

PREDICTORS OF CLIENT RESPONSIVENESS TO THE BONNY METHOD
OF GUIDED IMAGERY AND MUSIC (BMGIM)

A Dissertation
Submitted to
the Temple University Graduate Board

in Partial Fulfillment
of the Requirements for the Degree
DOCTOR OF PHILOSOPHY

by
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May, 2011

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ABSTRACT

Predictors of Client Responsiveness to the Bonny Method of Guided Imagery and Music

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Doctor of Philosophy

Temple University, 2011

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The purpose of this study was to identify predictors of responsiveness to the Bonny Method of Guided Imagery and Music (BMGIM), as measured by the Responsiveness to Guided Imagery and Music scale (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 BMGIM. Sixty volunteer participants were recruited from the general population. They all attended one research session where they participated in a group Guided Imagery and Music (GIM) experience. Prior to the group GIM experience, participants completed a demographic questionnaire (including a CME measure), the Spielberger State Trait Anxiety Inventory (STAI), and the SOC scale. After the group GIM experience, participants completed the RGIM scale. Once data collection was completed, the reliability and construct validity of the RGIM was examined. Exploratory factor analyses revealed that the RGIM contained five distinct factors: (a) Ability to Relax (AR), (b) Ability to Image to Music (AIM), (c) Responsiveness to Music and Guiding (RMG), (d) Comfort with Self-Disclosure (CSD), and (e) Meaningfulness of the Experience (MOE). These were the dependent (criterion) variables in this study. Before analyzing the data, the researcher ran diagnostics to check for assumptions of regression.

Correlational statistical techniques were used to identify significant relationships between variables, and three sets of exploratory multiple linear regressions were used to identify which combinations of variables were the most accurate predictors of RGIM factors. Results of the first multiple regression showed that together, SOC, classical music experience, and age are predictors of “Ability to Image to Music,” “Responsiveness to Music and Guiding,” and “Meaningfulness of the Experience.” Results of the second multiple regression showed that together, state anxiety, classical music experience, and age are predictors of “Ability to Image to Music,” “Responsiveness to Music and Guiding,” and “Meaningfulness of the Experience.” Results of the third multiple regression showed that together, trait anxiety, classical music experience, and age are predictors of “Responsiveness to Music and Guiding.” A number of other significant and non-significant results were found and are discussed. Limitations of the study as well as recommendations for future research, clinical practice, and education/training are presented.

DEDICATION

To James O. Walke who did everything he possibly could (and then some) to help me achieve this goal. Thank you for your unconditional love and unfaltering support. You are my family.

ACKNOWLEDGEMENTS

I would first like to thank my committee members. To my advisor Dr. Kenneth Bruscia, thank you for your steadfast guidance and wisdom, and for challenging me to fulfill my potentials. I will always be grateful and proud that I had the opportunity to study with you. To Dr. Jennifer Cromley, thank you for your time and for your statistical expertise. You are a wonderful teacher. To Dr. Darlene Brooks, thank you for your keen insights and candor. To Dr. Beth Bolton, thank you for your thoughtful feedback.

I would like to thank the entire Temple music therapy faculty. To Dr. Kenneth Aigen, Dr. Darlene Brooks, Dr. Kenneth Bruscia, and Dr. Cheryl Dileo – I have learned so many things from each one of you that have contributed to my growth as a music therapy professional and thus to my ability to complete this Ph.D. Thank you for giving so freely of your time and expertise, and also of yourselves. This has meant a great deal to me.

To my Temple friends and colleagues, each one of you in some significant way helped me to complete this journey and have a bit of fun along the way. Bryan, Lillian, Nadine, Scott, Adenike, Andi, Carol, Mike, and Seung-A – thank you for everything.

To my MMT “Group of 7,” Adrienne, Melissa, Noreen, Ruth, Susan, and Caryl Ann (who we dearly miss), and my other music therapy friends and colleagues, Jennifer, Cynthia, Erin, Tammy, and Trish, thank you for your support and friendship. I cannot imagine a better (or more attractive) cheering section!

To my dear friends Jamie, Lisa, and Lorrie, thank you for always being there.

To Liz and Nancy, thank you both for all that you have contributed to my life through GIM.

To the Board Members of the Canadian Music Therapy Trust Fund and the staff at the Music Therapy Centre, (especially Fran, Wanda, Jodi, and Christine), thank you for providing me with the space within which to conduct this research, and thank you for the help and encouragement that each one of you gave me at various points throughout this process.

I would like to thank Sunnybrook Health Sciences Centre for giving me time off to pursue my studies. I would also like to thank all of the study participants for giving of their time and of themselves.

Finally, I would be remiss in not thanking Dr. Rosemary Fischer who first taught me how to be a music therapist. Everything else has been icing on the cake.

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CHAPTER 1

INTRODUCTION

The Bonny Method of Guided Imagery and Music

The Bonny Method of Guided Imagery and Music (BMGIM)¹ is a form of music psychotherapy developed in the 1970's by Helen Bonny (Bonny, 1978; Clark, 2002). BMGIM is designed to facilitate an individual's exploration of consciousness through imagery experiences evoked by listening to specially designed recorded Western classical music programs (Bruscia, 2002a). Imagery experiences may include visions, thoughts, feelings, memories, fantasies, and/or body sensations (Grocke, 2005).

BMGIM evolved out of a time when LSD was being used in psychiatry to evoke altered states of consciousness. During this time, Helen Bonny was employed as a music therapist and researcher at the Baltimore Psychiatric Institute in the United States, and it was her job to design music programs to be used in conjunction with LSD therapy. Bonny discovered that she was able to use music to evoke altered states of consciousness without the use of drugs. By the time she completed her doctoral dissertation in 1976, the individual form of BMGIM had been fully developed, and practitioners were being trained through the Institute for Consciousness and Music (ICM), which had been founded by Bonny in 1973 (Bonny, 1978; Clark, 2002; Erdonmez Grocke, 1999).

Although individual BMGIM therapists may practice within different theoretical orientations or modify the method for a variety of reasons (Bruscia, 2002a), a typical BMGIM session consists of five phases, and lasts for approximately one-and-a-half to two hours. In phase one, the therapist and client engage in a *preliminary conversation* where they discuss relevant concerns or goals. Nonverbal techniques such as musical

¹ In the literature, BMGIM may also be referred to as the Bonny Method, or GIM.

improvisation or mandala (circle) drawing may also be utilized during this phase to help identify pertinent issues. In phase two, the client reclines, and the therapist guides him/her through an individualized *relaxation induction*. The therapist then provides a starting image that is usually related to information that emerged during the preliminary conversation. In phase three (*music listening*), the client listens to a specially designed recorded classical music program (chosen by the therapist for specific therapeutic purposes), and spontaneously creates images in response to the music. The client verbally relates these inner experiences to the therapist who in turn verbally responds in a non-directive, non-analytical, and supportive manner (Bruscia, 2002a, 2002b). The therapist transcribes the dialogue for future reference. When the music ends, the imagery is brought to a close and the therapist uses verbal suggestions to help the client return to a normal state of consciousness. The *return* is phase four. In phase five, a *postlude discussion* occurs where the client and therapist reflect upon the client's music-imagery experience using verbal discussion, mandala drawings, clay work, journaling, and/or other creative techniques. The client is given a copy of the session transcript and may also keep his/her creative expressions (e.g., artwork), which may be utilized for further private reflection. Afterward, the therapist independently reviews the session transcript noting key themes, images, or issues, and if applicable, plans for future sessions (Young, 2010).

BMGIM can be utilized with clinical and non-clinical populations. For normal healthy adults, it is most often used for the purpose of personal growth and development and/or to help individuals identify and work through psychological issues that may be impinging upon their lives (Meadows, 2002a). For clients who have clinical conditions

(i.e., post-traumatic stress disorder, depression, addictions, cancer, other), the method may be adapted accordingly, if necessary, and goals can address a wide variety of physiological, emotional, psychological, spiritual, social, and/or behavioral issues (Erdonmez, 1992).

The Need for Client Assessment in BMGIM

Not all persons are suited to BMGIM. According to Summer (1989), BMGIM is only appropriate for individuals who are capable of symbolic thinking, able to differentiate between symbolic thinking and reality, able to relate experiences to the therapist, and able to achieve positive growth as a result of [BM]GIM (p.41). Some practitioners modify the method to accommodate specific needs of individual clients (Bruscia, 2002a, 2002b; Clarkson, 1998-1999; Körlin, 2007-2008; Meadows, 2002a; Moffitt & Hall, 2003-2004; Muller, 2010), or to accommodate particular treatment contexts (Booth 2005-2006; Bruscia, 2002a, 2002b; Marr, 1998-1999; Powell, 2007-2008; Ritchey Vaux, 1993; Muller, 2010). Ultimately, it is the therapist's responsibility to determine if engaging someone in a BMGIM process (i.e., a series of sessions) could potentially be detrimental to that person in any way. Bruscia (2002b) has found that BMGIM is contraindicated whenever an individual lacks: (a) the medical and physical stamina needed to experience the music and images that may arise from the music, (b) the emotional stability and ego strength needed to undergo the feelings that may arise in response to the music and the images evoked, (c) the intellectual abilities needed to understand his/her own experiences in BMGIM, and not be dangerously overwhelmed or confused by them; (d) the verbal abilities needed to dialogue with the guide during and after the imagery experiences, (e) sufficient reality orientation to distinguish between the

imaginary and real worlds, and (f) the ego boundaries needed to maintain a separate sense of self after deep imagery experiences where boundaries between self and other (or the environment) may merge (p. 274). To determine if BMGIM is a safe and appropriate intervention for a particular client, or to determine if the method needs to be modified, BMGIM therapists must conduct an initial assessment. This process involves gathering information that will help the therapist to better understand the potential client's problem(s), condition(s), and resources, while also providing insight into how he/she might work most effectively with a particular individual (Bruscia, 2002b).

Although assessment is considered to be an integral and ongoing part of BMGIM, very little has been written on this subject and to date, only one publication provides an overview on this topic (Bruscia, 2002b). In this publication, Bruscia describes various kinds of assessment efforts that may be used in BMGIM. These include: (a) the types of goals that may be established, (b) intake procedures, (c) ways of observing clients' responsiveness during music and imagery experiences, and (d) ways of analyzing verbal data, imagery, mandalas, and other projective devices. While no similar publications exist, other clinical writings do refer to various assessment procedures utilized by BMGIM practitioners. These include: (a) history-taking/preliminary questionnaires (Bonny, 1999; Bruscia, 2002b; Pickett, 1995), (b) symptom examination (Pickett & Sonnen, 1993; Smith, 1996-1997), (c) psychological testing (Wrangsjö & Körlin, 1995), (d) mandala assessment (Borling, 1992; Bruscia, 1991; Bush, 1992; Ventre, 1994), (e) various approaches to analyzing clients' imagery (Bonde, 2004; Bruscia, 1992; Clark, 1995; McKinney, 1993; Short, 1991; Walker, 1993), analysis of clients' transference (Bruscia, 1995a), (f) questionnaires on the BMGIM experience (Bonny, 1978; Weiss,

1996-1997), and (g) the GIM Responsiveness Scale (GIMR; Bruscia, 2000).

Additionally, a study by Scott (2007-2008) suggested that self-report measures which determine clients' coping styles should be included as part of the initial BMGIM assessment process.

Surprisingly, the majority of assessment procedures have been borrowed or adapted from other psychotherapeutic modalities, some of which do not utilize either music or imagery. Furthermore, only three of these assessment tools (i.e., Bonny, 1978; Bruscia, 2000; Weiss, 1996-1997) are indigenous to BMGIM, and based on a review of the literature, none of these three tools are being used extensively in research or practice. It appears that in spite of the crucial role that assessment plays in BMGIM, very little research has been conducted in this area, and few attempts have been made to develop a standardized indigenous assessment tool. Additionally, it is not known if any of the assessment procedures being utilized in BMGIM adequately address the contraindications outlined above.

The GIMR Scale

Prior to the current study, the GIMR scale developed by Bruscia (2000) was the only existing assessment tool, indigenous to BMGIM, designed to provide a quantifiable means of assessing client responsiveness and evaluating progress in BMGIM. It was also intended to be used as a measurement tool in BMGIM research. The therapist/researcher utilizing the GIMR rates individual clients' responses to key dimensions of the BMGIM experience (i.e., relaxation, imagery, music, guiding, verbal processing, and general attitude) on a 28-item, 5-point scale. A total score is calculated for each dimension, and the overall total score is considered to be an overarching measurement of a client's

responsiveness to a particular BMGIM experience. The variables contained in the tool were regarded as central determinants of responsiveness, and therefore well suited for widespread use among BMGIM therapists/researchers (i.e., regardless of a practitioner's preferred theoretical orientation or clinical population).

In spite of the careful construction of the GIMR, however, the construct validity of this tool has been called into question. Meadows (2000) conducted a series of three studies where he examined the validity and reliability of the GIMR. In the first study, he found that the GIMR had satisfactory content validity (i.e., the items used in the scale collectively covered the material that the instrument was supposed to cover) by comparing it to imagery measures typically utilized in other therapeutic contexts. It was not possible to examine similar quantitative tools from the BMGIM literature as none exist. By comparing the GIMR to other imagery measures, and by identifying dimensions of BMGIM that are unique to the method, Meadows also demonstrated that the GIMR has face validity (i.e., the tool "looks like" it is measuring what is supposed to be measuring).

In the second study, Meadows examined the construct validity of the GIMR scale (i.e., does the scale measure the qualities that it is supposed to measure?) by comparing research subjects' GIMR scores to two different measures of psychological health: (a) Antonovsky's (1987; 1993) Sense of Coherence (SOC) scale, and (b) Gleser and Ihilevich's (1969) Defense Mechanisms Inventory (DMI). The rationale for this comparison was based upon Bruscia's idea that GIMR measures of responsiveness are indicators of a client's overall ability to benefit from BMGIM and that this ability may also be a function/predictor of a client's potential for psychological health (Bruscia cited

in Meadows, 2000). Therefore, the construct validity of the GIMR depended upon the extent to which GIMR measures related to other measures of psychological health. Although strong correlations were found between sub- and total scores on the GIMR itself (Pearson r correlation range was .43-.93, $p < .05$; indicating that the tool has internal consistency), no significant relationships were found among the total scores on the GIMR, SOC, and DMI, thus leading Meadows to conclude that the GIMR may not be a valid measure of these particular areas of psychological health.

Finally, in the third study, Meadows examined interrater reliability (i.e., the extent to which raters agree on their judgments of an outcome) by having himself, several BMGIM trainees, and a BMGIM trainer use the GIMR to rate BMGIM sessions that they either facilitated or observed. Results showed significant levels of interrater agreement (alpha range was 0.49-0.80, $p < .05$), which suggested that the GIMR is reliable in the way that it measures responsiveness. Although these results are encouraging, their importance is diminished by the fact that the construct validity of the tool was not established (i.e., it does not matter if the raters have a high level of agreement when one is uncertain about what is actually being measured).

Before dismissing the GIMR all together however, the limitations of Meadows' second study must be considered. Although subjects' SOC scores did fall within the bounds of scores for the general population (Antonovsky, 1993), there are several reasons why it is still difficult to make generalizations about the results. First, a convenience approach to sampling was employed, and no criteria for inclusion or exclusion were outlined. A power analysis was not conducted to determine a minimum necessary sample size and the sample size was small ($n = 30$). Second, although none of the subjects had

previous experience with BMGIM, 28 had previous experience in some form of therapy, and 24 had some experience with imagery in therapy. These variables were not accounted for in the analysis and may have inadvertently influenced the results. Third, although the SOC scale has been found to have good reliability and validity (Eriksson & Lindström, 2005; Feldt, et al., 2007), the validity of the DMI has been called into question (Crehan, 1998; DeStefano, 1998), and it may not have been an appropriate tool for this study. Finally, by his own admission, Meadows' GIMR scores may have been contaminated by his own personal reactions to the subjects (i.e., his countertransference) and/or his dual role as therapist/researcher. In the second study, Meadows both facilitated and scored subjects' BMGIM sessions. Upon analyzing the data, he found that "responsiveness to the guide" was a predictor of all of the other GIMR measures. He concluded that "the [therapist/guide] may be influenced by the client's verbal abilities and this may distort the [therapist's/guide's] perceptions of how the client is responding to all elements of the GIM experience" (Meadows, 2000, p. 29). Meadows also stated that "a variety of factors may have...contributed to the results of these tests of construct validity and that further research is indicated" (p.29). Based upon the evidence that satisfactory content validity, face validity, internal consistency, and interrater reliability of the GIMR were established, that Meadows' study on construct validity had significant limitations, and that great care was taken in the development of the tool, it was the current researcher's position that the GIMR still held promise as a measure of assessing clients' responsiveness to BMGIM.

The current researcher created an adapted version of the GIMR to address some of the aforementioned limitations of the tool and of Meadows' study. The Responsiveness to Guided Imagery and Music (RGIM) scale (see Appendix A) required research

participants to rate their own Guided Imagery and Music (GIM) experiences which eliminated the possibility of biased scoring on the part of the therapist/researcher. Additionally, the tool was administered to individuals who participated in a group GIM session rather than in an individual BMGIM session. In this way, the researcher was able to gather data from several individuals simultaneously which helped to increase the sample size. Consequently, the results may have implications for both individual and group GIM practice. The individual and group formats of GIM are quite similar with the main exceptions being that in group GIM, clients do not dialogue with the therapist during the music listening phase and the music programs utilized are shorter in duration (Bruscia, 2002a). The RGIM attempted to address these differences and the main purpose of the tool remained the same as that of the GIMR—to measure clients' responses to key dimensions of a GIM experience. Individual items contained in the RGIM were re-worded to reflect a self-report measure. It also utilized a 7-point rating scale which is generally considered to be a more sensitive measure than the 5-point rating scale used in the GIMR. Finally, the construct validity of the RGIM was examined using factor analysis techniques after the data collection was completed. Further details regarding the results of the factor analyses are contained in Chapter Three.

The Need to Predict Responsiveness to BMGIM

Identifying predictors of responsiveness to BMGIM would have considerable benefits for both clients and practitioners. Quantifiable variables could be used to create a concise screening tool which would provide objective evidence as to why BMGIM may be indicated, contraindicated, or modified for a particular individual. This is not only important for prospective clients but also necessary if BMGIM is to be offered as a

service in health care systems that subscribe to evidenced-based models of care. Identifying specific characteristics or qualities that generally indicate potential for responsiveness to BMGIM could also result in increased and more appropriate referrals. Areas where potential clients are most likely to encounter difficulty could be identified, and practitioners could make necessary modifications or adaptations. This might prevent clients from having certain kinds of unhelpful or difficult experiences which could in turn reduce client attrition.

These ideas are aligned with research conducted by Scott (2007-2008) who suggested that individuals' coping styles may predict responsiveness to BMGIM, and that practitioners could better serve their clients by knowing more about them before introducing them to BMGIM. Additionally, all of these factors have the potential to increase both the perceived and actual cost benefits of BMGIM intervention—a necessary consideration for all public and private health care services in today's financially troubled society. Finally and perhaps most importantly, identifying predictors of responsiveness to BMGIM would help practitioners to provide the safest and most ethical service possible. A review of the 2010 Association for Music and Imagery (AMI)² directory revealed that many BMGIM therapists (at least 75%) work in private practice. In these situations, referrals are received from a variety of professional and non-professional sources, and it is not unusual for a client to self-refer. Information obtained through a preliminary interview is essentially limited to what the potential client is willing to share and what the therapist is able to casually observe. It is possible that a potential client has an undiagnosed or undetected psychiatric condition. Identifying variables that predict

² The AMI is a professional organization created to maintain and uphold the integrity of BMGIM practice and to provide support to BMGIM trainees and practitioners.

responsiveness to BMGIM could help practitioners to detect important contraindications when background information about a potential client is limited or inaccurate.

Sense of Coherence as a Possible Predictor of RGIM

Given the importance of assessing responsiveness to BMGIM, the possible implications of identifying contraindications, and the potential benefits of this form of therapy, and given the present status of knowledge on the GIMR/RGIM, more research was clearly needed on responsiveness to BMGIM and possible predictors. Sense of Coherence (SOC) is a measure of the extent to which a person finds life comprehensible, manageable, and meaningful (see Appendix B). The SOC construct emerged out of Antonovsky's salutogenic model of health, which regards health promotion and prevention of disease as being inextricably linked to one's capacity to effectively respond to stressful situations. This is very different from a pathogenic orientation which focuses on the occurrence of disease and/or injury and the subsequent loss of health (Antonovsky, 1987; Olsson, Hansson, Lundblad, & Cederblad, 2006). The three subscales of the SOC scale (Comprehensibility, Manageability, and Meaningfulness) have much in common with fundamental aspects of BMGIM. Furthermore, Bruscia (cited in Meadows, 2000) has proposed that these three health traits must be sufficiently present in order for an individual to fully engage in and/or benefit from BMGIM.

Comprehensibility refers to whether inner and outer stimuli make sense to an individual in terms of being coherent, ordered, cohesive, structured, and clear (Antonovsky, 1987). In BMGIM, it is essential that the client be able to understand imagery responses, and how they may relate to one's personal life. Manageability refers to the extent to which one feels he/she has the resources at hand to meet the demands

posed by the stimuli to which he/she is exposed (Antonovsky, 1987). In BMGIM, clients are encouraged to work through the various challenges that inevitably arise in sessions (i.e., allowing oneself to relax, opening oneself up to the music, experiencing emotions, images, and memories that may be difficult, trusting and responding to the therapist), and to identify resources that will help them to constructively address these challenges. Meaningfulness refers to whether one can perceive difficulties as welcome challenges worthy of investment rather than burdens to be avoided (Antonovsky, 1987). In BMGIM, clients are encouraged to stay invested in the BMGIM process and to work through difficult issues even when things become painful or hard to bear. This requires that the client perceive life and its challenges (and BMGIM and its challenges) as worthy of investment. Given these similarities between Comprehensibility, Manageability, Meaningfulness, and the overarching purposes and challenges of the BMGIM process, it seems reasonable to propose that SOC could in fact be a predictor of clients' responsiveness to BMGIM.

Previous research indicates that SOC may be a measure that warrants further examination as a predictor of RGIM. Wrangsjö and Körlin (1995) conducted a study with 14 adult psychiatric clients who participated in several individual BMGIM sessions. Results indicated that participants experienced a significant increase in Manageability and Meaningfulness subscores as well as total SOC scores after BMGIM intervention. In 2002, Körlin and Wrangsjö conducted a follow up study with a convenience sample of 30 research subjects and again found that participation in BMGIM led to significant improvements in Manageability and Meaningfulness subscores as well as total SOC scores. Finally, in a two-group pretest, posttest quasi-experimental study involving adults

undergoing chemical dependency treatment, Heiderscheit (2005) found a significant increase in the Manageability subscores of those who had BMGIM sessions as compared to those who did not ($d = .99$). Although these results must be interpreted with caution (due to sampling procedures and other methodological issues), they do indicate that a relationship may exist between SOC and BMGIM, and therefore this topic was worthy of further investigation.

