

**AN EXPLORATION OF THERAPISTS' UNANTICIPATED REACTIONS TO  
CLIENTS' EXPERIENCES IN GIM**

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A Dissertation  
Submitted to  
the Temple University Graduate Board

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

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May 2019

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Guided Imagery and Music (GIM) is a unique method of psychotherapy that uses music and spontaneous imagery while the client is in a non-ordinary state of consciousness (NOSC). Therapists in any therapeutic modality including GIM have a wide range of unanticipated reactions to clients' experiences. Studies have indicated that reactions of the therapist can lead to different interventions and can impact the outcome of the session and perceived effectiveness as a therapist. Because GIM therapists often work with clients who have extensive emotional and physical issues, it is possible that the therapists have strong reactions to clients' experiences, which can lead to burnout. The purpose of this study, therefore, was to explore therapists' experience of unanticipated reactions through the within-case and cross-case analysis using phenomenology outlined by Moustakas (1994). Findings suggested that the GIM therapist had certain expectations in GIM and it was normal for the GIM therapist to have unanticipated reactions to clients' experiences when those expectations were not met. There were several factors that affected the decision-making of GIM therapists after unanticipated reactions, including self-mediation, cognitive foundation, self-awareness, therapist's past experiences, trust, surrender, being present, integration, and self-care. Findings also suggested that GIM therapists could deal with unanticipated reactions within the scope of practice as they engage in personal-growth, self-care, and continuing education. Two guidelines were

proposed to understand the process of GIM therapists in their moments of unanticipated<sup>iv</sup> reactions. Limitations and implications for further studies were discussed.

*Keywords:* Guided Imagery and Music, the Bonny Method, reactions, process research, phenomenology

DEDICATION

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*For the life and work of Dr. Helen L. Bonny*

## ACKNOWLEDGMENTS

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I would like to thank...

Dr. Darlene Brooks for allowing me to struggle, get lost, and make many mistakes, yet for always being there

My dissertation committee for their support: Dr. Shoemark, Dr. Ducette, Dr. Dilworth

The participants of this study for their courage to share their experiences and amazing insights.

Temple Faculty for their continuous support and wisdom that they shared with me:  
Dr. Dileo, Dr. Magee, Dr. Eyre, Peggy, and Dr. Flanagan

My Temple family, especially Adenike, Jen, Amanda, Heejin, & Meng-shan for teaching together, sharing a lot of time in our basement, and being on the same boat to get through rough waves...

Jim for planting the seed

My unique family for giving me freedom to be me, and my loving niece, Yurika

My Philly Family: Dee, Ryan, and two Loves

Bob and Steph

Alysa

Natsumi

Tomoka and Tomomi

All my friends for bringing comfort and laughter, especially Kari, Gaby, Suthyvat, Akane, Ai, Misa, Yuji, Natsu, and Yukie...

All my GIM clients and GIM trainees

...and my light.

From the bottom of my existence, thank you very much...

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## CHAPTER 1

### INTRODUCTION

The Bonny Method of Guided Imagery and Music (BMGIM) is “an experiential form of therapy or self-development involving listening to predesigned programs of classical music in a relaxed state. Insight, solutions, and healing come directly from the client, their spontaneous imaging, and their expanded experience during the music” (Association for Music and Imagery [AMI], 2017a, para. 2).

BMGIM was developed by Dr. Helen Bonny through her work at the Maryland Psychiatric Research Institute (MPRI) in 1970s. The group of researchers and scientists examined the effectiveness of psychedelic drugs used in therapy for patients with substance abuse, neurosis, and terminal cancer (Bonny, 2002a). Bonny used music to support the process of these patients during psychedelic therapy. Music was found to be helpful for patients in entering their inner world, facilitating their emotional release and peak experience, and providing structure and continuity to their experiences. In the course of her work, Bonny started using music independently without psychedelic drugs because she found music itself had the therapeutic effectiveness. Through many trials and experiments, Bonny established the method and developed the original 18 music programs to be used in BMGIM between 1973 and 1989 (Grocke, 2002). In 2002, Bonny

named the method “the Bonny Method of Guided Imagery and Music” to differentiate <sup>2</sup> from other forms of therapy that use music and imagery.

Currently there are many forms of adaptations derived from the original BMGIM that involve spontaneous imagery experience to music in a non-ordinary state of consciousness (NOSC) and they are inclusively called "Guided Imagery and Music (GIM)" (Bruscia 2002a, 2015). In this current study, I chose to use the term, GIM, because 1) I would like to include any forms of the Bonny Method of GIM; and 2) GIM still is a commonly used term.

In this unique method that uses music and spontaneous imagery for the client in NOSC, the qualified therapist works closely and collaboratively with the client to accompany, work through, and integrate what emerges in the client's imagery experience with the music (AMI, 2017a). The GIM therapist has an important role in the process of a session and it requires years of training to practice GIM.

### **Motivation for This Study**

My interest in this study came from my own practice of GIM as a qualified GIM therapist. Although GIM therapists are not supposed to expect specific experiences from the client during a session, I sometimes get very surprised by the client's imagery, overwhelmed by the significance of their work, and moved by the depth of their process. Once in a while, I also encounter unexpected moments in which I have no idea how to

make an intervention for the client. For instance, in one session, my client had an imagery<sup>3</sup> experience in which they<sup>1</sup> was wrapped by a lotus leaf and sank down in the mud on the bottom of a lake. It was nothing unusual until they stayed there for "years and years" which was much longer than what I had experienced with other clients. I was afraid because they did not respond to any verbal and music interventions and remained silent. I thought that they would stay there until the end of the music program. I felt that I had to do something although there was nothing I could do but to wait.

In another session, my client immediately had an imagery experience of being abused by their father despite the contemporary music program I chose to avoid an intense experience for them because it was their first GIM session. It was completely unexpected and I was very scared that they went right into the depth of their trauma. For a few minutes at the beginning, I was at a loss on what to do. I wondered if I should stop the music and bring them back to conscious awareness. I had a strong urge to rescue them from the imagery of trauma. I was thinking that it was their first GIM session and they should not go that deep. Somehow, I managed to stay with the imagery of the client; however, I felt like I was not the best therapist for them.

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<sup>1</sup> In order to avoid issues of gender pronoun and to protect the identity of the client and participant, I choose to use the third-person plural pronoun (they, them, their, theirs) instead of third-person singular pronoun.

In another example, the client had a hard time bringing themselves back to alertness after the imagery experience to music. Any directive interventions did not work and I was confused about what was going on and what I should do. I felt "Oh my goodness, what am I going to do?" When I completely ran out of my options for an intervention, I suddenly had a physical sensation on my forehead. So, I placed my thumb on their forehead, wrapped their head with other fingers, and told them to feel my fingers. They gradually came back to being alert, but I still wondered what was the sensation that I felt in that moment.

In addition to these examples, I was also surprised by the cultural differences in clients' imagery. In one session, my client said "I see a princess on the bridge." I imagined a western princess on a bridge made of rocks, but it was, in fact, a Japanese princess wearing *Juuni-Hitoe*, a type of Kimono, on a wooden red bridge. It did not affect the flow of the session, but my reaction took me out of the client's experience for a second. These experiences happened to me despite my clinical experience as a qualified GIM therapist. Some happened within a few months after becoming a GIM therapist, and others happened after over five years of clinical experiences. Because of these unusual experiences during a GIM session, I started to wonder if other therapists experienced similar occurrences.

I then began the process by asking some GIM colleagues if they had ever experienced some strong reactions to the client's experiences or something unusual and completely out of their expectations in the process of GIM. One therapist said they felt frustrated when the client did not get the answer which was obvious for the therapist. Another therapist said they felt like there was nothing that they could do for the client when their client could not express their anger. But then, the therapist intuitively had the client hold a plastic bat and allowed them to hit the sofa, which helped the client successfully express their anger. Another therapist said they changed the music in the middle of a session because they were scared when the client kept falling downward. Yet another colleague said they felt uncertainty because the client kept talking during the preliminary conversation. The therapist could not find a focus and wondered if GIM was the right method for the client.

It seemed that other GIM therapists also had experienced what they perceived as unusual occurrences in their GIM practice. Despite this, it was difficult to conclusively bring them to an intension of the study because they were all diverse. Some were personal reactions to the client or the client's experiences; some were unusual interventions; some were unusual events to which the GIM therapist did not know what to do; and others were cultural differences. But it is important to allow any experiences to unfold in the process of GIM; therefore, I thought that the key was the therapist's



reactions which were unanticipated. I started to question what reactions GIM therapists<sup>6</sup> had to the client's experiences, what caused those reactions, and how they continued the session after having such reactions.

Clients' experiences in GIM are diverse and different from one to another and in response, GIM therapists may have various reactions, some of which are unanticipated. If a GIM therapist is not fully aware of their unanticipated reactions, they may not be able to focus on client's experiences, understand them, and determine the most needed interventions for the client in the moment. Therapists' unanticipated reactions may unintentionally prevent GIM clients from having the GIM experience that they need. If it continues and if GIM therapists cannot have a full understanding of their reactions, then it is possible that GIM therapists also experience burnout.

The purpose of this study therefore, was to explore GIM therapists' unanticipated reactions to clients' experiences in GIM. By understanding what unanticipated reactions that GIM therapists had in response to the client's experiences and how they continued the session after those reactions, it was hoped that this study would increase GIM therapists' awareness of their reactions to client's unanticipated utterances and behaviors during GIM sessions. This study also aimed to provide additional but necessary elements to GIM training designed to enhance the therapist's work with clients. Lastly, understanding GIM therapists' reactions will provide quality interventions that support

the client's journey. Inherent in this would be the increase in GIM therapist confidence in<sup>7</sup> providing meaningful interventions during sessions, better insight into the client's process, and reduce the possibility of therapist burnout due to uncertainty.

## REVIEW OF LITERATURE

Because my interest in this study is about the process of the GIM therapist during a session, I will first clarify the major components of GIM, the role of the GIM therapist during a typical GIM session, and the current practice of GIM before reviewing the research studies in the related field. My intent here is to help readers understand the unique process and role of the therapist in GIM as well as the evolving practice of GIM, which potentially cause unanticipated reactions for GIM therapists.

### Major Components of GIM

What makes GIM a unique therapy are the following three components: non-ordinary state of consciousness (NOSC), music, and spontaneous imagery (AMI, 2017b). These three components work harmoniously and offer the potential for “expanded self-awareness, healing, transformation, spiritual growth, and lasting positive changes in behavior” (p. 2).

**Non-ordinary state of consciousness.** NOSC, also known as the altered state of consciousness (ASC), is defined as “a qualitative alteration in the overall pattern of mental functioning, such that the experiencer feels his consciousness is radically different from the way it functions ordinarily” (Tart, 1972, p. 1203). NOSC is not unusual and it can be achieved through practices such as meditation, fasting, and yoga as well as

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methods such as breath work and hypnosis. NOSC expands the consciousness and allows the client to access their inner space to search for an answer, insight, healing, transformation, and integration (Bush, 1995). This NOSC is induced by the presence of the music in GIM (Bonny, 2002a).

