24th INTERNATIONAL CONFERENCE

Association for Music & Imagery

June 14 - 17, 2017

Held at Concordia University Grey Nuns Residence
1190, Guy Street, MONTRÉAL, QC. CANADA

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RESEARCH SYMPOSIUM PROCEEDINGS

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PREFACE

On Saturday morning June 17th, 2017, a 3-hour long research symposium took place as part of the 24th International Association for Music & Imagery (AMI) conference. The overarching purpose of this event was to inform attendees about recent and/or new Guided Imagery and Music (GIM) studies, to identify gaps in knowledge, and to discuss potential future directions for GIM research. One of the pioneers of GIM, Marilyn Clark, opened the symposium by providing historical context that outlined how Helen Bonny’s participation (as a music therapy researcher) in psychedelic research that took place between 1968 and 1973 at the Maryland Psychiatric Research Center was highly influential in the development of the Bonny Method of GIM. She then presented an overview of psilocybin-assisted psychotherapy research and explained how GIM practitioners are well suited to be involved in the implementation of this treatment approach. This was followed by five 15-minute presentations where GIM researchers (Annie Heiderscheit, Andrea McGraw Hunt, Kathleen Murphy, Evangelia Papanikolau, and Laurel Young) highlighted key points of their work. These researchers, along with special guests Carolyn Arnason and Bryan Muller (who had presented on their own individual research projects earlier on in the conference), then participated in an interactive panel discussion where they, along with audience members, shared perspectives on the current state of research in GIM and discussed how the future of GIM research needs to unfold and why. Although it is beyond the scope of these proceedings to present all details of that discussion, one could say that there seemed to be general consensus on a need for research that: (a) demonstrates and communicates (using accessible language) the value/benefits of GIM to multiple types of stakeholders without compromising the integrity and/or essence of the method, (b) has relevance for various approaches to practice (including modifications), and (c) utilizes the methodology that best answers the research question(s) being asked (i.e., all methodologies are needed and/or valid).

All research symposium panel participants contributed to these proceedings. Their contributions include overviews of their own previously published research (sources for the complete publications are provided) as well as projects in the early stages of implementation. A range of methodologies is represented and each author decided how to organize her/his information within a flexible template that was provided. If one has further questions about a particular project, each author has indicated an address for correspondence.

This symposium along with research poster presentations and other conference happenings all seem to suggest that momentum for GIM research is building across the AMI community. As part of the preconference continuing education day, Editor of the AMI Journal Cathy McKinney, presented The Evolution of GIM as Seen Through the Research: Past, Present, and Future, a comprehensive overview which culminated in a lively interactive audience discussion on future research possibilities. In order to underscore their desire for biannual publication of the AMI Journal (which would require a significant increase in the current number of submissions), the AMI Leadership Circle announced a special, one-time, $1,000 research grant, funded by the Linda Keiser Mardis Fund. Given all of this positive energy, I for one am very much looking forward to hearing about how the latest GIM research developments have unfolded in 2019 at the 25th International AMI Conference being held in Vancouver, British Columbia, Canada. Hope to see you all there!

Laurel Young, Research Symposium Coordinator
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Through the Looking Glass: Psilocybin-Assisted Psychotherapy and the Bonny Method of Guided Imagery and Music

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The purpose of this presentation, given at the Research Symposium during the biennial meeting of the Association for Music and Imagery held in Montreal, Canada, June 17, 2017, was two-fold. The first was to illustrate how Helen Bonny’s participation as a music therapy researcher in psychedelic research taking place at the Maryland Psychiatric Research Center between 1968 and 1973 was highly influential in the development of the Bonny Method of Guided Imagery and Music. The second purpose was to bring into focus current research with psilocybin-assisted psychotherapy and the potential for GIM trained clinicians to participate professionally in the treatment modality proposed by current research.

Keywords: Helen Bonny; the Bonny Method of Guided Imagery and Music; psilocybin-assisted psychotherapy; research

Brief Overview of Psychedelic Research

The use of psychedelic substances has always been a part of the human story from indigenous and shamanic cultures to medical practices and recreational or private use. In the last century:

- mescaline, psilocybin have been synthesized and in use in medicine, psychiatry, psychotherapy, and privately;
- LSD in low dose (psycholytic) is used in psychotherapy in England and Germany.

Research into general medical applications yielded interest in:

- treatment of autism and childhood onset schizophrenia (ages 6-10);
- pain relievers and analgesics (cluster headaches and reduced pain in cancer patients);
- uses in psychiatry and psychotherapy for diagnosis and treatment of mental disorders including:
  - recovery from addictions;
  - existential conditions of life and death;
  - to facilitate trauma-recovery (e.g. Sessa, 2015).

Helen Bonny at the Maryland Psychiatric Research Center (MPRC)

Dr. Helen Bonny, musician, music therapist, and mystic, joined a creative and dynamic staff of researchers at MPRC in Catonsville, Maryland, USA, in 1968 with the understanding that she would organize and program recorded music to be used in the individual psychedelic sessions which were the heart of the psychedelic research underway at the time. She served as a co-therapist within the setting of individual sessions. While serving in these capacities, she was also granted permission to do a pilot study with a small number of persons with alcohol addiction using music only.
In 1972, an important article was published in Volume 9 of the *Journal of Music Therapy* (1972, pp. 64-87). Written by Helen L. Bonny and Walter N. Pahnke, “The Use of Music in Psychedelic (LSD) Psychotherapy” clearly delineates findings on how music enhanced the experience of the research volunteers and the milieu within which the sessions were held. The authors reported that music:

- enabled the volunteer to enter more fully into inner experience;
- facilitated release of intense emotionality;
- contributed toward a peak experience;
- provided continuity in an experience of timelessness;
- directed and structured the experience.

They described how the choosing of music for individual psychedelic sessions was a process of trial and error over many sessions. They gleaned information from all of the therapists as to what type of music worked well. In the consideration of choosing a volunteer’s personal preference for music over genres suggested by therapists, they concluded that personal preference is useful in the beginning and ending stages of the session, but in the high activity time, classical music was preferable. They employed a questionnaire entitled “Music Experience Questionnaire” (MEQ) in the preparatory stages with volunteers to assist in decisions about the music chosen for each volunteer.

The discreet phases of the psychedelic interaction were also a consideration in the type of music chosen. They used long-play records and reel-to-reel tapes in a 10 to 12 hour time frame changing the music as the experience of the volunteer indicated. The arc of the session included:

- pre-onset: during which the substance is being absorbed into the body;
- onset: when the substance is first felt with changes in sensorial perception;
- build to peak intensity: during which the intensity is increasing;
- peak intensity: the most intense point, or points, in the experience;
- re-entry: gradual diminishment of substance’s effect;
- return to normal consciousness.

Music was chosen to enhance and support the volunteer is they moved through these phases of the experience (Bonny & Pahnke, 1972).

**Psychedelic Therapist Qualities**

In the psychedelic sessions, the therapist intervenes when the volunteer’s response warrants it. At MPRC, it was important to have both male and female therapists in the room. The reasoning was both ethical and therapeutic:

- Ethics involved safety and privacy of volunteers whose behaviors might be outside of normal client-therapist relationships such as a volunteer’s urge to remove clothing, or dance.
- Therapeutic in that experiences of being a child might be furthered with the gentle holding of a parent for whom the therapist could be a stand-in.

Additional therapeutic qualities learned from psychedelic psychotherapy:
trust in the arc of the process: onset/peak/return;
appropriate use touch and without hesitation;
understanding and familiarity with alternative states of consciousness;
ability to join in experience of the volunteer without fear;
being sensitive to changes that necessitate a moment to moment response to a changing attitude and presentation;
being one’s authentic self while being able to accept behaviors, beliefs, experiences that are outside of one’s own experience;
understanding in the use of music in alternative states of consciousness (ASC).

Dr. Bonny’s Inquiry

Could music alone provide a meaningful ASC experience? Helen Bonny had observed that some volunteers had meaningful experiences listening to music in the preparatory stages of treatment well before the psychedelic was administered. She had also noticed that some persons became amnesic within the psychedelic session and essentially brought nothing back in their conscious memory. She had an unexpected opportunity to test the premise that a meaningful ASC experience with music could occur when she was asked to give support to the wife of a volunteer who felt anxious about her husband’s upcoming LSD experience. Dr. Bonny invited the woman to rest on the couch while she played music on the record player. The woman had a very meaningful experience listening to the beautiful music that was played.

Dr. Bonny then designed a small pilot study for persons hospitalized for alcohol addiction using classical music. While there were no remarkable outcomes from this study, it did give her the understanding that a relaxation exercise used to help relax the body and focus the mind was imperative before listening to music. Further exploration involved the imagery settings that Dr. Hanscarl Leuner, with whom she consulted, used in his Guided Affective Imagery process. He encouraged her to match music with the imagery. She used these settings and music pieces in further informal explorations with friends and colleagues (Bonny, 1998).

Similarities between Psychedelic Assisted Psychotherapy and Guided Imagery and Music

<table>
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<th>PAP</th>
<th>GIM</th>
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<tr>
<td>Preparation: screening and hours of individual therapy</td>
<td>Preliminary conversation: intake and prelude</td>
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<tr>
<td>Therapists/guides: male and female</td>
<td>Therapist/guide</td>
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<td>Relax and prepare:</td>
<td>Relaxation induction:</td>
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<tr>
<td>Ingest substance, recline, eyeshades, earphones</td>
<td>Recline, relax and focus</td>
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<td>Music to fit experience:</td>
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<td>Changing records</td>
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<td>Trust the process</td>
<td>Trust the process</td>
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<td>Closure, return, integration</td>
<td>Closure, return and integration</td>
</tr>
<tr>
<td>Follow-up to single session</td>
<td>Ongoing sessions until closure is agreed to</td>
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Dr. Bonny made her taped programs available for use by the staff at MPRC if they chose to use them. William Richards states, “I used them fairly often—especially her Positive Affect tapes, sometimes her Peak Experience tape, and on rare occasions her Comforting/Analytic tape. I also let my own intuition drive my selections” (W. Richards, personal communication, 2016).

Ending of Psychedelic Research

By the 1970’s, LSD was in wide use recreationally. Timothy Leary counselled everyone to “tune in, turn on, and drop out.” The “Bad Trip” became a favorite media story and fear about psychedelics spread throughout the United States. In 1966 LSD was banned in the U.S., but did remain in use. In 1977, the psychedelic research facility at MPRC closed. In spite of stories to the contrary, it had been proven that:

- When used with preparation and care with appropriate set and setting, outcomes were positive;
- Recreational use for persons with psychosis or difficult, unresolved issues is contraindicated;
- There is no credible evidence that links LSD as causal in relation to birth defects, psychosis, or cancer. (italics added; Sessa, 2015)

Current Developments in Psychedelic Research

In 1999, two researchers collaborated to launch a restart of the promising research that had ended amidst cultural and governmental paranoia. Working with high standards and strict oversight, Dr. Roland Griffiths and Dr. William Richards began researching the effects of psilocybin, known to be safer and to create an experience of shorter duration than LSD. Beginning with a double blind study comparing the effects of psilocybin and Ritalin, outcomes for those who had been given psilocybin were stunning:

- 1/3 rated their inner experiences as the most spiritually significant of their lives;
- 2/3 rated their experiences as among the five most important events of their lives;
- enduring positive outcomes were reported as long as fourteen months later.