Other Possible Predictors of RGIM

State Trait Anxiety (STAI)

The Spielberger State Trait Anxiety Inventory (STAI) is composed of two self-report scales that have been translated into over 45 languages and used extensively in research and clinical practice (Spielberger, Gorsuch, Jacobs, Lushene, & Vagg, 1983; Tilton, 2008). STAI Form Y-1 measures state (temporary) anxiety, which evaluates how respondents feel “right now, at this moment.” STAI Form Y-2 measures trait anxiety (anxiety proneness) which evaluates how respondents “generally feel” (Spielberger et al., 1983; Spielberger, 1985). Although the literature indicates that negative correlations may exist between SOC and anxiety scores (Konttinen, Haukkala, & Uutela, 2008), it has also been suggested that SOC may change on a temporary or permanent basis under highly stressful/traumatic circumstances (Schnyder, Büchi, Sensky, & Klaghofer, 2000). Furthermore, although some studies have shown that BMGIM can lead to decreased feelings of anxiety (Blake, 1994; Hammer, 1996) and reduced levels of cortisol (a stress hormone; McKinney, Antoni, Kumar, Tims, & McCabe, 1997), two studies were found which suggested that high levels of state or trait anxiety may have a negative impact on individuals’ ability to respond to BMGIM.

Burns et al. (2008) investigated the impact of a music imagery intervention on hospitalized individuals with leukemia. Although no significant differences were found in state anxiety levels between those who had received music imagery versus those who had not, they did find that patients with low negative affect at baseline who had received music imagery had a lower state anxiety mean score at the time of discharge than standard care patients who also had low negative affect at baseline (means of 48 versus 23, $p = 0.02$, $n = 18$). This led the authors to suggest that patients who were experiencing higher levels of distress at baseline may have had difficulty engaging in the music imagery thus limiting the effectiveness of the intervention.

Another study conducted by Scott (2007-2008) examined the extent to which individuals' coping styles impacted their responses to a single BMGIM session. Although all participants experienced significant reductions in both state and trait anxiety scores after the BMGIM session, persons who had a sensitive coping style (Sensitizers) had higher state and trait anxiety scores at posttest (after BMGIM) than those who had either a repressed coping style (Repressors; $d = -1.83$; $d = -2.33$) or a low anxiety coping style (Controls; $d = -0.96$; $d = -1.14$). There was no difference between the Repressors and Controls at posttest on state anxiety scores but Repressors' scores for trait anxiety were significantly lower than those of the Controls ($d = .86$). These results implied that although the most anxious people did have reductions in anxiety after BMGIM intervention, they were still significantly more anxious than the other study participants. Given the implications of these two studies, and given the fact that stress may be a mediating variable in the proposed relationship between SOC and responsiveness to

BMGIM, STAI appeared to be a measure that warranted further examination as a predictor of responsiveness to BMGIM.

Classical Music Experience

A common belief in BMGIM is that the music is regarded as a “co-therapist” (Bush, 1995; Skaggs, 1992; Stokes, 1992; Summer, 1998), and that one’s ability to benefit from BMGIM depends upon one’s ability to relate to the music (Abbott, 2005). The musical selections contained in the BMGIM programs come exclusively from the Western classical tradition—not only because this was Bonny’s area of musical expertise, but also because this genre contains structural qualities that make it particularly suitable for use in therapy (Bonny, 1978, 1994; Grocke, 2002; Summer, 1995). “The extent to which classical music is ‘familiar’ to GIM clients may differ according to the music preferences of the clients, their musical background and cultural background” (Grocke, 2002, p.94).

Although BMGIM therapists generally believe that clients’ perceptions of familiar music during BMGIM sessions will vary according to therapeutic need (Bonny, 1978; Grocke, 2002), practitioners have noted some unique issues that can occur when one is working with classically trained musicians or with others who are more familiar with the genre. These include: (a) musicians can over-analyze the music and/or feel unable to “let go” into the music, (b) due to conditioning, some performing musicians may disassociate themselves from the emotional aspects of music; (c) some performing musicians may experience body responses related to an area of musical expertise/experience (i.e., singers may experience music most vividly in the throat, nose, forehead, and diaphragm); (d) individuals who know the translations of vocal works may focus/fixate on the meaning of

the lyrics rather than experience the music in and of itself, and (e) individuals may have negative associations with classical music due to past distressing experiences that occurred during music lessons and/or performances (Keiser Mardis, 1989; Liz Moffitt, personal communication, June 5, 2009). In a publication about the cultural dimensions of music and imagery, Short (2005-2006) stated that in spite of its suggested archetypal qualities, the music used in BMGIM is in fact “culturally bound.” She used clinical examples to demonstrate this point and also emphasized that therapists need to have a heightened awareness of this issue in order to identify and understand culturally-based music responses.

Finally, in a recent Doctoral dissertation study on clients’ perspectives on the music in GIM, Summers (2009) found that the results appeared to support a previously held stance which maintained that great works of classical music have can have positive effects in GIM that supersede preconceived associations (Summers, 1992). She also stated however, that more research is needed because the preconditions (including the client’s previous relationship to music and to the genre of classical music in particular) that allow certain kinds of experiences (i.e., transpersonal) to unfold in GIM are not well understood.

All of this information raises an important question with regard to how an individual’s familiarity or lack of familiarity with the genre of Western classical music might affect ability to engage in BMGIM. Going further, a possible intervening variable in the proposed relationship between SOC and potential for responsiveness to BMGIM, one that was not considered in Meadows’ research, is an individual’s classical music knowledge and experience. It seems likely that persons who are more familiar with

Western classical music may respond differently to BMGIM than persons who are less familiar the genre. Thus, an individual's knowledge and experience of Western classical music was an important area of investigation in the present study.

Gender

There is also a distinct possibility that males and females may respond differently to BMGIM intervention. Some authors have suggested that the issues and experiences that clients bring to BMGIM therapy may be “engendered” (Bush, 1995; Meadows, 2001; 2002b). Others have suggested that the music itself is engendered and assumes a “mothering” role in BMGIM to which clients may have gender specific responses (Summer, 1995; Warja, 1999). Bruscia (1999) pointed out that most of the original BMGIM music programs were compiled by women and may contain certain qualities that do not adequately address the musical and therapeutic needs of men, thus implying that men and women may respond differently to the standard BMGIM repertoire. Finally, it has been suggested that the gender of the therapist in combination with the gender of the client can impact on the client's BMGIM experiences, and there may be conditions under which a female or a male therapist is indicated for a particular client (Brooks, 1998, 2000; Bruscia, 1995b; Meadows, 2001, 2002b). The literature certainly maintains that client gender is an important consideration in BMGIM intervention but very little research has been conducted in this area.

Although Meadows did not account for gender in his original investigation of the GIMR, he later re-examined the data to determine the role that gender might have played (Meadows, 2001). He found that out of 30 participants, the six male participants rated amongst the lowest in terms of GIM responsiveness. He conducted a series of Mann-

Whitney tests and found differences between males and females on their verbal ($U = 28.5$, $p = 0.02$) and total scores ($U = 34.5$, $p = 0.05$). These results led Meadows to suggest that gender may have been an intervening variable in his original study.

Meadows' suggestion is further supported by the results of a study conducted by Körlin and Wrangsjö (2001) who investigated the impact of gender differences on BMGIM outcomes (Inventory of Personal Problems (IPP), symptom-checklist-90 (SCL-90), and SOC). They found that male subjects had better results than female subjects in the Somatization subscale of the IPP (pre-posttest difference for men = 16.7, $p = 0.012$ versus pre-posttest difference for women = 5.9, $p = 0.044$) as evidenced in all three of the Mann-Whitney, Wilcoxon and Sign tests (data not provided). Women benefited more than men however, on relational aspects of the IPP, demonstrating significant changes on 7 out of 8 subscales (effect sizes ranged from .39 to .63) whereas men showed no significant changes on any of the IPP subscales. With regard to SOC, they found that male subjects improved significantly in Comprehensibility sub-scores ($d = 1.13$), whereas the female subjects remained statistically unchanged on this measure. Conversely, women showed improvement on Meaningfulness subscores ($d = .30$) and overall total SOC scores ($d = .40$) whereas men had no significant changes on these measures.³ The results of this study along with the literature outlined above indicate that gender could very well be another possible intervening variable in the proposed relationship between SOC and clients' responsiveness to BMGIM. Gender was therefore another important area of investigation in the present study.

³ Conflicting results are reported by the authors with regard to the Manageability scores; consequently, it is not possible to report on these findings here.

Age

Although the literature contains descriptions of modified versions of BMGIM that are utilized with adolescents or children (Powell, 2007-2008; Wesley, 2002), no studies were found that investigated potential relationships between clients' age and the efficacy of BMGIM intervention. Given the fact that functional and cognitive abilities can change over time (Kresevic, 2008), and that some publications have suggested that under normal circumstances, SOC may increase over the lifespan up to a certain point (Eeriksson & Lindström, 2005; Feldt et al., 2007; Klepp, Mastekaasa, Sandanger, & Kleiner, 2007; Richardson, Ratner, & Zumbo, 2007), it is reasonable to propose that age could be a fourth intervening variable in the proposed relationship between SOC and individuals' responsiveness to BMGIM. Age was the final area of investigation in the present study.

Statement of the Problem

BMGIM is a method of music psychotherapy that can be utilized with a variety of clinical and non-clinical populations (Bruscia & Grocke, 2002). Not all persons are suited to the method (Summer, 1989), and contraindications have been identified (Bruscia, 2002b). The literature refers to various assessment procedures utilized by BMGIM practitioners but it is not known if any of these tools adequately address potential contraindications, especially because most of the assessment methods are borrowed from other psychotherapeutic modalities and are not indigenous to BMGIM (Bruscia, 2000). The GIMR was the only indigenous assessment tool (prior to the present study) which provided a quantifiable measure of responsiveness to BMGIM but the construct validity of this tool was called into question (Meadows, 2000). The current researcher created an adapted version of the GIMR (the RGIM) in an attempt to address the identified

limitations of the measure. Identifying predictors of responsiveness to BMGIM could lead to the development of a concise screening tool that would provide practitioners with important information to help them determine if the method is indicated, contraindicated, or needs to be modified for a potential client. This in turn would enable BMGIM practitioners to provide a more knowledgeable, efficient, cost effective, and ethical service. This information could also lead to further development of much needed standardized BMGIM assessment tools. Results of the present study could also have implications for both individual and group GIM practice.

Given the fact that the three subscales of the SOC scale (Comprehensibility, Manageability, and Meaningfulness) have much in common with fundamental components of BMGIM, and that previous research indicates that a relationship may exist between SOC and BMGIM (Heiderscheit, 2005; Körlin & Wrangsjö, 2001, 2002; Wrangsjö & Körlin, 1995), SOC appears to be a measure that warrants further examination as a predictor of clients' responsiveness to BMGIM. Furthermore, current knowledge and literature implies that individuals' levels of anxiety (Burns et al., 2008; Scott, 2007-2008; Schnyder et al., 2000), classical music experience (Keiser Mardis, 1989), gender (Körlin & Wrangsjö, 2001; Meadows, 2001), and age (Eeriksson & Lindström, 2005; Feldt et al., 2007; Klepp et al., 2007; Richardson et al., 2007) could potentially be intervening variables in the proposed relationship between SOC and clients' responsiveness to BMGIM, and that each of these variables alone or in combination could also be predictors of individuals' responsiveness to BMGIM.

The purpose of the present study was to identify possible predictors of responsiveness to BMGIM, as measured by the RGIM. In order to do this, the reliability

and construct validity of the RGIM scale also had to be examined. Accordingly, the following questions were addressed: What is the underlying factorial structure of the RGIM scale? What are the relationships between RGIM factors and SOC? What are the relationships between RGIM factors and STAI? Do RGIM factors vary according to classical music experience? Do RGIM factors vary according to gender? Do RGIM factors vary according to age? Which of these variables, in combination, is the most accurate predictor of RGIM factors?

These questions were addressed by gathering data from individuals who participated in a group GIM session. The Sense of Coherence Scale (see Appendix B), a demographic questionnaire (see Appendix C), and the Spielberger State Trait Anxiety Inventory (see Appendix D for sample questions) were completed by participants prior to a group GIM experience, and the RGIM (see Appendix A) was completed after the session was over. Factor analyses were used to investigate the construct validity of the RGIM and the data were analyzed according to the factors that emerged. Correlational statistical techniques were used to identify significant relationships between variables, and exploratory multiple regressions were used to identify which combinations of variables were the most accurate predictors of RGIM factors. The hypothesis that guided this study was: When combined, SOC, STAI, classical music experience, gender, and/or age will account for a significant amount of variance in the factors contained in the RGIM. These Factors included: (a) Ability to Relax (AR), (b) Ability to Image to Music (AIM), (c) Responsiveness to Music and Guiding (RMG), (d) Comfort with Self-Disclosure (CSD), and (e) Meaningfulness of the Experience (MOE).

CHAPTER 2

RELATED LITERATURE

Introduction

As discussed in the previous chapter, responsiveness to BMGIM, as originally defined by Bruscia (2000), is a composite measure of one's ability to: (a) create imagery, (b) enter an altered state of consciousness, (c) respond beneficially to the music, and (d) respond psychotherapeutically to the BMGIM experience. As such, these were the foundational concepts used in identifying the criterion variables for the present study. The purpose of this chapter is to examine the extent to which the proposed predictor variables (SOC, anxiety, classical music experience, gender, and age) have been found to be predictive of the criterion variables (RGIM factors). This will be done through a review of the research literature (mostly from outside of the BMGIM literature). Whenever possible, this review will present effect sizes of statistically significant results, thus giving the reader a sense of the meaningfulness and practical significance of the research being cited. Effect sizes are generally defined as small ($d = .20$), medium ($d = .50$), and large ($d = .80$; Cohen, 1988). Effect sizes can also be negative, which means that scores are lowered rather than increased as a result of the intervention contained in the study.

Predictors of the Ability to Create Imagery

“Mental imagery refers to a process by which sensations [kinesthetic, olfactory, tactile, visual, auditory, and gustatory] can be... [experienced] without the appropriate stimuli being present” (Mulder, Hochstenbach, van Heuvelen, & den Otter, 2007). Since the late 1800's, a diverse range of imagery methods have been developed for use in therapy (Meadows, 2002c), and several methods for measuring imagery ability have been

devised for use in practice and research (Sheehan, Ashton, & White, 1983; Tower & Singer, 1981).

SOC

No studies were found indicating that SOC is predictive of mental imagery ability. However, since SOC is in part a measure of one's capacity to effectively respond to stressful situations, and since stress may affect one's ability to engage in imagery (Bryant & Harvey, 1996; Burns et al., 2008; Schienle, Schäfer, Pignanelli & Vaitl 2009; Scott, 2008-2009), it is reasonable to propose that a relationship may exist between SOC and mental imagery ability.

Anxiety

In a study that investigated visual imagery ability in persons diagnosed with varying degrees of Post Traumatic Stress Disorder (PTSD), Bryant and Harvey (1996) found that "Low Anxiety" subjects displayed greater visual imagery performance than either "PTSD" subjects ($d = -.73$) or "Specific Phobia" subjects ($d = -.77$). Additionally, when all subjects were included in the analysis, they found that both STAI-State and STAI-Trait anxiety scores were inversely related to visual imagery ability. This led the authors to suggest that anxiety may have impeded the cognitive processes required for subjects to experience visual imagery, or that traumatized subjects may be prone to avoid imagery activity all together because of possible associations with traumatic imagery. Similar suggestions were made in a study that investigated the neural correlates of aversive imagery and their association with worry tendencies. Schienle et al. (2009) found negative correlations between subjects' (19 females) worry scores and levels of brain activation during exposure to aversive images. This led the authors to propose that

“high worry” subjects may cognitively disengage when exposed to aversive imagery. It could also be the case that highly anxious individuals have difficulty freely engaging in a full range of imagery experiences thereby limiting potential benefits. In a study that investigated the nature and role of intrusive imagery in those who suffer from severe health anxiety (i.e., hypochondriasis), Muse, McManus, Hackmann, Williams, and Williams (2010) found that 78.2% of participants reported experiencing recurrent and distressing images which resulted in various responses including seeking reassurance, checking for symptoms, avoidance, distraction, and rumination. Although the results of these studies must be interpreted with caution, they do suggest that certain levels of anxiety may in fact be predictive of one’s ability to create imagery and/or freely engage in imagery experiences.

Classical Music Experience

Although research has been conducted on musical experience/background as a predictor of imagery ability, the results, especially with regard to non-auditory imagery abilities, are somewhat inconclusive. Herholz, Lappe, Knief, and Pantev (2008) used magnetoencephalography (MEG) to compare musicians and nonmusicians on a musical imagery task (i.e., imagining familiar melodies), and also compared the participants’ subjective judgments of their own imagery quality. Only the musicians exhibited a brain response to unexpected incorrect continuations of imagined melodies. Musicians also judged their imagery of the melodies to be better ($d = 3.90$) and more intense ($d = 1.47$) than that of non-musicians. The authors proposed that musicians’ intense training may lead to modifications of the neuronal network which results in superior musical imagery ability. Aleman, Nieuwenstein, Böcker, and de Haan (2000) found that musically trained

subjects performed better than musically untrained subjects on both a musical mental imagery task ($d = 1.02$) and on a non-musical auditory imagery task ($d = 0.79$). There was no difference however, between the two groups on a visual imagery task whereupon the authors proposed that musical training may result in more proficient processing of imagery in auditory cortical areas of the brain but not in occipital cortical areas.

Conversely, Brochard, Dufour, and Després (2004) found that musicians had better visuo-spatial perception and imagery abilities than nonmusicians on four reaction time measures with effect sizes being 1.31, 2.86, 4.61, and 1.57, respectively. It may be the case that the relationship between creative [musical] training and mental imagery ability depends on how the kind of training received relates to the task being used to measure mental imagery ability (Pérez-Fabello & Campos, 2007).

Gender

Some studies have indicated that gender may be predictive of certain imagery abilities but not others. Campos, Pérez-Fabello, and Gomez-Juncal (2004) found significant gender differences in imaging capacity among normal subjects, with men scoring higher than women on the performance based Spatial Test of Primary Mental Abilities (ST-PMA; $d = .49$). They did not however, detect any significant differences between men and women on a measure of self-perceived image control capacity (Gordon test). Similarly, Palermo, Iaria, and Guariglia (2008) found that men performed better than women on some imagery tasks including the Road Map Test ($d = 1.44$) and the Mental Rotation Test ($d = .83$) but not on others (the O'Clock Test, the Unusual Perspective Test, Familiar Squares' Description Test, and the Postcards Test). Heavey and Hurlburt (2008) examined the phenomena of inner experience (i.e., inner speech,

inner seeing (imagery), unsymbolized thinking, feeling, and sensory awareness) and found no statistically significant gender differences in the relative frequency of these phenomena, although there were large differences on these measures across participants. Chen, Comerford, Shinnick, and Ziedonis (2010) examined the efficacy of Qigong meditation (which involves the use of guided imagery and inward attention) versus other stress reduction programs in a residential treatment program for substance abuse. After a two week intervention period, females in the Qigong group reported more significant reductions in anxiety than any other groups (effect sizes not available) leading the authors to suggest that meditative therapy may be more effective for female versus male drug abusers. Research has also indicated that female gender is a strong predictor of the use of complementary treatment practices for cancer and other illnesses (Fouladbakhsh & Stommel, 2010). Although this may not be an indicator of imagery ability, it may indicate that generally, females are more inclined to engage in certain kinds of alternative healthcare practices including the use of imagery. It could also be the case that gender differences in mental imagery depend upon the nature of the material that the participants are required to mentally operate on, to which men and women may have different degrees of familiarity (Palermo et al., 2008).

Age

Some studies have provided evidence that age may be predictive of imagery ability. Isaac & Marks (1994) investigated developmental changes in image vividness among children and adults. They found that participants were capable of forming mental imagery from the age of seven onwards. Significant increases in imagery vividness occurred in females 8-9 years and in males 10-11 years. From 10-39 years of age, females

generally reported more vivid imagery than males but females over 50 reported significantly less vivid movement imagery (effect sizes not available). The authors suggested that differences in vividness ratings among the children's imagery may have been the result of physiological/hormonal differences, or that it may have been due to the gradual socialization of children into different gender roles. In the adult samples, the researchers suggested that movement imagery may be less relevant for woman over 50 who may be less physically active, or that reduction in imagery vividness could be associated with changes in hormonal levels that occur during menopause.

Dror and Kosslyn (1994) compared young and older adult participants on four visual imagery tasks and overall, found that older participants did not fare as well as younger adults in terms of image activation, image rotation, and image maintenance, although both groups were able to compose and scan visual mental images equally well (effect sizes not available). Mulder et al. (2007) examined the relationship between age and motor imagery (the ability to imagine movements) and found that elderly participants were slightly worse in motor imagery capacity than younger participants (mean difference between the elderly group and young group = 8.79, $SD = 2.51$; mean difference between elderly and intermediate group = 8.09; $SD = 3.04$). Finally, Campos et al. (2004) found that scores on the Spatial Test of Primary Mental Abilities (ST-PMA) significantly decreased with age. Subjects aged 20-40 obtained significantly better scores than subjects aged 41-60 ($d = -.78$) or subjects older than 60 ($d = -1.51$); and subjects aged 41-60 obtained significantly better scores than subjects older than 60 ($d = -.75$). Although these results must be interpreted with caution, they do suggest that age may be related to certain types of imagery abilities.

Predictors of the Ability to Enter Altered States of Consciousness

The second phase of a standard BMGIM session involves a relaxation induction, the purpose of which is to help the client screen out the external environment and give focus and attention to his/her inner environment or process. This shift in focus is considered to be an “Altered State of Consciousness” (ASC). ASCs can occur under a wide variety of circumstances. Typical examples of ASCs include daydreaming, meditation, hypnosis, sleep, etc. (Ventre, 2002).

SOC

No studies were found clearly showing that SOC is predictive of the ability to enter an ASC. Some research however, has indicated that a relationship may exist between SOC and ASCs in that meditation practices may improve SOC. Weissbecker et al. (2002) found that women with fibromyalgia who participated in an 8-week mindfulness meditation program showed a significant increase in SOC, while wait-list control participants maintained a stable SOC ($d = .42$). Similarly, Fernros, Furhoff, and Wändell (2008) found that treatment group subjects showed improvement in median SOC scores after 6 months of participation in a mind-body therapy training program that included guided imagery and meditation techniques, while no change was observed in the control group’s median SOC-13 scores (59-62 as compared to 64–64.5, respectively).