**Music.** The music used in the Bonny Method of GIM is carefully selected and sequenced western classical music designed to help the client explore their inner experiences and many layers of consciousness (Bruscia, 2002b). Music has the unique potential to facilitate NOSC; to go beyond the verbal defense; to intensify emotional reactions; to shift perceptions of time and space; to evoke imagery from the depths within the client; to influence the client kinesthetically and change energy; to work as a projective screen; to facilitate creativity and provide different perspectives; to allow spiritual experiences; to stimulate the client's ability to be integrated (Bonny, 2002b; Bonny, 2002e; Bonny & Savory, 1973; Bruscia, 2015; Stokes, 1992; Summer, 1992); and to "touch many levels of consciousness both simultaneously and/or in sequence" (Bonny, 2002d, p. 86). Music allows clients to work on issues and conflicts, and as a result, they may gain insight into themselves and their life, find meaning in something, and have a life-changing experience with the music.

Each music program used in GIM is designed with a specific therapeutic purpose. Music programs are different in their depth and complexity of contained emotions, which

reach different layers of consciousness and help the client to explore and work through<sup>10</sup> the core issues (Bonny, 2002d; Bruscia, 2015). Some GIM programs are named after their purpose. The original 18 music programs designed by Bonny are named: Affect Release, Caring, Comforting/Anaclitic, Creativity I, Expanded Awareness, Explorations, Emotional Expression I, Grieving, Imagery, Inner Odyssey, Mostly Bach, Nurturing, Peak Experience, Positive Affect, Quiet Music, Recollections, Relationships, and Transitions (Bonny, 2002c; Grocke, 2002). In addition to the original programs, GIM therapists have created over 100 music programs since the method was established, some of which are culturally sensitive (Bruscia, 2015; Grocke & Moe, 2015).

**Spontaneous Imagery.** The use of appropriate music in NOSC brings the client spontaneous imagery that often involves various human sensory modalities (Goldberg, 2002). Grocke (1999) classified 15 different types of imagery experiences in GIM: “1) Visual experiences; 2) memories; 3) emotions and feelings; 4) body sensations; 5) body movements; 6) somatic imagery; 7) altered auditory experiences; 8) associations with the music and transference to the music; 9) abstract imagery; 10) spiritual experiences; 11) transpersonal experiences; 12) archetypal figures; 13) dialogue; 14) aspects of the Shadow or Anima or Animus, and 15) symbolic shapes and images” (p. 15). Imagery in GIM may be connected to the life, myths and archetypes, transpersonal, or spiritual aspects of the client (Bruscia, 2015).

Three major components of GIM – NOSC, music, and spontaneous imagery – allow the client to a wide range of experiences, which sometimes could be very unusual and unanticipated for the GIM therapist. Although these three components are paramount, however, the presence of the therapist who holds expertise in these three components is also essential in the process of GIM.

### **The Role of the Therapist during a Typical GIM Session**

In order for GIM therapists to practice GIM, they must complete the training offered by a training program endorsed by the Association for Music and Imagery (AMI) or an international organization that is equivalent to AMI. GIM therapists need to develop knowledge and skills to work with the three components described above, but more importantly, GIM therapists are required to be patient, courageous, determined, flexible, imaginative, innovative, intuitive, confident, and non-directive (Bonny, 2002f). GIM therapists provide a session for a client with expertise gained through the training as well as personal qualities that are essential for supporting the client's processes. A GIM session may be different in the session length, but a typical individual session has five parts: the preliminary conversation, induction, imagery experience to music, return, and post session integration (Bonny, 2002f; Bruscia, 2015) and the role of the therapist is different depending on the phase of a session.

**Preliminary conversation.** The preliminary conversation is the initial dialogue phase where the client discusses their current life issues, dreams, and feelings (Bonny, 2002f; Ventre, 2002). The role of the therapist is to build rapport, actively listen to the client, ask for clarification, and identify arising client issues; however, the preliminary conversation is not verbal therapy in which the therapist helps the client address their issues (Bonny, 2002a; Bruscia, 2015; Ventre, 2002). The therapist assesses anxiety, physical manifestations of issues, and the client's energy level to understand the theme that arises in what the client verbally and non-verbally presents. It is also the time for the therapist to help the client focus internally by using verbal prompts and reflecting non-verbal cues to the client. The therapist may also assist the client in determining an intention for their imagery experience to music. While in discussion with the client, the therapist decides on a form of induction, a music program for the session, and a starting image if necessary.

**Induction.** The purpose of the induction is to relax the body and to focus the mind (Bonny & Savory, 1973). Through the induction, the mind shifts its focus from the outer environment to the inner world, which is often recognized as NOSC (Ventre, 2002). In typical sessions, the client lies down on a mattress or sofa, closes their eyes, and the therapist provides verbal guidance for relaxation and focusing. During the induction, the therapist continues to encourage the shift of consciousness so that the client can smoothly

move to the full imagery experience with music (Ventre, 2002). The role of the therapist<sup>13</sup> is to use appropriate voice, spacing, phrases, and sequences to help the client relax and focus (Bruscia, 2015). The therapist watches the client's physical responses and breathing carefully and when the client appears altered, the therapist will play the music for the imagery experience.

**Imagery experience to music.** In this phase, the client typically reclines and keeps their eyes closed during the imagery, although they may move their arms and legs from time to time. The therapist encourages the client to allow their imagery experience to unfold spontaneously with music and to verbally report their imagery to the therapist (Bonny, 2002f; Bruscia, 2015). The therapist continuously move between the client's inner space and the reality as they keep dialogues with the client and records of the client's imagery experiences. The guiding skill of the therapist is essential for a meaningful GIM session for the client (Bonny, 2002f). Guiding should be “non-directive, supportive, non-analytical, and music-centered” (Bruscia, 2015, p. 65) and is the most effective when it engages the client in their imagery experience as fully and deeply as possible. The therapist checks in, provides support, connects the client with music, reflects, encourages, engages the client's multiple senses, intensifies imagery and/or emotions, and deepens the client's imagery experiences by using skilled interventions (Bonny 2002f; Bruscia, 2015). Toward the end of the program, the therapist assesses the



need for another music piece and if it is not necessary, notifies the client that the music <sup>14</sup> has come to an end.

**Return.** After the music program, the therapist assists the client in returning to an ordinary state of consciousness (Bonny, 2002f; Bruscia, 2015). The therapist encourages the client to begin moving their hands and legs and opening their eyes when they are ready. Some clients may have regressed and the therapist is responsible for keeping the client safe and bringing them back to conscious awareness (Bonny, 2002f). The client may still be vulnerable and exposed and it is important for the therapist to allow as much time and support as needed for them. The role of the therapist is to take care of the needs of the client, encourage movement, and constantly check in with them (Bruscia, 2015).

**Post-session integration.** The final part of a session is to review, integrate, and close the session through verbal discussion, journaling, and/or mandala drawing (Bonny, 2002f, Bruscia, 2015; Ventre, 2002). After returning to an ordinary state of consciousness in a typical session, the client sits up and speaks consciously while they are still able to connect to their imagery. The purpose is to help the client gain insights into themselves, make connections among imageries, identify patterns and themes, and find the meaning of their imagery experience with music and its relevance to their life and life issues. The role of the therapist is to help the client process without analyzing.

Although three major components of GIM are the NOSC, music, and spontaneous imagery, the client's experience in GIM heavily depends on the therapist who assesses the client, understands their experience, asks questions, and chooses to provide appropriate interventions. Two qualitative studies that explored the client's experience of music (Abbott, 2005; Summer, 2011a) stressed the importance of the therapist especially in the difficult moments for the client. Both studies stated that the music and the therapist worked together in the GIM process to help clients work through their issues. Grocke (2005) pointed out that GIM therapists "bring their own personal style to the therapy, which is influenced by their training, personality, spiritual orientation, therapy orientation, and level of music knowledge" (p.52). Particularly during the imagery experience to music, the therapist shifts consciousness between the client's world, the therapist's personal world, and the therapist's professional world at sensory, affective, reflective, and intuitive levels (Bruscia, 1998). It is, therefore, important for GIM therapists to be aware of their own process and issues, including their unanticipated reactions, as much as possible.

### **Current Practice of GIM**

Since Bonny developed the method, GIM has been growing significantly especially in these years in terms of the forms of adaptations, countries of practice, and client populations served. Firstly, GIM therapists now practice various forms of

adaptations in addition to the original Bonny Method of GIM. One of the major adaptations is Music and Imagery (MI). MI is a more directive approach that uses a single image on which the client could focus (Summer, 2011b). Another adaptation is a shortened GIM program. This is the most commonly practiced adaptation of GIM (Muller 2010), which was originally proposed as a 50-minute time frame (Vaux, 1993). Other adaptations include the use of non-classical music programs, group format, and spontaneous programming of music (Bruscia, 2002a). It is important to note that not all GIM therapists receive trainings in various adaptations of GIM. Some only practice the pure Bonny method, and others use more adaptations than the Bonny method.

According to the online registry of the Association for Music and Imagery, there are a total of 274 qualified GIM therapists around the world, including Australia, Austria, Brazil, Bulgaria, Canada, China, Colombia, Denmark, Germany, Greece, Hong Kong, Hungary, Ireland, Italy, Japan, Mexico, Norway, Scotland, South Africa, South Korea, Spain, Sweden, Switzerland, Taiwan, United Kingdom, and the USA. There are also several international organizations that provide GIM trainings and give GIM qualifications (Cohen, 2018). Current GIM therapists have different cultural background and work with culturally diverse clients in the world. Short (2005-06) noted the importance of raising the cultural sensitivity and cultural competency for GIM therapists.

Global expansion of the method could potentially lead to cultural misunderstandings

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between the client and the therapist.

Client populations served by GIM are also expanding. When Bonny (2002a) started GIM at the Maryland Psychiatric Research Institute in 1970s, the clients were patients with substance abuse, neurosis, or terminal cancer. Since then, GIM has been applied to clients with different conditions and diagnoses. Current GIM client populations that appeared in case studies and research studies published after 1990 are summarized in Table 1, 2, and 3. The main populations cited by the number of published studies were intimate partner violence (IPV)/abuse, cancer, loss and grief, depression, and substance use disorders. Working with different populations requires that GIM therapists have different expertise and work differently depending on the clients seen. Even with skills and expertise, expanded client populations could be the cause of unanticipated reactions of GIM therapists.

GIM is a broadening practice throughout the world with a wide range of clientele using various forms of adaptations, which require GIM therapists to be more flexible and creative. GIM therapists, therefore, may experience unanticipated reactions more frequently than they used to. It may, then, suggest the need for additional content in GIM training. Because the role of the therapist is important in the process of GIM to support

the client, I felt it was important to clarify the process of unanticipated reactions of the 18

therapist and decision making after those reactions.