Studies with relatively small numbers of volunteers have also been completed with persons with cancer, persons with nicotine addiction, long time meditators, religious leaders, and healthy adults. There are plans for studies for persons with anxiety and depression. The inquiry process moves slowly and carefully (Richards, 2015).

Considerations for the GIM Guide in the PAP Setting

The GIM teacher, trainer, student, and Fellow will find that the importance of music in this approach is obvious. Applying known ways of assessing music in receptive, passive settings such as GIM could be of great interest to the researchers who may not know about current bodies of information and practice especially in the field of music therapy. Furthermore, the creation of new playlists based on evidence coming from knowledge gained in individual GIM practice could be of interest.

The most obvious implication for persons trained in GIM, especially in the Bonny Method, is the ability to be a facilitative presence within the individual psilocybin session. The depth training involved in both receiving and giving GIM sessions is particularly unique and leads to these abilities:

- ability to trust the inner process;
- understanding of music as a prime, sustaining presence;
• an experiential understanding of alternative states of consciousness;
• intuitive presence.

Aspects unique to PAP that will stretch the GIM guide:

• Session protocol: The length of preparation time (8 hours at least), introduction of substance, length of single session (6 hours at least), presence of two guides, volunteer reclines with eyeshades and earphones.
• Alternative States of Consciousness: Generally more intense with psilocybin and often take a person beyond familiar egoic experiences. There are multitudes of possibilities of experience pushed by the action of the psilocybin on the neuro-biological being.
• Role of guide in PAP is to be the ground, give assurance, and provide support. Words must be used sparingly. The guide must be ready to respond to experiences that fall outside of a normal therapeutic setting.

Conclusion
While it may seem a surprise to some, the evidence of growing interest in psilocybin and other substances gleaned from the natural world to enable transcendent experiences is obvious. Research is blossoming through private funding. Conferences focused on psychedelic experiences and research are being held around the world. Current research is breaking through old prejudices and fears largely fuelled by out-dated conclusions as well as irresponsible use of powerful substances. The possibilities for use in treatment for various ailments, education and creative avenues, and in spiritual settings are exciting. For the practitioner with the appropriate training such as one receives in the Bonny Method of Guided Imagery and Music, there is opportunity to participate in these truly transformational processes. As with any powerful process, it is imperative to learn and understand the parameters and conditions that lead to success or failure.

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References
The Effects of the Bonny Method Of Guided Imagery and Music (GIM) on Sense Of Coherence, Interpersonal Problems, and Salivary Immunoglobulin A of Adults in Chemical Dependency Treatment

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The purpose of this study was to explore the effectiveness of the Bonny Method of Guided Imagery and Music (GIM) on aspects of coping skills related to interpersonal skills and immune function in 19 adults admitted to inpatient chemical dependency treatment for an average of about 40 days. Psychological measures included the Inventory of Interpersonal Problems Short Circumplex Form (IIP-SC) that includes eight subscales, the Sense of Coherence Scale (SOC) that includes three subscales, and the physiological measure included levels of salivary Immunoglobulin A (sIgA). All pre-test measures were administered during the initial interview and all post-tests measures just following the last GIM session. Participants in the experimental group received one GIM session each week during their treatment. Study results indicated a significant decrease on the following subscales of the IIP-SC: domineering, cold, and non-assertive subscales and on the manageability subscale of the SOC scale. There was no significant change in the physiological measure of sIgA. Overall, GIM appears to be effective in addressing psychological issues underlying addiction, and demonstrates a positive impact on physical health.

Keywords: the Bonny Method of Guided Imagery and Music; addiction; coping

Addictions to drugs and alcohol continue to plague individuals from all walks of life and costs the United States over $600 billion annually (NIDA, 2010). There were over 1.6 million admissions to treatment in 2014 for individuals 12 years and older (SAMSHA, 2016). Additionally, the United Nations Office on Drugs and Crime report that the number of over doses has risen 300 percent in the past 30 years. The significant impact that addiction places on human lives and countries, demonstrates the need for effective treatment.

Treating addiction is a complicated matter as there are a myriad risk factors contributing to substance abuse (al’Absi, 2007; Arvelo, Prado, & Amaro, 2008; Gottheil, et al., 1987; Wilcox & Erickson, 2011) including genetics and family history (Kleber, 1997; Leonard & Blane, 1999; Wilcox & Erickson, 2011), cultural and societal influences (Dodgen & Shea, 2000; Hawkins, 2011; Heimemann & Estes, 1982; ) physical health and medical conditions (DiNitto & Webb, 2011; Schuckit, 2000), mental health issues and psychopathology (Doweiko, 2008; Heimemann & Estes, 1982; Robson, 2009; Wilcox & Erickson, 2011). Individuals may be impacted by multiple risk factors, leaving them vulnerable in their ability to cope and manage in their lives. Research suggests that individuals often engage in substance use as a means of managing and coping with interpersonal, psychological, and emotional issues they feel unable to deal with (al’Absi, 2007; Arvelo, Prado, & Amaro, 2008; Gottheil, et al., 1987; Wilcox & Erickson, 2011). Engaging in substance use to cope with any of these issues further complicates one’s life, but also has increased negative consequences (al’Absi, 2007; Arvelo, Prado, & Amaro, 2008). Ongoing substance abuse can lead to increased family and marital issues, work related struggles, chronic health issues, financial strain, and legal difficulties. Therefore, a key component in addressing an
addiction is changing maladaptive coping skills (al’Absi, 2007; Arvelo, Prado & Amaro, 2008; Wilcox & Erickson, 2011).

The literature surrounding the Bonny Method of Guided Imagery and Music (GIM) does demonstrate its use to address psychological issues and physical diseases. Previous GIM research has explored addressing improved sense of coherence and ability to manage emotions (Moe, 2002), mood, emotional expression, cortisol production, and immune function (McKinney, 1994), beta-endorphin levels and depression (McKinney, Antoni, Kumar & Kumar, 1995), blood pressure, hypertension and self-concept (McDonald, 1990), and mood and quality of life (Burns, 2001). These research studies provide evidence to suggest that additional systematic investigation is warranted into the impact GIM might have on psychological and physiological issues.

There is some research literature surrounding GIM and addictions treatment. It is worth noting that Helen Bonny’s work with a group of research scientists at the Maryland Psychiatric Research Center in the late 1960’s, originated in working with chemically dependent individuals (Bonny & Tansill, 1977). Since this early work, a limited number of GIM fellows have reported on their work with clients dealing with addiction. Bonny and Tansill (1977) reported on a case that included a series of six GIM sessions. Following the series of sessions, they reported the client demonstrated an improvement in his overall MMPI score, improved self-esteem, ego strength, and a decrease in illness severity.

Based on his practice with clients in addictions treatment, Borling (1992) suggested that GIM provides a pathway for dealing with the repressed emotions that often perpetuate addiction. In her case report using GIM with a woman with a dual diagnosis (including an addiction to alcohol), Pickett (1991) described how a woman was able to work through feelings of deprivation, rejection, and abuse. Skaggs (1997) identified how the complexity of dealing with addiction requires a client to address wounds related to emotional, verbal, sexual, and physical abuse. She also indicated that these issues are complicated further by fears, a client’s sense of helplessness, self-defeating behaviors, and a sense of having no control in one’s life. From her clinical cases she reported that GIM has allowed clients to examine their life from various perspectives, foster a sense trusting one’s self, resolve inner conflicts, change and improve mood, gain insight and self-awareness, and experience a healthier way of coping.

Murphy (2008) employed the use of group GIM with adults in addictions treatment. She explored the impact of group GIM sessions on depression, motivation, and resiliency. She found that after eight group sessions, participants experienced a 65% decrease on their Beck Depression Inventory scores compared to the 46% decrease of the control group. Additionally, the experimental group demonstrated a higher treatment retention rate of 75% compared to 50% in the control group.

Moe (2012) also explored the effect of group GIM with adults in chemical dependency treatment. In his experimental study, he examined the impact of ten weekly sessions on patients’ Sense of Coherence, and their appraisal of their therapy experience. The results demonstrated that patients reported improved SOC scores and they also reported that they valued the use of music in the therapy process, as it allowed them to discover that they could manage a variety of challenges. They also conveyed that they found the sessions to be calming and were able to develop insights related to maladaptive ways of coping. Patients also reported that they would like to increase the number of group GIM sessions and also requested longer sessions.

The anecdotal evidence surrounding GIM suggests that it is a viable therapeutic method for addressing the issues underlying addiction and can assist in addressing the related psychological and physiological components. The research evidence to date explores the use of group GIM with adults in addictions treatment and indicates that further exploration is warranted into the effect that GIM may have for individuals undergoing addictions treatment.

The purpose of the present study was to explore the effect of GIM on interpersonal problems, sense of coherence, and salivary immunoglobulin A of adults in addictions treatment. The hypotheses for this study included the following: 1. Participants enrolled in the experimental group (individual GIM
sessions) will demonstrate a decrease in the number of interpersonal issues from pretest to posttest, measured via the Short Form of the Inventory of Interpersonal Problems-Circumplex Scale (Soldz, Budman, Demby & Merry, 1995) as compared to those participants in the control group; 2. Participants enrolled in the experimental group (individual GIM sessions) will demonstrate an increase in their manageability, comprehensibility, and meaningfulness of life scores from pretest to posttest, measured via the Orientation to Life Questionnaire (Sense of Coherence Scale; Antonovsky, 1986) as compared to participants in the control group; 3. Participants enrolled in the experimental group (individual GIM sessions) will demonstrated increased levels of salivary immunoglobulin A (indicator of immune function), as compared to those in the control group.

The primary results of this study were recently published in full (see Heiderscheit, 2017), and therefore those results are not included here. A secondary data analysis is currently underway and being prepared for publication.

**IMPLICATIONS**

The research surrounding GIM in addictions treatment is limited and while this study was the first utilizing individual GIM sessions, additional research is needed to not only replicate this study and its findings, but to further validate GIM as an effective treatment method to address the complex needs of individuals in addictions treatment. Future research studies could explore follow up with clients after completion of treatment. Due to the chronicity and complexity of addiction, and the high incidents of relapse and readmission to treatment, it would be important to discover how GIM may help to address these issues.

Many addiction treatment programs incorporate the AA (Alcoholics Anonymous) philosophy. As this was not explored in the present study, it is not clear how the AA philosophy impacted or influenced the participants’ experience of GIM and how the method could potentially be integrated into this treatment philosophy. This would also be an area to explore in future research.

Given the limited body and scope of GIM research with clients in addictions treatment, there continues to be a myriad of opportunities to build the GIM literature in this area. In depth case studies utilizing GIM with clients working to recover from their addiction, phenomenological exploration of their imagery, as well as additional experimental research is warranted.