Anxiety

No research was found indicating that anxiety levels in normal subjects are predictive of one’s ability to enter an ASC. Some research however, has indicated that certain types of anxiety disorders may affect one’s ability or willingness to enter an ASC. In a study that compared patients with nocturnal panic disorder to patients with other

types of panic disorder patients and to healthy controls, Craske, Lang, and Tsao (2001) found that nocturnal panickers had significantly higher average anxiety ratings and maximum anxiety ratings than daytime panickers ($d = .44$; $d = .57$) and the control group ($d = 1.33$; $d = 1.72$) during a meditative relaxation condition. Additionally, both groups of panic disorder patients had higher scores than the control group on the Relaxation and Arousal Questionnaire (nocturnal panickers versus the control group $d = 2.44$; daytime panickers versus the control group $d = 1.44$). The authors concluded that persons with panic disorders and especially nocturnal panickers, are fearful of states that involve diminution of conscious awareness. In a later study that involved two of the same authors, Tsao and Craske (2003) assessed psychophysiological responses of patients diagnosed with panic disorder to imagery of traumatic events, panic attacks, and being hypnotized. They found that nocturnal panickers reported significantly more panic symptoms than daytime panickers in response to imagery of being hypnotized (i.e., imagining that they were being hypnotized; $d = 1.03$). There were no significant differences between the groups on the other conditions. Although these studies do not in fact measure individuals' ability to enter an ASC, the results do imply that anxiety associated with ASCs may inhibit certain individuals from being able to relax sufficiently to enter into certain ASCs.

Conversely, in a study on the effectiveness of an hypnotic imagery intervention on reducing alexithymia (difficulty processing emotion), Gay, Hanin, and Luminet (2008) found that although the treatment condition participants had a significant decrease in alexithymic scores as compared to those in the control condition ($d = -.86$), the intervention had no impact on STAI scores even though pre-treatment trait anxiety values

were found to be slightly above the norm (indicating light chronic anxiety). In this case, it appeared that anxiety was not a determinant of therapeutic response.

Classical Music Experience

No studies were found indicating that classical music experience/background is predictive of the ability to enter an ASC. This is surprising given the vast number of commercially available meditation and relaxation CDs that use classical music specifically for this purpose. There is a significant need for research in this area.

Gender

Research results on gender as a predictor of the ability to enter an ASC have been inconclusive. This may be due to the fact that the sample sizes utilized have generally been small, and it may also be the case that some studies have not accounted for potential confounding variables (Cardena, Kallio, Terhune, Buratti, & Löf, 2007). Various studies on “hypnotizability” have found no gender differences (David, Montgomery, & Holdevici, 2003; Kallio & Ihamuotila, 1999), whereas others have found statistically significant differences in favor of women’s ability to be hypnotized (Cardena et al., 2007 ($d = .34$); Page & Green, 2007 ($d = .24$); Rudski, Marra & Graham, 2004 ($d = .17$)). Additionally, a large-scale longitudinal study conducted by Giambra (1999-2000) found that females reported “somewhat” higher daydreaming frequency levels than males (effect size not available).

Age

Several studies have indicated that age may be predictive of one’s ability to enter an ASC. Giambra’s (1999-2000) longitudinal study included subjects from 17-95 years of age, with results indicating that older age diminished daydreaming frequency and

absorption. Similarly, other studies have indicated a decline in “hypnotizability” as people age (Cardeña et al., 2007; Page & Green 2007). Some very intriguing research however, was conducted by Lazar et al. (2005) who used magnetic resonance imaging (MRI) to examine the brain structures of persons who regularly practiced insight meditation. They found that the cortical thickness in areas of the brain associated with attention, interoception, and sensory processing was greater in meditation participants than it was in matched controls. Additionally, between-group differences were most pronounced in older participants (significant age by group interaction) suggesting that meditation might offset age-related cortical thinning ($d = 1.17$).

Predictors of the Ability to Benefit from Classical Music

SOC

No studies were found indicating that SOC is predictive of the ability to benefit (therapeutically) from classical music or from music in general. Research has shown however, that SOC is a significant predictor of quality of life in various treatment contexts (Bruscia, Shultis, Dennery, & Dileo, 2008a, 2008b, 2008c), and that music and/or music therapy can significantly improve quality of life (Ahonen-Eerikäinen, Rippin, Sibille, Koch, & Dalby, D., 2007; Burns, 2001; Walworth, Rumana, Nguyen, & Jarred, 2008). Since higher quality of life is often associated with participation in leisure activities (including music), it seems reasonable to propose that SOC may be predictive of one’s ability or inclination to engage with music and thereby benefit. Musical taste and/or genre however, may be intervening variables in the proposed relationship between SOC and the ability to benefit from classical music. These potential intervening variables

were taken into consideration when the results of the present study were being interpreted.

Anxiety

The literature contains some studies which indicate that listening to classical music can reduce anxiety in various contexts (Chang, M-Y, Chen, C-H, & Huang, K-F, 2008; Labbé, E., Schmidt, N., Babin, J., & Pharr, 2007; Lai et al., 2008). However, with the exception of the two studies cited in Chapter One, which pertained to the impact of anxiety on one's ability to engage in music and imagery techniques (Burns et al., 2008; Scott, 2007-2008), no studies were found which indicated that levels of anxiety are a predictor of one's ability to benefit (therapeutically) from classical music or music of any other kind. In fact, Montello, Koons, and Cantor (1990) conducted two experiments on the effect of group music therapy on classically trained musicians who suffered from performance anxiety and found a significant reduction in trait anxiety in the first experimental group (effect size not available). The current author however, has experienced a situation where a music therapy client's (non-musician) negative associations with classical music recordings were so strong, that hearing even a short excerpt of recorded classical music (both inside and outside of the clinical context) would cause her to experience debilitating anxiety and even disassociation (i.e., a shift in consciousness and/or awareness). Additionally, Hardy, Mullen, and Martin (2001) have hypothesized that anxiety in combination with other factors may exceed a threshold of attentional capacity, which in turn negatively affects task performance. Given all of these considerations, it is reasonable to propose certain levels or types of anxiety could affect one's ability to engage with and/or benefit (therapeutically) from classical music.

Classical Music Experience

No research was found directly indicating that classical music experience is predictive of one's ability to benefit from classical music or from music in general. A study by Wolfe, O'Connell, and Waldon (2002) found no significant differences between the ratings of musicians and non-musicians on the relaxation qualities of particular musical selections—many of which were classical. On the other hand, a recent study conducted by Bruscia, Dileo, Shultis, and Dennery (2009) found that patients with prior experiences in music therapy and/or music study had higher expectations of therapeutic benefit from active music-making and lower expectations of therapeutic benefit from listening to music as compared to those without these prior music experiences (based on comparisons of several mean ratings). Additionally, a study by Rawlings and Ciancarelli (1997) indicated that training in music was associated with breadth of music preference and a liking for classical and religious music. Similarly, Savage (2006) found a strong positive correlation between preference for classical music and university education, and Katz-Gerro (1999) found that higher levels of education were associated with higher levels of cultural consumption (including music). Although music education was not examined specifically as a variable, Savage concluded that the place of classical music in the UK educational curriculum seemed to construct an enduring taste for the genre. Although more research is needed, these findings suggest that musical background may affect an individual's musical tastes and expectations about music. It is therefore reasonable to propose that musical experience may be predictive of one's ability to benefit from particular musical activities or genres.

Gender

Only one study was found which directly investigated the effect of a music treatment intervention in relation to gender, and the results revealed no significant differences (Nilsson, U., Lindell, L., Eriksson, A., & Kellerth, T., 2009). Musical preference however, may be an important intervening variable in the proposed relationship between gender and the ability to benefit from classical music. In a study that examined sex differences in terms of responses to two musical genres however, Nater, Abbruzzese, Krebs, and Ehlert (2006) found that women liked rock/heavy metal music significantly less than men ($d = -.66$) and liked classical music significantly more ($d = .93$). Katz-Gerro (1999) also suggested that women are more likely to engage in “highbrow” culture, which implies that they may be more frequently exposed to the genre of classical music than are men. Conversely, although Savage (2006) did find that men preferred rock and heavy metal music more than women (using logistic regression), he found no gender differences in terms of preference for classical music. Clearly, more research is needed on this topic.

Age

No studies were found directly indicating that age is predictive of the ability to benefit from classical music or from music in general. In his study on musical preferences however, Savage (2006) found that age was the single most important stratifying feature for musical taste—older people indicated strong preferences for country and classical music whereas younger people liked other genres. It is also important to note that the literature contains a great deal of research and information on how music, music education, and music therapy is of benefit to specific age groups including infants,

children, adolescents, and the elderly although comparisons have not been made in terms of which age group might benefit the most.

Predictors of Client Responsiveness to Psychotherapy

Broadly speaking, psychotherapy can be defined as a treatment that is “concerned with helping a person make those psychological changes deemed necessary or desirable to achieve well-being” (Bruscia, 1998, p. 1). In music psychotherapy, music experiences are used in addition to or in lieu of more traditional verbal approaches. No studies were found that examined the proposed predictor variables (SOC, anxiety, classical music experience, gender, and age) and measures of client responsiveness in music psychotherapy contexts other than BMGIM. It is however, also important to consider what is known about relationships between the proposed predictor variables and client responsiveness in conventional psychotherapy settings.

SOC

Although the literature suggests that a relationship may exist between SOC and psychological resilience (Olsson et al., 2006), only one research study was found directly indicating that SOC is predictive of psychotherapeutic outcomes. Marttunen, Välikoski, Lindfors, Laasonen, and Knekt (2008) examined pretreatment predictors of remission from depression one year after short-term psychotherapeutic interventions. They found that the strongest predictors of successful therapeutic outcome were SOC, severity of psychiatric symptoms, and educational status. Although more research is needed to confirm these findings, other publications have provided indirect evidence which supports the idea that SOC may be predictive of psychological resilience.

A study conducted by Carstens and Spangenberg (1997) found that a breakdown in SOC seemed to be a predisposing factor to major depression. Similarly, Dudek and Koniarek (2001) found that low levels of SOC among firefighters were associated with high levels of post traumatic stress disorder (PTSD) symptoms. Joachim, Lyon, and Farrell (2003) suggested that the cognitive appraisal processes underlying the SOC concept makes it a particularly appropriate framework for psychotherapeutic intervention with individuals who have obsessive compulsive disorder (OCD), thus implying that improvements in SOC would provide these persons with the inner resources needed to change their behaviors. Wiesmann and Hannich (2008) found that subjective well-being among active elderly persons was positively related to SOC, leading them to propose that the promotion of a strong SOC should be a major aim of gerontological interventions. Finally, Gunnarson and Eklund (2009) found that a good initial therapeutic alliance was positively correlated to an increased SOC in clients after psychosocial therapeutic interventions. Although further research is needed, these publications suggest that a relationship may exist between SOC and psychotherapeutic outcomes.

Anxiety

Although various psychotherapeutic approaches are used to treat anxiety (American Psychological Association, 2004), only a few studies were found that investigated anxiety as a predictor of responsiveness to psychotherapy. Buwalda and Bouman (2008) examined the effect of a psychoeducational treatment group on hypochondriacal complaints and found that high pretreatment trait anxiety predicted less treatment gain. Similarly, in a study that examined the efficacy of parent-infant psychotherapy, Hervé et al. (2009) found that high pretreatment trait anxiety scores in

mothers predicted unfavorable outcomes for both the mothers and their children. There was a lack of sufficient data to analyze whether or not anxiety in fathers had any impact.

Additionally, it has been suggested that high pretreatment trait anxiety could be related to discontinuation of therapy. In a study that examined predictors of dropout from dialectical behavior therapy among women with borderline personality disorder, Rüscher et al. (2008) found that high pretreatment anxiety was significantly associated with premature termination of treatment (a comparison of “completers” versus “noncompleters” trait anxiety scores revealed an effect size of $-.72$). Conversely, in a study that examined prolonged imaginal exposure treatments for persons with PTSD, Van Minnen, Arntz, and Keijsers (2002) found that pretreatment levels of general anxiety did not predict treatment outcome or dropout, thus indicating that anxiety is not a contraindication for this type of therapy. Clearly, more research is needed to elucidate the relationship between anxiety and clients’ responsiveness to various forms of psychotherapy.

Classical Music Experience

No research was found indicating that clients’ musical experiences are predictive of clinical outcomes in music therapy, music psychotherapy, or traditional psychotherapy settings. As noted in Chapter One however, BMGIM practitioners have noticed specific issues that can arise when a client has had a significant amount of experience with Western classical music. The present author has also noticed similar issues in other music therapy contexts. It has been her experience that clients who have had a certain amount of formal musical training/knowledge sometimes find it difficult to engage in music therapy experiences that seem contrary to the way he/she learned how to play or think about

music. Other music therapy authors have noted similar issues (Montello, 2003; Stige, 2002). On the other hand, an in-depth case study by Lee (1996) on the music therapy experiences of a musician with AIDS demonstrated that a shared knowledge of music between client and therapist positively contributed to the therapeutic process and strengthened the therapeutic alliance. Increased knowledge about the relationship between clients' musical experiences and their responsiveness to psychotherapy would be helpful for all practitioners who utilize music in various psychotherapy or counseling contexts.

Gender

The impact of both therapist and client gender on process and outcomes in psychotherapy has been an ongoing topic of discussion where clinicians seem to either stress its relevance or minimize its importance (Gray Deering & Gannon, 2005; Meadows, 2001, 2002b). Overall, it seems that females not only access counseling and psychotherapy services more frequently than males, but that they also generally report more positive attitudes toward mental health treatment (Park & Hatchett, 2006). Although there may be a variety of reasons for these discrepancies, the current study was simply concerned with finding out if gender (i.e., biological sex) is predictive of responsiveness to psychotherapeutic [BMGIM] intervention. The current literature review is therefore limited accordingly.

Some studies have associated female gender with a better psychotherapy outcome. Marttunen et al. (2008) and Shepherd et al. (2005) both found that female gender predicted remission in short-term psychotherapy contexts. Ogrodniczuk (2006) and Ogrodniczuk, Piper, and Joyce (2004) investigated gender differences in terms of

responses to two models of short-term group psychotherapy, and they too found that women had better outcomes on several measures, including changes in symptoms of avoidance ($d = .76$), depression ($d = .87$), anxiety ($d = .82$), and general distress ($d = .86$), regardless of the type of therapy. However, when they compared the responses of men and women to two models of short-term individual psychotherapy, they found in general that men benefited more from interpretive therapy whereas women benefited more from supportive therapy ($d = .71$). In a randomized controlled treatment study for persons suffering from depression, Frank et al. (2002) found that women were significantly more likely to achieve remission, but no differences were found between pharmacological and psychotherapeutic interventions (i.e., it did not matter if the women had received paroxetine or problem-solving therapy, or a placebo). Finally, in a study that examined the extent to which gender was implicated in the constructs that BMGIM therapists used to describe their clients, Meadows (2001; 2002b) found that although female-like qualities were perceived as being more conducive to effective therapy, these qualities were not necessarily related to the sex of the clients. Overall, the combined results of these studies seem inconclusive. Furthermore, other studies have found that gender is not predictive of responsiveness to psychotherapy.

Beutel, Höflich, Kurth, and Reimer (2005) as well as Zlotnick, Elkin, and Shea (1998) both examined the effects of gender on the outcomes and processes of short-term psychotherapeutic interventions with depressed/psychiatric patients and found no significant differences between males and females. Clement (2008) examined the outcome data of 1,374 psychotherapy clients that he had treated throughout a 40-year period, and he also found no statistically significant gender differences. Clements' study

is unique in that he included data from clients who had had as few as one session to as many as 344 sessions. No other studies were found that examined gender as a predictor of outcomes in long-term psychotherapy.

The above results suggest that if gender differences do in fact exist, they are likely influenced by multiple personal and contextual factors, and that these factors must be better understood and accounted for before any conclusive statements can be made about client gender as a predictor of responsiveness to psychotherapy.

Age

A review of the literature has also revealed discrepancies among studies that examined age as a predictor of outcomes in psychotherapy. Both Beutel et al. (2005) and Shepherd et al. (2005) found no relationship between age and outcomes after brief psychotherapeutic interventions. Similarly, in a study that compared younger (16-65 years) and older (65+ years) adults enrolled in mental health programs on outcomes in cognitive behavioral psychotherapy (CBT), Walker and Clarke (2001) found CBT to be equally effective in both groups. Marttunen et al. (2008) however, found that age predicted remission, with older patients in their sample (age range was 20 to 46 years) achieving better outcomes after short-term psychotherapy. On the other hand, Clement (2008) identified a possible relationship between age at intake and treatment outcomes—with preschoolers having the best outcomes, and elderly persons having the poorest ones (age range was 6 months to 88 years). Finally, a systematic review of research relating to the effectiveness of counseling for older people produced strong evidence that counseling (especially cognitive behavioral therapy) is efficacious with older persons, particularly in the treatment of anxiety and depression, and in improving subjective well-being. Furthermore, outcomes were consistent with those found in younger populations

indicating that age in and of itself did not appear to affect one's ability to benefit from counseling (Hill & Brettle, 2005).

Conclusion

Research findings (from outside of the BMGIM literature) on the extent to which the proposed predictor variables (SOC, anxiety, classical music experience, gender, and age) are related to various components of BMGIM responsiveness are quite limited, diverse, and in most cases inconclusive. Additionally, many of the studies contain significant methodological issues which limit the interpretation and practical application of the results. Overall, more research is needed to address considerable gaps in the literature as well as to create order among such disjointed findings. The purpose of the present study was to identify possible predictors of responsiveness to BMGIM as measured by RGIM factors. The results of this study could lay the foundations for further research and theory development, while also making significant contributions to the practice of BMGIM, music therapy, and psychotherapy.

CHAPTER 3

METHOD

Design

This quantitative investigation used a correlation-prediction design to seek out statistically significant relationships between and among several variables. Sense of Coherence (SOC), state anxiety (STAI Form Y-1), trait anxiety (STAI Form Y-2), classical music experience (CME), gender, and age were assessed as possible predictor variables for responsiveness to a group GIM session as measured by five RGIM Factors (the criterion variables). The five Factors are: (a) Ability to Relax (AR), (b) Ability to Image to Music (AIM), (c) Responsiveness to Music and Guiding (RMG), (d) Comfort with Self-Disclosure (CSD), and (e) Meaningfulness of the Experience (MOE).

Participants

Participants were recruited from the general public over a 7-month period (January 2010– July 2010) through: (a) online classified ads, (b) recruitment posters displayed in public areas or e-mailed/mailed to local community arts organizations, and (c) selection of individuals contained in the researcher's professional address book. The recruitment poster was approved for public display by Temple University's Institutional Review Board (see Appendix E).

An a priori power analysis revealed that a minimum of 60 participants was needed to achieve a statistical power of .80 and an alpha of equal to or less than .05 with four predictor variables and an R^2 of .44 (Green, 1991). Recruitment efforts were discontinued once the minimum sample size was obtained.

Criteria for inclusion in the study were: (a) participants had to be 18 years of age or older, (b) participants had to be fluent in both spoken and written English, (c) participants must not have had any known history of psychiatric illness, (d) participants must not have been on medications for the purpose of treating mental illness/anxiety, (e) participants must not have had any significant cognitive impairments, (f) participants must not have been significantly hearing impaired, and (g) participants must not have had any previous personal experience with BMGIM, group GIM, or other therapy techniques that involved the use of imagery. These criteria were outlined on the recruitment poster, and they were also reviewed individually with each participant by the researcher (via phone, e-mail, and/or in person) prior to participation in the study. If an individual met the criteria for inclusion and expressed interest in participating, the researcher provided details regarding location and times of the research sessions.

Approximately 85 people contacted the researcher to inquire about participating in this study. Four individuals did not meet the criteria for inclusion —one was on anti-anxiety medication, another had been diagnosed with post traumatic stress disorder, another was not fluent in spoken English, and another had participated in music and imagery experientials in a music therapy classroom setting. Four individuals who confirmed their interest in participation missed their scheduled session times and chose not to re-schedule. Seventeen individuals (in spite of repeated attempts at scheduling) were unable to attend any of the scheduled times that the researcher was able to book the Music Therapy Centre. Thus, a total of 60 individuals participated in the study, representing 70.5% of the individuals who initially expressed interest in participation.

The average age of participants was 45.88 years ($SD = 15.37$); there were 44 females (73.3%) and 16 males (26.7%). Participants were not compensated in any way for their involvement in the research. At the beginning of each research session, the researcher obtained signed consent from each participant as well as written permission to audio record the group discussion portion of the BMGIM experience (see Appendices F & G).

Measures

Data for this study were collected using the following instruments: (a) a demographic questionnaire (which included a classical music experience measure), (b) Spielberger's State Trait Anxiety Inventory (STAI), (c) The Sense of Coherence scale (SOC), and (d) The Responsiveness to Guided Imagery and Music scale (RGIM) (designed by the researcher). The researcher maintained a log which contained notes and observations from the research sessions. These notes along with the audio recordings of the group discussion portion of the research sessions were used to clarify the interpretation of the quantitative results as well as to identify potential future directions for research and practice (see Chapters Five and Six).

Demographic Questionnaire

Demographic information on age, gender, and classical music experience (CME) was collected using a self-report questionnaire compiled by the researcher. For the CME measure, respondents were asked to rate four items on a 7-point Likert-type scale, and these items were added together to obtain a total score for this variable (see Appendix C). After data collection was completed, results from a Velicer's MAP (minimum averaged partial) and an exploratory factor analysis indicated that the CME measure contained only

one factor, and therefore the sum of the four items contained in the measure could be utilized as one predictor variable. CME accounted for 64.68% of the variance.

Sense of Coherence Scale (SOC)

The Sense of Coherence (SOC) scale used in this study, also known as the Orientation to Life Questionnaire, is a self-report inventory intended to measure the extent to which an individual finds life comprehensible, manageable, and meaningful. It was first published by Antonovsky in 1987 and is available for use by the general public (see Appendix B). The inventory includes a total of 29 items, with 11 questions related to the comprehensibility of life, 10 on the manageability of life, and 8 on the meaningfulness of life. Each question uses a 7-point scale ranging from most to least (Antonovsky, 1987; 1993). The range of the sum score is from 29 to 203, with a low score representing low SOC. A shorter version of the SOC is also available, but the original, longer version was used in the present study.

Based on an analysis of over 400 hundred studies, Eriksson and Lindström (2005) concluded that the SOC has good reliability and validity. In 124 studies using the SOC-29 version, Cronbach's alphas range from .70 to .95, demonstrating strong internal consistency. Retest correlations for the different periods are .69 to .78 (1 year), .64 (3 years), .42 to .45 (4 years), .59 to .67 (5 years), and .54 (10 years). In the present study, the Cronbach's alpha for this measure was .87. The SOC has acceptable face validity, construct validity, consensual validity (general acceptance amongst typical users of a test that it is valid), criterion validity (how well one variable or set of variables predicts an outcome based on information from other variables), and predictive validity (the degree to which any measure can predict future concrete events; Bruscia et al., 2008b).