*Table 1*

*Mental Health Populations*

<b>Conditions</b>	<b>References</b>
Depression	Bunt (2012), Clarkson (2009-10), Summer (2011b, 2012), Walker (1993), Weiss (1994)
Intimate Partner Violence/ Abuse	Beck (2005-06), Borling (1992), Clements-Cortes (2014), Førde (2015), Hahna & Borling (2003-04), Hearn (2009-10), Moffit & Hall (2003-04), Nadata (2014), Pickett (1995), Reher (2015), Rinker (1991), Smith (1996-97), T & Caughman (1999), Tasney (1993), Ventre (1994), Wesley (1998-99, 2003)
PTSD	Blake & Bishop (1994), Blake (1994), Maack (2012)
Personality Disorder/ Complex Trauma	Körlin (2010, 2007-08), Maack (2012), Pickett & Sonnen (1993)
Substance Use Disorders/ Addictions	Davis (2011-12), Dort (2015), Heiderscheit (2005), Moe (2011-12), Pickett (1992), Stokes (1992), Yawney (2014)
Eating Disorders	Heiderscheit (2016, 2015), Noer (2015), Papanikolaou (2015)
Schizoaffective Disorder	Moe (2015)
Psychiatric (Acute Inpatient, outpatient)	Bonde (2015), Clarkson (1994), Goldberg (1994), Wrangsjö & Körlin (1995)
Loss/ Grief/ Cultural Grief	Clarkson (2014), Kirkland (2007-08), Lewis (1993), Merritt & Shulberg (1995), Serna (2011-12), Skaggs (1992), Smith (1996-97), Trondalen (2009-10)

*Medical Populations*

<b>Population – by condition</b>	<b>References</b>
Cancer	Abrams (2016), Allen (2010), Bonde (2005a, 2005b, 2007), Burns (2001), Dimiceli-Mitran (2015, 2016), Gimeno (2008), Hale (1992), Hertrampf (2015), Meadows (2015), Miller (2016), Newel (1999), Short (1991), Wärja (2015), West (1999)
HIV/ AIDS	Bruscia (1991, 1992, 1995a), Perilli (2012)
Terminal/ Palliative/ End of Life	Abrams & Kasayka (2005), Cadrin (2005-06), Clements-Cortés (2016), Skaggs (1997), Marr (1998-99), West (2015)
Rheumatoid Arthritis	Grocke (2003), Jacobi & Eisenberg (2001-02), Merritt (1993)
Fibromyalgia	Torres (2015, 2016)
Multiple Sclerosis	Dimiceli-Mitran (2001)
Amyotrophic Lateral Sclerosis (ALS)	Erdonmez (1995)
Chronic Pain	Jackson (2013)
Paralysis	Pickett (1996-97)
Cardiac Rehabilitation	Short, Gibb, & Holms (2011), Short, Gibb, Fildes, & Holms (2013), Short (2016)
Pregnancy	Short (1993)
Elderly with Physical Illness	Short (1992)
Physical Disability/illness	Moffitt (1991), Short (1991)
Visually impaired	Samara (2016)
Head Trauma Recovery	Pickett (1996-97)
Brain Damage	Cohen (2015)

*Other Populations*

<b>Populations</b>	<b>References</b>
Stress	Beck (2011-12), Beck, Hansen, & Gold (2015), West (2003)
Relationship Issues	McKinney (1993)
Inner Family/ Inner Child	Weiss (1994)
Culture/ Ethnicity	Mclvor (1998-99), Short (2005-06)
Autism	Clarkson (1995, 1998-99)
Transition/ Changes in life	Bunt (2000), Clark (1995), Terry-Clark (2016)
Spirituality	Holligan (1994)
Abortion/ family issue	Beebe & Wyatt (2009), Clark (1991), W & Short (1999)
Anima Issue in Man	Brooks (2000)
Holocaust Shadow	Schulberg (1999)
Music Performance Dysfunction/ Performance Anxiety	Martin (2015), Nathan (2016)
Energy Healing	Clarkson (2005-06)
Schools	Band (2016), Powell (2007-08, 2015), Roy (1996-97),
Music Therapy Interns/ Supervision	Fox & McKinney (2015), Mårtenson-Blom (2003-04)
Psychoanalytic Psychotherapist	Clarkson & Geller (1996)

The literature search found more studies on the client's reaction to the therapist or the therapeutic process than those on the therapist's reaction to the client or the client's experiences. A limited number of research studies in various therapeutic modalities including psychotherapy, counseling, music therapy, and dance/movement therapy, revealed diverse reactions of the therapist in therapeutic settings.

In the literature, one of the most common reactions that therapists experienced in response to client or their experiences was countertransference. Since Freud (1910) first discussed countertransference in psychoanalysis, the term has been applied to broader circumstances. Countertransference can be currently understood as it occurs “whenever a therapist interacts with a client in ways that resemble relationship patterns in either the therapist’s life or the client’s life” (Bruscia, 1998, chapter 4, para. 5). Therapists' countertransference included a wide range of emotional, cognitive, and behavioral reactions toward both the client and the therapist themselves (Haynes, Nelson, & Fauth, 2015). In this study using grounded theory analysis, emotional reactions included feeling angry and envious of the client; guilty and inadequate about themselves; cognitive reactions included being forgetful, misunderstanding the client, making wrong interventions, and being confused; and behavioral reactions included intriguing, disputing, trying to impress, and working too hard or too little. The study showed that when the



therapist was able to articulate their experiences of countertransference, the outcome of<sup>22</sup> the therapy was successful. In another study that used the grounded theory approach to explore the experience of psychotherapist to client's anxiety and avoidance (Daly & Mallinckrodt, 2009), the therapist experienced different reactions to different clients. The therapist felt resented, angry, and frustrated when the client was anxious, while they experienced inadequacy, discouragement, rejection, boredom, and frustration when the client was highly avoidant. Although the researchers mentioned that not all reactions were countertransference, they stressed the importance of self-awareness to look at the therapist's internal process. Another study found that therapists experienced countertransference reactions not only during the session, but also after the session (Bimont & Werbart, 2018). This study described the phenomena of experiencing clients' presence within the therapist's inner world after the session as a distinctive kind of countertransference. In working with clients who had the history of trauma, most therapists experienced unclear boundaries, which resulted in feeling anxious and fearful as well as feeling love after the session. Because GIM therapists work with a wide range of clients, it is possible that they experience strong countertransference reactions which are emotional, cognitive, and/or behavioral. In addition, it is possible GIM therapists experience the prolonged effect of countertransference after the sessions are over with clients who have a history of trauma.

Secondly, another common reaction of therapists was emotional reactions<sup>2</sup> to clients or clients' experiences. In one study of music therapists, the researcher used a phenomenological approach to describe therapists' experience of being challenged (Quiroga, 2015). Therapists felt challenged when there was inconsistency in expectations for music therapy between the client and the therapist. As a result of inconsistency, the client became angry or left the therapy space, and the therapist had emotional reactions including being disappointed, helpless, and incapable as a therapist. Similarly, another study in psychotherapy described therapists' emotional reactions in working with clients who had a history of trauma or abuse (Smith, Kleijin, & Hutschemaekers, 2007). The researchers took a grounded theory approach to explore therapists' perceived difficult situations in working with clients' trauma and their reactions during a session. Three situations emerged: In traumatic situations where clients shared experiences of severe abuse, the therapist felt shocked, anxious, sympathetic, somatic sensations, and a need to talk; in interactional situations where clients showed strong verbal or non-verbal appeal to the therapist, the therapist felt helpless, frustrated, and manipulated by clients; and in existential situations where the clients' issues were difficult to handle, the therapist felt different dilemmas and responsible for the clients' process. Additionally, a survey study by Knight (1997) described therapists' emotional reactions to their work with adult

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<sup>2</sup> All reactions of the therapist can be understood as countertransference; however, I classify the reactions as authors described without making any judgement.

clients who experienced childhood sexual abuse. The majority of the therapists felt angry,<sup>24</sup> sad, overwhelmed, and horrified about the client's experience. These studies revealed that therapists do have various emotional reactions depending on the client or their experiences. Therapists seem to have a strong emotional reaction especially in working with clients who have a history of trauma; however, it is unclear through these studies whether these reactions of the therapist affected the client or the course of therapy.

Thirdly, therapists' reactions also included somatic/physical. Vulcan (2009) conducted a survey of literature on somatic reactions in dance/movement therapy (DMT). It showed that somatic reactions existed and suggested the importance of those reactions in understanding the dynamics in their relationship with the client. In another study, the researchers used inductive thematic analysis to examine nine therapists' reactions to child clients' sexually problematic behaviors (Shevade, Norris, & Swann, 2011). The therapists experienced both negative and positive feelings as well as somatic reactions. Negative feelings included being incompetent, powerless, uncomfortable, shocked, fearful, anxious, and feeling like an abuser or abused. Positive feelings included warmth, excitement, acceptance, and surprised at the child's communication ability. Somatic reactions included feeling nervous, sick, and blurry. The study suggested that these somatic reactions occurred along with emotional reactions. Similarly, therapists experienced somatic reactions in addition to emotional reactions in working with clients with a history

of trauma (Smith, Kleijin, & Hutschemaekers, 2007). These reactions included disgusted,<sup>25</sup> nauseating, tensed, and restlessness along with various emotional reactions. Yet another study described the somatic reactions of the therapist in working with trauma survivors in the refugee treatment setting (Holmqvist & Andersen, 2003). Their somatic reactions included heaviness, lack of energy, headaches, and stomach problems, which showed that therapists' reactions can impact their practice. Also, in another phenomenological study of DMT (Palmer, 2015), the therapists experienced somatic reactions and emotional reactions simultaneously in their work with clients diagnosed with eating disorders. Those reactions included warmth, headache, anxiety, flapping in the chest, uncomfortable feelings in the body, and change in posture. The therapists were also aware of the energy in the room and its shift during the session. It was noted that therapists should recognize and manage these somatic reactions by grounding and using the breath while they try to understand these reactions and where they came from.

Lastly, various reactions of the therapist may be related to the following action of the therapist. One research study explored the therapist's temporal disconnection from the client during the session using a grounded theory approach (Gross & Elliot, 2017). The therapist's action of disconnection with the client occurred for different reasons: 1) the client shared tragic memory; 2) the client was disengaged in the session; 3) the therapist felt overly responsible for the client's process; and 4) the therapist embodied the client's

strong feelings. During these moments of disconnection, the therapist felt unresolved pain,<sup>26</sup> momentary relief, irritation, anxiety, and a state of panic. Therapists also felt responsible and pressured to provide a good session. This study emphasized the importance of receiving supervision and support, engaging in self-reflection, and practicing self-care. This study also suggested that therapists experienced unanticipated reactions in combination with emotional responses. The therapist's reaction to the client or the client's experiences may not be a simple phenomenon; instead, it could be a complicated one involving actions and emotions; however, the process of the therapist's reaction was not clear.