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**References**


Plenum Press.
A Neurophenomenological Investigation of a Guided Imagery And Music Experience: Protocol and Methodological Challenges

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This research investigated participant responses to a modified Bonny Method session by applying the research method of neurophenomenology. The research aimed to integrate individual experiential reports with EEG data, leading to a description of neuronal and imaginal responses to the music and imagery experience. The presenter provided a step-by-step description of the neurophenomenological investigation, and discussed the clinical implications of the data collection process. In addition, the presenter described the methodological challenges in addressing such questions, and the problem-solving required to address them. The process of analyzing both kinds of data revealed additional questions about the nature of the GIM experience, as well as about the limitations of integrating the data, including: To what degree can participants fully convey their experiences to a researcher, and by extension, to a GIM therapist? How do participants recall their imagery experiences after the session, and what does this mean for practitioners during the session? To what degree can neuronal activity be attributed to specific imagery or perceptual experiences? What does a productive session look like from a neurophenomenological perspective? Pursuing these questions can lead to greater understanding of the mechanism of GIM’s effectiveness.

Keywords: the Bonny Method; Guided Imagery and Music; neurophenomenology; EEG; neuroimaging

Currently, our understanding of the neurological processes related to the Bonny Method or GIM experience is primarily theoretical in nature (Goldberg 2002; Körlin 2002; Perilli 2002) and does not yet draw from endogenous, in-situ clinical evidence of subjective experience and neurological activity. In this presentation, I discussed the methodology of my dissertation project (Hunt, 2011), which aimed to examine what occurs during a GIM session from the participant’s perspective in terms of both subjective experience and objective brain activity. I examined both perspectives concurrently to find how they relate to each other for each participant. By doing this, I attempted to provide as complete a description as possible of what a participant undergoes during the music and imagery portion of a session, illustrating relationships between mind and body. This involved using electroencephalogram (EEG) measures, which were integrated with phenomenological data, an application of Varela’s (1996) methodology called neurophenomenology.

There is a large body of knowledge regarding relationships between EEG and the many facets of travelers’ experiences in Bonny Method work. For example, concerning the altered state of consciousness (ASC), researchers have investigated brain states related to relaxation, dream states, and meditation. Of note is the involvement of gamma band activity during REM sleep which, may indicate involvement of emotional and memory structures in order to access and bind memories related to the imagery (Hori, Ogawa, Abe, & Nittono 2008). Literature regarding various categories of meditation involves increased frontal alpha power and coherence (Lutz, Slagter, Dunne, & Davidson, 2008). In terms of imagery, generally, the modality of the imagery, whether visual, emotional, kinesthetic, etc., is
reflected in the sensory areas of the brain known to process that sensory modality (Gerardin, Sirigu, Lehéricy, et al., 2000; Levine, Warach, & Farah, 1985; Overton, 2004; Pfurtscheller, Scherer, Müller-Putz, & Lopes da Silva, 2008; Posner & Raichle, 1997; Whersson, Kuhtz-Buschbeck, & Forssberg, 2002).

Very few studies examine neuronal responses to complete pieces of music; traditional neuroscience methods instead focus on brain responses to isolated musical elements or features. These few studies indicated that musical responses cannot be lateralized to either the right or left hemisphere (Petche, Pockberger, & Rappelsberger, 1987), whereas music listening while in a THC-altered state leads to increased alpha power in temporal and occipital regions, as well as changes in theta frequencies in temporal areas (Fachner, 2002). Prior to this project, one researcher examined EEG traces in a GIM context (Lem, 1998). This pioneering study pooled 27 participants’ responses to Pierne’s Concertstück for Harp and Orchestra. He found that participants showed sudden bursts of EEG activity and participants’ visual imagery, as well as a correlation between overall frequency changes in EEG and the intensity of sound as depicted by Lem’s psychoacoustic profile of the music. This research, along with the previously cited literature, demonstrates the relevance of EEG for investigating participants’ neuronal responses to the Bonny Method experience.

However, all these studies focus on pooled responses to the ASC, imagery, and music and imagery experiences. They do not account for individual responses. In regard to this question, phenomenology has been applied to Bonny Method contexts in many cases, showing a great deal of utility for explicating participants’ experiences (Abbott, 2005; Bonde, 2005; Grocke, 1999, for example). Furthermore, in regard to the specific question of addressing first-person neurological and phenomenological data, Varela (1996) developed neurophenomenology. This methodology sought to integrate valid first-person experiential accounts with objective neurological measures. Two studies (Lutz, Lachaux, Martinerie, & Varela, 2002; Petitmengin, Navarro, & Le Van Quyen, 2007) showed the utility of this approach, all of them using EEG and phenomenological interviewing to obtain each type of data, which were then integrated to reveal novel information.

Therefore, the objective of this research was to obtain a description of the GIM experience through an application of neurophenomenology to the GIM context by finding relationships between participants’ objective EEG data and their concurrent subjective imagery and experiential data. Such an investigation would seek to reveal patterns of subjective and objective responses to gain understanding of what occurs within an individual during a music and imagery session. This presentation focused on the development of the methodological protocol utilized to address these aims and the insights I gained from this undertaking.

**SUMMARY OF METHODOLOGICAL PROCEDURES**

**Trial Session**

I developed the final procedures though a trial session I conducted with myself as a research participant. Because of the limitations of EEG regarding signal artifacts resulting from facial muscle movement, I had to modify the session to eliminate verbal reports of imagery during the music and imagery phase. Thus, I developed an open-ended script which was mixed over an abbreviated music program used in GIM—two pieces of music from the Nostalgia Bonny Method program (Bruscia 2002a), Alwyn: Oboe Concerto Grosso #1 (Siciliano) and Barber: Piano Concerto – second movement (Canzone – Moderato). I had a colleague conduct a phenomenological interview immediately after the music and imagery session, using the acquisition station’s video footage to prompt my recall of the imagery. After transcribing the session and analyzing the various imagery experiences, I realized that imagery of different modalities and types occurred simultaneously, overlapping with different beginning and ending moments. It was impossible to pinpoint specific imagery experiences to a split-second moment in the music, particularly
in a post-hoc interview. Therefore, I needed to contain and limit the types of imagery experiences through the direction in the guiding script.

**Modified Music and Imagery Script**

The modified script maintained the general narrative storyline of the original script, which fit the theme-variations structure of the music. The storyline encouraged participants to recall people and memories from their past by encountering and then exploring a house. The modified script encouraged participants to focus on one specific image modality (Visual, Kinesthetic, Body, Interaction, Affect, or Memory) in a given guiding intervention. Each guiding intervention, or “probe,” was paced to fit the music selections, with a minimum of ten sections of no guiding (music alone) following each probe. The script also included an induction phase and a return phase, as used in Bonny Method sessions. Each guiding probe in these phases also focused on a single imagery modality. Table 1 shows the frequency of each probe category in the session script.

*Table 1. Frequencies of each probe according to category.*

<table>
<thead>
<tr>
<th>Frequency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Body</td>
<td>14</td>
</tr>
<tr>
<td>Visual</td>
<td>16</td>
</tr>
<tr>
<td>Kinesthetic</td>
<td>3</td>
</tr>
<tr>
<td>Affect</td>
<td>8</td>
</tr>
<tr>
<td>Memory</td>
<td>3</td>
</tr>
<tr>
<td>Interaction</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>42</td>
</tr>
</tbody>
</table>

**Data Collection**

**Participants.** I recruited a small number of participants due to the large amount of data this project would generate. Four participants responded to appeals to local Bonny Method Fellows and to flyers posted in a local university. Inclusion criteria included experience in the Bonny Method as a client (but not a present or former client of mine); no neurological or physiological limitations to participating, no current neurologic or psychotropic medication use; history or brain injury or degenerative neurological conditions. The four participants ranged in age from 33 to 58, had all been experienced Bonny Method travelers (ranging from 25 to 70 personal sessions), and all of them had experienced at least Level I training in the Bonny Method.

**Equipment and Materials.** EEG was recorded at an outpatient EEG office using a NicoletOne station with 21 channels placed at common sites using the 10-20 system. Additional electrodes were placed for ocular artifact detection and reference and ground. Music and guiding script was recorded, mixed, and burned onto a CD, which was played on a Sony portable CD player. During the session, participants relaxed in a reclined position on the provided examination chair. Following the session, I recorded the phenomenological interview using a digital audio recorder.

**Procedure.** Participants were seen individually for their single session and interview. A lab technician connected each participant to the acquisition station and left the room for the session to proceed. After reminding the participant to remain silent during the session, and to follow each guiding intervention as closely as they were able, I began recording the EEG signal and started the music/script CD. The session began and ended with a short period of silence to collect baseline EEG signal for
comparison to each of the imagery conditions. Immediately after the music and imagery session, and after disconnecting the participant from the station, the participant and I moved to a private room where we could view the video recording of the session and conduct the phenomenological interview. The interview focused on Petitmengin-Peugot’s (2000) interviewing method, which focused on eliciting descriptions of internal experience. I recorded these interviews and then transcribed them for analysis.

Data Analysis

Phenomenological Data Analysis Procedure. Working with the transcribed interviews, I reduced the text into descriptive aspects of the experience and then sequenced each participant’s experiences according to chronological order (Petitmengin-Peugot, 2000). This latter task was necessary as participants often recalled imagery according to its vividness or importance rather than simply according to its occurrence in time. I then developed my own categories of imagery experience out of this and from my own imagery in the test session, and coded each probe’s imagery description according to these categories.

EEG Analysis Procedure. I marked the 10-second music-only segment for each of the 42 probes on each participant's EEG record, labeling each segment according to its preceding probe category (Body, Visual, Affect, etc.). Coherence analyses were performed on the pooled data for each probe category in order to identify neural networks occurring during those probes. In addition, each participant’s coherence results were evaluated by frequency band to identify the meaning and functional significance of the neural networks. Raw EEG signal was also reviewed to determine each participant’s level of attention throughout the session, noting where participants were relaxed-alert, drowsy, and asleep. These interpretations were incorporated into the coherence results along with the phenomenological data.

Within and Cross-Case Interpretation of Analyses. I compared each participant’s phenomenological codes for each probe category to the corresponding coherence and brain state interpretations, and looked for patterns and differences within each case. I then compared these patterns and differences across the four cases.

MAIN IMPLICATIONS

Despite the need to modify the clinical experience from a typical Bonny Method session, this research still involved creative, imaginal listening to music while in an altered state; thus, the participants’ experiences still contain the essential features of the Guided Imagery and Music experience as defined by Bruscia (2002b) and this research has implications for GIM practice. Therefore, this study provides preliminary data that will guide future investigations and practice of GIM. Such knowledge is essential to understanding the demands of the GIM experience, considering the potential risks for negative or even re-traumatizing experiences that may emerge via vivid imagery. Future investigations need to account for the following clinical and methodological challenges in order to accurately examine the in-situ demands of undergoing a Bonny Method session.

Future in-situ research needs to account for the multi-faceted and complex nature of the participants’ imagery, often involving simultaneous and multisensory experiences. Clients may not be able to find words, space, or even the wherewithal in the moment to clearly report to their guide what is occurring during the session, thus necessitating post-session interviews to obtain a complete report of the imagery experience. Thus, pinpointing the exact moment an image occurred and correlating that experience to EEG traces is near impossible. Researchers may need to find other types of experiences or means of tracking experiences (e.g., broader categories of phenomena, behavioral observations) to make these connections.
There may be indications of brain states related to beneficial imagery experiences in the GIM context. Participants tended to report their imagery in the post-session interview according to their vividness or meaningfulness, and not necessarily according to the sequence in which they were experienced in lived time. However, those participants who had little difficulty remembering the ongoing narrative and sequence of imagery events also had more global gamma and beta coherence, implicating global attention and information binding. Similarly, the one participant who engaged in challenging imagery experiences showed the widest and most pervasive high beta and high gamma networks. A possible correlating brain state for these imaging phenomena beg the questions—to what degree does the client’s choice to actively engage with challenging imagery and to sustain the imagery narrative affect the client’s ability to do so, and to what degree does brain state influence one’s ability to engage with challenging imagery? To what degree is the clinical process related to neural processing? Understanding the mechanisms of the imagery experience in the Bonny Method/GIM can help practitioners refine the method and determine best practices, tailoring it to meet the neurological and psychological capabilities of clients.