Spielberger State Trait Anxiety Inventory (STAI)

The STAI is a well-known 40-item self-report instrument intended to measure both temporary (state) and enduring levels (trait) of anxiety. Each question is given a weighted score from 1 to 4, and the scoring weights of anxiety absent items are reversed. Scores for both state anxiety (STAI Form Y-1, questions 1-20) and trait anxiety (STAI Form Y-2, questions 21-40) can range from a minimum of 20 to a maximum of 80 with low scores indicating low levels of either state or trait anxiety (Spielberger, 1985). Studies have found that the STAI has demonstrated sufficient construct and convergent validity (Smeets, Merckelbach, & Griez, 1996), concurrent validity (Spielberger, Reheiser, Ritterband, Sydeman, & Unger, 1995) and test-retest reliability (Rule & Traver, 1983). Test-retest correlations for the State Anxiety Inventory range from .16 to .62 and for the Trait Anxiety Scale range from .73 to .86. The relatively low correlations on the State Anxiety measure are consistent with the transitory nature of the construct being measured (Spielberger et al., 1983). A high degree of internal consistency has been observed with Cronbach's alphas ranging from .38 to .89 for each of the 40 items, and .86 for the total score (Quek et al., 2004). In the present study, the Cronbach's alpha for state anxiety was .90 and for trait anxiety was .92. The original form of the STAI was published in 1970 and since that time it has been adapted into at least 48 languages (Tilton, 2008). Permission to use the STAI for the current study was obtained from the copyright holder (see Appendix H).

Responsiveness to Guided Imagery and Music Scale (RGIM)

The RGIM is an adapted version of the GIMR (Bruscia, 2000) designed by the current researcher. In the original version (GIMR), the therapist observes and rates the

client's responsiveness to GIM in various areas; in the adapted version (RGIM), clients rate themselves on the same areas. As initially adapted, the RGIM is a 27-item instrument, intended to measure the client's responsiveness to GIM in the following areas: (a) ability to relax (4 items), (b) ability to image during the music (8 items), (c) responsiveness to the music (5 items), (d) reactions to the facilitator (4 items), (e) reactions to the postlude discussion (3 items), and (f) general impressions (3 items; see Appendix A).

After the data collection was completed, the construct validity of the RGIM was examined using Velicer's MAP (minimum averaged partial) and exploratory factor analyses. Results from Velicer's MAP indicated that the RGIM had 6 factors. A Principal Axis Factor (PAF) analysis with 6 scales and a promax (correlated factors) rotation did not result in a simple structure. However, a PAF analysis with a promax rotation on 5 factors suggested a more simple structure, and after deleting cross-loaded items 1, 9, and 21, a simple structure was obtained with all but one item (item 27) showing high loadings (all above .40; see Table 1). Item 27 was subsequently also deleted from the tool which now contains a total of 23 items.

Table 1

Factor Analysis of Responsiveness to Guided Imagery & Music (RGIM)

Items	Extracted Factors and Factor Loadings				
	Ability to Relax	Ability to Image to Music	Responsiveness to Music and Guiding	Comfort with Self-Disclosure	Meaningfulness of the Experience
RGIM 2	.80				
RGIM 3	.87				
RGIM 4	.91				
RGIM 5		.77			
RGIM 6		.92			
RGIM 7		.62			
RGIM 8		.67			
RGIM 10					.68
RGIM 11		.63			
RGIM 12		.80			
RGIM 13		.61			
RGIM 14			.85		
RGIM 15			.53		
RGIM 16		.49			
RGIM 17			.69		
RGIM 18			.56		
RGIM 19			.59		
RGIM 20				.78	
RGIM 22				.98	
RGIM 23				.65	
RGIM 24					.65
RGIM 25					.71
RGIM 26					.73

The relaxation dimension was the same as it was in the original RGIM except that item number 1 was removed (as noted above). Items contained in each of the remaining four factors were reviewed in order to identify their shared features and label each factor accordingly. The five factors were interpreted to represent the following theoretically relevant dimensions: (a) Ability to Relax (RGIM Factor One), (b) Ability to Image to Music (RGIM Factor Two), (c) Responsiveness to Music and Guiding (RGIM Factor

Three), (d) Comfort with Self-Disclosure (RGIM Factor Four), and (e) Meaningfulness of the Experience (RGIM Factor Five). See Table 2 for the percentage of variance accounted for by each of these Factors. See Table 3 which outlines how individual items were categorized in the original RGIM as compared to the revised RGIM. Also see Appendices A and I to compare these two versions of the RGIM.

Table 2

Factor Analysis of Responsiveness to Guided Imagery and Music (RGIM)

Factors	% of variance explained
1. Ability to Relax	6.86
2. Ability to Image to Music	33.69
3. Responsiveness to Music and Guiding	12.16
4. Comfort with Self-Disclosure	4.14
5. Meaningfulness of the Experience	4.64

Table 3

Categorization of Items contained the Original RGIM as compared to the Revised RGIM

Original RGIM Dimensions with Corresponding Item Numbers	Revised RGIM Factors with Corresponding Item Numbers
Dimension 1, Rate Your Relaxation: Items 1,2,3, and 4	RGIM Factor 1, Ability to Relax: Items 2,3, and 4
Dimension 2, Rate Your Imagery Experience During the Music: Items 5,6,7,8,9,10,11, and 12	RGIM Factor 2, Ability to Image to Music: Items 5,6,7,8,11,12,13, and 16
Dimension 3, Rating the Music: Items 13,14,15,16, and 17	RGIM Factor 3, Responsiveness to Music and Guiding: Items 14,15,17,18, and 19
Dimension 4, Rating the Facilitator: Items 18,19,20, and 21	RGIM Factor 4, Comfort with Self-Disclosure: Items 20,22, and 23
Dimension 5, Rating the Discussion Afterward: Items 22,23, and 24	RGIM Factor 5, Meaningfulness of the Experience: Items 10, 24,25, and 26
Dimension 6, General Impressions: Items 25,26, and 27	

Moderate correlations among the five extracted factors also indicated that although the factors are somewhat correlated, they do in fact point to different clinical constructs (see Table 4). Additionally, each of the five factors contained in the RGIM showed acceptable to excellent reliability (Cronbach's alphas = .79-.91; see Table 5). Subsequently, these five factors were identified as the dependent (criterion) variables in the present study.

Table 4

Correlations among the RGIM Factors

Factors	AR	AIM	RMG	CSD	MOE
1. Ability to Relax	—	.34**	.19	.46**	.22
2. Ability to Image to Music		—	.63**	.13	.66**
3. Responsiveness to Music and Guiding			—	.15	.60**
4. Comfort with Self-Disclosure				—	.15
5. Meaningfulness of the Experience					—

Note. AR = Ability to Relax. AIM = Ability to Image to Music. RMG = Responsiveness to Music and Guiding. CSD = Comfort with Self-Disclosure. MOE = Meaningfulness of the Experience.

**Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Table 5

Reliability Statistics for RGIM Factors

Factors	Cronbach's alphas	Number of items
1. Ability to Relax	.90	3
2. Ability to Image to Music	.91	8
3. Responsiveness to Music and Guiding	.79	5
4. Comfort with Self-Disclosure	.82	3
5. Meaningfulness of the Experience	.79	4

Procedures

Approval was received from Temple University's Institutional Review Board (see Appendix J). Research sessions were held in Toronto, Canada at the Music Therapy Centre (<http://www.musictherapytrust.ca/en-centre.html>). The research project was not affiliated with the Music Therapy Centre in any way, but the charitable organization that oversees the Centre (The Canadian Music Therapy Trust Fund) agreed to provide space for this project, as one of their mandates is to support the advancement of music therapy research. At their request, they were given a copy of the research proposal as well as a

copy of the approval certificate from Temple's Institutional Review Board (IRB) prior to the collection of any data (see Appendix K).

Participants were required to attend one research session that lasted for approximately 90 minutes. The researcher facilitated 12 group sessions over a 7-month period until the minimum sample size ($N = 60$) was obtained. There were no less than four and no more than seven participants in each session. The format for each session was as follows: (a) participants were required to review and sign the information/consent form and permission to audiotape form, (b) participants completed the demographic questionnaire, the Spielberger State Trait Anxiety Inventory, and the Sense of Coherence scale; (c) the researcher gave a concise overview on BMGIM, and briefly described various ways of imaging (visions, thoughts, feelings, memories, fantasies, and/or body sensations); (d) the researcher facilitated a guided imagery practice exercise (with no music) to demonstrate the practice/concept of imaging (see Appendix L), (e) the researcher reminded participants that they could ask for assistance or discontinue their participation in the GIM experience if they became uncomfortable, (e) the researcher obtained verbal agreement from all participants regarding the confidential nature of others' participation in the session, (f) the researcher facilitated a group GIM experience which included a group postlude discussion, (g) after the group GIM experience, participants completed the RGIM ; (h) once all documentation was completed, the researcher directed participants' attention to a display of handouts on BMGIM and various counseling services (in case anyone wanted additional follow up as explained in the Information and Consent Form), and also reminded participants that the researcher and/or her advisor were available for follow up via phone or e-mail; (i) although

participants were free to leave at this point, the researcher de-briefed with those participants who expressed a desire for further discussion or who had questions; and (j) the researcher noted observations and reflections in her log after the research sessions.

The format for the group GIM experience was as follows: (a) a relaxation exercise and imagery focus, (b) semi-directed music imaging, (c) music imaging with no direction, and (d) a facilitated open group discussion. Normally, a preliminary conversation occurs at the beginning of a typical BMGIM session in order to help the client(s) identify pertinent issues, and to help the facilitator formulate an appropriate relaxation exercise and relevant starting image. Given that these sessions occurred within a quantitative research context, it was necessary that all participants be exposed to the exact same interventions (i.e., all research sessions contained the same relaxation exercise and starting image). As such, the preliminary conversation phase was excluded from the group GIM experience utilized in this study.

The relaxation exercise was approximately 5-7 minutes in length and was used to help the participants screen out the external environment and focus their attention inward. The facilitator then guided participants through a scripted relaxation induction where she asked them to imagine that they could use their breath to gather up and release tension from the various parts of their bodies. Once participants were in a relaxed state, they were provided with the starting image of walking along a nature trail. The facilitator gave the participants a moment to develop/personalize this image in their imaginations and then she started the recorded music.

During the first musical selection, Beethoven's *Fifth Piano Concerto in E-flat Major* (2nd movement), the facilitator "semi-directed" the imagery using a prepared

script which periodically presented “open-ended” images to which each participant could allow his/her own imagination to respond. The images were formulated to match qualities contained in the music, and were presented in a way that was meant to complement the music as much as possible (i.e., images were often presented near the beginning or end of a musical phrase). To ensure consistency among sessions, the timings of these interventions were notated in the script. During the second selection, Puccini’s “Humming Chorus” from *Madame Butterfly*, and third selection, Warlock’s “Pieds en l’air” from *the Capriol Suite*, the facilitator did not provide any verbal direction, and the participants were directed to allow their imaginations to respond freely to the music. In total, the musical selections were approximately 13 minutes in length and chosen specifically because they contain supportive qualities (necessary for novice imagers) but also suggestive qualities that are likely to evoke imagery responses. When the music ended, the facilitator gave verbal suggestions to the participants on how to return to a normal state of consciousness.

Participants were then asked to gather themselves into a semi circle. The facilitator reminded the group about their verbal confidentiality agreement, and then led a semi-structured group discussion. The facilitator used open-ended questions to help participants describe and better understand their experiences. Please see Appendices M & N for a more detailed outline of the group GIM experience (script and group discussion questions).

Data Analysis

All statistical analyses were conducted using the Predictive Analytics SoftWare (PASW) Statistics GradPack version 18.0 (formerly known as SPSS). Before the data

were analyzed, the reliability of the proposed predictor variable measures was examined and statistical tests were used to check for assumptions of regression. Means, standard deviations, correlations, and Cronbach's alphas (where applicable) were calculated for all variables. There were not enough male participants to include gender in the regression formulas, so independent samples *t*-tests (assuming unequal variances) were utilized to analyze this variable. Multiple linear regressions (using Ordinary Least Squares regression) were used to determine the extent to which the relevant predictor variables accounted for a significant amount of variance in each of the five RGIM Factors. Differences were considered to be significant when the probability (*p*) value was equal to or less than .05.

CHAPTER 4

RESULTS

Reliability of Measures

Cronbach's alphas were calculated for all proposed predictor variable measures.

Table 6 summarizes these results. All measures were found to have acceptable to excellent reliability (Cronbach's alphas = .73-.92).

Table 6

Reliability Statistics for Proposed Predictor Variable Measures

Measure	Cronbach's alphas	Number of items
CME	.81	4
SOC	.87	29
Comprehensibility (SOC subscale)	.79	11
Manageability (SOC subscale)	.75	10
Meaningfulness (SOC subscale)	.73	8
State Anxiety	.90	20
Trait Anxiety	.92	20

Note. CME = Classical Music Experience. SOC = Sense of Coherence.

Checking for Assumptions of Regression

To determine whether assumptions for multiple regression had been met, data collected in this study were tested for: (a) assumptions of normal distribution, (b) homogeneity of variance in residuals, (c) linearity, and (d) absence of multicollinearity.

Normal Distribution

Skewness and kurtosis statistics were reviewed and found to be within acceptable limits (skewness was < [2] and kurtosis was < [4]; see Table 7). With regard to normality of residuals, histograms showed neither violation of normality nor any common outliers across the regression diagnostics.

Table 7

Skewness and Kurtosis Statistics for all Measures

Measure	Skewness	Std. Error	Kurtosis	Std. Error
Age	.12	.309	-1.01	.608
CME	.01	.309	-0.88	.608
SOC	-.35	.309	1.01	.608
CO	-.68	.309	1.18	.608
MA	-.35	.309	.61	.608
ME	-.34	.309	-0.50	.608
SA	.60	.311	-0.09	.613
TA	.83	.309	.66	.608
AR	-1.36	.309	1.72	.608
AIM	-.95	.309	.78	.608
RMG	-.68	.309	-.18	.608
CSD	-1.37	.309	2.31	.608
MOE	-.75	.309	.08	.608

Note. CME = Classical Music Experience. SOC = Sense of Coherence. CO = Comprehensibility (SOC subscale). MA = Manageability (SOC subscale). ME = Meaningfulness (SOC subscale). SA = State Anxiety. TA = Trait Anxiety. AR = Ability to Relax (RGIM Factor 1). AIM = Ability to Image to Music (RGIM Factor 2). RMG = Responsiveness to Music and Guiding (RGIM Factor 3). CSD = Comfort with Self-Disclosure (RGIM Factor 4). MOE = Meaningfulness of the Experience (RGIM Factor 5).

Homogeneity of Variance in Residuals

The variance of errors should be the same across all levels of each predictor variable. All five RGIM Factors were checked for homogeneity of variance in residuals. A visual examination of the scatterplots of predicted scores versus residuals (the errors) showed no heteroscedasticity in any of the regression diagnostics.

Linearity

If a relationship between a predictor variable and a criterion variable is not linear, the results of the regression analysis will underestimate the true relationship. A visual inspection of scatterplots of each variable against every predictor with exploratory curve

fitting suggested no curvilinear relationships, nor did scatterplots of predicted scores versus residuals show any suggestion of curvilinear relationships.

Multicollinearity

Multicollinearity occurs when two predictor variables are collinear (highly correlated with each other). This can cause the beta coefficients (a measure of how strongly each predictor variable influences the criterion variable) to be inaccurate. A review of the collinearity diagnostics revealed a multicollinearity problem between SOC and STAI. Various methods were used to transform the STAI scores so that the state and trait anxiety measures could be included in the final regression analysis. However, none of these methods were successful; all diagnostic regressions that included both SOC and adjusted STAI scores had large multicollinearity problems. Additionally, it was found that state and trait anxiety scores were also highly correlated. It was therefore decided that state anxiety, trait anxiety, and SOC would each be entered into separate exploratory regressions in the main analyses, each of which would include the same additional variables, namely, age and classical music experience (CME).

Preliminary Analyses

Missing Data

There were three cases where participants skipped questions or circled more than one answer to individual questions on the STAI Form Y-1 (state anxiety). In one case, the researcher was able to reasonably predict the intended answers for three consecutive, inaccurate items by looking at the participant's other responses. In another case where a total of four answers were inaccurate, the researcher used a "nearest neighbor substitution approach" (Jennifer Cromley, personal communication, September 3, 2010) and

substituted the cumulative state anxiety score of another participant who had similar scores to this participant on both STAI Forms Y-1 and Y-2. Finally, it appeared that one participant had not read the questions carefully when completing the STAI Form Y-1, as several answers were contradictory. This did not appear to be the case for the answers that this individual gave on STAI Form Y-2 (trait anxiety). Therefore, this individual's total state anxiety score was not included in any of the analyses. There were no other missing data in this study.

Gender

As previously mentioned in Chapter 3, there were not enough male participants to include gender in the regression formula, so independent samples *t*-tests (assuming unequal variances) were utilized to analyze this variable. A difference was found between males and females on "Comfort with Self-Disclosure" showing that males had significantly higher scores than females on this variable. No other significant differences were found between males and females on any of the other predictor or criterion measures (see Table 8). For the sake of clarity and accuracy, results calculated with raw RGIM scores as well as results calculated with corresponding RGIM factor scores (in parentheses) are both included in the table.

Table 8

T-tests Results for Gender on all Variables (parentheses contain results calculated using factor scores)

Variable		<i>M</i>	<i>SD</i>	<i>t</i>	<i>df</i>
CME	Female	16.80	6.46	.44	25.86
	Male	15.94	6.69		
SOC	Female	150.57	17.00	1.71	25.74
	Male	141.81	17.70		
CO	Female	50.61	7.83	1.21	21.57
	Male	47.19	10.35		
MA	Female	53.55	7.38	1.75	27.53
	Male	49.88	7.13		
ME	Female	46.41	5.44	.98	24.85
	Male	44.75	5.90		
SA	Female	34.39	8.96	1.08	27.99
	Male	31.80	7.69		
TA	Female	37.86	9.08	-.05	25.02
	Male	38.00	9.78		
AR	Female	16.80	3.57	.09	21.87
	Male	16.69	4.61		
AIM	Female	(-.00)	(.94)	(-.02)	(23.87)
	Male	(.01)	(1.08)		
	Female	41.14	10.23	.58	24.94
	Male	39.31	11.06		
RMG	Female	(.06)	(.99)	(.75)	(28.13)
	Male	(-.15)	(.94)		
	Female	28.75	4.56	1.63	20.66
	Male	25.88	6.48		
CSD	Female	(.13)	(.83)	(1.51)	(20.97)
	Male	(-.35)	(1.15)		
	Female	17.30	3.51	-2.26*	47.33
	Male	18.94	1.98		
MOE	Female	(-1.16)	(1.09)	(-2.69*)	(49.45)
	Male	(.43)	(.58)		
	Female	22.82	4.15	.51	23.60
	Male	22.13	4.81		
	Female	(.04)	(.89)	(.44)	(22.64)
	Male	(-.10)	(1.09)		

Note. CME = Classical Music Experience. SOC = Sense of Coherence. CO = Comprehensibility (SOC subscale). MA = Manageability (SOC subscale). ME = Meaningfulness (SOC subscale). SA = State Anxiety. TA = Trait Anxiety. AR = Ability to Relax (RGIM Factor 1). AIM = Ability to Image to Music (RGIM Factor 2). RMG = Responsiveness to Music and Guiding (RGIM Factor 3). CSD = Comfort with Self-Disclosure (RGIM Factor 4). MOE = Meaningfulness of the Experience (RGIM Factor 5).

* $p \leq .05$.

Descriptive Statistics

Table 9 contains descriptive statistics for all of the variables in the present study with the exception of gender.

Table 9

Descriptive Statistics

Variables	Range	<i>M</i>	<i>SD</i>
Age	22-79	45.88	15.37
CME	4-28	16.57	6.47
SOC	94-184	148.23	17.47
CO	20-65	49.70	8.62
MA	31-67	52.57	7.44
ME	33-55	45.97	5.56
SA	20-55	33.73	8.66
TA	22-64	37.90	9.19
AR	4-21	16.77	3.83
AIM	8-55	40.65	10.39
RMG	12-35	27.98	5.24
CSD	6-21	17.73	3.25
MOE	12-28	22.63	4.31

Note. CME = Classical Music Experience. SOC = Sense of Coherence. CO = Comprehensibility (SOC subscale). MA = Manageability (SOC subscale). ME = Meaningfulness (SOC subscale). SA = State Anxiety. TA = Trait Anxiety. AR = Ability to Relax (RGIM Factor 1). AIM = Ability to Image to Music (RGIM Factor 2). RMG = Responsiveness to Music and Guiding (RGIM Factor 3). CSD = Comfort with Self-Disclosure (RGIM Factor 4). MOE = Meaningfulness of the Experience (RGIM Factor 5).

The widespread use of different versions of the SOC makes it difficult to establish normative data and there appears to be no consensus in the literature on what constitutes a normal SOC score (Eriksson & Lindström, 2005). However, the mean total score of the present study's participants ($M = 148.23$; $SD = 17.48$) seems comparable with normative data gathered by Antonovsky (1993). For example, he found that the mean total SOC score for a sample of Finnish men and women was 150.2 ($SD = 21.9$) and 146.1 ($SD = 22.7$) respectively.

Similarly, both the mean total state and trait anxiety scores in the present study also seem comparable to population norms compiled by Spielberger et al. (1983). They found that the mean total state anxiety score for a sample of working adult males and females was 35.72 ($SD = 10.40$) 35.20 ($SD = 10.61$) respectively. The mean total state anxiety score for participants in the present study (mostly female) was 33.73 ($SD = 8.66$). Spielberger et al. (1983) also found that the mean total trait anxiety scores for a sample of working adult males and females was 34.89 ($SD = 9.19$) and 34.79 ($SD = 9.22$) respectively. The mean total trait anxiety score for participants in the present study was 37.90 ($SD = 9.19$). Overall, it appears that the participants in the present study can be considered to be reasonably representative of a normal adult population with regard to both SOC and STAI measures.

Correlational Statistics

Table 10 contains correlational statistics for all of the variables in the present study with the exception of gender.

Table 10

Correlational Statistics

Variables	Age	CME	SOC	CO	MA	ME	SA	TA	AR	AIM	RMG	CSD	MOE
Age	—	.35**	.02	.01	-.06	.12	-.08	.02	.12	.21	.30*	.24	.23
CME		—	.13	.07	.04	.24	.02	.12	.18	-.06	.21	.03	-.06
SOC			—	.82**	.91**	.65**	-.42**	-.68**	.07	.31*	.42**	.03	.32*
CO				—	.62**	.19	-.24	-.46**	.07	.27*	.37**	-.07	.22
MA					—	.57**	-.44**	-.74**	.01	.22	.29*	.07	.19
ME						—	-.35**	-.43**	.11	.28*	.35**	.11	.41**
SA							—	.65**	-.07	-.37**	-.21	-.05	-.19
TA								—	-.12	-.21	-.22	-.24	-.22
AR									—	.34**	.19	.46**	.22
AIM										—	.63**	.13	.66**
RMG											—	.15	.60**
CSD												—	.15
MOE													—

Note. CME = Classical Music Experience. SOC = Sense of Coherence. CO = Comprehensibility (SOC subscale). MA = Manageability (SOC subscale). ME = Meaningfulness (SOC subscale). SA = State Anxiety. TA = Trait Anxiety. AR = Ability to Relax (RGIM Factor 1). AIM = Ability to Image to Music (RGIM Factor 2). RMG = Responsiveness to Music and Guiding (RGIM Factor 3). CSD = Comfort with Self-Disclosure (RGIM Factor 4). MOE = Meaningfulness of the Experience (RGIM Factor 5).