These studies described how therapists had various reactions during the session including countertransference, emotional, and somatic, which might be related to the therapists' actions. If therapists' reactions and actions are related, it is possible that the therapists could make an intervention based on their reactions to the client or their process. It is, therefore, possible that the reactions of therapists can influence the experience of the client. GIM therapists work with the exact population described in these studies such as trauma and childhood abuse; therefore, GIM therapists could experience similar reactions, including emotional and somatic. None of these studies, however, described the process of the therapists in the moment of those reactions as well as possible influences of the therapists' reactions on to the client and the therapeutic process.

After experiencing reactions, therapists have various choices of interventions. In<sup>27</sup> one music therapy study, the researcher examined therapists' reactions to clients' anger and interventions to address it (Jackson, 2008). Qualitative analysis of 29 survey replies revealed various aspect of the therapists' experiences. In less than a half of the cases ( $N = 12$ ), the target of anger was the therapist. Results indicated that a majority of the therapists felt fearful, were concerned about their safety, and became angry, and a minority of the therapists tried to understand and had positive feelings. Jackson found that there were four models in the therapists' interventions following the client's anger: Redirecting, validating, containing, and working-through. The outcomes of the therapist's response were positive ( $N = 16$ ), neutral ( $N = 6$ ), and negative ( $N = 7$ ). Therapists decided to provide different interventions to deal with clients' anger; however, it was not clear in this study how the therapist made a choice on an intervention, particularly what informed therapists to make different interventions.

Although the process of decision-making of therapists is still not clear, the reactions of the therapist may help them determine how they continue the session if they are aware of them. A study in psychotherapy examined therapists' reactions to client's anger through qualitative analysis of recollections of 13 therapists (Hill et al., 2003). As a result of client's anger, therapists experienced difficulty dealing with the situation because the therapists felt anxious, incapable, annoyed, and irritated and experienced

difficulty managing the client's anger. This study revealed that the difference in reactions created different outcomes in therapy. When the therapist felt annoyed and irritated at the client in anger situations, they were better able to solve the anger issue than when they felt anxious and incapable. In addition, how the therapist dealt with the client's anger made a difference in continuation of the sessions. In some cases, the therapist helped clients express and explore their anger; however, in other cases the therapist was unable to address the client's anger and the client did not return to the therapy. This implies that the therapist's emotional reactions have potential to inform how they should address anger expressions of the client. Similarly, another study suggested physical reactions might also inform them of what is needed in the session (Shaw, 2004). This study described therapists' somatic reactions during a session through grounded theory analysis of group discussions and interviews. Somatic reactions of fourteen psychotherapists included nausea, sweating palms, and gut sensations. In addition, the study found that therapists used body sensations to empathize and understand the client as well as to manage therapists' behaviors. This indicated that somatic reactions also have the potential to be a source of information for therapists to determine how they continue the session. These studies suggested that some of the reactions could be an important resource for the therapist to understand what is going on in themselves, the client, and the session; however, they did not clarify how therapists used these reactions during the session.

Additionally, therapists applied what they had experienced in the session differently to their therapeutic work. One study used consensual qualitative research methodology to describe therapists' different reactions to different negative feedback from the client and different timings of applying their learning from the client (Brattland et al., 2018). When the client showed anger in their verbal feedback, the therapist generally got surprised, felt the feedback was helpful but challenging, and experienced negative feelings, which led to negative feelings toward themselves. But the therapists immediately worked with the client in the session and in return, they had an improved relationship with the client. When the client showed a sense of giving-up, the therapist felt the situation was atypical and challenging and generally felt shameful, guilty, and helpless. In these cases, the therapist gained the full understanding of themselves and the client after the session; therefore, they used the information after the session to guide future interactions. When the client indirectly exhibited dissatisfaction with the therapist, the therapist felt it was atypical without any negative feelings. In these cases, the therapist did not use the feedback and most clients terminated their therapy. Therapists react differently to clients' different negative feedback and applied their experiences at different times; however, it was not still clear how the therapist processed their reactions to these negative feedbacks and how they made decisions on how to work with the client.



Furthermore, reactions of the therapist may impact their perceived effectiveness as a therapist. In the study of therapists who worked with trauma survivors (Holmqvist & Andersen, 2003), the researchers used thematic analysis of interview data, resulting in seven themes: “the work is meaningful and rewarding; guilt; view of life; uncertainty; exhaustion; symptoms; and protection mechanisms” (p. 296). It was interesting to note that the therapists not only felt guilty or uncertainty about their work, they felt positively overwhelmed by the significant meaning of their work. This meant that therapists could feel differently depending on how they react to the clients’ experiences. These studies suggested that the reactions of the therapist could affect their sense of effectiveness if they were not fully aware of them. Therapists, therefore, could experience burnout if they did not come to an understanding of their reactions. Another qualitative study in music therapy also explored the effective and ineffective moments with 11 music therapists (Comeau, 2004). Music therapists perceived themselves as ineffective when clients were overtly “crying, yelling, biting, being easily distracted, and having no reaction” and covertly “being disturbed, being resistant, avoiding issues, being powerless, and making no progress or getting worse” (p. 25). In responding to these clients’ experiences, therapists had both physical reactions, such as being tense as well as emotional reactions such as feeling fragile, frustrated, depressed, angry, and sorry for the client. The finding showed that some therapists questioned their ability as effective therapists because of the

client's experiences; however, it was not clear how these reactions to these occurrences led to an intervention and furthermore, feeling ineffectiveness as a therapist. 31

Therapists in various therapeutic modalities experience countertransference, emotional, and somatic reactions in their work with clients. These studies suggested these reactions could be related to different interventions. While these reactions may provide information about the therapist, the client, and the session if the therapist was aware of them, they could impact the perceived effectiveness of the therapist and could lead to burnout if the therapist was not aware of them.

### **Therapists' Reactions to Clients' Experiences in GIM**

Unlike literature in other therapeutic modalities, there was only one study that explored therapists' reactions to client' experiences in GIM. Grocke (1999) used a phenomenological approach to understand pivotal moments in GIM, which was defined as "intense and memorable GIM experience which stands out as distinctive and unique" (p. 117). At the client's pivotal moment, therapists had emotional reactions and were moved to tears by the significance of the client's experience, felt frustrated because clients did not respond, and perceived time slowed down. In those moments, therapists might leave space for clients or intentionally provided interventions to facilitate clients' experience of pivotal moment. Although the study found that the therapists might anticipate the pivotal moment from the clients, it was unclear if their reactions were also

anticipated. In addition, it raised the question on what made the difference in interventions provided at the pivotal moment.

Although there is only one research study on the topic, case studies have described different reactions of GIM therapists to client's experiences. The first example was countertransference of GIM therapists (e.g. Grocke, 2003, 2005). Similar to studies of other therapeutic modalities, countertransference could occur to GIM therapists at any point of the therapeutic process. In GIM, the objects of countertransference can be the music, imagery, or client (Bruscia, 1998). The countertransference reaction of the GIM therapist has potential to interrupt the therapeutic process for the client if the therapist is not aware of it. For example, Grocke (2005) reacted to the client's experience of not being able to go across the bridge and wanted to help the client cross it because of their countertransference. Grocke later realized that the client needed to stay on one side because they were not ready for the change while Grocke wanted them to successfully cross the bridge. In another case, the therapist mistakenly "rescued" the client from having necessary struggles by changing the music program because of countertransference (Grocke, 2003). These case studies show that it may change the process of therapy if therapists are not aware of their own countertransference reactions.

The second example is therapists' reactions to client's transference. Transference is "the client's replication within the therapy setting of past relationship with significant

others” (Bruscia, 1998, chapter 18, para. 1). It also occurs in any psychotherapy and the<sup>33</sup> client could have transference toward the therapist, but in GIM, the objects of transference may be the music, imagery, and therapist. For example, the client who had a history of being abused became very angry at the music and at the therapist for choosing the music because of transference (Borling, 1992). The strong transference from the client, especially when it was toward the therapist, could trigger strong reactions of the therapist. In another case study (Bruscia, 1995b), the client had negative transference to the music, imagery, and therapist and needed to take control over them. As a result, the therapist felt powerless. On the other hand, the client had a positive transference to the therapist as their father, and the therapist was afraid of letting the client down, thus allowing the session to continue in that manner (Bruscia, 1991). Whether the client's transference was positive or negative, the therapist seemed to experience some reactions.

The third example is emotional reactions of GIM therapists. As presented in the research study by Grocke (1999), therapists may have emotional reactions because of significant life-changing experiences of the client during a GIM session. In one session (Merritt & Schulberg, 1995), the client and the therapist together experienced an imagery of the whole German collective and Jewish collective coming together and they held hands with each other. The therapist was in tears and experienced something beyond words with the client. Bruscia (1991) stated;

For who I am as person and therapist, and how I feel as person and therapist ultimately determine how I will use music, imagery, mandalas, verbal discussions, etc. Without me being fully human as both person and therapist, these are artifacts of therapy. (p. 599)

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Because GIM therapists are genuinely present for the client, they normally engage in the client's imagery and feel their emotions. As a result, therapists have emotional reactions to client's experiences as well.

Similar to research studies in other therapeutic modalities, GIM therapists had various reactions to the client or their experiences during a session. It should be noted, however, that none of the GIM case studies mentioned somatic reactions as shown in research studies of other therapeutic modalities. This is interesting as GIM engages various human sensory modalities (Goldberg, 2002) and the client responds emotionally, somatically, and intuitively to music. In studying unanticipated reactions of GIM therapists, it seems important firstly to find out what unanticipated reactions GIM therapists experience in response to the client's experiences. Similar to studies in other therapeutic modalities, the process of the GIM therapist was also unclear including how they experienced these unanticipated reactions and how they continued the session. A comprehensive study on the process of GIM therapists in the moment of unanticipated reaction found to be important.

## Summary of the Literature

GIM is a unique method of psychotherapy that uses music and spontaneous imagery while the client is in a non-ordinary state of consciousness (NOSC). The role of the therapist is significant in this method and very different depending on the part of a session. Because of its broadening practice, it is possible that GIM therapists experience unanticipated reactions that did not occur when the method was created. Finding out what some of the unanticipated reactions GIM therapists experience may highlight the gap in the training and actual practice.

