Eternal Face, Observer Self, Inner Self-Helper, Christ Self, Lotus Self.) Does one of these names seem to work for you more than others? Is there another name that you prefer to use? What would you call this all-knowing part of yourself? (Dialogue until they determine a name with which they feel comfortable, and then write it down.) When we begin the process, we will ask this wise part of you to be with us.

During the process, you will be in a “meditative” or “relaxed” state of mind similar to daydreaming, but you will be completely conscious and in control of everything they experience. Your (use the term the participant chose for the High Self) will be in charge and guiding the process. You will not be hypnotized. This is not to criticize hypnotism, just an acknowledgement that hypnosis would not be consistent with Inner Counselor, since when you are hypnotized someone else is clearly telling you what to do and offering suggestions. During your process, we will be talking back and forth in the same way that we did when we were talking about your Place of Peace – you will be aware at all times.

Personal Guides are something that some people are familiar with, and others less so. In this process, a guide can take a wide variety of forms: angels, animals, spiritual
figures or symbols, someone either still living or who has passed on, or a mentor, among many others. If the guide who appears is a person, living or dead, know that it is not the part of the person that we know and experience in day to day living, with all of the “personality quirks” that we all have. It is their (use the term the participant chose for the High Self) – the very wise and knowing part of him/her. Whatever form the guide takes, they will really understand the issue that you choose to deal with. We will ask if there are any additional wise and loving guides who would like to help you with this issue. Once again, you do not have to “think up” the perfect guide – just be willing to say whatever or whoever pops into your mind. Sometimes guides show up to be with us, and sometimes they don’t – both ways are just fine. If no other guide comes to you, we know that your (use the term the participant chose for the High Self) is with you as your guide.

• During the Inner Counselor, we look at several parts of our issue; what was happening, the emotions we felt, and the related sensations that we felt in our bodies. We’re going to give you a chance to experience that now. I’ll get you to close your eyes again. Visualize doing a task that you don’t enjoy doing. What would that be? How do you feel about doing it? What are the emotions and sensations in your body that are connected to these feelings? You can open your eyes now. This is what we will do when we get in touch with the issue during the process — we identify what is happening, the emotions we have about that, and where we feel those emotions in our body. So now you know what that part feels like!

• So let’s take an imaginary example and walk through the IC Process© so that you have a sense of what it will be like.
• Imagine that someone said: “There are a lot of things in my life that just don’t seem fair – that is what I would like to work on with my process today.” I would have him go to his place of peace, feel himself totally there, then invite his (use the term the participant chose for the High Self) to be present.

• I would re-iterate the issue he wanted to explore (things in his life that don’t seem fair) and then ask him and his (use the term the participant chose for the High Self) if is it safe and advisable for him to address this issue at this time. This is a form of respect for the participant. You will have a sense if it feels right for you to look at the issue you identified, and you can let me know. If it doesn’t feel right, you can always choose another issue or feeling to address. If it does feel right, we’ll proceed.

• Then I would say, “Go to a recent time when you felt the same feelings and sensations.” The person might say, “Well, you know, it was last week. I was out in my garden, doing my own thing, and the neighbour came over and tore a strip off me for something that had nothing to do with me! And he went on and on and on, and it really upset me. It didn’t seem fair – I had nothing to do with it! It bothered me for days, and I admit I lost some sleep over it.” I would ask, “How did you feel when that happened?” and he might say, “Well, I felt angry at him for dumping all over me, and I felt confused, because I didn’t know why he was doing it, and I felt that it just wasn’t fair!” And then I would ask, “When you were having all those feelings, where did you feel them in your body – what sensations did you have?” He might say, “Well, my throat felt tight, because I wasn’t saying a lot of things I wanted to say, and my stomach was sort of churning, and my shoulders felt tense.”
• Then I would say, “Now, stay with the feelings, and let them carry you to an earlier time in your life when you felt the same feelings and sensations. How old are you? What is happening?” This is one of the places in the process where you do not have to “remember” or “think up” a perfect example of an appropriate time. Trust that the feelings you have will take you where you need to go. Just stay with the feelings, and know that you will become aware of a time in your life, which you can describe. You might become aware of several times when you felt the same sort of way – but one will probably come to the forefront for you. It’s the same idea as allowing something that makes you happy to come into your mind – just allow the time to surface in your mind. Know that when we do this, we stay with the feelings, and not the situation that created them. We are not asking to go to an earlier time when someone “dumped all over him” but rather an earlier time when he felt angry, confused, and felt something wasn’t fair, and felt a tight throat, churning stomach, and tense shoulders.

• Our imaginary participant might say, “Well, I’m 6 years old, and my big brother just took away my baseball bat, and he says he can have it if he wants, because he’s bigger than me, and he’ll beat me up if I try to take it back.” I’d say, “How do you feel?” and he might say, “Well, I feel scared, because he could beat me up; and I feel mad because he took the bat; and I feel like I must not matter very much, because he can have whatever he wants, and I don’t even get my own bat; and I feel that it’s just not fair!” I’d ask him, “Where do you feel those things in your body?” and he might say, “My legs want to run away, my heart is beating fast, my stomach is churning, and my shoulders feel tense.” So now we know how he felt at that earlier time.
• Then I would say, “Let those feelings take a form.” This is another one of the places where you allow whatever comes into your mind to be! This form is a symbol and we call it the Old Symbol, because it represents all of the old, reactive coping patterns that were created around this issue at that earlier time.

• Some people get worried that they might not “get” a symbol; that they are not used to thinking in symbols. You can relax – we’ve been doing this for quite some time now, and people do get symbols! Actually, we use symbols on a regular basis in everyday life. We think of a happy face to represent feelings of joy, or a thundercloud to represent someone with angry feelings. Numbers are simply symbols representing quantities, and words themselves are symbols of the meanings they hold, and we use them without thinking about them being symbols. So don’t fret about getting symbols. Sometimes they come to mind immediately, sometimes they take their time, sometimes they sort of evolve, but they come. Sometimes someone says, “I just see black… oh, wait, now it looks like a black cloud that is just hanging over my head…” or, “Now it has become a black hole that is sucking everything into it.” We have lots of time, and can give the symbols the time they need to show up.

• Different people experience the symbols in different ways. Some people see them in their mind’s eye. Other people just sense the symbol, or say, “This is what comes to mind.” Yet others may hear a piece of music, or “just know” what their symbol is. All of these ways are great!

• Symbols are personal – they carry the meaning you associate with them. I had a wonderful example of that several years back. One man got the symbol of a policeman to represent the qualities of being safe, fair, and just. The very next person I worked with
wanted a symbol to represent something that looked good on the outside, but was rotten on the inside. He had grown up in another country at a time when the police were very corrupt there – and his symbol was a policeman! Two very different meanings for the same symbol – the policeman. So whatever comes to you will carry the meanings you associate with it.

• Now, back to our imaginary example. When asked to let the feelings take a form, he might say, “It looks like a big green monster,” and I’d get him to describe it in a little more detail.

• When those Old Symbols are operating in our life, they are actually trying to help us out in some way. The Old Symbol has a protective intent – to keep you safe – and its responses were the best that we could do at the time. It may or may not have been doing a very good job of it – but it was doing its best. So we look for how the emotions and sensations that the Old Symbol represents served us at a time when our needs were not met, and we thank that Old Symbol, recognizing what it has been trying to do for us, often for many years. One of the wonderful things about these symbols is that we can interact with them, ask them questions, and listen to what they have to say! In our example, the person might say, “Well, nobody messes with a green monster, so it kept me safe by keeping those people away from me who were not being fair.” We would thank that monster for doing the best it knew how to do in that situation.

• Now, when we become aware of these Old Symbols, these old patterns of reacting, we are often tempted to just wish that they would go away, because they are not us at our best! Sometimes we even try to ignore them, in the hopes that they will do just that. Unfortunately, what often happens when we do that is that the old pattern does not
go away, but just sort of submerges, re-surfacing at different times in our lives. We say to ourselves, “Why do I keep doing that?” or, “Why does this keep happening in my life?” This is one place where the Inner Counselor takes a different approach. Instead of trying to make the Old Symbol go away, in Inner Counselor we work to transform it, “grow it up,” so to speak, so that it can become part of a new, more powerful and mature way of responding in that situation. We say that we include, transform, and transcend the old pattern of response or behaviour. How do we do that?

• Well, after we have identified the feelings that we had at that earlier time, we envision if we had been able to say right then, “I want! I need!” what we would have said. From there, we discover and identify the intrinsic qualities (qualities that are inside ourselves, and part of us) that we truly needed in that situation, and how that would have helped us.

• In our imaginary example, when asked what he would have said, if right in that situation, he had been able to say, “I need… I want!” the person might say, “I wanted someone to make my brother give my bat back!” and I would ask, “And if that had happened – if someone had stepped in and made your brother give you back your bat, what would that have gotten for you?” He might say, “Well, I would have felt safer, because he couldn’t beat me up with it, and I would have felt that it was fair that I had my bat, and I would have felt that maybe I did matter, since someone stood up for me, and I wouldn’t have been mad anymore.” So now we know the qualities he needed at that earlier time – he needed to feel safe, to know that he mattered, to know that there was fairness or justice in the world, and to be calm (not mad).
• We then talk to the Old Symbol (remember that we can do this!) and ask it if it is willing for you to find a new way to respond in situations where you feel the feelings that the Old Symbol represents. Sometimes the Old Symbols are very willing for you to find a new way; their attitude is “It’s about time! I am so tired of having all this responsibility, and I would be grateful for a new way!” Sometimes, the Old Symbols are very resistant – they feel that they have been doing a rather excellent job, thank you very much, and they see no reason for a change! Or the reaction could be anywhere between those two extremes. Whatever the reaction of the Old Symbol is, it is fine – it is part of the information and wisdom that that symbol holds for us. We will talk to it and work with it until it is comfortable with you looking for a new way to respond.

• Then we fully sense the qualities that would meet the needs, and get in touch with your _____ (High) Self again – that wise inner part of you that truly knows, and is connected to great wisdom – and we ask it to show you a New Symbol, someone or something that truly embodies the qualities that we have identified were needed. Once again, you don’t have to feel responsible for thinking up the perfect symbol to represent those qualities, it will just “pop into” your mind, as a gift from your ______ (High) Self. In our example, the person might say, “It looks like my Mom, who died several years ago. She had a wonderful sense of her self-value – she knew that she mattered, she was a very calm person, not easily angered, I always felt safe with her, and she treated everyone very fairly.”

• So now we have two symbols – we have the Old Symbol that represents the feelings and reactions we had when our needs in the situation were not met, and we have the New Symbol, which represents the qualities that we needed. We have the New
Symbol demonstrate to the old symbol (and to you!) how its qualities can protect you and fulfill your needs. We check to see that the Old Symbol understands the power of the New Symbol.

• Then we ask the Old Symbol if it would be willing to be completely absorbed into the New Symbol, letting it know that all of its protective intent will come with it. It will no longer be there in its original form, and the old reaction pattern will no longer be there, but the protective intent that it carried (the ways that it was trying to help you out) will become part of the New Symbol.