Acknowledgments
The author wishes to express deep gratitude to Dr. Kenneth Bruscia, advisor on this project, for his steadfast dedication, encouragement, and support. The author also acknowledges the helpful feedback and support of Dr. Cheryl Dileo, Prof. Richard Brodhead, and Dr. Alison Reynolds, members of the dissertation committee. The author would also like to thank Dr. Bryan Muller, Dr. Mercedes Jacobsen and the staff at Temple University Hospital EEG Lab, Dr. Richard Greenblatt and Dr. Demetri Voreades of Source Signal Imaging, Inc., Dr. Joshua Jacobs, and Mr. Neil Hunt for their support and assistance on this project.

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Note
This paper is a summary overview of work that has previously been published. The full papers can be found at:

References


Group Guided Imagery and Music for Adults in Addiction Treatment: A Pilot Randomized Control Trial Feasibility Study

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This randomized control trial assessed the feasibility of adding a Guided Imagery and Music (GIM) group into a residential addiction treatment facility. Either group GIM or an unstructured leisure condition was assigned to 42 adult participants. The study found that adding Group GIM to a structured treatment program was feasible and well received by participants and staff. Assessments included the Beck Depression Inventory (BDI), the Sense of Coherence Scale (SOC), and the Importance, Confidence, Readiness (ICR) motivational ruler. There were reductions in BDI and SOC scores for both groups and the ICR motivational level scores remained essentially the same. Retention in treatment was better for the experimental group. The study findings support the feasibility of integrating music therapy into inpatient treatment for addictions.

Keywords: Group GIM; addiction; substance dependence; residential treatment; feasibility

Substance use disorders continue to be a major health problem in the United States. A recent report from the Office of the Surgeon General noted that 66.7 million people reported binge drinking and 27.1 million people used illicit drugs or misused prescription drugs. Substance use disorders negatively impact families and society; resulting in reduced job productivity, lost earnings, increased hospitalizations, incarcerations, and periods of homelessness (National Institute on Drug Abuse [NIDA], n.d.). Treating substance abuse disorders is complex and to date, there is not one treatment approach that works for all those who have a substance use disorder (NIDA, 2012).

One of the earliest applications of the Bonny Method of Guided Imagery and Music (BMGIM) was in the treatment of individuals who were dependent upon drugs and alcohol. Bonny’s clinical work showed positive results, however, she did not conduct research to empirically validate her method in addiction treatment. Subsequent writings including one experimental study, (Heiderscheit, 2017), anecdotal reports and clinical case studies (Pickett, 1991; Yawney, 2014) continue to report positive outcomes. Further research is clearly needed.

Bonny also developed a group format for Guided Imagery and Music (GIM). The group format lends itself well to addictions treatment as group therapy is often in the norm in treatment centers. Again, there is a dearth of literature on the use of the group format in addictions treatment. To date there has only been one experimental study in addition to a few clinical case reports all reporting favorable outcomes.

It has been suggested that individuals who misuse drugs and alcohol do so to change their conscious experience (Frye, 1990). Further, 12-step groups encourage members to change in “consciousness and being” (McPeake, Kennedy, & Gordon, 1991). Some authors (e.g. McPeake et al., 1991) have suggested treatment focusing on changing conscious experiences might have a positive impact on treatment outcomes. BMGIM provides opportunities for clients to focus on this aspect of
treatment. Additionally, both forms of BMGIM have been shown to improve symptoms and behaviors associated with addiction such as depression, anxiety, inefficient coping skills, and poor interpersonal skills. Therefore, the purpose of this study was to determine if: (a) incorporating group BMGIM into a 28-day inpatient treatment program was feasible; and (b) participating in 8-group BMGIM sessions would improve the psychological health and motivation of adults undergoing substance abuse treatment as measured by the Beck Depression Inventory (BDI), Sense of Coherence Scale, and the Importance, Confidence, Readiness Ruler (ICR).

**MAIN RESULTS**

The Mann-Whitney U test showed that differences in pretest scores between the control group and treatment group were not statistically significant (BDI $U = 49 Z = -.174, p > .05$; SOC $U = 74, Z = -.783, p > .05$). As seen in Table 1, median posttest SOC and BDI scores decreased for both groups although the differences between the groups were not statistically significant. ICR scores remained essentially the same.

**Table 1.** Means, Standard Deviations, Medians, and Ranges for Pre- and Posttest Scores on Dependent Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Group</th>
<th>Pretest</th>
<th>Posttest</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean (SD)</td>
<td>Median (Range)</td>
</tr>
<tr>
<td>SoC</td>
<td>Control</td>
<td>112.43 (10.80)</td>
<td>112 (92–130)</td>
</tr>
<tr>
<td></td>
<td>Group GIM</td>
<td>111.11 (7.03)</td>
<td>111 (103–122)</td>
</tr>
<tr>
<td>BDI</td>
<td>Control</td>
<td>16.00 (8.62)</td>
<td>16 (7–27)</td>
</tr>
<tr>
<td></td>
<td>Group GIM</td>
<td>23.22 (12.82)</td>
<td>26 (4–43)</td>
</tr>
<tr>
<td>ICR</td>
<td>Control</td>
<td>26.71 (2.93)</td>
<td>27 (21–30)</td>
</tr>
<tr>
<td></td>
<td>Group GIM</td>
<td>28.56 (2.13)</td>
<td>29 (18–30)</td>
</tr>
</tbody>
</table>

*Table 1 Note:* SOC = Sense of Coherence Scale, BDI = Beck Depression Inventory, ICR = Importance, Confidence, Readiness Ruler
Feasibility. Both patients and facility staff had positive comments about group GIM. Patients noted that the group GIM sessions helped them to manage their anxiety and quiet their minds. Facility staff reported that group GIM fit within the facility program and reinforced concepts being addressed within counseling sessions.

Retention. Reasons for leaving treatment may be found in Table 2. Among participants in the study, 14.3% of those in the experimental group signed themselves out of treatment against clinical advice (ACA) in contrast to the control group where 38.9% signed themselves out ACA. The contrast of these rates was not significant based on a Fisher’s Exact Test (two-tailed p = 0.14)

Table 2. Reasons for Leaving Treatment

<table>
<thead>
<tr>
<th>Reason</th>
<th>Experimental</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signed Self Out ACA</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Insurance Benefit Ended</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Transferred to Another Facility</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Therapeutically Discharged</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

MAIN IMPLICATIONS

This study sought to evaluate: (a) the feasibility of integrating group GIM into a residential addiction treatment program, and (b) the effect of group GIM on mood, self-efficacy, and motivation. Both groups demonstrated improvement on all three variables, though the experimental group had a better retention rate. The acceptance of group GIM into the facility’s addiction treatment program and a design that allowed for a randomized trial give support to on-going research within addiction treatment.

Acknowledgments
The authors would like to thank Curtis Deutsch, PhD, Associate Professor, Department of Psychiatry, University of Massachusetts Medical School for his assistance with the statistical analysis.

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Note
This paper is a summary overview of work that has previously been published. The full paper can be found at:

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Heiderscheit A. (2017). The effects of the Bonny Method of Guided Imagery and Music (GIM) on
interpersonal problems, sense of coherence, and salivary Immunoglobulin A of adults in chemical dependency treatment. *Music and Medicine, 9*(1), 24-36.


Short Guided Imagery and Music (GIM) in Active Treatment of Gynecologic Cancer: A Feasibility Study

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This presentation outlined a new research study on the potential effects and usefulness of GIM as a complementary, psychological intervention with women diagnosed with gynecologic cancer while in chemotherapy treatment, in a Greek hospital setting. The study is still ongoing; therefore, no results were presented.

Keywords: GIM; gynecologic cancer; treatment; quality of life

Women with gynecologic cancer (GC) present with high incidence and mortality rates and literature suggests that they are at greater risk for psychological maladjustment than other cancer survivors, even after the treatment period (Johnson et al., 2010; Parker et al., 2003). Additionally, those experiencing psychological distress may be more inclined to resort to complementary medicine (Lengacher et al., 2006). There is growing evidence supporting the integration of non-pharmacological therapies as part of a multidisciplinary approach to mainstream cancer care (Cassileth, 2014; Society for Integrative Oncology, 2009) and the benefits of integrating creative arts therapies in the treatment of adults with cancer have been well documented (Gladding & Newsome, 2003).

It is therefore promising to explore the potential of GIM as a mind-body therapy and to hypothesize that it may potentially contribute positively to diverse aspects of quality of life (QOL) via its powerful components. Imagery evoked by music that comes from different layers of consciousness, including unconscious information, has the potential to be a powerful source of insight into and expression of deep life issues, as well as offer a creative path that sustains life energies.

Although GIM has been used with cancer patients and survivors, most studies have examined its applications within treatment, rehabilitation or palliative phases using modified or group forms of GIM (Allen, 2010; Bonde, 2004; Burns, 2001; Cadrin, 2009; Dimicelli-Mitrant, 2015; Hale, 1992; Hertrampf, 2015; Marr, 1998-99; Meadows, 2015; McDougal Miller, 2016; Wärja, 2015). However, there seem to be no previous studies exploring the potential of GIM offered in a series of a one-to-one therapy sessions during treatment of gynecologic cancer (GC), a fact that amplifies the need for implementing such a study. Thus, the rationale of this study lies on the potential role of GIM (with sessions of shorter duration) on various dimensions of the patients’ health including: physical health, psychological state, independence level, relationships, personal beliefs as well as the way they relate to salient features of the environment. Additionally, it is important to note that there is no provision of any form of psychological or complementary therapies in Greek hospitals where the treatment approach is mostly based on biological understandings of disease and provision of standard pharmacological care.

Therefore, the purpose of the current study is to explore and evaluate the potential impact of a series of six short individual GIM sessions as a psychological support therapy for women with GC in a post-operative phase, during chemotherapy or radiotherapy treatment. It will also investigate how a Greek hospital setting that generally ascribes to a medical approach, can make use of GIM as a complementary, psychological intervention to facilitate or enhance cancer care. The project will be executed in two parts: a feasibility study followed by a small clinical trial (not yet formulated). At this
stage, my focus is on the feasibility study where I am proposing a series of six short GIM sessions, up to 50-minutes long, with the following aims:

- **Aim 1**: To investigate the feasibility of short GIM sessions as a psychological intervention for women with GC who are receiving chemotherapy and/or radiotherapy treatment in a Greek hospital;
- **Aim 2**: To explore the usefulness of short GIM sessions by examining potential for decreasing anxiety and depression as well as improving quality of life, fatigue levels, and sense of hope amongst women with GC during preliminary level treatment;
- **Aim 3**: To discover participants’ perceived impact of the experience of short GIM sessions.