The literature review of various therapeutic modalities portrayed different reactions of therapists to clients' experiences in the process both positive and negative including countertransference, emotional, and somatic responses. These reactions were not necessarily described as unanticipated; however, some of them occurred as a surprise for the therapist and most were unusual in their course of the therapy process. It is, therefore, reasonable to consider them as unanticipated. These unanticipated reactions of the therapist may be a complicated phenomenon that is related to the actions of the therapist (Gross & Elliot, 2017). Because the therapist has various choices in interventions even to a single phenomenon during a session (Jackson, 2008), it is important to clarify the relationship between the therapist's unanticipated reactions and their interventions. Some studies suggested that these reactions might have informed the

way therapists responded to the client (Hill et al., 2003; Shaw, 2004). The gap in the literature, therefore, was the process of the therapist in the moment of unanticipated reactions and decision-making after those reactions.

Most authors stressed the importance of raising awareness of therapists' reactions to help them understand that all reactions are normal, engaging in self-reflection, and seeking appropriate support or supervision to recognize, acknowledge, and work on therapists' various reactions to client's experience (Comeau, 2004; Quiroga, 2015; Shevade, Norris, & Swann, 2011; Smith, Kleijin, & Hutschemaekers, 2007). Therapists' unanticipated reactions to client's experiences may be harder to be aware of and work on. But if they do not fully understand the meaning of their unanticipated reactions, it may lead to doubts about their effectiveness as therapists (Comeau, 2004; Holmqvist & Andersen, 2003). This can lead to burnout in therapists. It is necessary to explore what unanticipated reactions therapists may have and how they process and continue the session after these unanticipated reactions.

A research study and case studies in GIM have showed that GIM therapists also had unanticipated reactions to client's experiences during a GIM session, but the process was still unclear. Because GIM is a unique method that requires therapists to deeply involve clients' experiences, the impact of clients' experiences on the therapist may be significant. In addition, because GIM therapists often work with clients who are loaded

emotionally and physically, it is possible that the therapists have strong reactions to clients' experiences. The risk of burnout of GIM therapists is high if they are not aware of these unanticipated reactions. Because the lack of research studies of the therapist's process in GIM, firstly, it is important to describe what unanticipated reactions do GIM therapists have and secondly, it is essential to explore how GIM therapists continued the session after unanticipated reactions.

### **Purpose of the Study**

The purpose of this study was to explore therapists' experience of unanticipated reactions and discover if there is a commonality in meaning or the nature of this phenomenon as well as if there is a link between therapists' unanticipated reactions, their process, and decision making of an intervention afterwards. The findings of this study may help GIM therapists be more aware of their reactions to client' experiences and suggest possible content to be added to the GIM training. It is hoped that this study would help GIM therapists make better decisions on interventions and additionally motivate them to engage in self-reflections or seek supervision. In addition, by understanding the meaning of unanticipated reactions, the study may reduce the risk of feeling a lack of effectiveness as therapists and subsequent burnout.



## Research Questions

How do GIM therapists describe their unanticipated reactions to client's experiences in GIM?

1. What unanticipated reactions do GIM therapists have in response to client's experiences in GIM?
2. How do GIM therapists continue the GIM session after having unanticipated reactions?

## Definition of Terms

**Therapists' Unanticipated Reactions.** The working definition of therapists' unanticipated reactions in GIM is the following: Unanticipated reactions are atypical feelings, thoughts, physical sensations, or intuitions that therapists have in response to any experiences of clients at any part of a GIM session.

**Clients' Experiences.** Clients' experiences include any imagery, events, statements, feelings, thoughts, physical sensations, intuitions, and responses to the music, imagery, therapist, and non-ordinary state of consciousness that clients have during a GIM session.

**METHOD****Research Design**

The method used for this study was phenomenology as outlined by Moustakas (1994). Phenomenology is a method that focuses on a single phenomenon and explores commonality in participants' lived experiences of the phenomenon (Creswell, 2013). Phenomenology is employed in various fields including psychology, sociology, education, and health sciences, and explored phenomena are diverse such as symptoms, feelings, emotions, and procedures. For this study, I chose phenomenology because I explored a single phenomenon, unanticipated reactions, shared by GIM therapists. I was interested in GIM therapists' lived experiences of unanticipated reactions to client's experiences including how they felt, thought, sensed, and continued the session after having unanticipated reactions. Through descriptions of what unanticipated reactions GIM therapists had in response to client's experiences in GIM and how GIM therapists continued the session after them, I aimed to distill the essence of these experiences commonly shared by GIM therapists and gain in-depth understanding of the therapist's experiences of unanticipated reactions. Phenomenology helped me discover the meaning of unanticipated reactions of GIM therapists, which might have contributed to the process of decision making of GIM therapists in determining an intervention.

## Participants

I used purposive sampling for this study. Upon the approval of the study by the Institutional Review Board (IRB) at Temple University (See Appendix A), I sent the letter of invitation via e-mail to 20 candidates who I identified through the online registry of the Association for Music and Imagery (AMI) and through communication with qualified GIM trainers and experts in GIM (see Appendix B for the letter of invitation). Inclusion criteria for the study were the following: 1) a current or former qualified GIM therapist; 2) able to understand and communicate in English; 3) aged over 25 years old; 4) practiced GIM over three years as a qualified GIM therapist; 5) provided a minimum of 30 GIM sessions as a qualified GIM therapist; and 6) experienced unanticipated reactions to clients' experiences in a GIM session. I chose experienced therapists for this study because: 1) they might be able to identify unanticipated reactions that were not caused by a lack of skills and experiences in dealing with common events in GIM; 2) they might have experienced multiple unanticipated reactions to client's experiences; and 3) they would be able to share their in-depth experience. In addition, because GIM is expanding in terms of the different countries where it is practiced, the varied adaptations used, and client populations served, I aimed to gain diversity in participants and used the following criteria: 1) continents of residency, 2) BMGIM and adaptations practiced, 3) endorsed training programs, 4) client populations served, and 5) gender identities.

Table 4

*Demographic Data of the Participants*

Gender	Female	5
	Male	1
	Non-Binary	1
Race	Caucasian/ White	7
Age range	41-50	1
	51-60	2
	61-70	2
	71-80	2
Profession	Music Therapist	5
	Current/ Former Music Therapy Educator	5
	Licensed Professional Counselor	1
	Licensed Social Worker	1
	Gestalt Therapist	1
	GIM trainer	6
Location of practice	North America	6
	Other	2
Highest education	Master's Degree	4
	PhD/ Doctorate	3
Years of experience as a professional	11-20 years	1
	21-30 years	3
	Over 31 years	3
Years of experience as a qualified GIM therapist	11-20 years	3
	21-30 years	3
	Over 31 years	1
Area of specialty in client population	Anxiety	6
	Depression	5
	Eating Disorders	1
	Grief	2
	Addiction/ Substance abuse	4
	Trauma/ Abuse	2
	Medical	1
	Growth and Spiritual Exploration	1
	Women after Mid-life	1

Table 4

(Continued)

GIM sessions provided as a qualified GIM therapist	Less than 1000 sessions	2
	1001-2000 sessions	2
	2001-3000 sessions	2
	Over 3000 sessions	1
GIM used in practice	The Bonny Method of GIM	6
	Various Adaptations of GIM	6

Reminder emails to participate in the study were sent after a two-week period.

When likely participants responded to the invitation expressing their interest in participating, I sent them the informed consent form via e-mail (see Appendix C).

Seven GIM therapists agreed to participate in this study. Table 4 shows the summarized demographic background of seven participants at the time of interview. The number of GIM therapists who agreed to participate in the study was relatively small, thus preventing the achievement of diversity in participants that I originally intended for this study.

### **Data Collection**

Data were collected through in-depth semi-structured interviews with the participants. Interviews were conducted between July to September 2018. Six interviews were completed via Webex, an internet-based live interaction service. One participant preferred Skype because of the technical issue with Webex. I informed them that there was no guarantee for privacy and we used Skype for the interview. The interview was

recorded on Sony ICD-PX440 IC Recorder, WebEX, and my password protected iPhone<sup>43</sup> and computer.

Each interview lasted 60 to 90 minutes. This time frame allowed participants to become acclimated in their physical environment, find a comfortable position for an extended period of time, get acclimated to the interview platform, and focus on the interview. It also allowed me to build rapport with participants so that they could share their potentially uncomfortable experiences. Additionally, because I am not a native English speaker, this time frame allowed both participants and myself to get used to each other's English and ask for clarification. The semi-structured format allowed participants to openly talk about their experiences related to the research topic while I asked participants specific questions as well as questions that emerged during the interview, thus gaining rich data from the participants. Prior to the interview, I asked participants not to use the actual names for any clients during the interview to ensure confidentiality. The questions included the participant's general background, their experiences in GIM, and their unanticipated reactions to client's experiences during a GIM session. Participants also had an opportunity to freely talk about other relevant topics at any point of the interview. After the interview, if needed, I contacted the participants via e-mail for further explanation. Each participant's identifying information has been kept anonymously with

numbers to protect their privacy. The sample of the interview schedule is shown in

## Appendix D

Audio interview data were transcribed by either myself or a professional transcriber. Because my first language is not English, it was difficult to transcribe the interview data of some participants. A professional transcriber who was a native English speaker, therefore, ensured accuracy of the transcripts. I used full verbatim for transcripts including silence, laughs, and sounds such as “hmmm” "uh hum" and "ah!" and asked the same for the professional transcriber to ensure consistency in the content. All transcribed data were kept anonymous by using a number for each participant. All data were kept in my password protected computer and password protected USB and will completely be destroyed five years after the completion of this study.

## **Data Analysis**

I employed the phenomenological method outlined by Moustakas (1994) for data analysis and conducted both within-case and cross-case analysis. In this study, I present the findings of a within-case analysis in the Findings section and those of the cross-case analysis in the Discussion to answer the research questions (Abbott, 2005).

For a within-case analysis, the first step was to read each transcript multiple times to obtain an overall impression of it. The second step was to find significant statements from each transcript that were related to the therapist's unanticipated reactions to client's

experiences. In this process, I engaged in memoing to explore data by asking questions<sup>45</sup> and making comparisons, to develop ideas for further analysis and categorization, to note stories as they emerged, and to challenge my assumptions in data analysis (Corbin & Strauss, 2008). I also kept research notes to track the process of analysis. I repeated this process at least three times to ensure accuracy. The third step was to group the significant statements into meaningful units for each participant (Moustakas, 1994). I reviewed the meaningful units at least three times, added memos, and re-grouped them when needed (see Appendix E for the sample of analysis). I added a sub-step here that was not described in Moustakas in which I developed a brief description for each meaningful unit for clarification of the analysis (see Appendix F for these descriptions). This sub-step allowed me to focus on what was important within the meaningful unit before composing textural and structural descriptions. This might also provide extra information on each participant's experiences of unanticipated reactions that was not included in the textural and structural descriptions. The fourth step of the within-case analysis was to compose textural and structural descriptions of each participant. The textural description revealed the unanticipated reactions each participant experienced to clients' experiences in GIM, and the structural description revealed the process of how they continued the session after having unanticipated reactions.