• Sometimes, the Old Symbols are very willing to be absorbed – they feel that they have done their job, understand that they could not meet all of the needs in the situation, and are willing to become part of the more powerful and mature response of the New Symbol. Sometimes, they are not willing, or feel unsure. Again, whatever the Old Symbol’s willingness is, is fine – it is part of the wisdom it holds for us! – and we work with it until it feels comfortable and willing to be completely absorbed within the New Symbol. In our example, the green monster (the Old Symbol) might say, “No – she looks like a wimp. I don’t see how she is going to keep people away from you who won’t treat you fairly. I don’t want to be absorbed.” We would ask Mom (the New Symbol) to address that concern, and she might make it clear that when you are not afraid or angry, and know that you matter, you don’t need to keep people away – you can still be safe. The green monster might then understand that Mom had a very different way of keeping the person safe, a more powerful way, and be willing to be absorbed. We then imagine the absorption taking place, until there is no longer any trace of the Old Symbol left, only
the New Symbol, and we notice if the New Symbol has changed in any way, or if it still looks the same.

• Once the absorption is complete, we then ask that New Symbol for the wisdom and advice that it has to offer you regarding the issue that you chose to address with this process, and we also ask any guides for their wisdom. In our example, Mom might say, “You need to know that when someone dumps on you like that, it is not about you, it is about them, and you don’t have to take it on. Imagine a “Teflon coating” around yourself that lets it slide right off of you.” She might also say, “There are things in this world that may not be fair – and you may have to get used to that and not worry about all of them!” She might also say that she loves him and supports him.

• Now we have wise advice from our New Symbol, which is wonderful, but may seem a bit theoretical. So we get very practical and bring all of this wisdom and the new responses into the real world, see what it might look like in our everyday life, by having you describe a specific circumstance in the near future, when the qualities of the New Symbol that are now present within you will empower you to respond in a new way, and we feel that new response. In our example, the person might say, “If the neighbour decides to dump on me again, I’ll be able to listen to him, know that it is his stuff, not mine, and go home calm, cool and collected, and sleep well at night.”

• After thanking the various symbols and guides that have helped us, we visualize a gold light that carries the qualities of the New Symbol, and envision it moving throughout our bodies, carrying those qualities with it into every cell in our body – sort of a way of locking in or embodying those wonderful qualities within ourselves.
• And that, in a nutshell (!) is the *IC Process©*! I know that it probably feels like a big BLURT of information, so I am wondering if you have any questions, comments, or thoughts about it at this time. (Answer any questions….)

• The *IC Process©* uses the concepts expressed in the Integration Chart©. This is the Integration Chart© (show to the participant). I think of the Integration Chart© as sort of a visual picture of what Inner Counselor is about. I know it looks a bit complicated at first, but don’t worry, you don’t have to remember all of it, and there will be no short test at the end – I just like to show it to you as another way of helping to understand what this process is all about.

• These lists (point out the lists of qualities) are lists of the ways that we feel, or qualities that we seek in life, and they are divided into the various parts of us as human beings. So, for example, we have physical needs (identify column). When our physical needs are met, we tend to feel strong, have stamina, vitality, courage, and so on. When our physical needs are not met, we tend to feel weak, or powerless, or fearful, for example. We have personal needs (identify column). When our personal needs are met, we tend to feel that we’re OK; we have a sense of self-value, and have good self-assertion and self-expression. When our personal needs are not met, we might feel withdrawn, or jealous, or unworthy, for example. The next column identifies our interpersonal needs (identify column) – the needs we have to connect one-on-one with others. When these needs are met, we experience such things as kindness, and intimacy, and healthy boundaries, and appreciation. When the needs in this area are not met, we might feel disconnected, or rejected, or become rejecting or manipulative. The next column shows our group qualities (identify column) – the things we need in the groups
that we belong to, such as respect and harmony and cooperation. If those needs are not met, we might feel like we have to conform, follow the rules that are set out, or the roles that others want us to fill, and may feel pessimistic. The fifth column is labelled the coherent qualities (identify column). These are “higher” personal qualities, and include such things as integrity, self-knowledge, knowing that we are compassionate and have balance in our lives. If those needs are not met, we may rationalize, or become pretentious, hypocritical, or downright dishonest. The final column (identify column) contains the most spiritual of all the qualities – we call them the radiant qualities – and includes such things as lucidity and oneness, service and illumination. When those needs are not met, we could find ourselves feeling detached or remote, or becoming tyrannical or exclusive (“my way is the only way…”), or feeling like a martyr.

• We call the bottom section, the darker colours, the downdrafts (identify downdrafts), and this is where we find ourselves when we hit a bump in life. And as long as we are alive on this planet, we are very likely to hit bumps in life from time to time. Our Old Symbols will represent the kind of feelings expressed in the downdrafts.

• We call the upper section of these lists, the lighter colours, the updrafts (identify updrafts), and those are the feelings we have when our needs in these areas are met. Our New Symbols will represent these qualities.

• The purpose of the Inner Counselor is to help us updraft our downdrafts! The line between these two areas is the line of choice (indicate the line of choice). Sometimes when we hit a downdraft, we forget that we have choices, or we don’t see any choices, or we don’t know what those choices might be. The Inner Counselor can help us to recognize that we do have choices, and help us to find them.
• One of the things that I like about the Inner Counselor is that it does not involve any blame or shame or judgment. When we hit a bump in life, it is seen as experiencing a downdraft, and we are all likely to experience those from time to time. The difficulty in life is mostly not when we visit a downdraft, but when we get stuck in one. The Inner Counselor offers us a way to change that! So, for me, the Inner Counselor feels like hope!

• While we sometimes find that charts are meant to be read left to right and top to bottom, the Integration Chart© is definitely not linear. We move all over the chart throughout our life’s journey, and do not neatly finish up all of our work in any one column or area before moving on to another. The Integration Chart© lets us be fully human! I used to wonder if people like Mother Theresa and Gandhi lived all of their lives in the updrafts of the radiant qualities, but having read more about their life histories and experiences, I realize that they hit their bumps, too!

• The flow chart part of the Integration Chart© is a synopsis of all of this information, and offers some more information, as well. If, for example, you had to choose one word to summarize physical qualities, you might choose “strength” and that is the word used in the flow chart. The words written in red are summaries of the long lists below (point out).

• Then, the columns are combined further as part of the flow chart – the two columns of physical and personal qualities are shown to go together to make up the ideal survival and identity qualities. The two columns that involve ourselves and others (the interpersonal and group qualities) are combined to be the ideal relationship qualities. The coherent and radiant qualities continue to stand on their own.
The concepts of “extrinsic” or outside of oneself and “intrinsic” or within oneself are important in Inner Counselor. Extrinsic needs are met by someone or something outside of the self, and intrinsic needs are met inside the self. When needs are met intrinsically, people embody them as soul qualities. (Point out the appropriate connections with the Integration Chart©.) So, for example, when we are young and need love, we look to our parents, grandparents, siblings, and so on to love us – people outside of ourselves, extrinsic to us. As we mature, we realize that it is also important to love ourselves – not in an egotistical way, but in a healthy way. So, we take that inside ourselves – make it intrinsic – an inside job, so to speak! When we do that, and love ourselves, we embody the quality of love and can be seen as a loving person. In our example, the person originally needed someone else to make his brother give his bat back – that is extrinsic. We then ask, “What would that get for you?” which brings it inside and makes it intrinsic, so that we can identify a new symbol and new responses that offer us ways to embody those qualities and respond differently in the world.

I realize that this is a lot of information to take in all at once, but don’t worry – you don’t have to remember it all! I offer it as a way of helping you to understand what Inner Counselor is about and how the process proceeds. You’ll have a much clearer idea once you have experiences a process yourself. That’s why I like to do two processes with each person, so you have a chance to experience the process once you are more familiar with it, too! Do you have any questions at this time? Comments? Thoughts?

So, now that you have a better idea of what the IC Process© is about, what can we use it for? Well, we can use the Inner Counselor for a wide variety of purposes. Some people use Inner Counselor to address worries or concerns that they have in their
life – things that bother them, or that they find frustrating, sad, irritating, unfair, or unsettling. Others use Inner Counselor to address parts of their personalities – things like becoming more patient, or less of a perfectionist, or being less of a procrastinator.

Others use Inner Counselor to help them deal with their reactions to difficult life situations – loss of a loved one, grief, a disturbing medical diagnosis. Yet others use Inner Counselor to help them move forward in their lives from a place where they feel “stuck.”

• A “stuck” place was one of my personally most memorable IC Processes©. In my doctoral program, it was time for me to decide what I would like to research for my dissertation, and I simply could not come up with a topic that I felt good about! This was very unusual for me, since I don’t usually have any difficulty making decisions. I came up with a couple of topics that I thought other people might like me to do (that would be the pleaser in the downdrafts…). I had also been told that, since you will likely spend the better part of a year working on your dissertation, it is best if it is something you love. I was trying to determine what that would be for me. And I was stuck – nothing was coming to me! I could rationalize it beautifully – there were so many things that I was interested in, lots of areas that attracted me, maybe I should do some more reading in different areas… (Remember that rationalizing is also a downdraft????) It occurred to me that I had the Inner Counselor as a tool, and decided to use it. I sat down with one of my professors and did an Inner Counselor session on the issue of why I couldn’t seem to decide on a dissertation topic. When I went back to an earlier time, I went to the September that I started grade 6. The teacher asked us what we wanted to study in science, and I put up my hand, and announced that I wanted to study insects … except the
teacher didn’t hear the “in.” She thought I was being rude and a smart aleck and she humiliated me in front of the whole class, and then made me go and stand in the hall. Now, my Mom was the school secretary, so that was not a good place to be! And I had no idea what I had done wrong! Eventually, of course, one of the other students asked her what was wrong with studying insects, and she realized that had happened. She could not have been nicer – she apologized, did everything in her power to make me feel better, and I am sure she felt very sorry. However, you can see where my reluctance to state what I wanted to study came from! Nowhere in my logical, thinking mind would I have put those two things together. But by following the feelings, it took me right to where I needed to be. It was only a short while after my IC Process© that I knew exactly what I wanted to do my dissertation on. So, for me, it was a wonderful tool to use!

- Dialogue until participant identifies a feeling or concern that they would like to address.
- Are you comfortable?
- Are you ready to begin the process?
F.2 Pocketalker Pro™ Hearing Assist Device Specifications

Pocketalker Pro™ Personal Amplifier, model PKT C1

Please note: All of the following information was taken directly from the specifications material included with the Pocketalker Pro, and can also be found online at http://www.williamssound.com/williamssound/files/2006031661480217_PKTPROcat.pdf

Description:

The POCKETALKER amplifies sound clearly and easily for better understanding. 100 hours of battery life ensures long-lasting performance. Each Pocketalker includes a built-in sensitive microphone; and for the TV listener: a TV listening extension cord. Use the Pocketalker with a variety of available earphones and headphones of your choice, or, for optimal performance, use it with a neckloop and a telecoil-equipped hearing aid. With the optional Telelink adapter, listeners can use the Pocketalker to amplify telephone calls to a comfortable listening level.