**METHODOLOGY**

**Design**

The feasibility study is a mixed methods design, a synergetic model that integrates a combination of quantitative and qualitative research methods/procedures for data collection and analysis (Borkan, 2004; Mertens & Hesse-Biber, 2013) thereby strengthening the validity and reliability of the study. This design will address the study’s questions at different levels and is recommended at this stage as potential participants and practitioners can be actively involved in the research to assess the feasibility of an intervention and to ensure a good intervention-context fit (O’ Cathain et al., 2015). A mixed methods design will produce a range of qualitative and quantitative feasibility data, which will be gathered before, during, and after each participant’s series of short GIM sessions. This will include logs, event recordings, researcher’s and therapists’ notes, and psychometric questionnaires. Individual interviews will be conducted with participants at the end of the series of short GIM sessions. For the feasibility component of this study, more focus will be placed on the qualitative data (i.e., a qualitative-dominant mixed analysis) as it is expected to produce more important information upon which the rest of the study will be built. The various forms of data may be collected concurrently but elaboration on the results will require a sequential design.

The study aims to use the original format of an individual GIM session. However, because of the limited physical and psychological capacity of this client group, a shorter form of individual GIM will be used. Each session will have no more than 20 minutes of music and the duration of the entire session will be no longer than 50 minutes. The music selections will include shorter and supportive GIM programs (e.g., shorter versions of *Caring, Nurturing, Comforting*) as well as other selections from classical, film, new age, or world music genres. The music should provide some stability and a clear structure so as to be safe enough for the participants to complete their experience but at the same times contain qualities that will evoke a mixture of supportive and slightly challenging experiences (Wärja & Bonde, 2014). Music used in early sessions will be less complex and short in duration (small to medium container range). Once the women become more acquainted with the method, more complex music with a slightly stronger dynamic structure may be introduced. Repetitive music listening may also be explored as an option (Summer, 2015).

**Participants**

For the first phase of this study (feasibility) I will recruit a convenience, purposive sample of five women with any kind of GC, who have undergone surgery, and are in the beginning or middle of a chemotherapy or radiotherapy treatment course. These individuals will be recruited from the two major collaborating hospitals (Areteio University Hospital and Iaso Private Clinic). They must be at least 18
years of age, understand the treatment protocol, and be willing to provide informed consent. The research will exclude individuals that are not fully informed about their diagnosis, individuals with cognitive impairments, psychosis, or PTSD with untreated symptomatology, and those who are receiving other forms of psychological support.

Data Collection and Analysis Procedures

Initials appointments, GIM therapy sessions, and post-session interviews will take place at the hospitals, in rooms carefully chosen to meet the standards of a therapy environment. Each participant will meet once a week for six subsequent weeks with one of two GIM therapists who are facilitating the sessions for this study. The session format will include a pre-talk, relaxation induction, music listening, and post-talk. Before, during, and after termination of treatment, the participants will complete two quantitative psychometric questionnaires: The Hospital Anxiety Depression Scale (HADS) for anxiety and depression, and the Functional Assessment of Cancer Therapy-General (FACT-G) for quality of life. In addition, two Visual Analogue Scales (VAS) will be used before and after each single session to assess levels of fatigue and sense of hope. The week after completion of treatment, I will conduct semi-structured interviews with each participant. The same open-ended questions will be asked of each participant, focusing on significant aspects of their experience, their impressions, possible issues of practicality or other burdens, proposed changes, and recommendations for improvement. These interviews will each last approximately 30-50 minutes and will be recorded and transcribed.

A typical demographic questionnaire will be designed and used to collect information about age, gender, education, professional and marital status, and medical condition. The therapists and researcher will keep notes, narratives, and logs on all aspects of the feasibility study. These notes will be used to provide general information and evaluate feasibility questions as well as to identify key issues, problematic areas, and/or aspects of the research that need change or be further developed.

Data from all sources will be analyzed independently and integrated to address the overall study objectives. The therapists’ notes and narratives as well as the interview transcripts will be analyzed using Interpretative Phenomenological Analysis (IPA) where pertinent themes will be formulated by identifying and reporting patterns that emerge from the notes and interviews. The main steps of analysis in IPA as set out by Smith et al. (2009, p. 83-84) are: first impressions, initial comments, descriptive comments, linguistic comments, conceptual/psychological comments, and emergent themes. Themes will be grouped together into clusters of concepts organized under headings that specifically address the study objectives and research questions (Smith & Osborn, 2003).

Quantitative data will be analyzed following the analysis of the descriptive and exploratory (i.e., qualitative) data in order to provide an accurate outline of the parameters affected during this study. Although statistical analysis of preliminary data is usually not recommended in such a small sample, by examining distribution, central tendency, and dispersion I will still be able to determine if the measurement tools utilized are yielding trends in the predicted direction.

The research will be carried out according to the ethical standards of AMI and the University of Athens-School of Medicine. All procedures of the study protocol were reviewed and approved by the Ethics Review Board of Aretaeo University Hospital, in Athens, Greece, and assigned protocol number EE-2/01/31/1/2017

IMPLICATIONS

The feasibility study will help to establish the parameters needed for the main study—a small clinical trial. Findings of the feasibility study and the main study will both be evaluated and should these confirm that short GIM was an effective treatment in these Greek hospital settings, this will hopefully
encourage optimal clinical practice that uses GIM therapy during active cancer treatment. The findings may also implicate the need for a larger scale RCT protocol.

Acknowledgments
I would like to thank my supervisors, Cathy McKinney and Niels Hannibal for leading me this way, and Lars Ole Bonde for his encouragement and support in preparing this PhD project. I would also like to thank the doctors of Areteio and Iaso Hospitals, Prof. Christos Papadimitriou, Theodore Panoskaltsis, and Sofia Karageorgopoulou for their special contributions and collaboration to make this project happen.

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References


Client Experiences in Postlude Discussions in Guided Imagery and Music

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The purpose of this phenomenological study was to examine clients’ experiences of the postlude discussion phase in Guided Imagery and Music (GIM). Individual open-ended qualitative interviews were conducted with eight GIM clients in order to gather reflective perspectives on their experiences of this phase. The researcher created stories from each individual’s descriptions and conducted a cross-case analysis where she organized helpful and not helpful essences into overarching theme categories. Implications for GIM research, theory, practice, and training are presented.

**Keywords:** The Bonny Method of Guided Imagery and Music; postlude discussion; phenomenology; client experiences

GIM was designed by Helen Bonny to facilitate an individual’s exploration of consciousness through imagery experiences evoked through music listening. In its entirety, an individual GIM session is composed of five phases: preliminary conversation, relaxation, music listening [and imagery], return, and the postlude discussion (Bruscia, 2002a). The present study was concerned with this final [postlude] phase where the client and therapist review and reflect upon the client’s music-imagery experience by using verbal discussion, mandala drawing, clay work, journaling, and/or other techniques. In reflecting upon my experiences and the literature, it seems that the differences in how and when nonverbal modalities are used in the postlude vary considerably, as does the nature of verbal conversations after the music and imagery phase. However, very little has been written about the postlude discussion phase specifically and its impact on the efficacy of the GIM process. It is likely that the variations presented above have evolved out of individual practitioners’ training and clinical experiences, differences in clientele, and differences in theoretical orientations. However, we know very little about how clients experience the postlude discussion and what effects these experiences may have on them and their overall therapeutic processes and/or outcomes. Furthermore, very little is known about what interventions are typically used in this phase and under what circumstances they are employed. Therefore, the purpose of this phenomenological study was to better understand clients’ experiences of the postlude discussion phase in GIM.

**MAIN CONTRIBUTIONS**

**Summary of Methodology**

I conducted open-ended qualitative interviews with eight individual GIM clients (5 females, 3 males) in order to gather participants’ reflective perspectives on their experiences (helpful and not helpful) of the postlude discussion phase. I extracted all phrases or sentences from the transcripts that pertained to the phenomenon being studied and organized them into logically ordered meaning units. I used these to create third person narratives (stories) about clients’ experiences of the postlude phase. I extracted helpful and not helpful perspectives (essences). Finally, I conducted a cross case analysis where I identified common themes and organized these into overarching theme categories.
Summary of Results

Interviews with the eight participants resulted in 17 narrative summaries (stories) pertaining to client experiences of the postlude phase (not included here). “Helpful” and “not helpful” perceptions (essences) that emerged from participants’ stories resulted in themes that fell into four fundamental categories:

- **Client therapist relationship.** Clients needed to feel a sense of authentic connection with their therapist. Clients described several postludes where they felt disconnected from their therapists.
- **Structure of the postlude discussion.** Clients needed the postlude discussion phase to have structure and direction. There were instances where postludes lacked structure and direction.
- **Perceived impact of the music listening phase on the postlude discussion.** When clients perceived that they had had a negative music listening experience, they felt upset for the entire duration of the postlude. These two phases were sometimes perceived as one continuous process, and other times perceived as two distinct experiences.
- **Perceived overarching impact of the postlude discussion.** These participants tried to find meaning in all of their postlude discussion experiences. Note. This may be because the participants were also all therapists (GIM and/or music therapy).

**MAIN IMPLICATIONS**

**Research**

Research needs to be conducted with clients who are not therapists so we can better understand other individuals’ experiences of the postlude discussion phase. This information could potentially help GIM therapists facilitate more effective postlude discussions with “untrained” clients and clients from diverse backgrounds. It would also be helpful to study therapists’ interpretations of their GIM clients’ [postlude discussion] experiences as this would help provide a more well-rounded perspective on this topic.

**Theory**

The results of the present study could contribute to the development of a theory on the role of the postlude discussion phase in GIM. They could also play a significant role in the construction of a larger theory on how the various phases of GIM relate to one another and how each phase contributes specifically to the overall therapeutic process.

**Practice**

The findings indicate that the therapist’s ability to make authentic connections with the client during the postlude discussion phase may be of key importance. Having just returned from an altered state of consciousness, the client is especially vulnerable and the music that may have been used as a resource (by both client and therapist) in the previous phase is no longer part of the picture. The therapist must approach the postlude discussion phase with a sense of responsibility for the client and for the process.

The findings also indicate that countertransference reactions are especially likely to occur in the postlude discussion phase where the therapist is engaged in face-to-face interactions with the client and where the client’s transference reactions cannot be projected onto the music (Summer, 1998) or onto the imagery (Bruscia, 2002b) as they may have been in the previous phase.
Training

Many of the negative experiences that the participants highlighted occurred in sessions that were facilitated by GIM trainees. Therefore, it is essential that GIM trainees and practitioners participate in their own therapy on a regular basis in order to become self-aware and take responsibility for their own issues. GIM trainers have an ethical responsibility to be especially vigilant and ensure to the best of their ability that their trainees are self-aware and have developed enough personal insight to be facilitating practice sessions independently.

Acknowledgments
The author would like to thank Dr. Kenneth E. Bruscia for his guidance and support.