I then took a step further to conduct a cross-case analysis to answer the research questions, which is presented in the discussion. I clustered the textural and structural descriptions of each participant's experience of unanticipated reactions together based on the research questions, compared them for similarities and differences, and found common themes among those experiences of all participants. The sample of an analysis is presented in Appendix G.

Finally, from these themes, I composed the distilled essence which is a longer description of the common experiences of participants.

### **Trustworthiness**

In order to ensure trustworthiness, I engaged in several steps to gain multiple perspectives on the process of this research study. First, I asked each participant to check the accuracy of the transcript and make editions and corrections if needed. I also asked participants several questions regarding their statements to understand their feelings, clarify hidden messages, and ask for further explanations in the process of analysis. The second step in assuring trustworthiness involved the research supervisor overseeing the whole process of analysis, challenging my assumptions, and giving feedback. Next, one of the dissertation committee members checked my analysis on one participant, added memos, asked questions, and gave feedback. And lastly, I kept research logs to keep the progress of the study, note my own feelings, impressions, and physical sensations,

bracketed my assumptions, and wrote down connections that I found among the participants. All steps were reflected on my analysis.

### **Epoché**

I was born and raised in the suburb of a metropolitan area in Japan. I moved to the United States to receive a formal music therapy education at a university in Southwest Virginia. I started my training in the Bonny Method of Guided Imagery and Music (BMGIM) when I was in graduate school. My training included the traditional method of BMGIM as well as the Atlantis model of GIM that used some adaptations such as the use of contemporary music programs and shortened programs. In addition, my training included physical interventions which I extensively use in my practice. I became a Fellow of the Association for Music and Imagery (FAMI), a qualified GIM therapist, in September 2011. Because I moved back and forth between the US and Japan, I practiced GIM in both countries. In my practice, I have worked with diverse clients who experienced normal neurosis, grief, loss, anxiety, depression, various traumas, issues related to gender, post-traumatic stress disorder, abuse, and medical issues. None of my clients' imagery experiences were the same and I was often surprised by their imagery and sometimes I felt overwhelmed by the significance and the meaning of the client's experience. I believe the therapist has an important role in the client's experience throughout the session, which influences the effectiveness of the therapy.

I have experienced multiple unanticipated reactions to my client's experiences. I<sup>48</sup> have felt both joy and loss, been surprised and frustrated, had kinesthetic sensations and intuitions, and had laughter and tears to diverse experiences of clients. Sometimes my reactions to a client's experience guided me to provide an intervention for the client. I think it is natural for therapists to have reactions and some of them may come as a surprise. It is very important for all therapists to be aware of unexpected reactions and work on them if necessary. Although I challenged my assumption by memoing and supervision, my standpoint might have influenced the way I interviewed GIM therapists and analyzed the data.

**FINDINGS**

Presented below are the findings of the within-case analysis of seven participants in the form of the structural and textural descriptions of their unanticipated reactions to the client's experiences in GIM (see Appendix E for the sample of analysis). The structural description demonstrated the anticipated reactions each participant experienced during GIM and the textural description showed the process how each participant continued the session after having the unanticipated reactions. I used the number to represent each participant instead of giving them pseudonym to avoid identification by gender. Most participants used gender pronouns to describe their client; however, to ensure that confidentiality was maintained, I transformed them to third person pronoun.

To further ensure trustworthiness, I contacted the participants after the interview. All seven participants checked the accuracy of their transcripts, made corrections and additions to their transcripts, and answered my questions regarding their statements. Also, in the process of analysis, I again contacted the participants when I felt a need for further clarifications and asked if my analysis on their significant statements was accurate. These corrections, additions, and answers were included as part of the data for these analyses.

**Participant 1**

**Textural Description.** I had this client who was body oriented and found the benefit of moving their body and physical interventions during the imagery experience to music. I had 10 to 20 sessions with them and they were working on reclaiming their body and owning it. In the middle of the imagery experience to music in one particular session, the client sat up on the futon and said "I need to stand up" as they actually stood up. It was very unexpected and my first reaction was to flinch to stop them. I was taken back for a moment and felt a little bit out of control. I thought "No, you can't" because I was not trained to let it happen and because I had not had any client who initiated standing up before. I was not ready for that client's action, but it was very natural for them so that they would be surprised if I told them it was out of ordinary in GIM. In usual GIM sessions, physical safety of the client is not a top concern because they lie down on a mattress/futon or remain seated on a recliner so that their physical interactions are minimal. In this case, however, the client's physical safety suddenly got elevated to the highest level of concern. This emergent need took me out of the irrational mind and made me spike into the rational mind. I had to check the environment to see it was safe enough. Then, I had this gut feeling which said, "Maybe we could." All these experiences happened in a split second.

**Structural Description.** I made this decision to go with the client standing up because I trusted the client and their body that they should be coordinated enough to do all that they needed; I trusted myself as a clinician that I had been experienced enough to know how to interrupt them if I needed to; and I trusted the process. In addition, as I reflected, I remembered my experience in GIM as client where my therapist said "oh, no" when I asked if I could stand up during the imagery experience to music. Because of this experience, I had a deep understanding of the need for standing up in the cell of my body although I was not aware of it in that moment. This might have led to my gut feeling of "maybe we could." In that moment, I took in all information consciously and unconsciously and decided, "Let's give it a whirl."

## **Participant 2**

**Textural Description.** I had been working with this client over a couple of years and I felt comfortable in our work together. In this particular session, there was nothing unusual until the moment in which they were in a sanctuary with their father. Their father was dead and laid out like for a funeral and they were sitting next to him. It was beautiful in retrospect. But in that moment, I suddenly had this shocking and blooming awareness that over the last 20 or 30 sessions, they had been sitting there by his side ever since he died 20 years ago and they would not leave his side. And much to my sheer horror, I asked, "How long are you going to sit here?" It was a demanding statement instead of an

open-ending question that came out of nowhere and the moment I said it, I knew I was wrong. The question flew out of my mouth without any conscious awareness. It was my countertransference reaction because I was abandoned by my own father and had not been able to grieve over my own experience. The question was the question to myself. But more importantly, I was meeting my own personal need through their sessions by living vicariously through them. I expected that they would fight with their father as they had done in the past sessions so that I could have the fight that I needed to have with my own father. When they were about to make peace with their father, my younger self took over me and said "Holy Crap! You are about to forgive your father for all the shit that he just did and we are not going there!" I was not ready to make peace with my own father, so I stopped their process. It was a precious moment for them and hard earned after 20 or 30 sessions, and there was a ton of work that could have been done in the moment, but I stole it from them because of my countertransference.

**Structural Description.** The issue in that moment was that I did not go through the decision-making process. I wish I had a "self-mediation" which would have allowed me to feel how the client was experiencing, to think of the music and what it was doing, to check how I was experiencing and my countertransference, and then to take all information into account and gauge what would help the client be as present to that moment as they could be. All in a split second and only then, I would make an

intervention. It is so important that we all increase self-awareness so that this self-mediation can be functioning in working with a client.

### **Participant 3**

**Textural Description.** I had worked with this client for 45 sessions over several years, during which they wanted to leave the job but never did. Even when they resigned, they would return to the same job with a different position. In working with them, I was so sick and tired of hearing the same argument again and again. I was expecting to hear that they succeeded in leaving the job. In our work, we had a good collaborative relationship so I had used the challenging music programs such as Mostly Bach, Affect Release, and Emotional Expression I. But nothing was breaking through. I felt that I was not doing my best therapy work because I thought they should have gotten through by then. It challenged me that the Bonny Method and I as the therapist had not been able to shift this thing that they had been working on for years. I was very frustrated and suddenly, I had this gut feeling which said, "I'm going to give you Menotti" (See Appendix H for music programs). It almost sounded like "I'm going to punish you!" The whole experience was unusual for me. I chose Menotti, but it was not how I normally would think or practice.

**Structural Description.** I often experienced kinesthetic sensations in practicing GIM, but this gut feeling of "I'm going to give you Menotti" was different. I really



thought Menotti was sinister. It has the quality that is nasty, strange, weird, macabre, and<sup>54</sup> seductive and I had rarely used it in my practice. So, I was surprised by the way I chose the music program and I was uncomfortable with my own feeling. As I reflect on myself, I retired in the previous year from the job, which I had worked for 38 years. It felt like a tug instead of frustration for me, but I understood the feeling of "will I stay or will I go." It was hard to hear the same story again and again because there was a little bit of an element of a countertransference. In addition, I remembered my experience of traveling to Menotti as client. I was in some music club and I saw a brightly colored ball that kept going round and round and round. I really wanted to smash it, but I could not reach it. I remember feeling annoyed because I was absolutely stuck with the silly ball. Although I was not aware of it during the session, this feeling was similar to the frustration that I felt with this client. It could have been another countertransference, which led to the gut feeling of "I am going to give you Menotti." I think my frustration motivated me to try something very different than my usual practice, broke my hesitation to use this music that I thought was a sinister, and became the catalyst that opened something up for the client.

#### **Participant 4**

**Textural Description.** The client was about my age, recovering alcoholic, and dealing with severe trauma due to the abuse by their father. They had seen psychiatrists

and counselors but no one had been able to work with them. They needed an experiential<sup>55</sup> form of therapy and someone who would be there with them and not run away. As in usual sessions, I explained the typical process of GIM to the client and that they did not have to strictly follow the process, and they clearly said "Well, I will sit and I will keep my eyes open." They, then, actually did not close their eyes for the entire session. It was very unusual for me and I felt unsettled. It was a new territory for me because I was so used to having clients close their eyes. I also felt anxious because I did not have a therapeutic relationship with the client yet. As I reflect on it now, they were in fact in NOSC with their eyes open as in a deep meditative state; however, I interpreted as they were in an ordinary state of consciousness. So, I was self-conscious. I felt we were in a direct relationship as an individual unlike usual imagery experiences. This made me stay on the conscious plane so that I could always be available for them. I did not expand, had less kinesthetic feeling of the session, and had less intuitive sense as I guided because I knew at any moment they could look right at me. It was very unusual for me.

**Structural Description.** I made the decision by integrating all my experiences, wisdom, knowledge of different therapeutic models, and sense of energy into me as a being and by being present for the client. It was humanistic in that sense. GIM therapists have to be experts and professionals, but it is not our work. In that moment, I was particularly sensitive to the client's energy and what it was telling me. Although I had no

idea what was going to happen, it was OK to not know. I trusted the process and said to<sup>56</sup> myself, "Just do it." This integrative presence, however, takes a toll on the therapist; therefore, self-care is paramount. In working with this client, I had countertransference reaction even before they got to my office because I knew they would be prickly and I felt it would be difficult working with them. I was anxious and felt unprepared so I took time for spiritual preparation before they came. During the session, I had to use breathing and tapping of my chest to be present for them. And after the session, I felt anxious and I had to detox what I had taken on to my body unconsciously. GIM therapists must engage in self-care so that when they encounter an unexpected occurrence, we can handle it.