Applications:

• 1-on-1 Conversations • TV Listening • Listening in the Car • Small Groups and much more

Dimensions: 3 5/8" L x 2 3/8" W x 7/8" H (92.1 mm x 60.3 mm x 22.2 mm)

Weight: 3.8 oz (110 g) with battery

Color and Material: Gray, shatter-proof polypropylene

Battery Type: 1.5V (AA) x 2, Alkaline (BAT 001) or rechargeable AA NiMH (BAT 026)

Battery Life: 100 hours with BAT 001, 40 hours/charge with BAT 026, 8 mA, nominal current drain
Microphone: Omnidirectional condenser, plug-mount-type, 3.5 mm mini phone plug

Earphone (3 Styles): Headphone style, Dynamic, wide-range “earbud” type, Samarium-Cobalt magnet, 32 Ohm, 39” (1 m) cord, 3.5 mm mini phone plug (mono)

Controls: Volume: rotary on/off/volume control

Gain: Internal rotary maximum gain control (screwdriver adjust)

20–45 dB acoustic gain w/EAR 013

Tone: Internal rotary tone control (screwdriver adjust); +17 dB at 16 kHz at maximum setting

Microphone Connector: 3.5 mm mini phone jack (mono)

Earphone Connector: 3.5 mm mini phone jack (mono)

Charging Jack: External side jack, 2.1 mm, Charger TFP 008 can also be used as power supply

Frequency Response: 50 Hz–16 kHz, +1 –4 dB (electrical response)

Max. Distortion: .5% THD (electrical)

Max. Output Power: 125 mW into 16 Ohms (electrical)

Warranty: 5 years, parts and labor*

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F.3 Facilitator Inner Counselor Notes

Inner Counselor Facilitator Process Notes

Participant ____________________
Date _________________________
Session # 1  2

Place of Peace - describe

Issue/Feeling -

Ask self and (High Self) – is it safe and advisable to address this issue at this time?

Additional wise and loving Guides?

Recent and Earlier Times

Old Symbol - shape, colour

What do you really need and want? Intrinsic Qualities.

How did the emotions/sensations serve you when your needs were not met? (…thanking old symbol)
Old Symbol willing for you to find a new way to respond?

Fully Sense the qualities that will fulfill your need. New Symbol, Describe, Willing to Commit (Both)?

New Symbol show Old Symbol how its qualities will protect you and fulfill your needs.

Old Symbol willing to be completely absorbed?

Describe New Symbol absorbing Old Symbol

Completely absorbed?

How does New Symbol look now? Any changes?

Special Advice of New Symbol

Special Advice of Guides

Be aware of your original issue. Feel the qualities of the (new Symbol) in your body. Describe a specific circumstance in the near future when those qualities, now present within you, will empower you to respond in a new way. Feel the new response in your body.

Place of Peace – New Symbol a place of honour - within yourself - in Place of Peace. Thank guides, high self, yourself.
F.4 Participant Introduction to the Second Inner Counselor Process© Session

Participant Introduction to Second IC Process© Session

- Did you have a chance to think about last week’s IC Process©? (If yes:) What were your thoughts? (Discussion of these…)
- Was there anything you noticed this past week that you feel is connected to your experience of the process? (Discussion of this…)
- Do you have any questions or comments, now that you’ve had a while to reflect on last week’s experience? (Discussion of these…)
- Were there parts of the IC Process© that you are wondering about, and would like me to explain? Sometimes after people have experienced the process, they wonder why we did a certain part of the process, for example… (Discussion of these…)
- Is there anything else you would like to ask or chat about regarding the IC Process©? (Discussion of these…)
- Do you have a sense of what issue or feeling you would like to look at with today’s IC Process©? (If yes, go to next question. If no, dialogue until that is determined. Sometimes it was necessary to do a review of the ways that Inner Counselor can be used, to see if that “triggered” a topic for today’s session. When a topic is determined, proceed.)
- Are you comfortable?

Are you ready to begin the process?
APPENDIX G

G.1 Histograms of GDS and BAI® Data by Group

E group, GDS "A"

Mean = 4.86
Std. Dev. = 4.378
N = 43
E Group, GDS "D"

Mean = 3.56
Std. Dev. = 3.966
N = 43
	estgrp: E Group

E Group, GDS "E"

Mean = 3.35
Std. Dev. = 3.747
N = 43
	estgrp: E Group
E Group, BAI "A"

Mean = 3.35
Std. Dev. = 3.45
N = 43

E Group, BAI "B"

Mean = 3.02
Std. Dev. = 3.377
N = 43
E Group, BAI "E"

Mean = 2.16  
Std. Dev. = 2.716  
N = 43

testgrp: E Group

C Group, GDS "A"

Mean = 4.79  
Std. Dev. = 4.04  
N = 42

testgrp: C group
C Group, GDS "B"

Mean = 3.88
Std. Dev. = 3.827
N = 42

C Group, GDS "C"

Mean = 3.64
Std. Dev. = 4.333
N = 42
C Group, GDS "D"

- Mean = 3.71
- Std. Dev. = 3.808
- N = 42

C Group, GDS "E"

- Mean = 4.19
- Std. Dev. = 4.402
- N = 42
C Group, BAI "A"

![Histogram of BAI scores for Group A with mean 5.33 and standard deviation 4.673, sample size N = 42.]

C Group, BAI "B"

![Histogram of BAI scores for Group B with mean 4.93 and standard deviation 5.009, sample size N = 42.]
C Group, BAI "C"

Mean = 4.69
Std. Dev. = 4.598
N = 42

C Group, BAI "D"

Mean = 4.55
Std. Dev. = 4.402
N = 42
C Group, BAI "E"

Mean = 4.88
Std. Dev. = 5.606
N = 42

testgrp: C group
G.2 Excerpts of Written Anecdotal Material

General Information Regarding Excerpts of Written Anecdotal Material

Please note:

- Information in square brackets [ ] has been modified to remove personal or identifying information.
- An ellipsis (…) indicates where larger amounts of identifying information have been omitted.
- Anecdotal Material written before participants had experienced their Inner Counselor Processes© is not included.
- Other than the removal of identifying information, the feedback is transcribed as the participants wrote it.
- Because participant numbers have been removed, and each participant had the opportunity to complete more than one form, responses from alternate participants have been shaded to assist in identifying responses from a given participant.

Excerpts of Written Anecdotal Material

| Not sure if “full” of energy but certainly energetic. |
| Do seem to physically tire earlier than would like. |
| Generally a positive experience! |
| Generally positive feelings on chance to look at one’s self |
| I find it difficult to relate my feelings to a particular physical object. I believe I have |
an active imagination but I don’t think I have ever thought of my joy or sadness in
relation to my car or an aeroplane flying overhead! Exploring my early memories has
been more emotional for me than I ever thought it would be. Thanks for giving me that
opportunity.

Perhaps my responses to the Inner Counselor experience would have been different if
the period since we were first introduced if my personal time had been less difficult —
no wrong word! Let’s say eventful.

There were [stressful family events and illnesses]. It was difficult to focus on Inner
Counselor! I will look forward with anticipation to your results.

I am able to sleep better, or I should say that I go to sleep faster

Has helped me relax at night.

No, I haven’t really noticed anything significant. Yet there are times I feel
disappointed when I see a number of my friends “missing the bus.” They seem to be too
busy with mundane things even to the extent of not raising their children rightly. I quite
often have come to the conclusion that my wife and I keep praying, and if nothing seems
to be working out, I leave it in the hands of the Lord.

As this last week has been quite busy with family (problems) and music performance
responsibilities and, in relating these to my Inner Counselor (and Anne) I have realized
that I depend on and even refer to my basic living philosphys which included my
relationship with people whom I have enjoyed and have set good examples for me and
also as a Christian.

As discussed with the “Inner Counselor” I am quite comfortable in my old age
knowing full well that at this age unpleasant things may, and probably will, change and
happen to me and my wife. These will (would) change our pattern of living — but —
that is part of being OLD - I accept that.

Also, as discussed, I am quite happy living a pattern of life that is Christian, at least
while I am still alive — after that who knows???

Thanks for the opportunity to discuss these things with my “Inner Counselor”!!!

I found it to be a most interesting experience & feel it could be quite useful.

I thought the visual imaging to be very helpful. I expect to use the process fairly often in
times of stress.

I have found the technique taught useful in improving my mental attitude. I have been
able to motivate myself to get moving on tasks. My concern is that without
reinforcement, I may backslide. I will see. I have a large inertia to action which I think is
just a habit coming out of my need to procrastinate. It will take.

I have used the technique successfully on several occasions to avoid anxiety over tasks
and procrastination. I found the “Mood Assessment” too “black & white” to answer in a
manner useful to your research. A 1 – 5 scale would feel more honest and comfortable.

In hindsight, I am aware of biases that may have affected my answers.

1) The Hawthorne Effect where your attention alone may have caused a
   mood/attitude improvement

2) The “Desire to Please Effect”. Your likeability causes a bias toward giving
   pleasing answers. I believe you want to prove your therapy technique is
   beneficial so I may be biased toward feeling it was.

Having declared my possible biases I still think it was beneficial.

I found the experiences very helpful. Anne was very attentive to what I was saying
and she followed up on my responses. I hope that I can do this on my own from time to time.

I found it very helpful can use these images and exercises to relax and to solve problems and to understand myself and others

I don’t know if the process has changed me much (yet) but I find that I am thinking about the process. In other words, I find myself thinking about the fact that I should be able to calm myself consciously as was discussed — so when I need it, I intend to work at it.

Experiencing the “procedure” has illustrated ways for dealing with life’s “downs” and problems. I’ll eventually see how it works, no doubt.

The two “face-to face” sessions were useful in learning about using previous experiences to assist with current problems. I intend to make use of “Inner Counselor” should the occasion arise. I have used some similar process to rationalize my way through problems I could not “solve”. I guess it is just relying on one’s experience in a subliminal way.

Anyway, thanks for the experience and best wishes for your efforts to write a thesis.

Thank you so much for the Inner Counselor experience. The program certainly taught me how to look within myself for answers to some long term persistent problems which had been concerning me.

I think everyone should undergo the same experience. The program was much appreciated.

Best regards and wishes for success in the future.

The process put me back in touch with the self hypnosis I had learned a number of
years ago. Since participating in IC I have been again practicing “conscious relaxation”.  
This has been very effective in dealing with stress related muscle spasms and indigestion.

I very much appreciate the opportunity to experience the IC process.

It helped me acknowledge problems and an effective way of dealing with the identified problem. I felt very relaxed to speak up and out. The atmosphere was very conducive to the Inner Counselor and Ann had a very special way of helping me through the process and I feel she is very gifted in helping people in this manner. I felt I could tell her anything. My experience of the “Inner Counselor” carried through in my daily relationships and I am going to put this into practice on a daily basis and not feel I have to rescue everybody.

I am happy to say that I am 70 years of age and will continue to be a learner.

There is a great sense of peace because of my experience of the “Inner Counselor”. I appreciate the fact that I was able to be a participant with my Inner Counselor. Thank you.