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

Significant positive relationship was found between: (a) Age and “Responsiveness to Music and Guiding” (RGIM Factor 3; $r = .30$, $p \leq .05$); (b) SOC and “Ability to Image to Music” (RGIM Factor 2; $r = .31$, $p \leq .05$); (c) SOC and “Responsiveness to Music and Guiding” (RGIM Factor 3; $r = .42$, $p \leq .05$); (d) SOC and “Meaningfulness of the Experience” (RGIM Factor 5; $r = .32$, $p \leq .05$); (e) Comprehensibility (CO) and “Ability to Image to Music” (RGIM Factor 2; $r = .27$, $p \leq .05$); (f) CO and “Responsiveness to Music and Guiding” (RGIM Factor 3; $r = .37$, $p \leq .05$); (g) Manageability (MA) and “Responsiveness to Music and Guiding” (RGIM Factor 3; $r = .29$, $p \leq .05$); (h) Meaningfulness (ME) and “Ability to Image to Music” (RGIM Factor 2; $r = .28$, $p \leq .05$); (i) ME and “Responsiveness to Music and Guiding” (RGIM Factor 3; $r = .35$, $p \leq .05$); and (j) ME and “Meaningfulness of the Experience” (RGIM Factor 5; $r = .41$, $p \leq .05$). Finally, a significant negative relationship was found between state anxiety and “Ability to Image to Music” (RGIM Factor 2; $r = -.37$, $p \leq .05$).

No significant relationships were found between CME and any of the criterion variables, or between trait anxiety and any of the criterion variables. No significant relationships were found between any of the proposed predictor variables and “Ability to Relax” (RGIM Factor 1) or “Comfort with Self-Disclosure” (RGIM Factor 4).

Main Analyses

As a result of the multicollinearity issues outlined above, SOC, state anxiety, and trait anxiety were each entered into three separate sets of exploratory multiple regressions in the main analyses. Age and classical music experience (CME) were entered as predictor variables in all three sets of regressions. As outlined in Chapter Two, some literature indicates that age may be related to imagery ability. Additionally, preliminary

analysis of the data revealed a significant correlation between age and one RGIM Factor (“Responsiveness to Music and Guiding”) thereby further implicating its suitability to be included in the regressions as a predictor variable. Although no significant correlations were found between CME and any of the RGIM Factors (criterion variables), experienced BMGIM practitioners have provided convincing anecdotal evidence pertaining to the impact that classical music experience appears to have on clients’ ability to engage in BMGIM (see Chapter One). In this case, the inclusion of CME as a predictor variable in the regressions was based on this anecdotal evidence.

Multiple linear regressions (using Ordinary Least Squares regression) were computed to determine the extent to which CME, age, and SOC could predict each of the five RGIM Factors. Multiple linear regressions were also computed to determine the extent to which CME, age, and state anxiety could predict each of the five RGIM Factors. Finally, multiple linear regressions were computed to determine the extent to which CME, age, and trait anxiety could predict each of the five RGIM Factors. The results of all three sets of exploratory regressions are presented in Tables 11, 12, and 13.

Table 11

Summary of Linear Multiple Regression Analyses Using Age, CME, and SOC to Predict RGIM Factors

Variables	AR			AIM			RMG			CSD			MOE		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Age	.00	.01	.07	.02	.01	.28*	.02	.01	.27*	.02	.01	.26	.02	.01	.29*
CME	.02	.02	.15	-.03	.02	-.20	.01	.02	.07	-.01	.02	-.07	-.03	.02	-.21
SOC	.00	.01	.05	.02	.01	.34*	.02	.01	.41*	.00	.01	.03	.02	.01	.34*
R^2	.04			.18			.27			.06			.19		
<i>F</i>	.75			4.00*			6.80*			1.23			4.34*		

Note. CME = Classical Music Experience. SOC = Sense of Coherence. AR = Ability to Relax (RGIM Factor 1). AIM = Ability to Image to Music (RGIM Factor 2). RMG = Responsiveness to Music and Guiding (RGIM Factor 3). CSD = Comfort with Self-Disclosure (RGIM Factor 4). MOE = Meaningfulness of the Experience (RGIM Factor 5).

* $p \leq .05$.

Together, age, CME, and SOC accounted for a significant 18% of the variance in “Ability to Image to Music,” $F(3, 56) = 4.00$, $MSE = .82$, $p \leq .05$. Together, age, CME, and SOC accounted for a significant 27% of the variance in “Responsiveness to Music and Guiding,” $F(3, 56) = 6.80$, $MSE = .68$, $p \leq .05$. Together, age, CME, and SOC accounted for a significant 19% of the variance in “Meaningfulness of the Experience,” $F(3, 56) = 4.34$, $MSE = .76$, $p \leq .05$. Standardized beta coefficients indicated that age and SOC contributed significantly and positively to all three of these Factors. Additionally, SOC contributed slightly more than age to all three of these Factors. The results also show that when taken together, age, CME, and SOC were not significant predictors of “Ability to Relax,” $F(3, 56) = .75$, $MSE = .95$, $p \leq .05$, or “Comfort with Self-Disclosure,” $F(3, 56) = 1.23$, $MSE = 1.01$, $p \leq .05$.

Table 12

Summary of Linear Multiple Regression Analyses Using Age, CME, and State Anxiety to Predict RGIM Factors

Variables	AR			AIM			RMG			CSD			MOE		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Age	.01	.01	.10	.02	.01	.31*	.02	.01	.36*	.02	.01	.29*	.03	.01	.42*
CME	.02	.02	.15	-.02	.02	-.15	.02	.02	.12	-.01	.02	-.07	-.02	.02	-.18
SA	-.01	.02	-.07	-.04	.01	-.35*	-.02	.01	-.19	-.00	.02	-.03	-.02	.01	-.15
R^2	.05			.23			.22			.08			.19		
<i>F</i>	.97			5.32*			5.17*			1.57			4.35*		

Note. CME = Classical Music Experience. SA = State Anxiety. AR = Ability to Relax (RGIM Factor 1). AIM = Ability to Image to Music (RGIM Factor 2). RMG = Responsiveness to Music and Guiding (RGIM Factor 3). CSD = Comfort with Self-Disclosure (RGIM Factor 4). MOE = Meaningfulness of the Experience (RGIM Factor 5).

* $p \leq .05$.

Together, age, CME, and state anxiety accounted for a significant 23% of the variance in “Ability to Image to Music,” $F(3, 55) = 5.32$, $MSE = .76$, $p \leq .05$. Standardized beta coefficients indicated that age and state anxiety contributed significantly to this Factor (positive and negative contributions, respectively) and that state anxiety made a slightly higher contribution than age. Together, age, CME, and state anxiety accounted for a significant 22% of the variance in “Responsiveness to Music and Guiding,” $F(3, 55) = 5.17$, $MSE = .68$, $p \leq .05$. Together, age, CME, and state anxiety accounted for a significant 19% of the variance in “Meaningfulness of the Experience,” $F(3, 55) = 4.35$, $MSE = .66$, $p \leq .05$. Standardized beta coefficients indicated that age contributed significantly and positively to both of these Factors. The results also show that when taken together, age, CME, and state anxiety were not significant

predictors of “Ability to Relax,” $F(3, 55) = .97, MSE = .95, p \leq .05$, or “Comfort with Self-Disclosure,” $F(3, 55) = 1.57, MSE = 1.00, p \leq .05$.

Table 13

Summary of Linear Multiple Regression Analyses Using Age, CME, and Trait Anxiety to Predict RGIM Factors

Variables	AR			AIM			RMG			CSD			MOE		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Age	.00	.01	.06	.02	.01	.26	.02	.01	.25	.02	.01	.26	.02	.01	.28*
CME	.03	.02	.17	-.02	.02	-.13	.02	.02	.16	-.01	.02	-.03	-.02	.02	-.13
TA	-.01	.01	-.14	-.02	.01	-.20	-.03	.01	-.24*	-.03	.01	-.24	-.02	.01	-.21
R^2	.06			.11			.16			.12			.12		
<i>F</i>	1.08			2.19			3.66*			2.49			2.49		

Note. CME = Classical Music Experience. TA = Trait Anxiety. AR = Ability to Relax (RGIM Factor 1). AIM = Ability to Image to Music (RGIM Factor 2). RMG = Responsiveness to Music and Guiding (RGIM Factor 3). CSD = Comfort with Self-Disclosure (RGIM Factor 4). MOE = Meaningfulness of the Experience (RGIM Factor 5).

* $p \leq .05$.

Together, age, CME, and trait anxiety accounted for a significant 16% of the variance in “Responsiveness to Music and Guiding,” $F(3, 56) = 3.66, MSE = .77, p \leq .05$. Standardized beta coefficients indicated that trait anxiety contributed significantly and negatively to this Factor. The results also show that when taken together, age, CME, and trait anxiety were not significant predictors of “Ability to Relax,” $F(3, 56) = 1.08, MSE = .94, p \leq .05$, “Ability to Image to Music,” $F(3, 56) = 2.19, MSE = .90, p \leq .05$, “Comfort with Self-Disclosure,” $F(3, 56) = 2.49, MSE = .95, p \leq .05$, or “Meaningfulness of the Experience” $F(3, 56) = 2.49, MSE = .82, p \leq .05$.

CHAPTER 5

DISCUSSION

The purpose of this chapter is to examine each variable in relation to other variables contained in the study, to contextualize the findings within the existing literature, and to explore possible reasons for the current findings. Limitations of the study are also presented.

The Proposed Predictor Variables

Sense of Coherence (SOC)

When combined, SOC, classical music experience, and age contributed significantly and positively to the prediction of “Ability to Image to Music,” “Responsiveness to Music and Guiding,” and “Meaningfulness of the Experience.” The standardized beta coefficients indicated that SOC was the variable that contributed most to the prediction of each these three Factors. When examined alone, without classical music experience and age, total SOC was positively and significantly correlated with these same three Factors.

These results indicate that the extent to which an individual finds life comprehensible, manageable, and meaningful (total SOC; alone or in combination with age and CME) predicts the extent to which an individual is able to: (a) engage in a music and imagery experience, (b) respond favorably to the music and to the directions of the guide, and (c) find meaning in a music and imagery experience. Thus, SOC appears to be predictive of responsiveness to BMGIM in three of the five Factors. SOC did not significantly predict “Ability to Relax” or “Comfort with Self-Disclosure,” either alone or in combination with other predictor variables.

The current study also revealed several significant positive correlations between the SOC subscales and the RGIM Factors. These included: (a) Comprehensibility and two different RGIM Factors (“Ability to Image to Music,” and “Responsiveness to Music and Guiding”); (b) Manageability and one RGIM Factor (“Responsiveness to Music and Guiding”), and (c) Meaningfulness and three different RGIM Factors (“Ability to Image to Music,” “Responsiveness to Music and Guiding,” and “Meaningfulness of the Experience”). No significant correlations were found between any of the SOC subscales and RGIM Factor One, “Ability to Relax,” or RGIM Factor Four, “Comfort with Self-Disclosure.”

These results suggest that: (a) participants who found life more comprehensible were more adept at using music to create imagery, more responsive to the music, and more adept at following the facilitator’s directions during the group GIM session, (b) participants who found life more manageable were more responsive to the music, and more adept at following the facilitator’s directions during the group GIM session, and (c) participants who found life more meaningful were more adept at using music to create imagery, more responsive to the music, more adept at following the guide’s directions during the group GIM session, and more inclined to find meaning in their music and imagery experience.

These findings contradict those of Meadows (2000) who found only one significant correlation between SOC and GIMR (the previous version of RGIM which was completed by the therapist/researcher rather than the participants). Comprehensibility (a SOC subscale) was negatively correlated with responsiveness to the guide (a GIMR subscale; $r = -.36, p < .05$). Given the fact that the RGIM is an adapted version of the

GIMR created specifically to address identified limitations of the original tool (i.e., possible lack of construct validity and contamination of scores due to the researcher's countertransference), it may be the case that some of the RGIM Factors are more valid and sensitive measures of responsiveness to BMGIM than the original dimensions of the GIMR.

Although the literature contains many studies which indicate that a strong SOC does seem to predict health from a salutogenic viewpoint (Eriksson & Lindström, 2006), no previous studies were found which investigated SOC as a predictor of responsiveness to BMGIM. Other studies were found however, which examined SOC as an outcome variable in relation to BMGIM or an adapted GIM intervention (Brooks, Bradt, Eyre, Hunt, & Dileo, 2010; Heiderscheidt, 2005; Körlin & Wrangsjö, 2002; Wrangsjö & Körlin, 1995). The results of three of these studies suggested that BMGIM intervention led to an increase in total SOC scores, and in Meaningfulness and/or Manageability subscores. Brooks et al. (2010) however, found no differences on total SOC scores or SOC subscores when comparing subjects who experienced group music and imagery sessions with subjects who had not.

The cumulative results of these studies along with those of the present study seem to suggest a multivariate relationship between SOC and BMGIM. Specifically, it appears that one's orientation to life (SOC) can be predictive of how comfortable a person will be engaging in BMGIM therapy, and at the same time, SOC can also be a measure of the effectiveness of BMGIM therapy in changing one's orientation to life. But how can this multivariate relationship be explained? Is SOC a stable measure of personality, or is it subject to change after certain types of therapeutic intervention? Is the stability of SOC

dependent on whether a person scores above, at, or below a particular norm? And what implications do these questions have for the use of SOC in the clinical assessment of readiness for BMGIM, and in the evaluation of progress as a result of BMGIM?

Antonovsky originally conceived of SOC as a relatively stable measure of one's potential for health (Antonovsky, 1987). Research has supported this notion by showing that SOC is correlated with other health trait measures (Carmel & Bernstein, 1989; Kontinen et al., 2008; Schnyder et al., 2000), findings which were also consistent with the results of the present study (i.e., SOC and trait anxiety scores were highly collinear and negatively correlated). However, Schnyder, Büchi, Mörgeli, Sensky, and Klaghofer (1999) have also suggested that SOC may be more accurately defined as “a ‘world view’ that remains largely stable but also has a degree of plasticity, being subject to modification by exceptional experiences” (p. 109). Others have suggested that SOC could be a “mediating variable that shifts roles from effects to causes depending on the focus of the analysis (Eriksson & Lindström, 2006, p.377). Thus, it seems that SOC may be stable under certain conditions, and plastic under others.

When all of this SOC research is considered in light of research on SOC in BMGIM, the present findings seem to qualify Bruscia's notion that the three health traits measured by the SOC scale must be sufficiently present in order for an individual to *benefit* from BMGIM (Bruscia cited in Meadows, 2000). Instead, it may be that these three health traits must be sufficiently present in order for an individual to comfortably *engage* in BMGIM without specific kinds of modification. Thus, an individual who scores low on the SOC may need and benefit from BMGIM, but if as predicted in this study, an individual also scores low on the RGIM, the therapist has clear indications of

what aspects of the BMGIM experience must be modified for the individual to comfortably engage in the BMGIM experience as originally designed. Ideally then, both SOC and RGIM seem to be equally important tools in the clinical assessment of indications and contraindications for BMGIM.

On the other side of the equation, if these three health traits measured by SOC are sufficiently present at the onset of BMGIM, it may mean that the person is not in need of intensive psychotherapy (i.e., re-educative or reconstructive levels of psychotherapy), but could still benefit from BMGIM as a means of self-development or as a means of personal support. And if, as predicted in this study, this person also scores high on the RGIM, she or he will be able to fully engage in the BMGIM experience toward these ends.

Of course, this poses some limitations on the use of SOC as a measure of BMGIM's effectiveness, at least with regard to research. Whereas the person who starts BMGIM with a low SOC may be able to significantly increase their SOC scores statistically, the person who starts BMGIM with a normal or high SOC may not be able to do the same. For these individuals, it may be that BMGIM can contribute to an increase in SOC up to a point of maximum potential for each individual, and the amount of this increase, though clinically significant, may or may not be large enough to achieve statistical significance. This may explain the different findings in research studies that use SOC as a measure of BMGIM's effectiveness. Perhaps the starting level of SOC varied within and between the participants of these studies. Some of the participants may have started low and ended high, whereas others may have started at higher levels and not improved that significantly.

Unfortunately, these questions cannot be answered by the results of the present study since SOC data was only collected before but not after the group GIM experience. Additional research studies with adequate sample sizes and clear criteria for inclusion are needed in order to more explicitly identify and define various aspects of the relationship that exists between SOC and RGIM. Furthermore, the circumstances under which both BMGIM and modified BMGIM are contraindicated (based on SOC and RGIM scores) need to be more clearly defined.

Finally, it is important to note that age may be an intervening variable in the proposed relationships between SOC and the RGIM Factors. This issue will be discussed further in the subsection below on age.

Anxiety (STAI)

When combined, state anxiety, classical music experience, and age contributed significantly to the prediction of “Ability to Image to Music,” “Responsiveness to Music and Guiding,” and “Meaningfulness of the Experience.” The standardized beta coefficients indicated that while age made a significant and positive contribution to all three of these Factors, state anxiety made a significant and negative contribution to only one RGIM Factor: “Ability to Image to Music.” Furthermore, state anxiety contributed slightly more than age to the prediction of this Factor. When examined alone without classical music experience and age, state anxiety was significantly and negatively correlated with this same Factor. State anxiety did not significantly predict “Ability to Relax” or “Comfort with Self-Disclosure,” either alone or in combination with other predictor variables. These results indicate that temporary feelings of anxiety in combination with classical music experience and older age, predicts responsiveness to

BMGIM in three of the five Factors: “Ability to Image to Music,” Responsiveness to Music and Guiding,” and “Meaningfulness of the Experience.” Furthermore, it appears that higher levels of state anxiety alone can have a negative impact on one’s ability to fully engage in the music and imagery phase of a BMGIM session. These results are supported by previous research which indicated that persons experiencing higher levels of distress or anxiety may have difficulty engaging in imagery processes (Bryant and Harvey, 1996; Burns et al., 2008; Schienle et al., 2009), or may have more difficulty processing (i.e., finding meaning in) the BMGIM experience (Scott, 2007-2008).

Surprisingly, state anxiety did not predict one’s “Ability to Relax” or “Comfort with Self-Disclosure,” either alone or in combination with other predictor variables. Possible reasons for these findings will be presented in the subsections below which discuss these two RGIM Factors.

When combined, trait anxiety, classical music experience, and age contributed significantly to the prediction of “Responsiveness to Music and Guiding.” The standardized beta coefficients indicated that trait anxiety was the only variable that made a significant and negative contribution to this Factor. When examined alone, without classical music experience and age, no significant correlations were found between trait anxiety and any of the RGIM Factors. Furthermore, trait anxiety in combination with classical music experience and age did not significantly predict “Ability to Relax,” “Ability to Image to Music,” “Comfort with Self-Disclosure,” or “Meaningfulness of the Experience.” These results indicate that proneness to anxiety in combination with classical music experience and age predicts lower responsiveness in only one RGIM

Factor: “Responsiveness to Music and Guiding,” but that trait anxiety alone does not predict responsiveness to BMGIM in any of the RGIM Factors.

Given the fact that state anxiety, trait anxiety, and SOC are highly collinear variables, and that previous research has shown that higher levels of trait anxiety can negatively affect task performance (Sadeh & Bredemeier, 2010), it is surprising that more significant relationships were not found between trait anxiety and the RGIM Factors. However, it may be the case that only exceptionally high levels of trait anxiety negatively affect responsiveness to BMGIM (i.e., are associated with lower scores on RGIM factors), and that the current study’s participants did not exceed this trait anxiety threshold given that they were drawn from the general population and had no known history of psychiatric illness. In other words, it is possible that relationships between trait anxiety and measures of responsiveness to BMGIM are mediated by underlying clinical conditions that were not present in this study’s sample. The potential relationships between trait anxiety and responsiveness to BMGIM need to be further explored, particularly with clinical populations who are prone to anxiety.

Classical Music Experience (CME)

When combined, classical music experience, SOC, and age contributed significantly to the prediction of “Ability to Image to Music,” “Responsiveness to Music and Guiding,” and “Meaningfulness of the Experience.” When combined, classical music experience, state anxiety, and age contributed significantly to “Ability to Image to Music,” “Responsiveness to Music and Guiding,” and “Meaningfulness of the Experience.” When combined, classical music experience, trait anxiety, and age contributed significantly to the prediction of “Responsiveness to Music and Guiding.”

However, the standardized beta coefficients indicated that classical music experience did not make any significant contributions to the prediction of any RGIM Factors in any of the regressions, and no significant correlations were found between classical music experience and any of the RGIM Factors. This is surprising given the anecdotal evidence provided by experienced BMGIM practitioners who have noted that classical musicians and others who are very familiar with the genre often seem to experience difficulties which affect their ability to freely engage in BMGIM (Keiser Mardis, 1989; Liz Moffitt, personal communication, June 5, 2009). Similar observations have been made by the current researcher in her BMGIM practice. Based on this anecdotal information, it was reasonable to expect that higher classical music experience scores would have resulted in significantly lower scores on at least some of the RGIM Factors but as previously noted, this was not the case.

During the postlude discussion phases that occurred in the present study however, participants made some noteworthy remarks. Some expressed that they had difficulties engaging in some or all of the group GIM experience which they attributed to the music. Some stated that familiar selections distracted them from their imagery experience, some, who identified themselves as trained musicians, stated that they felt compelled to analyze or “just listen” to the music, and some stated that they found it difficult to use classical music to engage in the session when they regularly utilized it for another purpose (i.e., to fall asleep, listen to it while at work). On the contrary, other individuals who also identified themselves as classically trained musicians expressed that they had very meaningful experiences, and did not cite any difficulties with engaging in the group GIM

process. Finally, some individuals who stated that they did not like classical music expressed surprise at their ability to engage in the experience.

Perhaps the significance of classical music experience in relation to BMGIM responsiveness depends upon its collinearity with other variables that were not accounted for in the measure. These variables could include but are not limited to: (a) formal instruction received on particular instruments, (b) amount and type of performance experience (i.e., solo versus ensemble, amateur versus professional); (c) individuals' cultural backgrounds and the roles that music plays in a particular culture, (d) relationship of individuals' occupations to music, and (e) educational backgrounds. It is also important to note that a significant positive moderate correlation was found between classical music experience and age ($r = .35, p \leq .05$). This finding aligns with research done by Savage (2006) who found that older people expressed stronger preferences for classical music than younger people, and that age was the single most important stratifying feature for musical taste. Older individuals' preferences for classical music in the current study and/or the possibility that they may have had more opportunities than younger participants to be exposed to classical music, may have contributed at least in part to findings which identified age as a significant and positive predictor variable for "Ability to Image to Music," "Responsiveness to Music and Guiding," and "Meaningfulness of the Experience."