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Note
This paper is a summary overview of work that has previously been published. The full paper can be found at:
http://www.barcelonapublishers.com/Periodicals

References
Predictors of Client Responsiveness to the Bonny Method of Guided Imagery and Music (BMGIM)

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Prior to the current study, Bruscia’s Guided Imagery and Music Responsiveness scale (GIMR) was the only existing quantitative assessment tool, indigenous to the Bonny Method of GIM, designed to assess client responsiveness. The Responsiveness to Guided Imagery and Music scale (RGIM) was designed to address identified limitations of the GIMR. The purpose of this study was twofold: (a) to examine the reliability and construct validity of the RGIM, and (b) to identify predictors of responsiveness to the Bonny Method of GIM, as measured by the revised RGIM. It was hypothesized that when combined, Sense of Coherence (SOC), state trait anxiety (STAI), classical music experience (CME), gender, and/or age would account for a significant amount of variance in responsiveness to GIM. Data were gathered from 60 individuals, who participated in a group GIM experience. Exploratory factor analyses revealed that the RGIM contained five factors, each one addressing a distinct area of responsiveness to GIM. Correlational statistical techniques were used to identify significant relationships between variables; three sets of exploratory multiple linear regressions were used to identify which combinations of variables were the most accurate predictors of RGIM factors. Selected results are presented. Although the present study has limitations, the results contribute to our understanding of responsiveness in GIM and lay the groundwork for further development of GIM assessment tools.

Keywords: GIM; assessment; client responsiveness; RGIM scale; factor analysis

Prior to the current study, the Guided Imagery and Music Responsiveness (GIMR) scale developed by Bruscia (2000) was the only existing assessment tool, indigenous to the Bonny Method of GIM, designed to provide a quantifiable means of assessing client responsiveness and evaluating progress. It was also intended to be used as a measurement tool in GIM research. Meadows (2000) conducted a series of three studies wherein he examined the validity and reliability of the GIMR. Although he found that the GIMR had satisfactory face validity, content validity and interrater reliability, he also found that it did not demonstrate construct validity. Based upon the fact that Meadow’s research did establish some aspects of validity as well as interrater reliability of the GIMR, that his study on construct validity had significant limitations, and that great care was taken in the development of the tool, it was my (the current researcher’s) position that the GIMR still held promise as a measure of assessing clients’ responsiveness to the Bonny Method of GIM. I therefore created an adapted version of the GIMR to address some of the identified limitations of the tool and of Meadows’ study. The purpose of this study was: (a) to examine the reliability and construct validity of a revised version of the GIMR re-named the Responsiveness to Guided Imagery and Music scale (RGIM) and to revise the RGIM according to the these results, and (b) to identify predictors of responsiveness to the Bonny Method of GIM, as measured by the revised RGIM. Based on a review of the literature, it was hypothesized that when combined, Sense of Coherence
(SOC), state trait anxiety (STAI), classical music experience (CME), gender, and/or age would account for a significant amount of variance in RGIM.

**MAIN CONTRIBUTIONS**

**Data Collection Procedures**

- After receiving ethics approval from Temple University’s Institutional Review Board, participants were recruited from the general population (had to meet inclusion criteria)
- N = 60 (44 females, 16 males); Mean age (SD) = 45.88 (15.37)
- Age range: 22–79
- Participants completed demographic questionnaire (included CME measure), STAI, and SOC scales (i.e., the predictor variables)
- Brief verbal description of GIM provided by facilitator to participants
- Practice imagery exercise (no music)
- Group GIM experience (semi-directed & undirected music imaging; postlude discussion)
- Participants completed the RGIM (i.e., the revised GIMR)

**Data Analysis and Summary of Results**

**Part One.** Factor analyses were used to investigate the construct validity of the RGIM. This helped to isolate constructs and concepts by re-grouping items contained in the RGIM (as rated by participants) into clusters (i.e., factors) based on shared variance. This resulted in five distinct, theoretically relevant measures of responsiveness (i.e., factors):

1. Ability to Relax
2. Ability to Image to Music
3. Responsiveness to Music and Guiding
4. Comfort with Self-Disclosure
5. Meaningfulness of the Experience

**Part Two.** Chronbach’s alphas were calculated for all proposed predictor variable measures and all measures were found to have acceptable to excellent reliability. Data were checked for assumptions of multiple regression: assumptions of normal distribution, homogeneity of variance in residuals, linearity, and absence of multicollinearity. A multicollinearity problem was found between SOC and STAI; state and trait anxiety scores were also highly correlated. Statistical procedures were used to transform the STAI scores but it did not eliminate the problem. Therefore, SOC, state anxiety, & trait anxiety were each entered into separate exploratory regressions in the main analyses. Means, SDs, and ranges were calculated. There were not enough males to include gender in the regression formula, so t-tests (assuming unequal variances) were used to analyze gender and there was an interesting result—males had significantly higher scores than females on RGIM Factor 4: “Comfort with Self-Disclosure.”

Correlations were used to determine relationships between variables; 11 significant correlations were found between the predictor variables (including subscales) and three RGIM Factors (2, 3, & 5). No significant correlations were found between CME and the RGIM factors and trait anxiety and the RGIM Factors. Three sets of exploratory multiple regressions were used to determine the extent to which combinations of predictor variables (SOC, STAI, CME, gender, age) accounted for a significant amount of variance in each of the 5 RGIM Factors (i.e., were the most accurate predictors of each of the five RGIM
factors). Somewhat complex, yet interesting statistical results led to the following cautious conclusions (taking limitations of the study into account):

- SOC alone and SOC, CME, and age together predicted participants’ ability to image to music (RGIM Factor 2), respond favorably to the music and to the directions of the guide (RGIM Factor 3), and find meaning in their BMGIM experiences (RGIM Factor 5).
- The more state anxiety participants felt, the less capable they were of imaging to music (RGIM Factor 2).
- State anxiety, CME, and age together predicted participants’ ability to image to music (RGIM Factor 2), respond favorably to the music and to the directions of the guide (RGIM Factor 3), and find meaning in their music and imagery experiences (RGIM Factor 5).
- Trait anxiety alone was not related to participants’ responsiveness. Trait anxiety, CME, and age together predicted participants’ ability to respond favorably to the music and to the directions of the guide (RGIM Factor 3).
- CME alone or in combination with other variables did not seem to be related to participants’ responsiveness.
- Males were more comfortable with self-disclosure (RGIM Factor 4) than female participants; there were no other differences between male and female participants in any other areas of responsiveness.
- The older participants were, the more adept they were at responding to the music and to the directions of the guide (RGIM Factor 3).
- Age, SOC, and CME together; and age, state anxiety, and CME together both predicted participants’ ability to image to music (RGIM Factor 2), respond favorably to the music and to the directions of the guide (RGIM Factor 3), and find meaning in their music & imagery experiences (RGIM Factor 5).
- Age, trait anxiety, and CME together predicted participants’ ability to respond favorably to the music and to the directions of the guide (RGIM Factor 3).

**MAIN IMPLICATIONS**

- The RGIM Factors that emerged and examination of the identified predictor variables revealed information about the Bonny Method of GIM that could be applied in current practice.
- The RGIM is not yet an established, standardized, or complete assessment tool. It needs to be further refined and developed.
- There is a need to examine responsiveness to GIM in clinical populations. This study only examined the general [non-clinical] population.
- The RGIM (in its current form) may be used in GIM training contexts to: (a) teach some basic assessment skills, and (b) provide a concrete structure in which to [self] assess individual trainee’s responsiveness to key components of the Bonny Method of GIM. One could argue that trainees should demonstrate/develop a certain level of responsiveness on all of the RGIM factors before becoming a Fellow. It would be difficult for a GIM therapist to help a client improve her/his responsiveness in a particular area if the therapist does not inherently understand that aspect of responsiveness from her/his own personal GIM sessions.

**Acknowledgments**
The author would like to thank Dr. Kenneth E. Bruscia for his support and advisement throughout the research process, Dr. Jennifer G. Cromley for her statistical guidance, and the Canadian Music Therapy...
Trust Fund for their in-kind support of this project.

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**Note**
This paper is a summary overview of work that was initially undertaken at Temple University (Philadelphia, PA) as part of a doctoral dissertation. A paper based on part one of this study has also been published. These documents can be found at:

**References**
An Artful Process: Developing an Arts-Based Research Methodology for Analyzing GIM Sessions

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The purpose of this arts-based research study is to implement a methodology that I, as the principal researcher, developed for interpretively analyzing participants’ therapeutic and musical processes in GIM sessions (the Helen Bonny Method of Guided Imagery and Music). The methodology emerged organically from a client’s long term process in GIM. The study is collaborative in that both participants and the principal researcher will use the methodology to explore their respective experience of GIM sessions, and each will interpretively analyze the data. A guiding research question is: How do reflexive practices affect the intersubjective experience of a GIM process? Steps in the methodology were crafted from reflexive practices used in GIM sessions and sources for data analysis will include: journaling, session transcripts, music improvisation, poetry (imagery poems), visual art (Mandalas), and listening to music. This research is influenced by the theoretical frameworks of alchemical symbolism, the transcendent function, liminality, and intersubjectivity. The study aims to enhance participants’ self-awareness and knowledge of the safe and effective use of self, which will potentially be beneficial for their professional work as clinicians as well as their self-development.

*Keywords:* arts-based research; GIM; improvisation; intersubjectivity; alchemy

Romanyszyn (2013) affirms that “research is a vocation. A researcher is called into a work, claimed by it...chosen by a work...” (p. 320). The practice of GIM (the Bonny Method of Guided Imagery and Music) calls on our courage to enter into mystery and it requires an equal partner with which to study such dynamic, sensory, and emotion-laden processes. Arts-based research (ABR) is well suited to be this partner since GIM practice goes beyond mere physicality and ego functioning to imaginal spaces and transpersonal realms less familiar to ordinary consciousness. In ABR, the researcher can use artistic and musical tools for developing a topic, formulating research questions, collecting and analyzing data, and representing research findings (Viega & Forinash, 2016). There is creative potential to uncover conscious and unconscious processes in the therapeutic process through spontaneous music improvisation and reflective art making (Seabrook & Arnason, 2010).

The value of a deeply reflective, experiential process is evident in Bruscia’s (1995) heuristic study where he explored his modes of consciousness as therapist through analyzing the transcript of one GIM session. In reference to Bruscia’s study, Kenny (1998) underlines the power of images for understanding “what is meaningful and real” about the human condition (pp. 210-211). Schenstead (2012) created a reflexive and self-interrogative method “of analyzing artistic data [that] encourages the researcher to ask various questions to her/himself and interact with the data by creating intuitive arts as responses to internal dialogue and feelings” (Abstract). Levine (2009) advocates for easing the tension between image (imagination) and word (thoughts). In order to conduct imaginative research we need, as researchers, to involve ourselves “in what we interrogate...we confront the work with our own being, in a passionate encounter in which it speaks to us in a way that shatters our preconceptions” (p. 158). Absolon (2011)
emphasizes that *Self is central to the search* and research is a process of *coming into the knowing*. Rossiter (2007) reframes the use of self as subjectivity; “this concept of self complicates the use of self by asking us to interrogate our responses in light of our social selves...such a use of self facilitates greater possibility for respectful recognition, and thus orients practice in justice” (p. 31).

There are theoretical frameworks that influence my GIM clinical work as well as the development of this arts-based research methodology: alchemical symbolism, the transcendent function [individuation], and liminality. Schwartz-Salant (1998) states that “alchemical thinking is metaphorical and neither/nor is its focus...Rather than seeking the differences between things, alchemy searches for the connections. Relatedness, no causality is alchemy's focus” (p. 17). The transcendent function is a central concept in Carl Jung’s theoretical framework and “the essence of the transcendent function is a confrontation of opposites, one from consciousness and one from the unconscious, from which emerges some new position or perspective” (Miller, 2004, p. 4). There is a close connection between liminality and the transcendent function as “liminality is the archetypal wellspring from which the transcendent function emerges” (Miller, 2004, p. 106).