Following my first Inner Counselor session, I did not feel any change, but in spite of not indulging in any more physical activity than usual, I was exhausted and went to bed at eight thirty and slept until after six A.M. Perhaps there may be some significance to this.

I have delayed returning this note for a week in case something occurred to me that might be useful, but nothing has. Some years ago (1954) I was under the care of a psychiatrist for chronic depression. I was treated with electrotherapy, and apparently it
worked. Perhaps I became acquainted with my inner self at that time and maybe it is second nature to me now.

I would like to share with you my feelings after I had two sessions with my inner counselor.

I feel like a new person, I feel like I can conquer the world now.

It is a wonderful experience. I feel at peace. I can honestly say that throughout the experience with the inner counselor I now, can get in touch with myself, with a person whom I have never met, but now is part of me. I feel so much more comfortable about life in general.

I can contact within myself the strength to overcome or eliminate the feeling of anxiety. I can be perfectly at ease with the help of the power within me.

I am so thankful that I was given the opportunity to partake in this research program.

If it would be possible, to explore my inner self some more, I would

The thing I found most helpful was the opportunity to work on something in a warm, comfortable, helpful and confidential manner. In addition, I learned that I have the personal power to effect change in the things I need to change — perhaps I knew this before but the process re-affirmed it.

The long-range benefit was the getting in touch with the “place of peace” to which one can go when needed.

Naming the guides was an interesting revelation.

Thanks, Ann, for making your project — and expertise — available not only to me but many others. You have a great gift and share it most generously.

This Inner Counselor Process was a new experience for me. While in the past I prayed
and meditated more intensively during periods of stress or decisions, I have not thought of asking [symbols from within] for suggestions or advice. I plan to call on them in the future. Neither have I thought of developing and resting in a [Place of Peace]. There are, of course, many actual places in the world to relax. As an agriculturalist, I enjoy nature and enjoy to have lunch or dinner on our patio admiring the long border of impatiens at the end of our lawn.

As I indicated, we have our Catholic (and other Christian) churches and healing masses where designated parishioners in the name of Jesus (!) lay hands on people for healing. I told you of the healing (or disappearance) of a lump in the breast of [a family member]. My wife and I personally felt a healing after parishioners layed hands on us after the sudden death of our son.

Another form of healing, again in the name of Jesus, takes place when people prayed over fall backwards on the ground (held by assistants) and thus “rest in the spirit.” I have not yet experienced this type of healing but I am told that it is a completely wonderful and relaxing state of mind.

May I respectfully suggest that you should make reference of those healings in your thesis.

May the Lord bless you, and with kind regards.

I find the IC experience believable and sometime may again be very useful to me.

The loss of my wife last year is the severe episode I have been dealt. There is very much an emptiness in my life, particularly in the social areas. Trying to run the household for 1 is a major effort for me. I can’t get excited about cooking so meals are a problem. I guess I never stopped to think how busy she was, but accomplished so much
on a day.

My children are absolutely the best. I could weep. They’re very supportive, thoughtful, and share their life with me. Yesterday with daughter, granddaughter and son-in-law.

BAI — no mention of feeling TIRED. I am most of the time. I can fall asleep anytime and wake up somewhat refreshed and often do. Controlled option, however.

In addition to a heart problem, I have prostate cancer. The PSA tests significant increase in activity recently. Using the “Let’s go to a place of peace, contentment, and enjoyment” I have been able to reduce significantly anxiety related to this new status of my prostate cancer problem. Similarly the addition of Eltroxin [used to treat thyroid problems] relates to new anxieties of low thyroid activity. Somewhat worrisome but controlled similar to Prostate cancer.

I am very pleased to have been able to participate in your study and wish you all the best for its conclusion. I must say that I am sometimes skeptical of many things related to religious principles, but am impressed with this Inner Counselor Process. It seems to work for me. All the best.

An interesting exercise.

I haven’t gained in any way from “Inner Counselor”

The process does draw out subconscious knowledge that aids in arriving at a conclusion in an orderly manner

Sorry I am so late getting back to you. I have been away a lot lately with friends and family & trips. So getting that said, your program was superb. I think I liked the one on one [sessions] best, it was very new to me and very interesting also very informative. I
think of it often as the days go by with the different conversations I have with friends and mostly strangers, I use it often. You do a great job. P. S. I am not good at writing letters like this. My wife used to do this. Thank you very much.

As one who has thought in parable and metaphor for aeons, I was not really finding the IC was making a big difference in my life or attitudes. Perhaps it will take hold as I ponder it more in days to come. Sorry I forgot to get this out on time.

Perhaps as I have aged I have become less open to symbols and metaphors. I understand them still, almost immediately, but I do not take them with me & live with them. This has it’s pros and cons — Maybe I am more practical, more straightforward than I once was but maybe I am less thoughtful and wondering also. It is more important for me to pay attention to sensate things, like steps, so I don’t fall — don’t stop & drink in the beauty because it takes longer to do everyday tasks so must pay attention. Harder to pick up audio & visual cues so have to concentrate more on what is right in the here and now. Inner counselor sometimes must take a backseat!

I have enjoyed the last five weeks — and would like to thank you for the experience. There hasn’t been any great breakthrough. I would like better health + greater energy but that doesn’t seem to be happening. Good luck with your project: Shall be interested to hear the results.

I realize I have a fairly good support system that I can call on in a time of need. I have tried to prepare myself, or my power of attorney financial, or health or if the case may be — my executors to have my affairs in order in the case of death or serious illness.

I am thankful I have a church family and I am sure God will walk with me in the days ahead.
It is good to be able to talk about issues.

I don’t know what the future holds but I know who holds the future “Quote”

This is a very interesting process. And I realize that without by active participation in organizations working for social + environmental change, I would be depressed and unable to get out of bed in the morning.

Re fear: I feel the future does not bode well for our children and this troubles me to be active in the pursuit of change. Lifestyles need to be simplified, distances shortened, appetites curbed + moments with nature savoured as well as those with ties. I endeavour to do all — hence some satisfaction + hope.

Find the interviews interesting will work on some of the processing symbols.

I wish you success in your data collecting.

I spoke to several of my friends and they might try relaxing sitting with eyes closed. And think of pleasant things and sometimes what is unpleasant. I have really been calm — taking control of decisions. But I am cheesed off with this man whom I thought so nice…..

PS. In my closed eyes taking me back to a pleasant place and as Ann talked about the [Old Symbol] as a protector. So I was able to make friends with him to stand back of my family as a guardian.

Thanks for insight to ones inner spirit

This past month every time I am to meet this gentleman he has excuses…. A very rich relative on the grandchildren … was very mean to them this weekend. Threatening to cut them out of their will. I told them I read her a long time ago. NOT TO WORRY — GO ON WITH YOUR LIVES & ignore her as I did when my parents
did the same to me. I lived and brought up your Mom and aunties, and I enjoy my life as
LIFE IS A CHALLENGE.

I feel empowered! I believe I have been taught the steps to use in solving difficult
situations. Thank you Ann

There have been times this week when I have used the information learned from Anne
through the inner counselor sessions.

I feel sure that I have benefited from the 1 ½ hour sessions.

Thank you so much

I have enjoyed the program and am hoping to be able to use it. It seems I have already
done so a couple of times. Thanks Anne

I found the time spent with Ann very helpful! How many people I wonder are
burdened a little (or a lot) with things from the past? that with some guidance can be
resolved or at least lightened. Thank you, Ann! and God Bless you in your future
counseling and studies.

Sorry this is late! It’s a good sign. I’m feeling well and out about doing things and I
forgot to mail it. I got too much heat yesterday and was ill for a few hours. Finally we
booked into an “air conditioned” motel ☺ so I’m really taking it easy today. I have taken
time to close windows and blinds here at home so it’s much better here. (Lots of big
shade trees.) All the best Ann & Thanks again.

Perhaps because guided meditation has been a real challenge for me, I found parts of
the I.C. process difficult, especially visualizing the old and new symbols, and really
feeling the emotions (and sustaining those feelings when requested) and the golden
light.
I honestly don’t think I’d use the I.C. process when dealing with deep emotional issues as much as I’d use the (for me, tried and true) prayer and journaling and scripture reading which have been my source of strength all along.

Nevertheless, The I.C. process was enlightening and cathartic and beneficial. It was good to verbalize with a wise and caring listener, some of the concerns which are a reality in my life. I really appreciated the opportunity to experience the process and to contribute to this very worthwhile research study.

My first appointment of the Inner Counselor process was moving, insightful, and helpful. I felt clarity in my thinking after the process but did not notice a lingering effect…things seemed to be back to ‘normal’ quite soon….

Second session with Inner Counselor. The awareness of Spirit came quickly, first seen as a violet color with a pale gold centre, then as The Master. A huge feeling of homesickness and a lot of tears. I felt the Presence move into my field at my right shoulder. I recognize the vibration as one previously and often identified to me. That Presence lingered for much of the session, confirming the counsellor’s words that I had, within me, the ability and insight to face a situation requiring my attention for a very long time.

This has been a profound learning for me, about me. I have felt the added benefit of accelerating my spiritual growth … or at least the awareness that it had not halted!

I am so gratified that I was able to access this modality and its’ benefits.

The last part of the IC session involved my concerns around a meeting where I expected to be strongly encouraged to act against my own assessment of a situation. IC suggested I could refuse, with grace, the ‘opportunity’ being offered. I felt, previous to
IC that I was being gently but firmly “bullied” to do what was against my best interests.

A meeting later that day allowed me to set aside my concerns, because I knew what I could do. I could refuse. Knowing this, I entered into the meeting with an open mind and heart and found that, indeed, the proposed activity which had previously threatened my values could now be considered in a different light! The decision was made, by me, to enter into an agreement with my “bully” and both of us were content with the prospect of working together. I could see the positive direction of her intent was not to take advantage of me, rather it was focused on serving others. As we completed our transaction, I felt an echo of the Visitor at this morning’s IC session and my “bully” “saw” us both encased in a bubble of white light, which I felt.

The IC session of this morning, guided by the counselor, allowed me to see the options I had so I was not consumed with being guarded. I am left, though, with the renewed awareness of how to access the inner wisdom rather than give in to concerns of being overwhelmed by the enthusiasms of another.

I was simply able to see more clearly.

Yes — the sense of increased access to inner resources. To know it, that’s one thing. To have a renewed sense of access — that’s empowering.

Also the “urgency” to confront, for my own satisfactions, has dwindled. Past issues take on less importance.

Being on holidays with my siblings also gives me a huge lift & allows past (shared) experiences to be understood in a different light, because of the I.C. sessions.

I could have one every week! Thank you so much. Thank you for everything ….and really know, you are making a difference!
In the first Inner Counselor Session, I decided to focus on procrastination. During that session, I went back to an incident in my youth, and identified what role procrastination may have played at that time — protector. I visualized a symbol of that “old protector” then identified the strengths I would have needed not to procrastinate — i.e. courage, integrity, resolve. Then I visualized a helper who symbolized the strengths that would enable me to avoid procrastinating in the future…. Gradually the [Old Symbol] agreed to be absorbed by the helper, and gradually the helper was replaced by a symbol of light. I then identified a task where I could begin changing my habit of procrastinating and visualized how I would have approached it.