Gender

As there were not enough males to include gender in the regressions, independent samples *t*-tests (assuming unequal variances) were used to analyze this variable. A significant difference was found between males and females on RGIM Factor Four,

“Comfort with Self-Disclosure,” showing that males had significantly higher scores than females on this measure. Although research findings on the relationship between gender and responsiveness to psychotherapy are mixed, a study conducted by Ogrodniczuk et al. (2004), found that men benefited more from participation in interpretive psychotherapy whereas women benefited more from participation in supportive psychotherapy ($d = .71$). Therefore in the context of the present study, it is possible that males felt more comfortable than females about self-disclosing in the postlude discussion phase, as the main purpose of this phase was to help participants interpret (i.e., make meaning of) their own BMGIM experiences. However, male participants’ comfort with self-disclosure did not seem to give them an advantage over females in terms of finding meaning in their experiences as no differences were found between males and females on RGIM Factor Five, “Meaningfulness of the Experience.” In fact, no other significant differences were found between males and females on any of the other predictor or criterion measures.

To an extent, these findings contradict research conducted by Meadows (2001, 2002b), and also by Körlin and Wrangsjö (2001); both of whom found differences between males and females on a variety of outcome measures after BMGIM intervention. However, as previously noted, research findings from outside of the BMGIM literature which pertain to gender differences on the ability to create imagery, enter an altered state of consciousness, respond beneficially to music, and/or respond to psychotherapeutic intervention, are limited, inconclusive, and sometimes contradictory (see Chapter 2). In the present study, it may have been the case that there were not enough males to make valid comparisons. Additionally, these current findings could indicate that it is more appropriate to investigate gender constructs (i.e., female-like and male-like qualities) as

predictors of responsiveness to BMGIM rather than biological sex. This suggestion aligns with research conducted by Meadows (2001, 2002b) who examined gender implications in BMGIM therapists' constructs of their clients. He found that gender qualities as described by therapists were not necessarily related to the sex of their clients, and that therapists seemed to perceive differences in responsiveness to BMGIM based on the gender qualities of their clients. The proposed relationship between gender constructs and responsiveness to BMGIM warrants further investigation.

Age

When combined, age, SOC, and classical music experience contributed significantly to the prediction of "Ability to Image to Music," "Responsiveness to Music and Guiding," and "Meaningfulness of the Experience." The standardized beta coefficients indicated that age contributed significantly and positively to all three of these RGIM Factors, and that age made slightly smaller contributions than SOC to each of these three Factors. Thus, older age in combination with higher SOC and classical music experience is predictive of three of the five RGIM Factors. Although no significant correlations were found between age and SOC, or age and the SOC subscales in the present study, it is important to note that previous researchers have indicated that SOC may increase in the general population over the lifespan up to a certain point (Eriksson & Lindström, 2005; Feldt et al., 2007; Klepp et al., 2007; Richardson et al., 2007). It could be the case that age and SOC are related in ways that were unaccounted for by the present study, and that this may have affected the results. Additional research is needed to elucidate the nature of any relationships that may exist between these two variables, and how this in turn might affect responsiveness to BMGIM.

When combined, age, state anxiety, and classical music experience contributed significantly to the prediction of “Ability to Image to Music,” “Responsiveness to Music and Guiding,” and “Meaningfulness of the Experience.” The standardized beta coefficients indicated that age contributed significantly and positively to all three of these RGIM Factors, and also contributed slightly less than state anxiety (a significant negative predictor) to “Ability to Image to Music.” Thus, older age in combination with state anxiety and classical music experience, is predictive of three of the five RGIM Factors.

When combined, age, trait anxiety, and classical music experience contributed significantly to the prediction of “Responsiveness to Music and Guiding.” The standardized beta coefficients indicated that age did not make a significant contribution to this Factor. Thus, age in combination with trait anxiety and classical music experience, is predictive of one of the five RGIM Factors.

Although no significant correlations were found between age and state or trait anxiety in the present study, other researchers have found negative correlations between both state anxiety and age, and trait anxiety and age in the general population (i.e., older age is related to lower anxiety). For example, in a study that administered the STAI to a sample from the general Chilean population, Vera-Villaruel, Buena-Casal, and Spielberger, (2007) found that adults had significantly lower state anxiety ($d = .36$) and trait anxiety ($d = .40$) scores than adolescents. It could be the case that age and anxiety are related in ways that were unaccounted for by the present study, and that this may have impacted upon the results. Additional research is needed to elucidate the nature of any relationships that may exist between age and state anxiety, and age and trait anxiety, and the potential implications for BMGIM responsiveness.

When examined alone, (without SOC, state anxiety, trait anxiety, or classical music experience), age was positively and significantly correlated with only one RGIM Factor, “Responsiveness to Music and Guiding,” thus indicating that older age was an independent predictor of higher scores on this particular RGIM Factor. No significant correlations were found between age and “Ability to Relax,” “Ability to Image to Music,” “Comfort with Self-Disclosure,” or “Meaningfulness of the Experience.” These results suggest that older participants were more responsive to the music than younger participants, and also were better able to follow the directions given by the guide during the group GIM session. As noted above, older participants’ tended to have higher scores on the classical music experience measure, and this correlation may have inadvertently confounded the results which identified age as a significant positive predictor for “Responsiveness to Music and Guiding.”

No previous research was found in the BMGIM literature which investigated the relationship between age and responsiveness to BMGIM. Other research has indicated however, that imagery abilities may decline with age (Campos et al., 2004; Dror & Kosslyn, 1994; Isaac & Marks, 1994; Mulder et al., 2007), and that older individuals may experience a decline in their ability to enter an altered state of consciousness (Cardena et al., 2007; Giambra, 1999-2000; Page & Green, 2007). However, these findings are contradicted by the results of present study which indicated that age in combination with SOC and classical music experience made a significant and positive contribution to “Ability to Image to Music,” and when examined alone, age was not correlated with “Ability to Image to Music.” It may be the case that aspects of the imagery session that are unique to BMGIM (i.e., the relaxation induction, the use/role of music, the role of the

therapist) helped older participants to remain engaged in the imagery process. This suggestion is also supported by the fact that a significant correlation was found between age and RGIM Factor Three (“Responsiveness to Music and Guiding”), indicating that older participants were more responsive to the music than younger participants, and better able to follow the facilitator’s directions during the relaxation induction and during the semi-directed imagery portion of the music listening phase. In other words, heightened responsiveness on RGIM Factor Three may have helped older participants to generate images and remain engaged in the music and imagery process.

The RGIM Factors/Criterion Variables

The RGIM Scale (see Appendix A) is an adaptation of the GIMR Scale. The GIMR was originally designed to provide a quantifiable means of assessing client responsiveness and evaluating progress in BMGIM (Bruscia, 2000). The RGIM was designed to address some of the identified limitations of the GIMR, including lack of construct validity (Meadows, 2000). Meadows concluded that “certain sub-scores may be more independent measures of [BMGIM] responsiveness, although [still] related to the total score. Further research is indicated to examine these relationships more fully” (p.29). In the present study, exploratory factor analyses revealed that the RGIM (with four items removed) consists of five distinct moderately correlated Factors which are organized somewhat differently than the original dimensions of the RGIM (see Appendices A & I, and Table 3, p.51 to compare the original and revised versions of the RGIM). This meant that participants’ total RGIM scores could not be utilized in the present study’s data analysis because responsiveness to BMGIM as measured by the RGIM is not a single composite measure, but rather five separate Factors, each one of

which addresses a particular area of responsiveness to BMGIM. This finding has significant implications for BMGIM theory and practice.

BMGIM is a unique and complex method of intervention. This is due at least in part to the fact that BMGIM practice is defined by the method itself (i.e., it is a particular way of using music and imagery), rather than being defined by the nature of the outcome (i.e., a medical outcome, a psychological outcome, etc.; Bruscia, 2002a). It may be the case that it is not possible to design a single composite measure of responsiveness to BMGIM that would adequately account for the full range of possible effects. However, a RGIM Inventory comprised of several valid and reliable measures, each one assessing a fundamental and distinct area of responsiveness to BMGIM, could help therapists to clearly identify salient issues prior to engaging a new client in a full-fledged BMGIM process. However, further consideration must now be given to developing guidelines on how to administer and interpret the results of such an assessment tool given that a potential client may demonstrate varying levels of responsiveness in particular areas. Recommendations regarding the ongoing development of the RGIM Inventory and potential implications for BMGIM practice are discussed in Chapter Six.

The following five subsections not only examine each RGIM Factor and its relationship to other variables contained in the present study, but also look at the items/construct(s) contained in each Factor to determine the suitability of each measure of responsiveness to BMGIM from a theoretical and practical perspective.

RGIM Factor One: Ability to Relax (AR)

Three separate multiple linear regressions revealed that, when variously combined, SOC, state anxiety, trait anxiety, classical music experience, and age were not

significant predictors of one's "Ability to Relax." Moreover no significant correlations were found between these predictor variables and the "Ability to Relax." This is surprising given the fact that SOC (a measure of one's capacity to respond to stress) and state anxiety were both significant independent predictors of other RGIM Factors. It is possible that the three items contained in the "Ability to Relax" measure do not adequately capture all facets of this dimension, or that individuals may have different understandings of what it means to feel relaxed or be in an altered state, thus affecting the face validity of this measure, and the overall results.

Furthermore, previous research has shown that individuals' self-reported feelings of relaxation do not always align with physiological measures of arousal (i.e., individuals report feeling relaxed but physiological measures contradict this), and also that individuals' perceived feelings of relaxation may be due in great part to their perceptions of an activity rather than being a result of the activity in and of itself (i.e., if one believes that an activity is relaxing, one reports that he/she is feeling relaxed; Burns, Labbé, Williams, & McCall, 1999). It appears as though it is quite difficult to obtain accurate results on self-reported measures of relaxation. However, the ability to deeply relax and enter into an altered state of consciousness is a necessary component of being able to engage in a BMGIM process, and therefore an area of responsiveness that still needs to be assessed. In addition to revising the items contained in the "Ability to Relax" Factor, it might also be beneficial if BMGIM practitioners could measure or observe relevant aspects of physiological arousal. These data in combination with results from revised self-report items could result in a more comprehensive and valid measure of "Ability to Relax."

RGIM Factor Two: Ability to Image to Music (AIM)

Two separate multiple linear regressions revealed that predictors of the “Ability to Image to Music” were: (a) SOC, classical music experience, and age; and (b) state anxiety, classical music experience, and age. A third regression revealed that trait anxiety, classical music experience, and age were not significant predictors of the “Ability to Image to Music.” Standardized beta coefficients indicated that SOC and age contributed significantly and positively to the first regression, and that state anxiety and age contributed significantly to the second regression (positive and negative contributions, respectively). Significant positive correlations were found between three predictor variables and “Ability to Image to Music:” (a) total SOC, (b) Comprehensibility (SOC subscale), and (c) Meaningfulness (SOC subscale). A significant negative correlation was also found between state anxiety and “Ability to Image to Music.” No significant correlations were found between three other predictor variables and “Ability to Image to Music:” (a) classical music experience, (b) Manageability (SOC subscale), and (c) trait anxiety. Overall, these results suggest that older age in combination with other variables is related to one’s ability to image to music. Furthermore, individuals who felt less anxious prior to the relaxation induction, or those who found life to be more comprehensible and meaningful, were more adept at creating and/or engaging with imagery during the music listening phase of the group GIM experience.

Prior to the factor analyses, the eight items that make up RGIM Factor Two were initially contained in two different dimensions of the original RGIM: “Rating your Imagery Experience during the Music” and “Rating the Music.” However, these eight items appear to fit together very well in that they all directly pertain to participants’

ability to create imagery or engage with imagery during the music listening phase of a BMGIM experience. Imaging to music is the main activity in which one must engage during a BMGIM session. Identifying difficulties that a potential client might have in this area could help to prevent frustrating experiences and prompt the therapist to use a modified version of BMGIM and/or work with the client to improve this area of responsiveness before engaging him/her in a traditional BMGIM process. Therefore, RGIM Factor Two, “Ability to Image to Music” should be considered a fundamental measure of responsiveness to BMGIM from both a theoretical and practical perspective.

RGIM Factor Three: Responsiveness to Music and Guiding (RMG)

Three separate multiple linear regressions revealed that predictors of “Responsiveness to Music and Guiding” were: (a) SOC, classical music experience, and age; (b) state anxiety, classical music experience, and age; and (c) trait anxiety, classical music experience, and age. The standardized beta coefficients indicated that SOC and age contributed significantly and positively to the first regression, that age contributed significantly and positively to the second regression, and that trait anxiety contributed significantly and negatively to the third regression. Significant positive correlations were found between five predictor variables and “Responsiveness to Music and Guiding:” (a) total SOC, (b) Comprehensibility (SOC subscale), (c) Manageability (SOC subscale), (d) Meaningfulness (SOC subscale), and (e) age. No significant correlations were found between three predictor variables and “Responsiveness to Music and Guiding:” (a) state anxiety, (b) trait anxiety, and (c) classical music experience. Overall, these results indicate that older age in combination with other variables is related to one’s ability to respond positively to the music and to the directions of the guide, and that those who

found life more comprehensible, manageable, and meaningful, were more responsive to the music and to the directions of the guide. Additionally, higher trait anxiety in combination with classical music experience and age is related to lower responsiveness in this same area (RGIM Factor Three).

RGIM Factor Three contains five items, three of which pertain to the participants' responses to the music itself, and two of which pertain to the participants' ability to follow the facilitator's suggestions during the BMGIM experience (i.e., during the relaxation induction and the semi-directed guiding). As first glance it may seem as though these items do not belong together and lead one to wonder why the participants' ratings of these items would have them fall under the same Factor. However, this finding actually provides convincing support for the idea that the music and the therapist in a BMGIM session act as "co-therapists," a common belief held by many prominent BMGIM practitioners (Bush, 1995; Skaggs, 1992; Stokes, 1992; Summer, 1998). According to this belief, the BMGIM therapist or the music or a combination of both can serve as primary agents of change within the therapeutic process, and both can also serve as objects for the clients' transferences. In the present study, it appears as though the participants had an instinctual understanding of this concept and therefore had similar responses to the directions of the guide and to the "directions" of the music. Furthermore, these results also suggest that "responsiveness to music" and "responsiveness to the guide/guiding" may not be isolated dimensions in BMGIM as is commonly thought. Although the music may still be an integral part of the internal imaging experience, it may also be the case that both the music and the guide are perceived by clients as interrelated external stimuli that mediate their internal experiences. Given that the present

study involved novice imagers, it could also be the case that clients' perceptions of these external stimuli might change over time. More research is needed to elucidate this finding and the potential implications for practice.

In any case, the ability to respond to both the music and the guide is an essential part of participating in a BMGIM process. Therefore, RGIM Factor Three, "Responsiveness to Music and Guiding" should be considered a fundamental measure of responsiveness to BMGIM. Additionally, this measure should be revised to include an item that pertains to the client's responsiveness to the non-directive guiding that normally occurs during the music listening phase of an individual BMGIM session.

RGIM Factor Four: Comfort with Self-Disclosure (CSD)

Three separate multiple linear regressions revealed that: (a) SOC, classical music experience, and age; (b) state anxiety, classical music experience, and age; and (c) trait anxiety, classical music experience, and age, were not significant predictors of "Comfort with Self-Disclosure." No significant correlations were found between any of the predictor variables and "Comfort with Self-Disclosure" although independent samples *t*-tests (assuming unequal variances) revealed a significant difference between genders, with males scoring significantly higher than females on this measure. Possible reasons for this finding are discussed above in the subsection on gender.

The three items contained in this Factor refer to participants' level of comfort in discussing the details of their music and imagery experience with other group members or with the facilitator. Interestingly, this Factor is significantly correlated with only one of the other RGIM Factors: "Ability to Relax." As previously noted, it is difficult to obtain accurate results on self-reported measures of relaxation, and there may be a similar issue

with RGIM Factor Five given that “comfort” and “relaxation” are closely related concepts. Furthermore, although this Factor could potentially help to determine an individual’s suitability for group GIM, it does not assess one’s level of comfort in disclosing details to the guide about their imagery experience during the music listening phase. This omission is due to the fact that the current study was unable to address this area of responsiveness in a group GIM context. Although the amount of importance placed on self-disclosure during the preliminary conversation and postlude discussion phases can vary according to practitioners’ philosophical orientations (Bruscia & Grocke, 2002), the need for clients to openly dialogue about their music and imagery experience with the therapist as that experience unfolds is a defining feature of individual BMGIM (Bruscia, 2002a). Therefore, the items contained in RGIM Factor Four should be revised in order to account for this key component of responsiveness. Additionally, the overall validity of this measure should be further explored and items revised accordingly.

RGIM Factor Five: Meaningfulness of the Experience (MOE)

Two separate multiple linear regressions revealed that predictors of “Meaningfulness of the Experience” were: (a) SOC, classical music experience, and age; and (b) state anxiety, classical music experience, and age. A third regression revealed that trait anxiety, classical music experience, and age, were not significant predictors of “Meaningfulness of the Experience.” The standardized beta coefficients indicated that SOC and age contributed significantly and positively to the first regression, and that age contributed significantly and positively to the second regression. Significant positive correlations were found between two predictor variables and “Meaningfulness of the Experience:” (a) SOC (total), and (b) “Meaningfulness” (SOC subscale). No significant

correlations were found between six predictor variables and “Meaningfulness of the Experience.” (a) Comprehensibility (SOC subscale), (b) Manageability (SOC subscale), (c) state anxiety, (d) trait anxiety, (e) classical music experience, and (f) age. Overall, these results suggest that older age in combination with other variables is related to one’s ability to find meaning in their music and imagery experience, and that participants who found life to be more meaningful were also more likely to find meaning in their music and imagery experience.

The four items contained in this measure appear to fit together very well in that they all pertain to participants’ ability and desire to make meaning out of their BMGIM experience. Although practitioners may use a variety of methods to help clients make meaning out of their BMGIM experiences (i.e., verbal processing, mandalas, clay, etc; Bruscia, 2000), or practice within different philosophical orientations (Bruscia & Grocke, 2002), traditional BMGIM practice is rooted in a humanistic orientation wherein clients are encouraged to formulate their own meanings about their BMGIM experiences (Bonny, 1999; Bruscia, 2002a). Assessing a potential client’s ability or desire to find meaning in their BMGIM experiences could provide practitioners with information that they need to determine what kind of support might be most helpful for a particular client (i.e., use of verbal versus non-verbal methods of processing), or it may help them to determine if BMGIM is in fact a good “philosophical fit” for a particular client (i.e., some individuals struggle with the concept and/or use of symbolic thinking). Thus, “Meaningfulness of the Experience” appears to be an important measure of responsiveness to BMGIM from both a theoretical and practical perspective.

Limitations

The present study had some limitations. As previously mentioned in Chapter One, the individual and group formats of GIM are similar with the main exceptions being that in group GIM, clients do not dialogue with the therapist during the music listening phase and the music programs utilized are shorter in duration (Bruscia, 2002a). Although the research protocol tried to compensate for the lack of interactive dialogue through the use of semi-directed guiding, the fact remains that participants were assessed on their responses to a group GIM session which limits the generalizability of these results to an individual BMGIM context.

Furthermore, the traditional structure of the session was changed in order to accommodate a quantitative research study. A standard group or individual BMGIM session format includes a preliminary conversation after which the relaxation induction, starting image, and music are specially created to address specific needs of the client(s). In the present study, the preliminary conversation phase was not included as part of the group BMGIM experience, and all participants experienced the exact same session format so that their responses could be compared within a quantitative framework. Although this change in format also limits the generalizability of the results to traditional BMGIM clinical contexts, the standardized session format utilized in this study could be used as part of a screening tool or preliminary assessment process for potential BMGIM clients. Therefore, the results of the present study can still be considered directly applicable to practice. However, since participants in this study were drawn from the general population, the findings of this study are not generalizable to clinical populations that may be served by BMGIM. Furthermore, because it was necessary to limit the

number of predictor variables being investigated, cultural backgrounds of the participants were not accounted for and this also limits the generalizability of the findings.

The limitations of self-report questionnaires must be noted. Various factors may have motivated participants to provide socially desirable rather than truthful responses including: (a) the desire to represent oneself in a favourable light, (b) the setting in which the research was conducted, and (c) the beliefs of respondents about the purpose of the research (Razavi, 2001). Additionally, some literature indicates that self-report measures associated with imagery ability are correlated with egoistic measures of socially desirable responding (Allbutt, Ling, Heffernan, & Shafiullah, 2008; Allbutt, Ling, & Shafiullah, 2006). In the present study, participants were given written and verbal clarification with regard to the purpose of the study, and were instructed to answer all questions as truthfully as possible. However, it is still possible that some participants may have consciously or unconsciously responded in a manner that was personally desirable rather than fully accurate.

The current author's dual role as the researcher and the group GIM session facilitator may have inadvertently affected this study's results. It is also important to note however, that the researcher had no previous therapeutic relationships with any of the participants, and that verbal clarification was given to all participants with regard to the fact that they were participating in a research session and not a therapy session.

Finally, although the revised RGIM Inventory may provide important information pertaining to clients' responsiveness to BMGIM, it does not provide a precise measure of exactly when BMGIM or modified BMGIM is indicated or contraindicated. Therefore,

further development of the tool is necessary, and practitioners should not use the current version of the tool for this purpose.

CHAPTER 6

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The purpose of this study was to identify predictors of responsiveness to BMGIM, as measured by the RGIM, an adapted version of the GIMR (Bruscia, 2000). The RGIM was designed by the current researcher to address some of the reported limitations of the GIMR (Meadows, 2000). Identifying predictors of responsiveness to BMGIM could lead to the development of screening tools and standardized assessment tools which could help to determine if BMGIM is indicated, contraindicated, or needs to be modified for a potential client. Sense of Coherence (SOC), state anxiety, trait anxiety, classical music experience (CME), gender, and age were assessed as possible predictor variables for responsiveness to BMGIM. Data were gathered from 60 individuals, each of whom participated in one group GIM experience. After data collection was completed, exploratory factor analyses revealed that the RGIM contained five distinct underlying factors which became the criterion variables in the present study. These included: (a) RGIM Factor One: Ability to Relax (AR), (b) RGIM Factor Two: Ability to Image to Music (AIM), (c) RGIM Factor Three: Responsiveness to Music and Guiding (RMG), (d) RGIM Factor Four: Comfort with Self-Disclosure (CSD), and (e) RGIM Factor Five: Meaningfulness of the Experience (MOE). Correlations were used to determine relationships between variables. Three sets of exploratory multiple linear regressions were used to determine the extent to which relevant predictor variables accounted for a significant amount of variance in each of the five RGIM Factors.

Conclusions

Given the exploratory nature of regressions and correlations, and the limitations of the study with regard to internal and external validity, the conclusions that can be drawn from this study are more suggestive than definitive. Given this caveat, the findings of this study are summarized below.