There are notable intersections between ABR and GIM. ABR is an integrative process with the flexibility to accommodate multilayered consciousness. Data analysis procedures integral to ABR allow the researcher as artist to be true to their art, which, in the context of this study is music-centred psychotherapy. Viega (2016) points out: “…the aesthetic knowledge revealed within ABR can bring new understandings of musical processes in therapy and allow the complexities of social phenomena relevant to music therapy be seen via artistic engagement and performance” (para.11).

ABR has the creative power to uncover conscious as well as unconscious dynamics through images. Images are the data generated by artistic modalities. Imagery has the creative power to represent the real more fully and truly. The imaginal world reveals realities that can be analyzed and the imagination becomes an agent of unfolding research findings. Levine (2009) encourages researchers to find an imaginative, energetic way of thinking when analyzing data communicated through images. Related to the imaginal world, Prendergast (2009) writes that poetic inquiry:

is a way of knowing through poetic language and devices; metaphor, lyric, rhythm, imagery, emotion, attention, wide-awakeness, opening to the world, self-revelation...a means to communicate experiences of memory, identity, place, relatedness, hope, fear and/or desire. (pp. 562-563)

The purpose of this research study is to implement an arts-based methodology that was developed from a client’s long-term GIM process with myself as therapist. The emotional intensity, plus the amount of material being generated in this work were reasons why I felt the need for an artistic procedures to process, distill, and better understand the intersubjective process. I believe in the role of multilayered consciousness within the research process and acknowledging the role of unconscious dynamics in data analysis. But, for this to happen consciously, we require procedures.

This methodology provides a framework with which to encounter, explore, and understand the music-imagery process. The steps in the methodology are crafted from reflexive practices used in GIM practice; poetry, music improvisation, embodied listening, journaling, Mandalas, verbal processing, and/or expressive movement. The research approach is collaborative and aesthetic in that clients/participants and the therapist/researcher will explore their intersubjective musical experience of the GIM process.

The research questions will likely evolve. The initial questions are:

1. How do reflexive practices affect the intersubjective experience of a GIM process? [interacting musical selves]
2. What awarenesses emerge from analyzing a GIM process with artistic, musical modalities? [music-centred experience]

3. How does the exploration of multilayered consciousness in a research context reshape worldviews and assumptions? [personal, professional relevance]

Participants

There will be 5-7 participants in this study. Participants will be invited because of their experience in GIM sessions and familiarity with the method or because they have expressed an interest in the GIM method and in using reflexive practices to analyze their experience.

Procedures

The approach in this study is collaborative in that participants and the principal researcher will both use the methodology to explore their intersubjective experience within GIM sessions, and each will contribute to analyzing the data. The steps in this methodology were crafted from reflexive practices used in GIM sessions and data analysis will include the intermodal study of: music improvisation, narratives (journaling), poetry (imagery poems), verbal processing, and visual art (Mandalas). A key element in the methodology is the process of creating, recording, and listening back to music improvisations. I believe that music improvisation as a reflexive practice is relevant for GIM practice to process and analyze the music-imaging experience. Improvisation is described as:

> a field of experimentation where we may learn to transcend previous borders of freedom. It is a space of experience where processes of listening are expanded to the extent that there is nothing ‘wrong’ or without value. We find ourselves in a space emptied of experience where something more honest may come out of the hidden. (Fritz Hegi, cited in Even Ruud, p. 97)

Participants will be asked to participate in five GIM sessions, plus one review session that focuses on verbal, musical, and artistic processing, for a total of six sessions. Each session will be 1.5 to 2 hours in length. As principal researcher, I will be the therapist guiding the GIM sessions. I will work with a clinical supervisor as well as a research assistant (2nd year Master of Music Therapy student). All sessions will be audiotaped for the purpose of data analysis and for recording the music improvisations.

GIM can feel like a spiral process and, therefore, the steps in this methodology do not have to be done sequentially. The right balance between the artistic-musical modalities is an emergent practice. Music improvisations can be done as often as needed. Music improvisation is featured in Step 1, but improvisations can be created as interludes between steps in the methodology, created in GIM sessions, e.g., during the Prelude or Postlude phases, and they can be created in response to imagery poems. For practical reasons, audio recording equipment and instruments should be accessible in order that technology becomes part of the experience. The overarching steps are outlined as follows:

- **Step 1: Centering.** Create a music improvisation to ready your mind and body for starting the process of analyzing GIM work, e.g., a particular session or part of a session). Start the recording device, allow silence, then create a short form improvisation (3-4 minutes). It is possible to do a Take 2 or Take 3 improvisation based on the first music improvisation (Take 1). These further takes can focus on emergent musical motives, images or be openly improvisatory, allowing whatever emerges. Make notes on this experience.
• **Step 2: Entering.** Listen to a recorded GIM session in order to re-experience the flow of imagery in response to the music. You have the option to follow the session transcript, or not while listening. If necessary, write down dialogue details that may be missing from the session transcript. Note your reasons for choosing this particular session or particular part of the music-imaging experience.

• **Steps 3 and 4: Highlighting and Shaping.** Highlight key imagery from a session transcript; new, thematic or evolving images. Intuitively combine these key images to create (shape) an Imagery Poem. You may want to note any connections between the music playing and key images in your poem. This process may take several “takes” to create a poem that communicates the message you are trying to illustrate.

Imagery poems distill and convey meaningful imagery in one’s process, e.g., memories, emotions, relationships, allies, paradoxes, breakthrough moments, meaningful themes. Here is an imagery poem that I created (as therapist) originating from the process of the client mentioned earlier in this paper:

**It Won’t Turn Black**
I can find my way even if it ends
I don’t have to be afraid, I can find my way for myself
The strings want me to be their friend, they need me
I can just be me, the strings can just be them
There will always be water, wind, notes, magic and it will never go black
I am the wind and it’s freeing, the power of letting go
I’m learning to see things differently
It will never end
It won’t turn black
(Session 43, Quiet Music)

• **Step 5: Musing.** Read your Imagery Poem(s) silently or out loud. Make notes on this experience. Create a music improvisation in response to the poem. The poem can also be recited during the improvisation or sung while improvising (improvised song writing). Alternatively, you can draw a mandala in response to the poem. At any point in this methodology, Mandalas can be created.

• **Step 6: Reflecting.** Write a narrative on the process so far, e.g., reflective or analytic memo, story, letter to self). You may wish to create a music improvisation with a particular intention (e.g., what stands out so far) or draw a Mandala. However, it is important at this stage to put your reflections into writing so as to anchor emerging thoughts and feelings.

**Concluding Remarks**
When writing this paper for these proceedings, I had not yet implemented this arts-based research study because I was still completing revisions for ethics approval from Wilfrid Laurier University’s Research Ethics Board. The study will be implemented during my 1-year Sabbatical Leave, which starts July 1, 2017.

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References


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For his doctoral dissertation (completed at Temple University), the author surveyed Fellows of the Association for Music and Imagery regarding their use of the various practices that have become associated with Guided Imagery and Music. Modifications to the individual and group forms of GIM that were created by Helen Bonny had been reported in the literature, but their prevalence was unknown. Fellows were asked to rate specific practices in terms of the frequency used in their GIM practice. Demographic data were also gathered. T-tests, ANOVAs, and Spearman correlations were also computed; however, the results of these tests will not be presented here. Further analysis of the prevalence data revealed that practices that were part of Bonny’s original design (the Bonny Method) were in frequent use by a majority of GIM Fellows. All of the modified practices were also in use, although less frequently. Factor analyses indicated that Fellows who tended to use Bonny Method practices tended not to use modifications and those who tended to use modifications tended not to use Bonny Method practices.

Keywords: Bonny Method; modifications; GIM Fellows; survey; factor analysis.

More than four decades ago, Helen Bonny conceived of the use of deep listening to predesigned programs of classical music while dialoguing with a trained guide for healing and self-actualization (Bonny & Goldberg, 2002). In her final design, an individual Guided Imagery and Music (GIM) session lasts 1½ to 2 hours and consists of four phases: Prelude (20-30 min.), Induction (10-15 min.), Music Listening/Imaging in an expanded state of consciousness (30-50 min.), and Postlude (20-30 min.). Group sessions can vary in length, structure, use of music, and guiding. Traditionally, GIM was used in private settings with adults, and practiced within a humanistic orientation that emphasizes self-exploration and integration of all aspects of the self (Bonny, 2002).

In the years that followed, GIM spread around the world, and the clinical applications and permutations of the method widened (Bonny & Goldberg, 2002; Bruscia, 2002a, 2002b; Clark, 2002; Grocke, 2002; Lewis, 2002; Summer, 2002). Mostly used in private settings to help individual adults with anxiety, depression, loss, life transitions, and self-actualization, individual and group GIM practices grew to treat persons with a wide variety of illnesses and disorders in psychiatric and medical hospitals, substance abuse programs, hospices, and nursing homes. GIM also became used with children and adolescents. In conjunction with this growth, modifications to Bonny’s individual and group forms of GIM were reported. Three reasons for modifying the Bonny Method were found in the literature: client need, practitioner preference, and setting. Modifications include variations in the length of session and duration of music listening, variations in the selection and use of music, and variations in verbal dialogue and guiding. Modifications to theoretical orientation were also reported. Some referred directly to the use of non-humanistic orientations, while others used GIM in combination with other therapeutic methods and techniques. One caveat here regarding modifications to accommodate client need (e.g., fragile ego, physical frailty, limited attention span, or impaired cognition) is that other authors report using the Bonny Method with clients in similar condition (Meadows 2002).
Parallel to this growth, imagery techniques both with and without music were being developed outside of the GIM community, and often times these were referred to as Guided Imagery (Bruscia 2002). In response to both this and to the modifications, Bonny decided in 1996 to change the name of her method from Guided Imagery and Music to the Bonny Method of Guided Imagery and Music. Despite this, there was a lack of consensus within the GIM community regarding which practices belonged to the Bonny Method, which belonged to GIM, and which belonged to music therapy or other professions (Bruscia 2002). In 2017, this lack of consensus remains.

By December 2009, when the survey data was collected, the prevalence of the various practices used by GIM Fellows was unknown. An anonymous 59 item electronic survey was designed to explore the incidence, nature, and growth of GIM practice both inside and outside of the United States. Those GIM practitioners whose listing in the 2009 Association for Music and Imagery (AMI) Fellow’s Directory included an e-mail address (207 of 210) were invited to participate in the survey.

MAIN CONTRIBUTIONS/SELECTED RESULTS

Demographics, Client Characteristics, and Treatment Delivery

107 GIM fellows responded to the survey, a response rate of 52%. 16% of these respondents were male and 84% were female. Compared to the percentage of males in the 2009 Fellows’ directory (12%), males were slightly overrepresented. More than 50% of the respondents reported being 50 years of age or older; it is unknown whether these data are representative. 9% of respondents reported having more than 20 years in practice, 30% percent reported 11-20 years, another 30% reported 6-10 years, and 32% reported having 0-5 years in practice. These data seem to correspond to the length of time that the GIM method has been in existence and seem to indicate a gradual expansion in the number of GIM fellows in practice. The number of respondents who indicated practicing within the U.S. (54%) and outside the U.S. (46%) closely matches that of the demographics in the 2009 Fellows Directory where 53% of fellows had U.S. addresses and 47% had addresses outside the U.S. Most respondents reported a master’s or doctoral degree as their highest level of education, while the remaining 12% reported having a bachelor’s degree. 61% of respondents reported being primarily trained as music therapists. The majority of the non-music therapist respondents indicated being primarily trained in a mental health profession (e.g., psychology, counseling, social work).