During the session, Ann guided me to visualize a golden light moving through my body from head to toe and back up again — all symbolizing the Divine healing presence bringing healing to every cell in my body.

That evening, I reviewed the session and made notes on it. I also relived the Inner Counselor process that evening (and several times again during the week) with the result that, next day, I willingly took up the task I had identified … and worked on it for several hours that day and continued working on it through the week. It felt good to be [doing this thing] that I had been avoiding. In addition, I willingly began to [do other things that supported this change]. It feels so good to believe that I have begun to form a habit that will make my life much more pleasant. Meanwhile, I have not finished clearing the [backlog], but I feel resolved to complete it, and then, to keep up with [it] day by day.

In [my second] Inner Counselor session, I chose to deal with procrastination again because I had found some doubts creeping in re the possibility of returning to my old
I identified two incidents in my earlier life when I feared something difficult. The (old) symbol that I identified was a loose net encircling me. As helpers, I identified [a symbol and a guide] who reassured me and who symbolized the strengths I needed to overcome my fears — inner strength, self-confidence, reliance on God’s grace. My [New Symbol] was gradually replaced by the symbol of an angel — beautiful, graceful, full of light, reaching upward.

Again, Ann guided me to visualize a golden light, symbol of the Divine healing presence, flowing upward and downward through my body, bringing healing to every cell in my body. Also to select another task that needs to be addressed and visualize how I would undertake it.

Last evening I was not able to sit down and make notes and relive the Inner Counselor process as I had last week because of another commitment. And today is not available, either…. But I will pick up on it over the weekend!

“Eruptions of grace”! Three almost simultaneous blessings in my life, each contributing to my wellbeing … and the Inner Counselor process that is helping me deal with a longstanding habit of procrastination.

Amazing grace! Day after day, now, I feel that new habits are taking hold in my life. As time permits each day, I resume work on the huge backlog … that I had allowed to build up over the past years and I’ve accomplished a lot! I had always [done the essentials, but not the extras]…. [I have now created a way to make this easier] and I feel encouraged that it will now be easier to keep up-to date.

What is so amazing and wonderful to me is that now I have a different attitude toward
looking after [my responsibilities]. My focus in the Inner Counselor process had been on overcoming my longstanding procrastination with regard to [one issue]. But, to my delight, not only am I experiencing a new attitude and practice re [that issue], but simultaneously I have been developing a new practice [for related issues]. Quickly, without really planning it, I have fallen into a routine [that supports this new habit]. And consequently, [there are other wonderful benefits!]. Furthermore, I’m spending much more time at home, instead of [finding excuses to put] in time away from home where I couldn’t face what I knew I needed to do!

In addition to all of this, approaching these various tasks … no longer appears to be onerous — something to run away from as I had been doing for so long. In fact, I am usually quite eager to resume work, whenever I can, on what remains [to be done]. These tasks are time-consuming, and my physical stamina, while much improved, is still not 100%. So it will take several more weeks to complete them. I feel very much at peace, calm, not hurried or pressured, yet resolved to bring it all to completion.

All in all, I’m in awe and so grateful that I don’t have to go on for the rest of my life dissatisfied with myself for the way I’ve been managing my life. I feel that I’m being freed of a huge burden so that my life can become more purposeful. What this will mean, I do not know at this time. I just sense that as one door closes, others will open — as has happened so many times in my life. Thanks be to God!

Now, back to the Inner Counselor process itself. As I indicated on my last sheet of comments, I was not able to concentrate on the focus of Session II for a couple of days because of some other distractions. By the third day, however, I spent some time recalling the main features of that session. What stood out most was the image of my
[New Symbol] — her inner strength and her reliance on God’s grace — models for me of what I needed to pursue my goal of overcoming procrastination. (I had forgotten the other qualities I identified during the session).

Also, I continued for several days to recall the image of the angel that replaced the image of my [New Symbol], but the image of my [New Symbol] seemed to have more impact on me. I also prayed that my [New Symbol]’s strength and diligence would become mine as I looked ahead at the tasks I need to resume. Gradually, the doubts I had identified in Session II faded and I was able to continue the work I had started with a calm spirit. Occasionally, when a doubt has flitted through my mind I pay no attention to it. It’s almost like being in a state of suspended animation! I’m just “hell-bent for election”! ha!ha!

Looking back, I had some difficulty in the two sessions with the process of visualizing. I don’t have confidence in my ability to visualize. So it was quite a challenge for me. And while images did emerge, and quite symbolic ones at that, they came slowly, and were quite hazy, and therefore I had some difficulty believing in their credibility. I just had to give it all the benefit of the doubt! After Session II, I thought I should have asked you before the session began if, once you had given me the instructions for each segment of the session, you could give me more time, in silence, without further coaching, to come up with the images. Your additional comments seemed to distract me. But I didn’t ask, and the miracle of it all is that it worked anyway! (I mention this now for the possible benefit of future ‘non-visualizers’ that you might come across.)

Thank you, Ann, for this invaluable experience. Would that all doctoral thesis research
has such outcomes for the participants!

I do think I’ve felt somewhat more “upbeat” since the 2 sessions — somewhat more “positive” — and have made some choices that have reflected a renewed sense that I had the right (and power) to choose the activities and “duties” that life presents and need not feel obligated to always meet the expectations or demands of others.

Thank you very much for the time and interest you took in your meetings with me — and best wishes for the successful completion of your studies.

I had my last session this week and I feel better, more at peace with myself than I have in years. I am hoping that I can deal with my life in a much better way now that a burden has been lifted from me. I also hope that with me looking at things in a different way it might help [a relative], although only he can do that. I’m going to look at life in a different way, now that I am rid of some of the burdens that have been drawing me down all these years. I thank you so much, Ann, for all your help; it has made me think in such a different way.

My “shining star” is a great comfort & encouragement. If I am tired & need a lift — it is there.

I have found that the Inner Counselor process is very helpful in uncovering my inner wisdom. It helped me to resolve issues in my life that I had experienced as painful and hurtful. The Inner Counselor helped me to reach new conclusions as to how to better handle any similar experiences that I may encounter in the future. This is a BIG discovery and will be of immense help to me. I am truly grateful to the Inner Counselor process for this gift to me.

I found my facilitator very easy to be with — I felt relaxed and she was most receptive
and absolutely non-judgmental. Ann made this a truly rewarding and peace-giving experience.

I want to thank you for the opportunity to experience the IC process with you. I am grateful for the revelations which occurred during the Process and I refer to the review notes that I wrote at the end of each process. It helps to remind me of what I learned and the goals I set for myself.

I was able to find the courage to call [the person with whom I was having difficulty] and she seemed to be happy to hear from me. Unfortunately, neither of us discussed the difficulties in our relationship, but at least we are on speaking terms again. It is an ongoing situation that will require a lot of love & patience and acceptance.

Once again, Ann, many thanks for your help, and I hope this will stay with me for the rest of my life!

I found the program under the capable hands of Ann Osborne to be very interesting and thought provoking.

Due to her ability to bring out ideas and questions it was easier for me to express my inner thoughts and feelings which is usually difficult for me to do.

I can use this information to understand myself and problems in a better way and find the “inner peace” within me. I am trying to take the time for me to do so.

I felt uplifted and inspired after my sessions.

First, I found you were very, very good, Ann. I understand better now what Inner Counselor means but still struggle with connecting things, and sometimes still don’t understand why we have to do this. I’ve been thinking a lot about our two sessions, Ann, and you are very, very good, but sometimes I like an opinion whether I agree or not I
still like to know what you think. I know there is no right or wrong, but just like to hear
what you feel or think about a concern or feeling I have.

I guess I like to listen to you rather than go into deep thought. Thanks again for your
great input. Ann, look after yourself. You are working very, very hard. God Bless.

Thank you for including me in this thesis project — it was an exciting experience.
It would be interesting to know what you gleaned from the 5 questionnaires.

The Interviews were very professional, friendly and informative. I think most of us
know we have the ability to resolve our major or minor issues but not always “how to.”

Now we have a greater awareness of this Inner Counselor to work with or seek a
facilitator to work through the process. Thanks, Ann.

I think the first session went very deeply into my subconscious — not as a miracle
cure, but as a “lover” newly present, countering the old thinking with better, grounded,
hopeful reality. Example: Hour after hour packing, then lugging boxes upstairs, I found
myself whisper-whistling an old love song “-and after all is said and done, to think that
I’m the lucky one; I can’t believe that you’re in love with me!” At 70 — THAT is fresh
thinking/feeling! And it is feeling that’s shifting, because, as the song says, I don’t yet
quite believe this true event.

I suspect the second session was premature because need to digest first session before
can use no. 2. It’s not lost, it’s being held like knowledge — in memory: “understand”
retroactively, like children do.

That said, it is possible that this whole move has been like laying an egg is for a
chicken — consuming, straining, Sacred Event, now to sit back down on and not only be
still & occupied here, but gestating, incubating this new phase of creativity. An exquisite thought.

[The wisdom I accessed] is still richly giving — beauty in its detail still revealing as I create a new home….

Thank you for requesting me to write again to you. The move — which is in time, has integrated more into the out of time qualities of creativity which I’ve been seeking. Of course, it can be painful to transit from one world of consciousness to a material level world — and transformative, bringing the energy along….

Back to work now — I have a deadline looming. (with a renewed heart!)

This project has made me more aware of my own mood changes.

I feel the process is well named — Inner Counselor for wellbeing.

I found the process non-threatening and helpful, for it helped me to remember and re-affirm values that are mine and served me well in the past but got a bit blurred as I face new problems and circumstances.

I am left with renewed purpose and greater self-worth.

It seems to me that the form or technique is fairly uncomplicated and could be learned by members of any helping profession (who are good listeners and reflectors) and could help folk who avoid psychological help. The person who leads the reflection must create an atmosphere of trust — which Anne did!

Now I will listen for my Inner Counselor!

Well — The new symbol has brought new insights — my world is larger than I thought.
Abilities — speak and act more effectively in meetings and discussions.

I’ve loved geometry since 2⁰ form high school, and as an adult could never find anything that grabbed me in Sacred Geometry — a source of information has come to me recently — my world has enlarged.

Also, I’ve had some health problems, T.I.A. transitory ischemic attack — no damage.

I can check out of my blah blah blah thinking into more clarity than I’m used to — I’ve always been pretty clear in action and response and not so clear in thought — takes energy.

This is eno’ to give you an idea of a major change.

The Inner Counselor Experience showed me how to relax and look for something in the past that could relate to the current problem to help get the answer. To be vigilant and watch for any changes in the situation.

I am trying to use the techniques I learned e.g. going to my quiet place where I feel at peace and secure, saying to myself that I am an okay person and feeling good about that.

Also, to be able to talk about my worries for my [adult child’s] health and happiness … to let [this child] know that I am there for [them] no matter what… I have continued to tell [this child] all through the rough times that I would never stop loving [them], but I did not have to like what [this child] did….