SOC and Responsiveness to BMGIM

The extent to which one finds life comprehensible, manageable, and meaningful (as measured by the total SOC score) was found to be predictive of several areas of responsiveness to BMGIM:

1. Based on bivariate correlations, the higher one's total SOC score, the better one is able to image to music, respond favorably to the music and to the directions of the guide, and find meaning in his/her BMGIM experience.
2. Based on multiple regressions, SOC, classical music experience, and age together predict one's ability to image to music, respond favorably to the music and to the directions of the guide, and find meaning in his/her BMGIM experience. SOC made significant contributions to the variance in all three of these areas. As SOC, and age increase (in combination with classical music experience), so does one's responsiveness in all three of these areas.
3. Based on bivariate correlations between SOC subscales and areas of responsiveness to BMGIM:
 - Individuals who find life more comprehensible are better able to image to music, and also respond more favorably to the music and to the directions of the guide.

- Individuals who find life more manageable, respond more favorably to the music and to the directions of the guide.
- Individuals who find life more meaningful, are better able to image to music, respond more favorably to the music and to the directions of the guide, and are more likely to find meaning in their BMGIM experience.

State Anxiety and Responsiveness to BMGIM

Temporary feelings of anxiety were found to be predictive of several areas of responsiveness to BMGIM:

1. Based on bivariate correlations, the more state anxiety one feels, the less capable one is of imaging to music.
2. Based on multiple regressions, state anxiety, classical music experience, and age together predict one's ability to image to music, respond favorably to the music and to the directions of the guide, and find meaning in his/her music and imagery experience. State anxiety made a significant contribution to the variance in only one of these three areas: the ability to image to music. As state anxiety decreases, and age increases (in combination with classical music experience), one's ability to image increases.

Trait Anxiety and Responsiveness to BMGIM

Proneness to anxiety was found to be predictive of one area of responsiveness to BMGIM:

1. Based on bivariate correlations, trait anxiety alone is not related to one's responsiveness to BMGIM in any of the Factors.

2. Based on multiple regressions, trait anxiety, classical music experience, and age together predict one's ability to respond favorably to the music and to the directions of the guide, with trait anxiety making a significant contribution to the variance in this area. As trait anxiety decreases, (in combination with classical music experience and age), one is better able to respond favorably to the music and to the directions of the guide.

Classical Music Experience and Responsiveness to BMGIM

Classical music experience in combination with other variables was found to be predictive of several areas of responsiveness to BMGIM, whereas classical music experience alone was not predictive of any areas of responsiveness to BMGIM:

1. Based on bivariate correlations, classical music experience alone is not related to responsiveness to BMGIM in any of the Factors.
2. Based on multiple regressions:
 - Classical music experience, SOC, and age together predict one's ability to image to music, respond favorably to the music and to the directions of the guide, and find meaning in his/her BMGIM experience, with classical music experience making no significant contributions to the variance in any of these three areas.
 - Classical music experience, state anxiety, and age together predict one's ability to image to music, respond favorably to the music and to the directions of the guide, and find meaning in his/her music and imagery experience, with classical music experience making no significant contributions to the variance in any of these three areas.

- Classical music experience, trait anxiety, and age together predict one's ability to respond favorably to the music and to the directions of the guide, with classical music experience making no significant contributions to the variance in this area.

Gender and Responsiveness to BMGIM

A significant difference was found between males and females in terms of their level of comfort with self-disclosure:

1. Based on independent samples *t*-tests (assuming unequal variances), males are more comfortable with self-disclosure than females. There are no other differences between males and females in any other areas of responsiveness to BMGIM.

Age and Responsiveness to BMGIM

Age was found to be predictive of several areas of responsiveness to BMGIM:

1. Based on bivariate correlations, the older one is, the more adept one is at responding to the music and to the directions of the guide.
2. Based on multiple regressions:
 - Age, SOC, and classical music experience together predict one's ability to image to music, respond favorably to the music and to the directions of the guide, and find meaning in his/her music and imagery experience, with age making significant contributions to the variance in all three of these areas. As age and SOC increase (in combination with classical music experience), so does one's responsiveness in all three of these areas.
 - Age, state anxiety, and classical music experience together predict one's ability to image to music, respond favorably to the music and to the directions of the guide,

and find meaning in his/her music and imagery experience, with age making significant contributions to the variance in all three of these three areas. As age increases and state anxiety decreases (in combination with classical music experience), one's responsiveness increases in all three of these areas.

- Age, trait anxiety, and classical music experience together predict one's ability to respond favorably to the music and to the directions of the guide, with age making no significant contributions to the variance in this area.

Recommendations

Future Research

The findings of the present study suggest a number of possibilities for future research. The exploratory factor analyses revealed important preliminary information about the underlying factorial structure of the RGIM. Therefore, the revised RGIM Inventory (see Appendix I) should be used as a starting point for further development of this tool. As noted in Chapter Five, items currently contained in each of the RGIM Factors need to be refined, and in some cases items need to be added in order to fully capture all aspects of each measure of responsiveness from a theoretical and practical perspective. Once these Factors are revised, additional exploratory and confirmatory factor analyses need to be conducted in order to further re-fine and validate each measure/Factor contained in any revised RGIM Inventory.

More specifically, future research needs to look at finding more valid and reliable ways of measuring individuals' ability to relax as well as their level of comfort with various aspects of self-disclosure in a BMGIM context. The original RGIM Scale used in the current study was designed as a self-report measure in order to eliminate the

possibility of biased scoring on the part of the therapist/researcher as this was identified as a possible confounding variable in the original GIMR study (Meadows, 2000). As previously noted however, the possibility of biased scoring also exists with self-report measures, and research has shown that it is particularly difficult to obtain valid information using self-reported measures of relaxation (Burns et al., 1999). However, novice BMGIM clients will likely have fewer preconceived notions than therapists about how they “should” be responding to BMGIM. Therefore, it is the position of the current author that a carefully constructed self-report RGIM measure used in conjunction with other kinds of measures (which may include therapist ratings) is the optimal way to gather information about an individual’s initial responsiveness to BMGIM. Further research is needed to investigate the validity and reliability of a revised “Ability to Relax” measure as well as a revised “Comfort with Self-Disclosure” measure, both of which should contain more comprehensive collections of revised self-report items as well as relevant objective measurements (i.e., physiological responses, objective observations of the therapist, etc.).

Additional research is also needed to better understand the multifaceted role of music in BMGIM. On one hand, the factor analyses showed that the ability to image and some aspects of “responsiveness to the music” (as measured by the original RGIM) are not two separate factors, but combine to form one factor: the ability to image to music. This suggests that responding to the music is an integral part of the internal process of imaging in BMGIM. This calls into question the commonly held notion that the client’s responsiveness to music and his/her ability to image are two distinct skill sets, as evidenced in Bruscia’s original division of items in the GIMR. On the other hand, the

factor analyses also showed that other aspects of “responsiveness to music” (as measured by the original RGIM) and “responsiveness to guiding” are not two separate factors or skill sets, but rather form one factor: responsiveness to music and guiding. This suggests that music and the guide may not be perceived as separate and distinct external stimuli, but rather as integrally related stimuli belonging to one external environment.

Put together, then, music is part of the internal process of imaging, and it is also part of the external stimulus environment in BMGIM, which also includes the guide. Music is both internal and external to the BMGIM experience; it is not merely an external stimulus to an internal process. Thus, responding to music and creating images may form one skill-set related to the internal BMGIM experience, and responding to music and the guide may form another skill set relating to the external BMGIM environment.

Research is also needed to further develop the classical music experience (CME) measure that was designed for this study. Given the limited findings on this variable, it is possible that the CME scale did not sufficiently account for all of the variables that are relevant to this measure. Furthermore, it may also be the case that participants’ perspectives on their knowledge of Western classical music are somewhat relative and subjective (i.e., a few participants who indicated that they had five or more years of classical music training, rated themselves as being less knowledgeable than other participants who indicated that they had little or no training). Since BMGIM practitioners have noted certain difficulties when working with some classical musicians, increased understanding of this issue is still needed. In addition to revising the CME scale, it would also be helpful to explore more objective ways of measuring CME and its relationship to BMGIM responsiveness. This could include the use of brain scanning techniques such as

magnetoencephalography, which has all ready been successfully used to detect differences between musicians and non-musicians on their processing of musical stimuli (Herholz et al., 2008; Pantov, Wollbrink, Roberts, Engeliën, & Lükenhöner, 1999).

A significant feature of the present study is that all participants were drawn from a normal population. Thus, it will also be important for future studies to cross-validate or add to the present findings by examining the predictive impact of the significant predictor variables (namely SOC, STAI, and age; alone and/or in combination) on BMGIM responsiveness in clinical populations. Of particular interest would be the differential effects of state anxiety versus trait anxiety on responsiveness to BMGIM in clinical populations where anxiety is either a defining component of a specific disorder, or in situations where anxiety is likely to increase as a result of the complications related to a disorder (i.e., hospitalization).

Additional research studies are needed in order to more explicitly identify and define aspects of the multivariate relationship that exists between SOC and RGIM and more specifically, how this information might apply to particular clinical populations. Furthermore, the results of the present study in combination with the literature suggest that there may be relationships between age and SOC; age and STAI; and age and CME. The ways in which these relationships might affect the outcomes of future BMGIM studies needs to be examined.

Given that the current study raised further questions around some of the proposed predictor variables, and that it did not account for all possible predictors of responsiveness to BMGIM, other potential predictors should be investigated. These might

include but are not limited to: (a) culture, (b) gender constructs, (c) education, and (d) therapist qualities (including theoretical orientation).

Finally, although the postlude discussions of the group GIM experiences were audio recorded, it was beyond the scope of the current study to qualitatively analyze this material. A more detailed follow-up analysis of these discussions could help to clarify or strengthen the validity of the current findings. Additionally, future studies that use qualitative or mixed method designs to investigate responsiveness to BMGIM would also make significant and much needed contributions to the literature.

Clinical Practice

Although the current results are preliminary, and more research is needed in order to refine the RGIM Inventory, the present study still has several possible implications for practice.

Guidelines on how to use and interpret the current and future versions of the RGIM Inventory must be established. For example, rather than engaging a potential client in a full length BMGIM session in order to assess responsiveness, it might be more appropriate to create a few standardized BMGIM assessment session formats to be used in conjunction with the RGIM Inventory (i.e., similar to the GIM group session format utilized in this study). In this way, results of each assessment could be compared to established RGIM norms, and more objective measures of responsiveness could be obtained. A contained and brief assessment format would also help to ensure the safety of each new client and decrease the likelihood of an abreactive first experience. It should also be noted that the present study assessed participants' responsiveness on their very first experience of BMGIM. It is possible that the RGIM could be used to assess

responsiveness in subsequent sessions, especially if the therapist and client have been working together to improve responsiveness in identified areas.

All of the Factors contained in the current and future versions of the RGIM Inventory need to be carefully reviewed in order to better understand how they relate specifically to the indications (Summer, 1989), contraindications (Bruscia, 2002a), and modifications (Muller, 2010; Summer, in press) that are outlined in the literature. Responsiveness to BMGIM could be defined as one's ability to engage in the fundamental dimensions of BMGIM for the purpose of building inner resources to facilitate significant life changes, promoting self-development, and/or receiving personal support. BMGIM needs to be modified if a client's condition might be worsened by BMGIM (Summer, in press). Modified BMGIM is contraindicated when the modifications do not eliminate the risk of harm, or when the client does not have the capacity to build the inner resources needed to engage in and benefit from modified methods. Each item contained in any revised version of the RGIM Inventory needs to be assessed and given a weighted score based on the significance of its relationship to indications, contraindications, and modifications outlined in the literature, the significance of its relationship with SOC, and its relative importance to the total Factor score. In this way, guidelines on calculating and interpreting the total scores on each Factor can be established. This would help to provide therapists with objective indications of when: (a) BMGIM is particularly suitable for an individual, (b) BMGIM needs to be modified for an individual, or (c) modified BMGIM is contraindicated for an individual.

As implied above, it may also be the case that BMGIM only needs to be modified for certain individuals on a temporary basis if that individual has the capacity to improve in the areas indicated by the RGIM and/or the SOC scale. Some ways in which a practitioner could work with a client to improve responsiveness might include: (a) helping the client to develop “on the spot” techniques/strategies to cope with stress or anxiety that arises in the BMGIM context (i.e., breathing techniques, establishing a “safe” image, etc.); (b) using other therapeutic interventions (not directly related to BMGIM) to help the client improve self-esteem, self-confidence, and/or, self-acceptance; (c) using the SOC subscales as a template to help the client cognitively re-frame stressors that may be impacting on his/her ability to engage in BMGIM, (d) use of focusing exercises to increase the client’s attention span, and (e) teaching the client how to image by using therapist directed imagery scripts (with or without music). There are two further observations that must be made in relation to this last point. First, during the postlude discussions of the present study, some participants stated that they found the practice imagery exercise (without music; see Appendix L) to be very useful because it helped them to understand the concept of imagery which in turn helped them to feel better prepared to engage in the GIM group experience. Second, some participants indicated that they found the semi-directed guiding portion of the group GIM experience to be very helpful whereas others found that it interfered with their experience. Although there may be several possible reasons for this discrepancy, it may be the case that the semi-directed guiding helped certain types of participants (i.e., older participants or others) to stay engaged in a GIM experience where they otherwise might have experienced difficulty.

Therefore, practitioners should consider that the temporary or ongoing use of semi-directed guiding may be very helpful for certain types of clients.

The results also indicated that males felt more comfortable with self-disclosure than females in this BMGIM research context. Practitioners should maintain an awareness of this potential issue and work with clients to increase comfort in this area when necessary. As previously noted, a study conducted by Ogrodniczuk et al. (2004), found that men benefited more from participation in interpretive psychotherapy whereas women benefited more from participation in supportive psychotherapy. BMGIM therapists may need to adjust their interventions accordingly during various phases of the session.

Education and Training

Not all persons are suited for BMGIM therapy, and similarly, not all persons are well-suited to become BMGIM therapists. As part of their training, trainees are required to participate (as a client) in a series of individual BMGIM sessions for the purpose of personal and practical learning. Lewis (2002) states that “Requiring personal sessions may also help to identify students whose motivation for doing the training is more personal than professional and who can then be redirected to another field of study if necessary” (p. 510). Primary trainers or other BMGIM therapists who work with BMGIM trainees could use the current or future versions of the revised RGIM Inventory to gather quantitative information that they could use in conjunction with their own expertise to help determine if an individual is suitable to become a BMGIM practitioner, or to help determine specific areas of responsiveness that need to be addressed in therapy with the trainee in order to help him/her become a competent practitioner. In fact, one

could argue that all BMGIM trainees should achieve a sufficient level of responsiveness on all RGIM Factors before becoming fully certified practitioners. Otherwise, it would be very difficult for a BMGIM therapist to help a client improve his/her responsiveness in a particular area if the therapist does not inherently understand that aspect of responsiveness from his/her own personal BMGIM experiences.

Finally, given the importance of assessment in BMGIM and the noted lack of indigenous standardized assessment tools (Bruscia, 2000; 2002b), current and future versions of the RGIM Inventory could provide trainers with a standardized format for training individuals in basic diagnostic BMGIM assessment. The trainees could use this RGIM Inventory in their independent practice sessions with clients and/or in training seminars, and BMGIM trainers and supervisors could review and discuss this information with the trainees. In addition to giving trainees a solid foundation in basic diagnostic assessment skills, this practice would also help to monitor the safety of BMGIM trainees' clients. Supervisors and trainers are not present for the majority of the trainee's required practice sessions, and it can be the case that some trainees need time and assistance to develop the ability to independently recognize when the method is contraindicated or needs to be modified for a particular client.⁴

Throughout the data collection phase of the present study, several participants expressed surprise, curiosity, and/or gratitude with regard to what they had experienced during their group GIM session. Some had overt emotional responses. Given the fact that these research sessions were very short and contained, participants' reactions speak to the

⁴ As part of their training, BMGIM trainees are normally required to independently conduct a minimum of 75 BMGIM sessions with volunteer clients. This number does not include supervision sessions where a BMGIM supervisor is present in order to provide feedback to the trainee.

inherent power and potential contained in BMGIM. The findings of the present study have contributed to our understanding of responsiveness in BMGIM and have laid the groundwork for further development of indigenous BMGIM assessment protocols. In turn, it is hoped that this knowledge and future advancements will further enable BMGIM practitioners to provide the most insightful, effective, and ethical services possible for their clients.

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APPENDIX A

THE RESPONSIVENESS TO GUIDED IMAGERY AND MUSIC SCALE

PARTICIPANT #: _____

INSTRUCTIONS: The following questions are designed to help you rate your responses to today's Guided Imagery and Music experience. There are no "right" answers and it is important that you answer each question as truthfully as possible.

RATE YOUR RELAXATION

1. How easily and freely did you enter into a relaxed state during the relaxation exercise that occurred before the music began?

1-----2-----3-----4-----5-----6-----7
Not easily Very easily

2. At any point in time during this session, how deeply did you enter a relaxed or altered state?

1-----2-----3-----4-----5-----6-----7
Not deeply Very deeply

3. How long did you stay in a relaxed or altered state?

1-----2-----3-----4-----5-----6-----7
For none of the experience For most of the experience

4. How completely were you able to let go and enter into a relaxed or altered state?

1-----2-----3-----4-----5-----6-----7
Not very much Very completely

RATE YOUR IMAGERY EXPERIENCE DURING THE MUSIC

5. How easily were you able to generate images during the music listening and imagery experience?

1-----2-----3-----4-----5-----6-----7
Not very easily/freely Very easily/freely

6. How vivid were your images during the music listening and imagery experience?

1-----2-----3-----4-----5-----6-----7
Not very vivid Very vivid

7. How long did each imagery scene last?

1-----2-----3-----4-----5-----6-----7
Very short/fragmented I had sufficient time

8. How physically involved were you in the images?

1-----2-----3-----4-----5-----6-----7
Not involved Very involved

9. How emotionally involved were you in the images?

1-----2-----3-----4-----5-----6-----7
Not involved Very involved

10. How relevant were the images to your life?

1-----2-----3-----4-----5-----6-----7
Not relevant Very relevant

11. How unusual or out-of-the-ordinary were any of your images?

1-----2-----3-----4-----5-----6-----7
Very ordinary Very fantastic/unusual

12. How pleased were you with the images you had?

1-----2-----3-----4-----5-----6-----7
Not at all pleased Very pleased

RATING THE MUSIC

13. To what extent did the music affect your images?

1-----2-----3-----4-----5-----6-----7
Very little Very much

14. To what extent did the music affect your body?

1-----2-----3-----4-----5-----6-----7
Very little Very much

15. To what extent did you respond emotionally to the music?

1-----2-----3-----4-----5-----6-----7
Very little Very much

16. How helpful or useful was the music in supporting your images?

1-----2-----3-----4-----5-----6-----7
Not at all Very helpful/useful

17. To what extent did you enjoy the musical selections that were used?

1-----2-----3-----4-----5-----6-----7
Very little Very much

RATING THE FACILITATOR

18. How well were you able to follow the facilitator's suggestions during the relaxation exercise?

1-----2-----3-----4-----5-----6-----7
Not very well Very easily

19. How well were you able to follow the facilitator's suggestions during 1st part of the music listening and imagery experience (i.e., suggestions made while the music was playing)?

1-----2-----3-----4-----5-----6-----7
Not very well Very easily

20. How comfortable did you feel discussing your music and imagery experience with the facilitator during the group discussion?

1-----2-----3-----4-----5-----6-----7
Very uncomfortable Very comfortable

21. Overall, how comfortable did you feel with the facilitator?

1-----2-----3-----4-----5-----6-----7
Very uncomfortable Very comfortable

RATING THE DISCUSSION AFTERWARD

22. How comfortable did you feel discussing your music and imagery experience with others in your group?

1-----2-----3-----4-----5-----6-----7
Very uncomfortable Very comfortable

23. How easy was it for you to describe to others the experiences and images that you had during the music?

1-----2-----3-----4-----5-----6-----7
Very difficult Very easy

24. How interested were you in wanting to understand your imagery experience and find meaning in it?

1-----2-----3-----4-----5-----6-----7
Not interested Very interested

GENERAL IMPRESSIONS

25. To what extent did you find the entire experience (including all your responses to every component) relevant to yourself and to your life?

1-----2-----3-----4-----5-----6-----7
Not relevant Very relevant

26. Overall, how meaningful did you find this entire session?

1-----2-----3-----4-----5-----6-----7
Not meaningful Very meaningful

27. Overall, how comfortable were you with this entire process?

1-----2-----3-----4-----5-----6-----7
Very uncomfortable Very comfortable

Please deposit all of your forms in the designated box before you leave.

THANK YOU VERY MUCH FOR YOUR PARTICIPATION!

APPENDIX B

ORIENTATION TO LIFE QUESTIONNAIRE (SOC)

PARTICIPANT #: _____

INSTRUCTIONS: Here is a series of questions relating to various aspects of our lives. Each question has seven possible answers. Please mark the number which expresses your answer, with numbers 1 and 7 being the extreme answers. If the words under 1 are right for you, circle 1; if the words under 7 are right for you, circle 7. If you feel differently, circle the number which best expresses your feeling. Please give only one answer to each question.

1. When you talk to people, do you have the feeling that they don't understand you?

1-----2-----3-----4-----5-----6-----7
never have always have
this feeling this feeling

2. In the past, when you had to do something which depended upon cooperation with others, did you have the feeling that it:

1-----2-----3-----4-----5-----6-----7
surely wouldn't surely would
get done get done

3. Think of the people with whom you come in contact daily, aside from the ones to whom you feel closest. How well do you know most of them?

1-----2-----3-----4-----5-----6-----7
you feel that you know them
they're strangers very well

4. Do you have the feeling that you really don't care about what goes on around you?

1-----2-----3-----4-----5-----6-----7
very seldom very often
or never

5. Has it happened in the past that you were surprised by the behavior of people whom you thought you knew well?

1-----2-----3-----4-----5-----6-----7
never always
happened happened

6. Has it happened that people whom you counted on disappointed you?

1-----2-----3-----4-----5-----6-----7
never always
happened happened

7. Life is:

1-----2-----3-----4-----5-----6-----7
full of completely
interest routine

8. Until now your life has had:

1-----2-----3-----4-----5-----6-----7
no clear goals very clear goals
or purpose at all and purpose

9. Do you have the feeling that you're being treated unfairly?

1-----2-----3-----4-----5-----6-----7
very often very seldom
or never

10. In the past ten years your life has been:

1-----2-----3-----4-----5-----6-----7
full of changes completely
without your consistent and
knowing what will clear
happen next

11. Most of the things you do in the future will probably be:

1-----2-----3-----4-----5-----6-----7
completely deadly
fascinating boring

12. Do you have the feeling that you are in an unfamiliar situation and don't know what to do?

1-----2-----3-----4-----5-----6-----7
very often very seldom
or never

19. Do you have very mixed-up feelings and ideas?

1-----2-----3-----4-----5-----6-----7
very often very seldom
or never

20. When you do something that gives you a good feeling:

1-----2-----3-----4-----5-----6-----7
it's certain that it's certain that
you'll go on feeling something will
good happen to spoil
the feeling

21. Does it happen that you have feelings inside you would rather not feel?

1-----2-----3-----4-----5-----6-----7
very often very seldom
or never

22. You anticipate that your personal life in the future will be:

1-----2-----3-----4-----5-----6-----7
totally without full of meaning
meaning or purpose and purpose

23. Do you think that there will *always* be people whom you'll be able to count on in the future?

1-----2-----3-----4-----5-----6-----7
you're certain you doubt
there will be there will be

24. Does it happen that you have the feeling that you don't know exactly what's about to happen?

1-----2-----3-----4-----5-----6-----7
very often very seldom
or never

25. Many people—even those with a strong character—sometimes feel like sad sacks (losers) in certain situations. How often have you felt this way in the past?