Respondents were asked to indicate the age and the health concerns of the clients they treated in their past and current GIM practice. Past GIM practice was defined as the time frame between the date the respondent became a GIM fellow and December 31, 2008. Current GIM practice was defined as the time frame between January 1, 2009 and the December 2009 when the survey was conducted. Predictably, the data indicated that Adult clients aged 18 to 64 years dominate the past and present caseloads of GIM fellows. There was a marked decline from past to current practice in work with the other three age groups: Older Adults, Adolescents, and Children. A majority of the respondents reported never having worked with children in the past (88%) or in the present (98%).

Seven client concerns were presented for respondents to rate in terms of the percentage addressed in their past and present practice. In summary, Normal Neurosis, Anxiety and/or Depression, and Psychological Trauma were the most common clinical issues addressed in their past and current practice. Overall, the data showed a decrease from past to current work with each of the client concerns included in the survey. The greatest decreases from past to present were in therapists’ work with Substance Abuse/Addiction, Cancer, and Terminal Illness. There was, however, an increase in the mean percentage of practice that each of the client concerns occupied, suggesting increased specialization.

Respondents were asked how many individual and group GIM sessions they provided on average per month (0, 1-5, 6-10, 11-15, or More than 15). Adding the responses together revealed that
prior to 2009 at least 417 and as many as 680 individual, and, at least 78 and as many as 215 group GIM sessions were offered worldwide each month. During the year 2009, at least 317 and as many as 557 individual, and, at least 79 and as many as 215 group GIM sessions were offered each month worldwide. This indicates a decrease in the number of individual sessions and virtually no change in the number of group sessions provided from past to current practice but since the respondents were asked to rate ranges of sessions per week it is impossible to be certain.

Regarding practice settings, 85% of respondents indicated that they primarily practice individual GIM in private practice. In contrast, 93% of respondents conducted group sessions in therapeutic facilities or agencies, psychiatric hospitals, medical hospitals, universities, and conferences/workshops.

Concerning their primary theoretical orientation to GIM practice, respondents favored humanistic/existential (30%), followed by psychodynamic (22%), transpersonal/spiritual (19%), and Jungian (13%). Few respondents indicated Bioenergetic, Somatic, and/or Chakra (1%) or Cognitive/Behavioral (1%) and no respondents indicated “Gestalt” as their primary theoretical orientation. The remaining 14% of respondents indicated ‘Other’ orientations: Eclectic (9%), Integrative Psychology (3%), Feminist (1%), and Resource-Oriented (1%).

Practice Ratings

The remainder of the survey was devoted to the individual and group practices, though the ratings for group practices will not be presented here. Respondents were asked to rate each of 59 practice items in terms the frequency used in individual sessions since becoming a GIM Fellow using the following scale: never, seldom, sometimes, often, always. What follows is a summary of the frequency data for individual practices.

A majority of respondents reported using the following session and music lengths often or always: 1½ to 2 hour session (83%), 30 minutes or more of music for a 1½ to 2 hour session (76%), and 21-30 minutes or more of music for a 1½ to 2 hour session (67%). A majority of respondents reported using a 1 hour session at least sometimes (39% sometimes, 27% often, 2% always) while a ½ hour session was used seldom or never by 90% of respondents. For sessions lasting less than 1½ hours, a majority of respondents reported using 6-30 minutes of music sometimes or more frequently.

A large majority of respondents reported often or always using pre-designed programs (89%) while extemporaneous programming was used less frequently (35% seldom or never, 44% sometimes, 18% often, 3% always). 70% or more of respondents reported sometimes or less frequently using directive interventions during the prelude and postlude and directive guiding techniques.

At least 70% of respondents indicated using the following orientations sometimes or often in formulating interventions during the prelude and postlude and during the music: humanistic/existential, transpersonal/spiritual, psychodynamic, and Jungian. Ratings of always were low (2%-9%) in using humanistic/existential and transpersonal/spiritual to formulate intervention during all session phases. Except for one respondent’s report of an exclusive use of a psychodynamic orientation during the prelude and postlude, no respondents indicated always using psychodynamic or Jungian orientations to formulate interventions during the prelude and postlude or during the music imaging. At least 80% of the respondents reported sometimes or less frequently using the following orientations to formulate interventions during the prelude and postlude and during the music imaging: Gestalt, Bioenergetic Somatic Chakra, and Cognitive/Behavioral.

Respondents were also asked to indicate how frequently they offer clients theoretical interpretations of their imagery and/or process during the prelude and postlude. 95% of respondent’s indicated sometimes or less frequently using theoretical interpretation during the prelude while 81% used it sometimes or less frequently during the postlude.
Respondents were asked what types of music they use when programming extemporaneously or in creating pre-designed programs for use in GIM. 85% reported *often or always* using classical music. The following types of music were used *sometimes* or less frequently by a majority of respondents: Movie (85%), World (90%), and New Age (90%). 100% of respondents reported that they *seldom* or *never* use Pop music.

Ratings for other practices used in individual sessions that were collected but are not included here include use of: mandalas during the prelude and postlude, specific programmers’ programs, a starting image, dialogue during the music imaging, having the client sit upright during the music, having the client travel with their eyes opened, music-centered interventions, introducing an image during the music, specific approaches to shortening music programs, types of extemporaneous programming, physical intervention, and making music during the prelude and postlude.

**Bonny Method and Modifications**

*Cross item analysis.* Using distinctions evident in Bonny’s writings and detailed by Bruscia (2002), a cross item analysis was conducted on respondent ratings for six practices associated with the Bonny Method. The results revealed that 72% *often or always* used at least one of the following: 1½ to 2 hour session, 30 minutes or more of music, verbal dialogue during the music imaging, and pre-designed programs. In contrast, only 46% of respondents *often or always* used all four of these. As previously revealed, 49% of respondents *often or always* use a humanistic/existential or transpersonal/spiritual orientation, yet only 25% *often or always* use one or both of these orientations in combination with all four of the practices listed above.

*Factor analysis.* Two factor analyses were computed to study the relationship among frequency ratings for individual practices; one of these is presented here. In simple terms, a factor analysis is an advanced level correlation that calculates relationships among several variables at the same time. Variables were chosen for analysis by observing a Pearson’s correlation matrix that allowed each of the ratings for practices in individual GIM to be viewed in one to one relation to each other. The matrix showed significant positive correlations between frequency ratings for practices associated with the Bonny Method, and, significant positive correlations between frequency ratings for practices associated with modification. The matrix also showed significant negative correlations between frequency ratings for Bonny Method practices and modifications, and vice versa. Thus, for the first factor analysis, frequency ratings were chosen to represent a balance of Bonny Method practices (1½ to 2 hour session, predesigned programs, humanistic/existential orientation, and verbal dialogue during the music imaging) and modified practices (1 hour session, extemporaneous programming, psychodynamic orientation, directive interventions, directive guiding). The results provided statistically significant support for the observation that respondents who tend to use practices associated with the Bonny Method tend not to use practices associated with modifications, and vice versa. Only two practices were positively related to each other across this boundary, verbal dialogue during the music imaging and extemporaneous programming.

**DISCUSSION, IMPLICATIONS, AND RECOMMENDATIONS**

Some of these survey findings seem ripe for discussion. That 70% or more of respondents indicated using *sometimes* or *often* using a humanistic/existential, transpersonal/spiritual, psychodynamic, and Jungian orientation in formulating interventions is curious. Are GIM practitioners using multiple

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1 Correlations were initially computed using the Pearson coefficient, but were later more accurately recalculated using the Spearman coefficient with no/minimal impact on the results (Muller 2014).
orientations within a single session? Where did they learn how to do this? Are some GIM trainings teaching more than one orientation to the method? Is this reasonable? Perhaps respondents confused the notion of intervening from within an orientation with using concepts from different orientations to understand the client’s unfolding process. From the beginning, Bonny found concepts from many orientations helpful in understanding clients’ myriad experiences in GIM. This explanation seems supported by the vast majority of respondents’ *sometimes* or less frequent use of theoretical interpretation during the prelude and postlude. Perhaps more fellows are intervening from within a humanistic orientation than is shown by the data? More research is needed to investigate how theoretical orientations are used in the Bonny Method and in modified GIM.

That only 46% or less of respondents *often or always* use, in combination, the four practices and theoretical orientation(s) included in the cross item analysis of Bonny Method practices raises some questions. To what extent are GIM trainers teaching the combined use of these practices? To what extent are practitioners modifying the Bonny Method to accommodate client needs, to suit their own personal preference, or to adapt to a therapeutic setting? As mentioned in the introduction, both the Bonny Method and modified GIM have been used with clients who have similar health concerns. As presented in the previous section, 85% of respondents identify private practice as the primary setting for individual GIM. Private practice is also the primary focus of training under the AMI. In contrast, many authors who write about modifying the Bonny Method to accommodate psychologically or physically fragile clients refer to sessions occurring in non-private practice settings (e.g., inpatient and outpatient hospitals). Add to this the questions raised in the previous paragraph regarding using theoretical orientation(s) to understand the client’s process versus intervening based on one or more. Further research is needed to investigate the relationship between modifications, client need, therapist preference, setting limitations, and the impact that different configurations of these have on the client’s experience and process in GIM.

That boundaries detailed by Bruscia (2002a) are reflected in GIM fellows’ practice ratings raises some questions: Do some training programs favor Bonny Method practices, while others favor modified practices? If so, are some GIM fellows better trained in modified practices than they are in the Bonny Method and vice versa? Should some degree of mastery of the Bonny Method precede being trained to use modified GIM? Can the reverse be true? In learning the Bonny Method, is being a client in modified GIM as informative as being a Bonny Method client, or vice versa? Can modified GIM be safely and effectively practiced without prior supervised practice and personal experience? Research is needed to explore these questions objectively. Moreover, it is recommended that the GIM community get together and adopt a system for distinguishing between the Bonny Method and modified practices. Bruscia (2002a, 2015) has detailed clear boundaries between the Bonny Method, modified GIM, and non GIM practices, some of which have been validated by analysis of the survey data. Without clarification of these boundaries who knows who is trained to do what? Who knows what practices are potentially harmful and what training is needed to practice them safely?

In conclusion, the survey data show that many forms of individual and group GIM are being practiced worldwide in a variety of settings to help a wide range of clients. The results also indicate that there is more to learn about GIM practice, and that deeper study of modifications can help practitioners to better know the Bonny Method. Given the recent proliferation of modifications in the GIM literature, it is important that GIM practitioners endeavour to more fully explore the nature and potentials of the Bonny Method, and to remain vigilant in noticing and detailing how even the slightest modification might compromise its alchemy.

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Note
This paper contains a summary overview of the author’s doctoral dissertation and portions of a subsequently published book on variations in GIM. The full versions can be found at:

References