It was a good experience for me; a very deep soul searching I might say as to who I am and that I am trying to be me (that okay person) who isn’t 100% at everything.

Thanks, Ann for the experience.

I must say I did not know when asked if I wanted to do this, but thought why not. So, for me, I feel that with all the help I received …over the years I was able to say “yes” and
not be afraid of the process.

Thanks again and all best wishes go to you in your work.

I have enjoyed the time I spent working with you. I wish I had finished this when I was meant to. A lot has happened in the last couple of weeks. My granddaughter has been diagnosed with cancer …so I’m afraid that’s where my head is, but I will try. I have my written notes which help me recall my processes. You are very easy to talk to. One day, we were dealing with [an issue.] I have to say I still [do that some.] But my new symbol … [offers me a way to start] and at the [end] is blue sky and freedom. I would like that blue sky and freedom. I had really [noticed a change in my behaviour.] It is really quite amazing that simple act [makes such a difference.] I thank you for that. That’s one step [forward] for me!

I felt lighter after my processes. I could use that lightness during this [difficult time.]

Thanks, Anne.

Thanks for giving me a chance to have the experience of the Inner Counselor. I have gained confidence in choosing to do what is best for me. I will let you know of the outcome of my [issue] in the near future.

I am cool, calm, and collected.

I was delighted to learn of this technique — would support my role as a spiritual director as well as my own experience.

A new way to look at the pain each of us carry without revisiting too deeply the trauma. A good tool for inner child work — leaving one with peace and security.

I find it very comforting to go to the “quiet place” where you can work through your problems or feelings.
Seniors are also prone to many of the mental health issues which also affect younger people.

I learned that you cannot solve all problems involving your family or friends, but your friendship & support may help to ease their problems.

I enjoyed the process very much. After I left, I felt relaxed, yet exhilarated. It was also a learning process to carry over to everyday happenings. I have found a new approach to use in dealing with problems that seem mountainous but really aren’t.

Thank you for this opportunity.

My experience with the Inner Counselor has given me a useful tool to use when life seems to become somewhat tedious. It’s not a panacea, but an additional way of achieving peace of mind. Thank you for your time.

I hope your draft is taking shape and will be done for completion date.

I found the work that I did with Rev. Ann Osborne very rewarding.

It was extremely useful for me to find a way to draw on help in making decisions, being able to take steps for making changes and knowing when to leave problems alone.

The work gave me much peace and I certainly continue to draw on this help from my “Inner Counselor.”

Thank you, Rev. Osborne, for working with me. May you continue to follow your heart and pursue your goals that have meaning for you.

A good learning experience.

It helped me realize the importance of listening to our inner being.

Over the years, I believe, I have used these “tools”. However, the two sessions opened more doors to me, emphasizing the power from within a person can experience.
Thank you for your time Ann, and God Bless.

Sorry to be so long with this

In the week following my first helpful meeting with you, I realized that I have had an “inner counselor” for many years. For me, it has been my faith in God. I find that a short chat relieves my anxiety & “lifts the bad.”

The process is great! Thank you for guiding me through it. I find I am using the process often and it is very helpful!

I found the experience very uplifting. It was not intrusive and it helped me solve a lot of life’s little problems and to understand the messages we receive throughout life. Thank you for letting me be a part of this experience.

I now notice that I am not bothered or upset by a number of things that upset me before, as I worked through why they happen. Thank you, Ann

During my second session I came away with a great feeling of peace — I felt during the session that someone had wrapped their arms around my shoulders and it was so comforting — I still have that feeling whatever it is I’m hoping that it never leaves.

- the experience was amazing I’m glad I had the opportunity to help with this research — I learned so much from it! Thank-you

- I enjoyed this process very much

- it allowed or gave me an opportunity to deal with/discuss an ongoing hurtful event in my life and made me come to a conclusion that perhaps I’ve done all I can to ease the
situation and that somewhere in the future things might turn around. The weight is lifted!

THANK YOU SO MUCH!!

I feel so privileged to be a part of this study.

I have more or less realized that if I decide to do something and if I weigh the situation and if it feels right discuss it with my husband so he knows what I’m considering. In this instance we will go ahead with getting help [in the area discussed] but try and get references if possible or seek someone who is carrying some proof of good service.

Coming to realize other people have help and I am as worthy of that help as some folk I already know.

Being to independent perhaps robs oneself of time we could be doing something we enjoy or is a luxury.

Being a little more determined to get help would be another asset to my well-being.

Also try to have more confidence in other people.

I realize now why one needs time alone to think and just plain relax.

My health is not great but I feel if I take it easy and meditate regularly I do feel it helps.

I am not a loner, feel the need of sincere, one-on-one company which my husband and I share and find we have the same deep feelings about many things.

Just listening to nature in a quiet place is excellent therapy.

As always, visiting someone who is less fortunate than myself makes me realize how fortunate I am.

Also I must be careful not to be impatient with others who are more ambitious than I
I am very thankful to have been a part of this Inner Counselor Study.

At the time with Rev Osborne I didn’t like being pushed for answers. I prefer guided meditations. I feel a little better about the Inner Counselor. I still do not like to be prodded into answering.

Thank you for guiding me.

Good luck with your research.

Directions to spend time on this would help.

Have not spent time because of other commitments.

Bill Tiller sent info on Dr. Norm Shealy, your principal at Holos U. His material on Alzheimer’s is much like what I received from the Dr. in UCLA — Interesting!!!!

I’m sorry I couldn’t get more into this.

The hot weather will bother me sometimes. When this happens, I will take my blood pressure at home. When the blood pressure is normal, I lay down for about 20 minutes and that seems to adjust my feelings of felling slightly dizzy. A little rest always makes me feel much better and more relaxed.

Many thanks for giving me a chance to be involved in your research study. I learned to see my own needs and search my past, and become aware how I can move past any obstacles to true happiness. I thank the Lord for your guidance and insight. Take care, Ann, and success in your endeavours.

I noticed about an hour after our session with the counselor that my head felt much clearer and lighter. It was a good thing that I went straight home and was able to be quiet and observe this. Otherwise I’m sure I may not have noticed.
Ann, my counselor, had a very relaxed approach to drawing out the past life information from me.

It was very interesting and relaxing visit for me. Not knowing for sure where all this information is going to lead to. Good luck.

I enjoyed the experience for the most part. I am now able to “go” in my mind’s eye, to a place of peace and comfort, and that is a very helpful strategy when I am feeling stressed — great to know that I can always escape, if only for a few minutes.

The “still, small voice within” is always there, and I know that it is always worth listening to. I am confident that my “Inner Counselor” will never misguide me.

When I first heard of this study I thought it would be interesting. As I got into it, I wondered can I do this, but seniors have personal problems just like younger people. It gave me a chance to work out my problems which seemed to help. It gave me more confidence as to the way I was leading my life. It felt to me like I was doing the right thing.

I never realized how lucky I was to have [Dad] as my father. Strict, but never unkind. Always understanding and supportive. Always a watchful eye for pitfalls a teenage girl might fall into. This is not to say that my Mom wasn’t always there for me, too, but she was much more critical, but maybe, no I am sure, that was very much needed at times.

Another thing that stands out in my memories that you brought forth was how sometimes the simplest kind acknowledgement of an accomplishment or deed is so rewarding. Several instances stand out in my memory and I have resolved to try and show my appreciation more often in the future. So thank you, Ann for your love and acceptance of all us over 80s. We do appreciate it.
P.S. I love [my New Symbol!]

Very calm.

Feeling free from past concerns.

Helped me to get in touch with my feelings and worries and come to realize and remember that God is with us always and to ask for his help in making decisions. In time of troubles feel his love.

More confident.

More able to express love.

Sorry I have taken so long to write to you. As you know I was very busy with my walk for [a charitable cause]…. Yes, I did cross the finish line. It was an incredible journey!

I am glad that I met you and had the experience of the Inner Counselor. My biggest problem was with [a person] who will never change, but now I can tolerate her. Perhaps we tolerate each other. But I have a very positive outlook on life that will always carry me through the negativity of people like [her]. I find it sad, but now choose not to dwell on it. Life is too precious!

Thank you again for this insight and your compassion. It was a pleasure to meet you.

Hope all is well with you and good luck to you in all your endeavours.

My Inner Counselor enabled me to more clearly understand my complicated family situation and gave me strength to look at the options available and carry them out.

… Solutions became clear how I could take control and not be taken advantage of.

Also, [my learning] re my marriage for 39 years to an alcoholic and his put-downs was enlightening.

I could say things to [Ann] that I could never say to friends.
Thank you Ann Osborne, so very much.

It made me realize how many things are cluttering up my life, and that I need to sell, toss, or give many things away. It brought to the surface resources within me that I had forgotten I even had. I allow myself to be ruled by circumstances when what I really need to do is think and realize it’s up to me to order my time.

I am promising myself to clear out other people’s property from my home, and would appreciate you sending me a note to ask if this has happened, perhaps about the end of March 2007. This may sound strange, but it would help to keep me on track. I will try to go ahead with this project even though I don’t know if I will hear from you.

Pertaining to the inner counselor sessions, I found it a bit unsettling when I shared my [Old Symbol] and tried to see how he wanted to help me.

It was also unsettling the next week when I imagined my [Old Symbol] which I believe goes about like a roaring lion seeing whom he can destroy. I believe that [Old Symbol] is a liar and deceiver who would never want to do anything good for anyone. My strength is in knowing Jesus has all the power and through Him I can conquer my shortcomings and fears.

Not sure if any of this ties in with Inner Counselor work as you know it. Hope it is of some help in your study.
G.3 Excerpts of Vocally Reported Anecdotal Information

This information comes from what participants said to the PI after their experiences of their Inner Counselor Process©. The PI made notes in participants’ files after they had left, recording what they had told her.

- I’ve had this struggle all of my life. I feel different — better — now. I’ve always had [this place] as my Place of Peace, but didn’t know that that was what it was. I’m glad to have suggestions for personal notes; when I was told to journal another time I didn’t know where to start.
- This past week, I’ve been more present in the moment. I’ve used my Place of Peace for calm.
- I am very relaxed — if I had gone to sleep, how long would you have left me? I have been [a counsellor] so wanted to experience this from the other side of the situation and learn what that was like!
- When you come to your own solutions, that is best! I see an important place for this in working on the emotional/spiritual aspects of problems.
- I feel like I could have dozed off — very relaxed.
- I am surprised how emotional I get as I do these processes!
- I’m sleeping better, and I often have had trouble getting off to sleep, but now I just go to my Place of Peace, relax, and go to sleep. I feel much better.
• I can really feel the energy in the last part. I can feel the energy of the earth coming up into me — it is strong. I like the golden light part. I can feel it moving through my body.

• Are you only doing this with seniors because younger people would not be willing to look honestly at themselves? [Participant admitted that 20 years ago, would not have been willing, either.]

• What a wonderful peaceful feeling! I want it to stay with me always!

• I realize that my anger, like my [Old Symbol], was eating me up from the inside. I can see many places where it was operating. I feel so much calmer now.