### **Participant 5**

**Textural Description.** In my GIM experiences as a guide, I make decisions based on my cognitive thinking of what would be just right for this client right now. I often doubt myself and need validation before making any actions. In my first session with this client, who was a GIM trainee, I chose Expanded Awareness as the music program through my cognitive decision making process. I thought they needed a program that was mostly positive and growth oriented (See Appendix for music programs). As the second piece of the program, *Romanza*, was approaching the end during the imagery experience, I felt the energy that the client was holding in their body, saying "I'm going to struggle." By feeling that in my body, I knew the music after this piece did not match what the

client was expressing with their body. I felt I might have overestimated where they were<sup>57</sup> by even choosing Expanded Awareness. Then, all of a sudden, without even trying, a piece of music came to my mind. I was very surprised because it was a deep intuitive knowing rather than a cognitive idea which I had no idea where it came from. I had positive bias toward both programs, but as a person who did not have the classical music training and who did not receive a training specifically to change the music, I rarely did so in the middle of a program. I felt it was too directive as an intervention to change music because it would change the experience of the client. It was more surprising that I did not even doubt myself and just intuitively knew "I need to go to *Dirge*."

**Structural Description.** In this session, I was more comfortable in taking a risk in this situation where we had time and space and where the client was a GIM person. In addition, I felt connected to the client in a deeper place because of what they spoke about and how they presented themselves, and we entered into the NOSC together. In that moment of decision-making, I was all integrated including my foundational training in GIM, my skills as a guide, myself as a kinesthetic traveler, and my teaching as a trainer. I was present as a human being. When I was connected to the client and felt their energy, it all coalesced into one moment of "Do this." Of course, there was a little battle between intuition and cognition, which tried to talk me out of it because I felt it was such a big change. But I gave up on my cognitive thinking and trusted the process. When it all

integrated into myself, it became a knowing that was bigger than the pieces. The client<sup>58</sup> said the session was incredibly profound as they were able to sing the last piece of the program which was their "wake-up" music every morning, which I did not know.

Because of the experiences like this, I think I am more able to trust my intuitive knowing.

### **Participant 6**

**Textural Description.** The client was the most extremely traumatized among all my trauma clients and the way that they lived their life was disoriented, detached, and dissociated. Because of severity of their trauma, none of their past therapists was able to support them. It was a very hard work for me as a therapist and I experienced a wide range of feelings from real sadness to outrage. Because GIM therapists open ourselves to the client's experiences, we sometimes have deep feelings. I felt one method could not address the need of the client, and I took an integrated approach to the client including gestalt, GIM, and improvisation. I wanted to continue the work with them because I liked them and to do so, it was essential to do my own work, receive supervision, and have support. In GIM, their imagery to even gentle music was dark and self-destructive including the memories of all kinds of abuse, and I had somatic reaction as I guided them before I had any conscious awareness. I felt dizziness and kept floating up to the ceiling which was as if my psyche wanted to escape from their imagery and disappear. I felt like being traumatized by engaging in their destructive and painful imagery.

**Structural Description.** The kinesthetic reaction, or countertransference, informed me that I needed to protect myself. I kept both my feet on the ground although GIM therapists are trained to keep one foot on the client's imagery. I also had a stone with sharp points in my pocket so that I could be present for the client and bear witness of their process and that I could have an anchor for my own safety. Music also had an important role in sessions with them. It not only served as a primary therapist for them during the imagery experience, but also helped me unconsciously by giving me all qualities, structure, and form that I needed to hold the space in myself to keep the appropriate distance from the client's experience. Despite these external solutions during the session, the internal influence of the work with this client continued even after sessions. In a particular case, I was ruffled and unsettled all through my body as the residue of the dark and heavy session. Again, my physical reactions notified me of my need to cleanse myself and to be centered again for my daily life. I called up my GIM colleague and we improvised together for three hours. It was loud, dissonant, and long, as if I was doing my own trauma work with a therapist. I made these connections and understood what happened after the session. The informative countertransference was possible because of the cognitive foundation, self-awareness, understanding of the client, and openness to the situation in the moment. All these elements allow GIM therapists to have an encompassing framework to process atypical reactions. When GIM therapists

take risks to deal with unexpected reactions, they can stretch their ability as a GIM guide<sup>60</sup> and potential of GIM as a method.

### **Participant 7**

**Textural Description.** This client was referred to me for a one-time session by a talk therapist. The therapist regarded me as "music healer" and gave an incredible expectation to the client that they would have a transforming experience with me in only one session. I was very angry at the talk therapist for giving such a high expectation for the client and restricting it to one time. I felt the pressure to give a great session which put me in a very cognitive place. In the preliminary conversation, I saw the client's fragility and emotional instability which limited the kind of GIM that I could have with them. They were sobbing and draining their energy as they spoke, thinking they were having such an amazing session. At that point, I wanted to give them a Resource Oriented Music and Imagery experience to give a focus and for them to be centered in themselves. The piece that they chose, however, was the opposite of what I wanted it to be. It was a piece by Miles Davis, which sounded so crazy. It had no form, no consistency, and no structure. It exactly represented the client's state of fragmentation and instability. I felt it was so unhealthy and I would not call it a resource oriented music. Despite my intention, the client was very centered on this piece of music. I felt there was no way that the session would come out in the way I wanted it to and I was very scared. It went from the

feeling of wanting to do a good session to the realization that I needed to do no harm to<sup>61</sup>  
the client. I felt as if everything I had done led to the crazy Miles Davis piece. I was so  
afraid to dive into the rough waves with the client and my fear made me want to take  
them to a safer shore. I wanted to get out of there for myself. There was no solution that I  
could cognitively think of and I felt like I put myself into a corner.

**Structural Description.** I am still not sure exactly what happened in the moment  
of decision-making, but all of sudden, something in me let go of my wish to have a good  
session, my fear, my impulse to get out, my cognitive judgments of the music, and my  
rejection of the part of the client. I turned off my brain and I finally surrendered to where  
"we" were. I felt "Screw this! I'm gonna do it!" I had this feeling of wanting to take a risk,  
bravery to jump into scary waves with the client, and openness of curiosity. The very  
thing that I was scared of was exactly what the client needed to do. When I followed the  
client, the consequence was so far beyond what I could have imagined. The client heard  
creativity in the music that I did not hear by cognitively judging it. By taking a risk, I felt  
like a new dimension of therapy had opened up for me, just like a new dimension of the  
client had emerged for them.



**DISCUSSION**

The main research question of this study was "How do GIM therapists describe their unanticipated reactions to client's experiences in GIM?" and the sub questions were: "What unanticipated reactions do GIM therapists have in response to client's experiences in GIM?" and "How do GIM therapists continue the GIM session after having unanticipated reactions?" To answer these questions, I further analyzed the structural and textural descriptions of all participants presented in the findings and conducted a cross-case analysis (see Appendix G for the sample of analysis). I read through all descriptions multiple times, compared similarities and differences, grouped common phenomena to allow a theme to emerge from the descriptions. Several themes emerged to answer each sub research question. I present these themes with examples of the participants' verbatim during the interview in italics.

**Sub Research Question 1**

The first sub-research question was "What unanticipated reactions do GIM therapists have in response to client's experiences in GIM?" Each participant shared various unanticipated reactions before, during, and after a GIM session. There were some themes in these reactions as well as the process of these reactions. The following Table 5 shows the themes and sub-themes emerged from the cross-case analysis.

Table 5

*Themes Emerged for the Sub Research Question 1*

<b>Themes</b>	<b>Sub-themes</b>
Expectations of the GIM Therapist	
Unmet Expectations	Countertransference Reactions Somatic Reactions Intuitive Reactions Emotional Reactions
Shift of Consciousness	
Before Cognitive Awareness	
Timing of Reactions	
Process of Unanticipated Reaction	

**Expectations of the GIM Therapists**

The first theme amongst the participants was expectations, which had a relationship with unanticipated reactions of the participants. GIM is a fluid process and all experiences of the client during GIM are spontaneous; therefore, the GIM therapist is not supposed to expect any specific experiences from the client. All participants in this study, however, shared their expectations during GIM. Some expectations were created through the GIM training – client lies down during session and client responds to guiding interventions – or the past experience with other clients such as how to work with a certain population. Yet unexpected events for the therapist do occur. For example, Participant 1 had the client who stood up in the middle of the Imagery experience, which was uncommon for GIM and was unexpected for Participant 1. Similarly, Participant 4

had the client who kept their eyes open for the entire imagery experience. Also, Participant 6 had an unanticipated reaction because their client was more severely traumatized than their past clients with trauma. All three cases could be interpreted as that the client or their behavior was beyond the participants' expectation developed through their GIM trainings, previous clinical experiences, and their work with other clients. The following example was one of the significant statements shared by Participant 1.

Example 1-1

The traveler was in motion to do something I've been trained not to let happen. Maybe not very specifically mentioned – “Don't let the traveler stand up.” But the kind of unspoken message in all the discussion of keeping clients safe while they travel in non-ordinary state [of consciousness] [P1B6]<sup>3</sup>

On the other hand, Participant 2 expected that the client would have a similar experience to their previous sessions, which was to fight with their father. Similarly, Participant 3 wanted to hear that the client had successfully resigned from their work. For these two participants, the expectations were developed through their previous work and the relationship with the client. Participant 2 stated their experience as follows:

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<sup>3</sup> I included the combination of letters and numbers after quotes for my own clarification. It shows the placement of the statement in the original transcript.

## Example 1-2

I don't remember all [their] sessions ever being in a place specifically like this or never in the moment in which it was peaceful and [they were] sitting by [their father's] side, never a moment like that before. Many, many interactions about [their] father and with [their] father but not an experience. To that point of time they had been in moments in which [they] confronted him or got angry with him [P2B19]

For the other two participants, expectations were for the process of the clients which could be interpreted as the therapist's intentions reflected on the client's process.

Participant 5 chose the music program based on their expectation of the process for the client to be mainly positive and growth focused. This might be based on the assessment of the client; however, choosing a program could have the potential to reflect some expectations of the GIM therapist. Participant 7 also expected the client would find a piece of music that would help them be centered in themselves. These two cases seemed to show some directionality toward which the participants wanted the client to move.

## Example 1-3

I remember choosing it precisely because I thought the Tallis [a piece in the music program "Expanded Awareness"] will help [them] reflect a little and get some sense of where [they have] been, and do all this sort of dialogue... I have a cognitive thought process... [they] needed a big container, that [they] needed music that was mostly positive like something that was growth oriented [P5B15]

This discussion on expectations of the participants suggests that it is more natural to think that GIM therapists do develop expectations for the client or for the process of the client based on their GIM trainings, clinical experiences with other clients, and the past clinical work with the client. When the client's behavior did not meet the

expectations of the therapist, the therapist seemed to experience unanticipated reactions.<sup>66</sup>

Sometimes GIM therapists have an expectation as an intention for the client's experiences.