1-----2-----3-----4-----5-----6-----7
never very often

26. When something happened, have you generally found that:

1-----2-----3-----4-----5-----6-----7
You overesti-
mated or under-
estimated its
importance
you saw things
in the right
proportion

27. When you think of difficulties you are likely to face in important aspects of your life, do you have the feeling that:

1-----2-----3-----4-----5-----6-----7
You will always
succeed in over-
coming the difficulties
you won't
succeed in over-
coming the difficulties

28. How often do you have the feeling that there's little meaning in the things you do in your daily life?

1-----2-----3-----4-----5-----6-----7
very often
very seldom
or never

29. How often do you have feelings that you're not sure you can keep under control?

1-----2-----3-----4-----5-----6-----7
very often
very seldom

APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE

PARTICIPANT #: _____

INSTRUCTIONS: All of the following information will be included in the data analysis of this study. Please complete all parts of the questionnaire.

1. Please indicate your current age: _____

2. Gender: _____

3. To what extent do you enjoy/like classical music?

1-----2-----3-----4-----5-----6-----7
Not at all Very much

4. How often do you listen to classical music?

1-----2-----3-----4-----5-----6-----7
Never Everyday

5. How knowledgeable do you feel about the genre of classical music?

1-----2-----3-----4-----5-----6-----7
Know very little Very knowledgeable

6. What amount formal instruction/training have you had in classical music?

1-----2-----3-----4-----5-----6-----7
None Extensive training
(5+ years of lessons)

APPENDIX D

STAI: FIVE SAMPLE ITEMS

SELF-EVALUATION QUESTIONNAIRE STAI Form Y-1

DIRECTIONS:

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you feel *right now*, that is, *at this moment*. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

- 1. I feel calm.....1 2 3 4
- 2. I feel secure.....1 2 3 4
- 3. I am tense1 2 3 4

1. Not at all 2. Somewhat 3. Moderately so 4. Very much so

SELF-EVALUATION QUESTIONNAIRE STAI Form Y-2

DIRECTIONS

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you *generally* feel.

- 21. I feel pleasant1 2 3 4
- 22. I feel nervous and restless.....1 2 3 4

1. Almost never 2. Sometimes 3. Often 4. Almost Always

APPENDIX E

RECRUITMENT POSTER

Temple University
Department of Music Education and Therapy

129 Presser Hall (012-00)
2001 North 13th Street
Philadelphia, PA 19122-6079

**PARTICIPANTS NEEDED FOR RESEARCH ON
“PREDICTORS OF CLIENT RESPONSIVENESS TO
THE BONNY METHOD OF GUIDED IMAGERY
AND MUSIC (BMGIM).”**

In order to qualify for participation in this study, you must: be at least 18 years of age; be fluent in spoken & written English; not have any history of psychiatric illness; not have any significant cognitive or hearing impairments; not be on medications for the purpose of treating mental illness/anxiety; & not have had any previous personal experience with BMGIM/other therapies that involve the use of imagery.

As a participant in this study, you would be asked to: complete a demographic questionnaire; complete two brief self-report measures on stress/anxiety; participate in a group music, imagery & discussion experience; and complete a self-report questionnaire about this experience

Your participation would involve attending one session that would last for approximately 75-90 minutes.

There is no remuneration for participating in this study.

Sessions will take place at 1175 Bloor Street West, Toronto, Ontario.

For more information about this study, or to volunteer for this study, contact:
Laurel Young, MMT, MTA, FAMI, PhD Candidate (Temple University)
(416) 480-5841 or Email: rlyoung@temple.edu

This project has received ethics approval from Temple University's Institutional Review Board. This information has been approved for public display and is associated with project # 12794.

APPENDIX F

INVITATION TO PARTICIPATE AND CONSENT DOCUMENT

Study Title: Predictors of Client Responsiveness to the Bonny Method of Guided Imagery and Music (BMGIM)

Researcher: Laurel Young
Esther Boyer College of Music & Dance
Temple University
416-480-5841
rlyoung@temple.edu

Faculty Advisor: Dr. Kenneth E. Bruscia
Esther Boyer College of Music & Dance
Temple University
215-204-8314
kbruscia@temple.edu

Purpose of Research: You are being invited to participate as a volunteer in a research study. The purpose of this study is to better understand the qualities that may predict an individual's ability to benefit from the Bonny Method of Guided Imagery & Music (BMGIM). BMGIM is a method of music psychotherapy where the client listens to music in a relaxed state while dialoging with the therapist. The researcher, Laurel Young is an experienced music therapist and a certified BMGIM practitioner and is currently enrolled in the PhD Music Therapy program at Temple University in Philadelphia, Pennsylvania USA. The research material will be the subject of a PhD dissertation. The results of this study may also be submitted for future publication.

Information: In order to participate in this study you must: be 18 years of age or older, be fluent in both spoken and written English, not have any known history of psychiatric illness, not currently be taking medications to treat mental illness/anxiety, not have any significant cognitive impairments, not be significantly hearing impaired, and not have had any previous personal experience with BMGIM, group GIM or other therapy techniques that involve the use of imagery. You will be required to attend one research session that will last approximately 75-90 minutes. During this session you will be asked to provide demographic information, complete two self-report measures on stress/anxiety, participate in a group Guided Imagery & Music (GIM) experience and complete a self-report questionnaire about this experience. The group GIM experience will be facilitated by the researcher and will include a relaxation exercise, imaging while listening to music in a reclined position, and a post imaging group discussion. There is no cost or remuneration for participating in this study.

Risks and Benefits: All efforts will be made to ensure the highest level of comfort possible during the research session. While there are no expected physical risks associated with group GIM, you may experience both positive and negative emotions and sensations; unpleasant emotional reactions to the music or images, and/or unconscious material may surface that you may need to address. The facilitator is available at all times during the session and afterward to provide support should you have any negative experiences. You may also withdraw from the research session at any time. Should you require additional emotional support as a result of participation in this study, please contact the Psychotherapy Referral Service in Toronto (<http://prstoronto.com/index.html>) or the Gerstein Centre (<http://www.gersteincentre.org/>). For more general concerns, please contact kbruscia@temple.edu.

Participant's Initials _____

Predictors of Client Responsiveness to BMGIM

Potential benefits of your participation may include the opportunity for you to: learn about BMGIM and group GIM, have a unique experience, and/or gain personal insights which may lead to positive changes in your life. Additionally, information obtained in this study will contribute to the researcher's knowledge and execution of BMGIM practice as well as provide useful information to other BMGIM therapists, music therapists, psychotherapists, educators and students which in turn will benefit future BMGIM clients.

Confidentiality: The data you provide (i.e., questionnaires and self-report measures) will be labeled anonymously using research participant numbers and will be stored in a locked cabinet in the researcher's home. Only the researcher and her faculty advisor will have access to the raw data. No demographic or personal information will be revealed which could identify you in any way.

Also, because the research session involves group discussion about individuals' personal experiences during the GIM exercise, extra measures will be taken to protect each participant's privacy. The researcher will begin the discussion portion of the experiential by asking each of the participants to verbally agree to keep everything discussed in the group confidential. She will also remind participants at the end of the research session about this agreement.

Participation: Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled.

Consent: Questions about your rights as a research participant may be directed to Richard Throm, Program Manager & Coordinator, Institutional Review Board, (tel. 215-707-8757), 3400 North Broad St. (509-00), Philadelphia, PA, 19140.

Signing your name below indicates that you have read and understand the contents of this Consent Form and that you agree to take part in this study.

Participant's Signature

Date

Investigator's Signature

Date

APPENDIX G

Permission to Audiotape

Principal Investigator's Name: Kenneth E. Bruscia

Student Investigator's Name: Laurel Young

Department: Music Education and Therapy (Boyer College)

Project Title: Predictors of Client Responsiveness to the Bonny Method of Guided Imagery and Music (BMGIM)

Participant: _____ Date: _____

I hereby give Laurel Young permission to audiotape me during the group discussion portion of the above project. This audiotape will be used only for research purposes, and the results of the research may be published. At no time, will my name be used, and the content of the tape will be kept strictly anonymous.

I have already given written consent for my participation in this research project.

I agree to be audio taped during the time period: November 13, 2009 to November 13, 2010

Data will be stored until October 15, 2011.

I give my permission for these tapes to be used from November 13, 2009 to November 13, 2011

I understand that I can withdraw my permission at any time. Upon my request, the audiotape(s) will no longer be used. This will not affect my care or relationship with Kenneth Bruscia or Laurel Young in any way.

I understand that I will not be paid for being audio taped or for the use of the audiotapes.

If I want more information about the audiotape(s), or if I have questions or concerns at any time, I can contact:

Primary Investigator's Name: Dr. Kenneth E. Bruscia
Student Investigator's Name: Laurel Young
Department: Music Education
Institution: Boyer College of Music – Music Therapy
Street Address: 2001 North 13th Street, Temple University
City: Philadelphia
State: PA
Zip Code 19122
Phone: Office – 215 204-8314
E Mail: kbruscia@temple.edu; rlyoung@temple.edu

This form will be placed in my records and a copy will be kept by the person(s) named above. A copy will be given to me.

Please print

Subject's Name:

Date:

Address:

Phone:

Subject's Signature:
(Or signature of parent or legally responsible person if subject is a minor or is incompetent to sign.)

Relationship to Subject:

Subject cannot sign because:

but consents orally to be audiotaped under the **conditions described above.**

Witness Signature

Date

Witness Signature

Date

APPENDIX H

PERMISSION TO USE STAI INVENTORY

For use by Laurel Young only. Received from Mind Garden, Inc. on September 25, 2009



www.mindgarden.com

To whom it may concern,

This letter is to grant permission for the above named person to use the following copyright material;

Instrument: *State-Trait Anxiety Inventory for Adults*

Authors: *Charles D. Spielberger, in collaboration with R.L. Gorsuch, G.A. Jacobs, R. Lushene, and P.R. Vagg*

Copyright: *1968, 1977 by Charles D. Spielberger*

for his/her thesis research.

Five sample items from this instrument may be reproduced for inclusion in a proposal, thesis, or dissertation.

The entire instrument may not be included or reproduced at any time in any other published material.

Sincerely,

A handwritten signature in black ink, appearing to read "Vicki Jaimez", written in a cursive style.

Vicki Jaimez
Mind Garden, Inc.
www.mindgarden.com

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Published by Mind Garden, Inc., www.mindgarden.com

APPENDIX I

REVISED RESPONSIVENESS TO GUIDED IMAGERY AND MUSIC INVENTORY

ABILITY TO RELAX

1. At any point in time during this session, how deeply did you enter a relaxed or altered state?

1-----2-----3-----4-----5-----6-----7
Not deeply Very deeply

2. How long did you stay in a relaxed or altered state?

1-----2-----3-----4-----5-----6-----7
For none of the experience For most of the experience

3. How completely were you able to let go and enter into a relaxed or altered state?

1-----2-----3-----4-----5-----6-----7
Not very much Very completely

ABILITY TO IMAGE TO MUSIC

4. How easily were you able to generate images during the music listening and imagery experience?

1-----2-----3-----4-----5-----6-----7
Not very easily/freely Very easily/freely

5. How vivid were your images during the music listening and imagery experience?

1-----2-----3-----4-----5-----6-----7
Not very vivid Very vivid

6. How long did each imagery scene last?

1-----2-----3-----4-----5-----6-----7
Very short/fragmented I had sufficient time

7. How physically involved were you in the images?

1-----2-----3-----4-----5-----6-----7
Not involved Very involved

8. How unusual or out-of-the-ordinary were any of your images?

1-----2-----3-----4-----5-----6-----7
Very ordinary Very fantastic/unusual

9. How pleased were you with the images you had?

1-----2-----3-----4-----5-----6-----7
Not at all pleased Very pleased

10. To what extent did the music affect your images?

1-----2-----3-----4-----5-----6-----7
Very little Very much

11. How helpful or useful was the music in supporting your images?

1-----2-----3-----4-----5-----6-----7
Not at all Very helpful/useful

RESPONSIVENESS TO MUSIC AND GUIDING

12. To what extent did the music affect your body?

1-----2-----3-----4-----5-----6-----7
Very little Very much

13. To what extent did you respond emotionally to the music?

1-----2-----3-----4-----5-----6-----7
Very little Very much

14. To what extent did you enjoy the musical selections that were used?

1-----2-----3-----4-----5-----6-----7
Very little Very much

15. How well were you able to follow the facilitator's suggestions during the relaxation exercise?

1-----2-----3-----4-----5-----6-----7
Not very well Very easily

16. How well were you able to follow the facilitator's suggestions during 1st part of the music listening and imagery experience (i.e., suggestions made while the music was playing)?

1-----2-----3-----4-----5-----6-----7
Not very well Very easily

COMFORT WITH SELF-DISCLOSURE

17. How comfortable did you feel discussing your music and imagery experience with the facilitator during the group discussion?

1-----2-----3-----4-----5-----6-----7
Very uncomfortable Very comfortable

18. How comfortable did you feel discussing your music and imagery experience with others in your group?

1-----2-----3-----4-----5-----6-----7
Very uncomfortable Very comfortable

19. How easy was it for you to describe to others the experiences and images that you had during the music?

1-----2-----3-----4-----5-----6-----7
Very difficult Very easy

MEANINGFULNESS OF THE EXPERIENCE

20. How relevant were the images to your life?

1-----2-----3-----4-----5-----6-----7
Not relevant Very relevant

21. How interested were you in wanting to understand your imagery experience and find meaning in it?

1-----2-----3-----4-----5-----6-----7
Not interested Very interested

22. To what extent did you find the entire experience (including all your responses to every component) relevant to yourself and to your life?

1-----2-----3-----4-----5-----6-----7
Not relevant Very relevant

23. Overall, how meaningful did you find this entire session?

1-----2-----3-----4-----5-----6-----7
Not meaningful Very meaningful

APPENDIX J

IRB APPROVAL CERTIFICATE



Office for Human Subjects
Protections
Institutional Review Board
Medical Intervention Committees A1 & A2
Social and Behavioral Committee B

3400 North Broad Street
Philadelphia, Pennsylvania 19140
Phone: 215.707.3390
Fax: 215.707.8387
e-mail: richard.throm@temple.edu

Research Review Committee B

Certification of Approval for a Project Involving Human Subjects

Protocol Number: **12794**
PI: **BRUSCIA, KENNETH**
Approved On: 13-Nov-2009
Review Date: 12-Jan-2010
Committee: B BEHAVIORAL AND SOCIAL SCIENCES
Department: MUSIC-THERAPY (2207)
Project Title: Predictors of Client Responsiveness to the Bonny Method of Guided Imagery & Music

In accordance with the policy of the Department of Health and Human Services on protection of human subjects in research, it is hereby certified that protocol number 12794, having received preliminary review and approval by the department of MUSIC-THERAPY (2207) was subsequently reviewed by the Institutional Review Board in its present form and approved on 13-Nov-2009 with respect to the rights and welfare of the subjects involved; appropriateness and adequacy of the methods used to obtain informed consent; and risks to the individual and potential benefits of the project.

In conforming with the criteria set forth in the DHHS regulations for the protection of human research subjects, and in exercise of the power granted to the Committee, and subject to execution of the consent form(s), if required, and such other requirements as the Committee may have ordered, such orders, if any, being stated hereon or appended hereto.

It is understood that it is the investigator's responsibility to notify the Committee immediately of any untoward results of this study to permit review of the matter. In such case, the investigator should call Richard Throm at 707-8757.

A handwritten signature in black ink, appearing to read 'Zebulon Kendrick', written over a horizontal line.

ZEBULON KENDRICK, Ph.D.
CHAIRMAN, IRB

APPENDIX K

PERMISSION TO USE THE MUSIC THERAPY CENTRE

from: Wanda Gascho-White <wandagaschowwhite@sympatico.ca>
to: Laurel Young <rlyoung@temple.edu>
cc: Jodi Greenwood <MTCManager@musictherapytrust.ca>
date: Mon, Jul 6, 2009 at 6:36 PM
subject: research proposal

Dear Laurel,

The Canadian Music Therapy Trust Fund is happy to support your research project by providing space at the Music Therapy Centre for conducting sessions.

Please forward a copy of the final research proposal as well as the IRB approval certificate from Temple University prior to the collection of data for your research project: "Predictors of Client Responsiveness to the Bonny Method of Guided Imagery and Music."

Thank you,
Wanda Gascho-White

Wanda Gascho-White, MTA
Chair, Board of Trustees
Canadian Music Therapy Trust Fund
Music Therapy Centre
1175 Bloor St. W
Toronto, ON
M6H 1M9
416 535 0200

APPENDIX L

GUIDED IMAGERY PRACTICE EXERCISE

Length: Approximately 3 minutes

Music: None

Body Position: Sitting upright in chairs

Transcript:

Become as comfortable as possible in your chairs, close your eyes, and take a few deep relaxing breaths (pause and breathe). As you continue to breathe naturally, imagine in your mind's eye, the refrigerator that you have in your home. Imagine that you are standing in front of the refrigerator door and take a moment to examine it. Notice any postings or trinkets that are on the door. Before you open the refrigerator door, take a moment to look around the room and become aware of the things that surround you in this room. Perhaps there is some furniture, other appliances, cooking utensils; other items that you are familiar with - notice the shapes and colors of these things. Now – bring your attention back to the refrigerator. Put your hand on the handle and pull open the door. Notice the feeling of the cool air. Lean your body into the refrigerator and become aware of how it smells. Look around the refrigerator for a while, and find something that you would like to eat or drink. Allow yourself to do that. Notice everything about how it tastes. When you are finished, close the refrigerator door and find a place somewhere to sit down. Now that you are sitting down, become aware of how your body feels in the chair that you are sitting in right now, here at the Music Therapy Centre. I will count backwards from 5 and when I reach 0, it will be time to open your eyes. 5, 4, 3, 2, 1, 0...it is now time to open your eyes.

APPENDIX M

GROUP GUIDED IMAGERY AND MUSIC EXPERIENTIAL

Length: Approximately 30-40 minutes

Body Position: Reclining on floor mats or cots.

Relaxation Induction Script:

Before you recline, remove your glasses, shoes, etc. so that you will feel as comfortable as possible. Now, lie down on your back and find a comfortable position on your mat or cot. Put your hands at your sides or wherever it feels natural to rest them. There is no need to stay still throughout this experience and you can move your body around if you feel the need to shift positions.

As we begin, close your eyes and allow them to become accustomed to the darkness. Eyes comfortably closed...becoming accustomed to the darkness. Allow the weight of your body to sink into your cot or mat...sinking into your cot or mat...you are beginning to feel relaxed. Now take a long deep breath...slowly taking in as much as you can and then exhaling...slowly breathing in and out...in and out. Imagine as you inhale that you are gathering up all of your tension and as you exhale that you are letting go of all the tension...Breathe in...and out...gathering up the tension and letting it go...feeling more and more relaxed.

And now imagine that your breath is able to gather and release tension from each and every part of your body. Beginning with your head...let your breath move gently around and through your head and face...gradually gathering up the tension... and then slowly letting it go...feeling more and more relaxed. Now let your breath move gently around and through your neck and shoulders...gradually gathering up the tension... and

then slowly letting it go...feeling more and more relaxed. Let your breath move gently through your arms and hands...gradually gathering up the tension and then slowly letting it go...feeling more and more relaxed. Let your breath move gently through your upper torso – your chest, your back, your stomach...gradually gathering up the tension... and then slowly letting it go...feeling more and more relaxed...Let your breath move gently into your hips and buttocks, gradually gathering up the tension.... And then slowly letting it go...feeling more and more relaxed. Let your breath move gently down your legs, all the way down to your feet... gradually gathering up the tension and then slowly letting it go...feeling more and more relaxed. Notice how your whole body feels...as you breathe naturally and become more and more relaxed

And now, imagine that you have planned a leisurely day. You have no appointments or commitments. You are outdoors walking along a nature trail. And as the music begins, allow it to guide you and be your companion as you freely explore your surroundings.

Music for Semi-Directed Imagery: 1. Beethoven's *Fifth Piano Concerto in E-flat Major* (2nd movement)

Semi-Directed Imagery Script:

As you walk along the trail, notice how the ground feels beneath your feet...notice what kind of day it is outside. Allow yourself to become aware of the sights, sounds and smells. (1:15)- You come upon a field of wildflowers. Take a moment to leave the path and explore this field. (1:52) You notice a flower that appeals to you. Pick it. Notice everything about how this flower looks, feels and smells. (2:20) You decide to get back onto the trail. You continue to walk along, – still noticing all that surrounds you.(3:30) You look up ahead and notice a person standing in the distance. You walk

toward them. (3:46) As you get closer, you realize that this is someone you know. (4:14) You greet each other and continue to walk along the trail together. Notice what it feels like to walk along this trail with this person. (5:22) You and your companion are having a conversation. Notice your feelings and responses. (6:49) You have come to a fork in the trail. You and your companion stand there contemplating which route to take... (music ends).

And now allow the music to guide you for the remainder of your journey.

Music for Undirected Imagery: 2. Puccini's "Humming Chorus" from *Madame Butterfly*

3. Warlock's "Pieds en l'air" from *the Capriol Suite*

Return:

Now that the music has ended, it is time to move away from your imagination and focus your attention on the here and now. Become aware of the feeling of your breath in your body. Notice the feeling of the weight of your body as you lie on the mat/or cot. You may want to shift your body into a more comfortable position. Notice the sound of my voice as I am speaking to you in this room and notice other sounds that are happening both inside and outside of this room at the Music Therapy Centre. Become aware of the feeling of the dim light in the room and if you haven't all ready, open your eyes and give yourself a moment before you sit up. Once you sit up, we will arrange ourselves in a circle for a brief discussion.

APPENDIX N

GUIDING QUESTIONS FOR POSTLUDE GROUP DISCUSSION

1. What is the first image or feeling that comes to your mind?
2. Can you think of a word/phrase that describes your reaction to this experience?
3. (a) Were you surprised at any of your images or by any aspects of this experience? (b) Why or why not?
4. Is there anything about this experience that you have not shared that you would like to share?