• I always thought my [sensations] were physical — maybe a digestive problem or a vitamin deficiency. But they are gone now, so my head tells me that they were emotional, or they wouldn’t go away that fast. Interesting that I knew that in my “inner wise self,” but not in my mind.

• I always thought I would have been a better person if [I had not experienced the early difficulties]. Now I see that I am a good person, I just need to deal with the emotional stuff. I actually have strengths and capabilities that came from the fact of [those difficulties], and if I work with the emotions, I’ll only enhance that. What a relief of a heavy issue! I can use this process to look at lots of things — and will!

• It is not everyone “out there” who is at fault. It was just easier to get mad at [outside things] than to deal with emotions. I think somewhere I knew that, but couldn’t act on it.

• I feel so good! I feel so relaxed!
I have never experienced anything like this before, and find it very helpful. I didn’t know you could work with emotions like this. I have not felt this calm and relaxed in many years.

This process may just be a way of focusing your thoughts about a problem. I do feel relaxed and peaceful.

I might have eventually come up with the same advice on my own, if I had thought about it. This just speeded the process along.

I am less afraid of my problems now, more comfortable with myself. I learned helpful approaches to my problems.

I slept better last week than I have in ages. The mind is a strange and wonderful thing! I feel relaxed, a bit tired, but calm.

I think of Inner Counselor as a form of prayer — and may have been using something like it without calling it IC for a long time! I like that this is available to people! I feel peaceful and grounded.

This could be an excellent tool for people in times of decisions or concerns. I would use it again!

This was new to me; I learned things. I am reminded that I do have a choice. I feel better — more relaxed and calm.

I liked that I learned a new approach to solving problems. I feel relaxed and easy. I don’t have any really pressing issues right now, but if I did, I would like to use this process. I think I may have done something similar on my own, in a way. This made it very clear.
❖ I was surprised at the conclusions I came to after my first process. I thought I was doing that, but in reality, I wasn’t! This was very helpful for me to see myself more clearly.

❖ I enjoyed experiencing this process. I have had experience with self-hypnosis and find this to be similar, so it brought that back to me.

❖ I now see a new approach to something that has been bothering me. My old approach wasn’t working, so this feels hopeful! I feel good — relaxed, calm, settled.

❖ I’ve had a great week! I could see that my reactions changed as a result of the IC Process®, and I feel much better about myself. I have felt weighed down by [this issue] for years, but now feel confident that change has taken place, and have even had a chance to prove it to myself!

❖ If I have more [issues like this], can I call you?

❖ I am amazed — this came from me! I know my New Symbols and Guide gave me advice, but they were just symbols — this came from me! I have so many places in my life where I could use this process!

❖ This is an amazing process! I’ve thought so much about it this week, and come to even more realizations. I had a big success this week — a direct change as a result of what I worked on in my process. It feels so good! I feel less tense and anxious, more relaxed.

❖ I feel relaxed, but don’t notice other changes.
I was expecting great things from the last part [Energy Exercise]. I thought I should feel charged up or something, but instead I just feel relaxed and peaceful. Not sure how I feel overall — I’ll see.

I feel great! I could feel the golden light energy moving through me, just like when I used to do t’ai chi and feel it.

My current decision was made clear to me as the light moved — I know this has changed.

Thank you for the journey.

I feel like I could just get up and walk; as though [my disease] does not have the power it did.

I feel empowered!

Last week was excellent! I was able to [use what I learned] easily. I told my friends and my daughter about my experience; I think others could benefit from this process, too! I feel so good, for two reasons: because I am different and react differently, and because I feel that I am a better person now.

This is the first time in my life that I’ve been able to connect with my birth mother. It feels very good. It changes how I feel about myself; knowing that she loves me, I love myself.

I feel the calmness and the peace. I’m not sure I ever really felt it before; I just knew it in my head.

I am amazed at how fast the changes happen. They are just there!

This has been a very wonderful experience! Can I call you if I need to work on something else?
I feel good, and I’ll feel even better when I’ve used what I now know to deal with [the situation]! Mostly just feel relaxed right now.

I addressed [the situation] and it went well. I felt better after! I can think of many times in the past several months when I could have benefited from this process, probably more than at the current time.

This is very new to me. I don’t have many problems right now — maybe I’m not a good person for your study. But I am open to learning and having new experiences.

The [situation I worked on last week] went well; I changed my approach as a result of my process, and got good results! What I learned from within helped. Accessing this inner wisdom is like praying and getting an answer right away! I feel so peaceful, especially in my place of peace, where I can go any time I want.

I feel relaxed and quiet. I can see lots of places in my life where IC could be useful, and places that would be helpful for my wife, as well. I really like the process, and value that the wisdom comes from self. I like what I learned. In the past, I have done something similar, internally.

I feel calm and relaxed. This reaffirmed what I already knew. I feel less worried that [my situation] won’t go well. It would be very helpful in a time when I had a major problem.

This has value in a decision-making process because it incorporates both the thinking and the emotional aspects of a person. It leaves me feeling settled and peaceable.
I feel “aglow,” peaceful and calm. I don’t want to make notes after; I want to stay in the feeling.

My last week has been the best in memory! I reacted very differently [in my difficult situation] and got a whole new response! I felt wonderful!

I like this because it is not religious; the information comes from inside me. I have never heard anyone talk about things like this before, and I have learned a great deal from this. Can you use this with people of all religions and faiths?

I enjoyed this process. I’m glad it was suggested to me. I might have come to the same conclusions on my own, but I came to them sooner and with more clarity this way.

This process is illuminating — not earth-shattering — but very helpful.

[Laughing] I asked a beloved minister a question once, and in his own words, he said, “Go and ask your Inner Self!” I think I’ve done that!

I feel relaxed, calmer, and less anxious. The bigger picture makes all the difference! I can’t control [what I was worried about], but I can feel OK about it even so. My worrying doesn’t help anyone or anything, so I won’t! Can I send my friend to you?

I liked last week’s process — I have felt calmer and less distressed by [events]. I have a better perspective, things don’t “get to me” or “bug me” as easily.

This process is different, but good! Using what I learned today could make a big change in my life. I now have a much better idea of how to do [what I have wanted to do] for quite a long time!

I think I needed this! I must have!
I did move ahead with [my project], but then got stuck again. I can think of several people who could benefit from this process.

The last part [Energy Exercise] feels wonderful! Did we do that last week as well? It feels stronger this time.

I feel good, relaxed, as if I have had an eight-hour sleep!

I feel very peaceful, which is a nice contrast to the frustration and shame I felt when I first got here. I remembered the process on a night when I was having trouble sleeping, and went off to sleep. I’m particularly glad I learned about the Place of Peace.

I feel happy, even though I cried! I feel settled, more sure of myself, less adrift, and a little tired.

I had a much calmer week. I [followed through on the advice I got] and did it in a good way, but said what I needed to say!

I know much more about my feelings now and the process I am going through in my life. I have begun the grieving process, [and] I am not going crazy. Imagine that I had this within me all along!

I don’t have big difficulties right now, so I may not be too helpful to you. I am always interested in learning, and learning about this process was interesting!

I was so relaxed, I was “drifting” at times — your voice brought me back to the process.

[Before the first IC Process©] I need to know that this is not one of those weird cult things. In this day and age, you can’t be too careful, you know.
I feel startled by the depth of wisdom I accessed. I am deeply touched. I am fascinated by the process and what I learned; [I’m] sleeping better, getting off to sleep easier. I feel like I am in control of me, instead of letting my reactions control me — that’s personal power!

Is this like Transcendental Meditation? I’ve tried that, but like this better because I am in control of what is happening. Because I am in control, I am more willing to relax and get into the process. With TM, I felt that they were trying to get me to give up control, so I felt the need to retain control even more!

IC Processes© are very relaxing, which is a good thing for someone [who is] highly organized and a “doer” [like me]. I sometimes forget the value of relaxation.

It was hard for me to get in contact with my Spiritual Self; that part of me just does not want to show up! I’m glad it eventually did.

This time, it was easy to get in contact with my Spiritual Self — I like that! I had a much calmer week. I can think of several friends who could benefit from this! This is a pleasant way to learn things about yourself and feel better.

I’ll remember it when I need it again and use it.

I feel relaxed. I could go to sleep.

I thought that I might not have issues to deal with, but when I finally admitted to myself that I did, I came up with many positive suggestions for ways to deal with it — I have choices! That feels good!

I have some experience with guided imagery. I have used it to go to sleep, and will use this process and the Place of Peace to help me as well.
This process is very valuable. I did sleep better! My whole week was better — calmer and not so tense. I did what I learned last week, and everything went better. I want to explore my intuition and my spirituality more! It is amazing what we have within us. I would like to have a chance to do more IC Processes®.

I have thought a lot about what I learned from my process. I am fascinated that the feelings took me where they did — feelings were the same for very different reasons. No wonder you call it inner wisdom. [My issue] is no longer a concern to me.

This is a wonderful process! I would love to do several more! I loved the last part [Energy Exercise]. I feel calm, even through all my tears!

I have experienced an episode of severe anxiety and depression in my life. This would have been so helpful had I known about it at that time!

This process is so good. I felt better (less stressed) and coped better this week. Maybe that is partly because I also slept better this week! I thought of my process often, and my [New Symbol] was very much there for me. I didn’t know that could happen, before! [My problem] is solved.

I don’t meditate well, or follow guided meditations well, but I do pray well. I have a prayer life that is very comforting to me.

I feel peaceful now, even though I can’t change the situation.

Although it wouldn’t be my first approach, it is good to know that IC is available as a tool to use in gaining clarity and inner wisdom.
The Integration Chart© acknowledges our emotions and where we go with them, and also shows us that we have choices to make a difference. I find it very helpful. I am able to use the advice immediately and feel confident in my actions.

After my last process, I felt calm and knew I could do this thing that had seemed too huge! This process focuses my spirit so that instead of accessing a range of information, I access wisdom about the specific issue I am addressing.

I feel good — not as anxious as I was before — more certain. I realize that I need to take some steps toward creating change, and that hiding in my [Old Symbol] will not create the change I want and need!

I would not have believed that I could feel this differently in this short a time! I feel lighter, as if a heavy weight had suddenly been lifted from my shoulders. And moreover, that I could find the answers within myself!

I noticed such a change last week! I [did what I needed to do for me] and did not feel guilty! I am in awe of this process — I am confident that it has helped me [with my issue]. I can do this! If I have other things that bother me, I would like to call you!

I feel very peaceful and very supported. I am glad to have been in this study!

I feel relaxed. I didn’t know what to expect, but I learned a lot.

This is not what I thought it would be — it is better!

This has given me great joy! I feel happy and peaceful and have great anticipation of good things! I also feel a little tired, so will go home and rest. I have always been a spiritual person, but this process adds to that!
- I am very excited! This has made a difference in my life in an area where nothing else has been able to do that. I can see how much [my issue] has been affecting my life, and in so many ways. I am glad I did my second process on the same topic as the first, because I feel so very confident about it now!

- I have a very large issue that I would like to address with this process, once your studies are done.

- I feel comforted.

- I feel relaxed and happy, and also stronger.

- Things are working out well. I’m not sure how much of it is due to IC and how much to other things, but I’m glad they’re working together. I realized that [when] I remembered an unpleasant incident, there were positive aspects to it that I had been unable to see before.

- I feel relaxed. I am fascinated — I got a “personal barometer” for choosing that feels just right for me; choices I make this way will be right! I feel happy.

- I’ve taken lots of courses and learned a lot about [my issue], but I never felt better before now! Who knew that this was all it took to find what I knew inside! I feel lighter, less burdened. I am a bit exhausted, but at the same time energized!

- I had a great week! I was happier, calmer, better able to cope. I noticed lots of changes. I know what I can’t control, and didn’t spend my energy trying to!

- I feel light, radiant — I get it! I can see my mistakes as just lessons that needed to be learned. I am not the person I used to be. I can make the same choices if I want, but for different reasons. I may need to do this many more times for other issues!
I feel wonderful, peaceful, hopeful. I know I can’t change others, but I feel better. I believe I can overcome this.

After my last process, I realized that I have not expressed my needs and feelings well. Now I am able to speak up and do it compassionately and kindly.

Who knew that I had all that wisdom inside of me? We are not taught that we have it or can accept it. People should learn this at an earlier age! It has brought healing into my life. I like this process! It is very helpful!

I feel a little silly for crying, but mostly I feel calm.

I noticed a big change this week. I feel more relaxed, less pressured, more able to cope, less onerously responsible. I am surprised at what a difference it made. I always suspected I should have seen a counselor years ago, but I did not. I am glad to have a chance to deal with this now and get rid of the heavy feelings!

I feel good — relaxed and happy.

I feel empowered! I noticed that [the situation I addressed in my process] no longer had power in my life; I could think about it and not get upset. So my inner wisdom was right!

I realize the power of changing my response. I don’t have to feel obliged to do things; I can check inside myself and make positive choices. I have choice and freedom!

I feel elated! I have a sense that I will get more pieces to this over time. I want to journal my experience. This feels rich in meaning. I love the idea that my new symbol is loyal — that has great meaning for me. I have carried this issue since
childhood, and knew parts of it, but had not accessed the inner knowing. I have released it now.

- An incredible, empowering process! I gained deep, deep insights, rich with meaning.
- Before experiencing the process, I felt some trepidation, but [afterward] I feel relaxed, meditative. It was not difficult or scary!
- I now have a way to know for myself. I feel inner joy! I feel relaxed and hopeful. Things can change!
- I have worked for years on [this issue] with not much success; this feels different. I trust what I learned, because it came from my wise inner self. I no longer feel at the mercy of [this issue]. I liked the “focus” of staying right with the issue that the process provides. If you have a place for a volunteer when you are all done, I’d be interested!
- I felt a little bit “down” the day after my first process, but it could also be other problems I was having, and all the noise outside my home, which I find hard to handle. I don’t know. After a day, I felt better.
- I feel good! That was quite the journey, quite the experience! I’ll think about it this week. I like the place of peace and working with the symbols. I have worked with them before, and feel good at it.
- This process is very helpful! When I experienced depression earlier in my life, they just filled me full of drugs. I didn’t like it. This process helps without drugs by accessing the wisdom within me.
I feel good — relaxed and confident. It is interesting to connect my feelings around [my daughter’s issue] with my feelings around my experience of [a similar issue].

For the first time, I feel unencumbered.

When I arrived, I was feeling depressed, like everything was too much, I was weighed down. After, I feel lighter, happier, so pleased! I was both the teacher and the student.

[Before process] I do not want to be hypnotized; I have had a bad experience with that. I have had childhood experiences that were very traumatic, and I do not want to re-live them. [After process] I feel calm This was comfortable, and I still got results and information! This is much better than other things I have tried.

I feel lighter, happier, “unburdened.” I can see the way ahead, now.

I feel calm, peaceful, lighter. It’s a good feeling! I am somewhat tired, so will go home and be nice to myself.

I thought a lot about my last process. I know that [my New Symbol] represents the qualities I needed, but the process makes those very real and personal to me. They make my inner wisdom visible to me!

I feel strong — no longer worried — this situation will go well. I no longer have the anger that was “hooking me” into poor responses.

After the process, I feel calm and relaxed. I believe in angels! My [Old Symbol] really represented my feeling of being burdened. I feel much lighter now.

This was wonderful, and I am glad I had a chance to participate. I learned so much.
I had heard that when you are worrying you can think of something else, but I could never do it. Now I can, using my Place of Peace.

I like that I can feel better, even if I can’t change the situation. I have more inner strength.

This definitely helped! I want to see it continue. Why didn’t I “get it” before? I’ve spent (wasted) so much time thinking about [that issue]? I feel so much calmer about it — they can’t get me ruffled now. I feel calm, sure, able to handle this.

I arrived feeling overwhelmed and angry and sad. After, I feel peaceful, relaxed, (maybe even a little tired), empowered. I can [do what I need to do], and do it well! I believe in myself more!

I didn’t know how hard I was on myself. It is a huge relief to understand that I don’t have to know it all; I just have to be willing to learn! That the inner wisdom is there for me if I will look for it! This was such a help!

At first, before I did the Inner Counselor, I felt very unsure about it. But this is very interesting; I’ll want to think about it more. I feel good — I have a way to approach this now. It affirms that I am approaching [this issue] in a positive and helpful way.

I am excited by the process. I feel calmer, more relaxed. I am using what I learned from the process to help myself.

I feel quiet inside, and glowing outside. I am much more confident — I’ll know!

I’d like to be able to use this process for some of my other concerns. Can we do that at another time?
I feel confident, hopeful, relaxed. I somehow knew that I had inner wisdom, but the process reinforced that for me. I sort of learned what I already knew! My ability to work with my spirit has grown.

This process is great. I can see lots of uses for it for myself and for others.

I feel relaxed, at ease with myself.

I see the benefit of IC: you get direct information from your wise self, and the answers come soon — even if they are not necessarily what you would expect! That feels to me like true spiritual growth. It feels real to me, not imposed or textbook information. I can see lots of uses of the IC Process®, and can think of many people I would recommend it to. Would you come and speak to our women’s group about this?

I am looking forward to the next session and doing this again. I feel supported and relaxed at the same time.

When I was going home after my first session, I was very aware of my [New Symbol] with me (sort of like having my inner wisdom on the outside!), and felt it several times during the week. I felt empowered — I could do anything, but I didn’t have to!

Nothing outside of me has changed: all the same people and issues are still there, but I feel different inside — it no longer “gets to me” and I know I can cope.

I have thought a lot about my first process, and [made several important connections]. I learned so much! I need not to lose myself! If I had known this earlier, maybe I could have avoided [difficult situations]! It is so helpful when
the wisdom comes from inside, because you know it can be trusted! This was very helpful to me at this time.

- This was draining, but good!

- It’s so amazing that we can do this! Last week I felt drained, and went home and had a sleep. This week I feel energized! The inner advice I got was very wise; it will make a difference in my life! I want to use this process again when the need arises.

- You and this process are a blessing, a gift.

- I really enjoyed the process. I felt lighter, like relief or release. Even though I don’t dwell on what happened in my past, it is good to have released it. I now have a sure idea of what to do — and I am worth it!

- I may want to look at the same issue next week, and get more pieces. It is like artwork: each class you learn more — one week brush strokes, one week colour, one week composition — they all help you to put it together.

- Hard to go to places you do not want to go, even though I did not say so. After, I felt “like an angel,” very relaxed and light. I didn’t think I saw any effects of the Inner Counselor, but then I realized I have begun to follow the wisdom that I received last week.

- Why do we not learn to do this when we are younger? Younger would be better! I’ve thought a lot about [my Old Symbol] and how much energy I’ve expended trying to “keep ahead” of it. That problem is solved now.

- Does this process work differently with people of different nationalities? Perhaps it might be affected by how you think and how you were raised?
Life is different now — easier, lighter. I like myself better. I did my best [in the past] and that was good enough; I learned that. I am back in touch with the Spirit within, reconnected. I feel happy, calm.

I feel very good afterwards. Will the [golden] light go out, or will it be with me always? I am looking forward to next week.

My head was much clearer and calmer after last week. I felt calm, more relaxed. I feel like the problem is gone.

I feel confident, able to handle it!

I have carried this burden for a very long time. I knew it in my head, but was unable to change it. It is different when you know something in your head than when you also add in the feelings and sensations. The burden has been lifted.

What is the basis of IC? Knowing that Holos is in the middle of the Bible Belt, how “hokey” is this? I am always cautious. I felt good after my process — valued — can see lots of places where this will change my life. This past week, I have still been aware of [some of my emotions], but they have been more controlled and managed.

I have thought often about my IC Process©. It’s quite a feeling! I feel relaxed, calm. I think I’ll feel better now, not so despairing. I have a sense of life moving on.

That was quite the journey! Sometimes it is the “little things” that give us the most grief and, evidently, can hold the most wisdom for us.

I feel more peaceful. I have a way to approach this worry that will work for me and [the other person].
I feel so peaceful! Relieved! A burden has been lifted. I learned a great deal. I also got good advice. I can see how to act on it right away.

I felt calmer this week, even in situations with [a difficult person]. I have a different perspective after having accessed my inner wisdom. [The difficult person] is not as able to upset me. I learned and now see how [this difficult person] is treating me in the same way that [a relative] did when I was young — and I responded with the same helplessness. I’ll respond differently now, because I see [the difficult person] in a different light. She is not able to upset me anymore. I’ve taken back my power.

I felt nervous about coming, but some of the people I know who have been here said it would be OK. I don’t know if I can do this. I really don’t like myself very well. [After process] I feel like I am glowing! I am relaxed! I feel excited — I could feel the light moving through my body. I feel amazing, confident, happy. I want to use the “light exercise” every day. I’ll give myself that time. I like myself!

My whole life has changed after I found my inner wisdom. I haven’t felt this good as long as I can remember. [The difficult people] in my life treated me well this week. I feel happy, contented. I bought some new clothes and shined my jewelry so that I look as good as I feel.

I have been looking after my whole extended family for way too long. I now value myself; I can choose to have some time for me, and deserve to be treated well! My inner spirit is right! I feel calm when I think about that now, and I used to feel upset.
I feel confident and know I have value! I have made many new decisions this week from what I learned last week, and told the people that they affect. It will be good for them to look after themselves! I did not feel mean; I deserve to have a good life and to do what is good for me. I can see so many more possibilities now. I feel less weighed down and burdened, more peaceful. This process changed my life — it gave my life back to me!

This has been so hard for so long, and now I finally have some peace with it. I wasn’t sure I ever would.

I didn’t know if I would come back for a second session if I didn’t like the first one, but now I definitely want to come back!

Last week was a good week; I did not feel “not good enough.” I am not so quick to assume that if someone questions me that it is because they think I’m not good enough — maybe it’s because they know I know lots and they want to learn! I had heard about finding your inner wisdom, but never been able to do it reliably before.

[After second process] I feel calm, relaxed. I don’t want to open my eyes; I want to hold on to this feeling. Doing the first process made me feel safe and good about myself, so then I could look at the issue I did today.