Those expectations may have been reflected in choice of music, interventions, or the adaptations of GIM to be used. The database search on a related journal article could not identify any studies on the expectations of the therapist for the client unlike expectations of the client for the therapist and the therapeutic process. This may be an area that needs to be explored further.

### **Unmet Expectations**

When the client's experiences did not match expectations, the participants had various reactions: Countertransference, somatic, intuitive, and emotional reactions.

**Countertransference reactions.** More than a half of the participants of this study recognized their countertransference reactions during a GIM session. This indicates that GIM therapists are generally aware of their countertransference; however, the reactions of countertransference were different among those participants. For example, Participant 2 had a countertransference reaction because of their past experiences with their father. Participant 2 wanted the client to keep fighting with the client's father so that they could have the fight that they wanted to have with their own father. Because of this expectation, Participant 2 had an unexpected, yet strong response when the client was about to forgive

their father. This reaction directly connected to the action of Participant 2, which was to<sup>67</sup> say "How long are you going to sit here?" Participant 2 shared the following example.

Example 1-4

Intuitive part of myself was saying "Holy Crap! You are about to forgive your father for all the shit that he just did and we are not going there" [P2B22]... I was not managing my countertransference well at all. [P2B7]

Similarly, Participant 4 had negative somatic countertransference that was an unsettled response to the client, but unlike Participant 2, this negative countertransference notified them of the needs in the moment. Participant 4 was aware of the countertransference and processed it soon enough not to reflect in the client's process in GIM.

Studies have described that therapists experience an emotional, cognitive, and behavioral countertransference during and after a psychotherapy session (Bimont & Werbart, 2018; Daly & Mallinckrodt, 2009; Haynes, Nelson, & Fauth, 2015). GIM therapists seemed to experience countertransference reactions like therapists of other forms of psychotherapy. Bruscia (1998) wrote that a therapist can make an intervention that causes a sudden change in the direction of the session without any good explanation for the action due to unaware countertransference. The countertransference reactions could be completely unexpected and inexplicable for GIM therapists in the moment, which has potential to entirely change the therapeutic process for the client. In this study, most therapists shared that they used countertransference as a source of information. The

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difference in the outcome of their unanticipated countertransference reactions might have been the awareness of their own internal process in the moment.

**Somatic Reactions.** The participants of this study also experienced somatic reactions. Although some participants recognized their somatic reaction as countertransference, I created a separate sub-theme to clarify the differences in how they sensed the reaction. For example, Participant 6 had the kinesthetic response to the client and explained it as the following example.

Example 1-5

When we were talking about our somatic or kinesthetic responses to clients, that comes from our unconscious... we're picking up something, but it's not something that we necessarily put words to or have conscious awareness of, but our bodies have picked it up... It's not in our conscious awareness [P6B33]

The somatic reaction of Participant 6 was emergent and informative signaling the need to protect themselves from getting traumatized by the client's horrible imagery experience.

Similarly, Participant 3 experienced an immediate reaction of frustration, a negative countertransference, followed by the secondary somatic reaction. It was the gut feeling of "I am going to give you Menotti!" This was unconsciously connected to their past GIM experience as client and it motivated them to try something different and challenge the client with the piece of music. This somatic reaction worked positively in this case.

## Example 1-6

There is maybe a connection! Because [their] argument was going round and round and round... and I know I wish I could really smash this argument that they kept on bringing session after session after session... so, there could be a connection [P3B16]... I was not aware of it consciously but maybe that's what I felt in my body... I think it was my countertransference that I felt in my body [P3B17]

The participant said this somatic reaction almost felt like "I am going to punish you." It was not how they generally practiced GIM and they felt uncomfortable about that reaction.

## Example 1-7

I felt that in my body "I'm going to give you Menotti," a piece of music that is really tricky to see if that would break through [P3B14]. It's almost like "I'm going to punish you!" [P3B10] It's not normally the way I would think, or it's not normally the way I practice [P3B11]

Participant 1 also had the gut feeling of "maybe we could" after shifting from irrational mind to rational mind to see if it was safe environment for the client to stand up. This reaction was important for Participant 1 in supporting their decision-making. Somatic reactions of both Participant 3 and 1 seemed intuitive, and to have a connection with somatic knowing.

GIM therapists seem to experience somatic reactions frequently as research studies in other therapeutic modalities described (Holmqvist & Andersen, 2003; Palmer, 2015; Shevade, Norris, & Swann, 2011; Smith, Kleijin, & Hutschemaekers, 2007; Vulcan, 2009). Somatic reactions in these studies included stomach problems, tensed body, headache, beating in the chest, and feeling sick, heavy, lack of energy, and blurry.



Somatic reactions of GIM therapists seemed to be more instantaneous like an emergency<sup>70</sup> response and intuitive like a somatic knowing. The somatic reactions of GIM therapists can be a helpful resource in making decisions on an intervention and furthermore, validate the therapist in the decision-making process.

**Intuitive Reactions.** Similar to somatic reactions, one participant had an intuitive reaction. Participant 5 experienced a deep intuitive knowing when the client was moving toward different direction than they expected. It was a clear sense to change the music for the client as explained as follows.

Example 1-8

It wasn't an idea, it was a knowing. I think that's how we describe the difference, it wasn't an idea, it was knowing that just was there [P5B3].  
And it was really this, just intuitive knowing "go to this piece of music" [P5B4].

Unlike their usual practice, which relied on cognitive processing, Participant 5 followed this intuitive knowing through the decision-making process. This intuitive reaction was not yet described in any research studies found through the database search. This may be a specific reaction of GIM therapists. Bruscia (1998) described intuitive experience as one of the ways to experience the client's world, therapist's world as a therapist, and therapist's world as a person in the GIM process. The intuitive experience is beyond somatic, emotional, and cognitive experiences and that these intuitive experiences are not logically based on the outer resources. As this intuitive reaction seems to be one of the phenomena in GIM, it may need further exploration.

**Emotional Reactions.** Another reaction as a result of unmet expectations was emotional, which included frustration, feeling unsettled, flinching, and feeling scared. Participant 3 felt frustrated because the client repeated the same argument over and over again in the pre-session. Their expectation was to hear that the client resigned their job, but it did not happen. This expectation of the participant caused this emotional reaction of frustration. Participant 4 felt unsettled because they were self-conscious about being in the direct relationship with the client during the imagery experience. The participant came to an understanding later that the client was actually in the non-ordinary state of consciousness (NOSC) with their eyes open, but in the moment, unsettled was their immediate reaction. They shared as follows:

Example 1-9

[They] actually wouldn't even close [their] eyes and that was unsettling for me [P4B2]. I was self-conscious, [they] might look at me or [they] might see what I'm doing, which is with the music or writing down. [P4B3]

Participant 1 felt flinching to stop the client because they felt the client should not stand up during the imagery experience. Because of the learning from their training and their typical sessions, their first reaction was "no, you can't." This, then, caused Participant 1 to move out of irrational mind to physically check the environment for the client's safety. Similarly, Participant 7 felt scared and fearful because they thought the session would not turn out as good as they wished. Because of the pressure to provide a good session for the client, the therapist stayed in conscious mind but there was no cognitive solution for the

situation. Because of their emotional reaction, they wanted to save the client from the dark ocean to a safe shore. In addition, Participant 5 felt that they might have overestimated the client's process and chosen a wrong music program. Participant 5 did not use a specific emotional word, but I interpreted this as having some emotional reaction by analyzing their interview data.

Many research studies have described a wide range of emotional reactions of therapists including disappointment, helplessness, anxiety, shock, frustration, anger, and sadness (Knight, 1997; Quiroga, 2015; Smith, Kleijin, & Hutschemaekers, 2007). GIM therapists also experience various emotional reactions. Unlike countertransference, somatic, and intuitive reactions, emotional reactions of the participants did not seem to be directly related to the decision making of an intervention, but they brought some attention to the participants so that the participants could take a further step to come to an understanding of these reactions in order to continue the session.

**Summary.** These four reactions caused by unmet expectations emerged through the cross-case analysis. In addition to the expectations of GIM therapists, it is reasonable to think that GIM therapists experience unanticipated reactions due to unmet expectations during GIM. Most of these reactions, except the intuitive reaction, were shared with other therapeutic modalities described in the literature review. It is interesting to note the simultaneous occurrence of multiple reactions especially in working with clients with a

history of trauma. The research studies described strong emotional and somatic reactions<sup>73</sup> of the therapist in response to the work with traumatized clients (Knight, 1997; Holmqvist & Andersen, 2003; Smith, Kleijin, & Hutschemaekers, 2007). Similarly, in this current study, Participants 4 and 6 experienced both emotional and somatic reactions together in working with severely traumatized clients. Because it is one of the major populations with whom GIM therapists work, it is important to be aware that multiple reactions could occur simultaneously.

Bruscia (1998) described four levels of experiencing three worlds in GIM: the client's world, the therapist's world as a person, and the therapist's world as a therapist. The levels were somatic, emotional, cognitive, and intuitive. Bruscia states that in the cognitive level of experience, the therapist makes sense and finds the meaning of the somatic and emotional experiences, and the intuitive level of experience is the deep knowing without any external source of information. This might be common with the findings of unanticipated reactions in the current study. Some of the reactions of the participants were directly related to the choice of intervention and others needed more cognitive processing before making decisions on an intervention.

### **Shift of Consciousness**

One theme shared by the participants was the shift of consciousness. For example, Participant 7 reported staying in the conscious mind because of the pressure to do a good

session put onto them and this continued during the session because they were scared of<sup>74</sup> failing. The participant, then, felt fearful that they might fail to abide the fundamental ethics of doing no harm to the client, which made them want to take the client to a safe place. But there was no cognitive solution that the participant could think of and they felt trapped in the corner. Similarly, Participant 4 felt unsettled which made them stay in the conscious mind. Unlike their usual sessions, they did not expand, had less kinesthetic feeling, and had less intuitive sense as they shared in the following example.

Example 1-10

I do believe it influenced the way I did guide them. I think I was more 'conscious' during this guiding. I did less feeling of the session with my body, less intuitive sense as I guided. I knew at any moment he could look right at me. [P4B4]

These participants stayed in the conscious state and cognitively sought for an answer unlike their usual sessions, which was unusual and caused unanticipated reactions.

Additionally, Participant 5 also stayed in consciousness until they unexpectedly had an intuitive knowing to change the music. Although the participant stated that they usually had a good cognitive reason to make an intervention that could cause a big turn in the session, they were surprised by the knowing that came from a different conscious state.

On the other hand, Participant 1 experienced a sudden shift in consciousness. They shifted out of the irrational mind to the conscious mind when the client unexpectedly stood up. The shift in consciousness was necessary to check the environment for the safety of the client.

Because NOSC is one of the distinctive components of GIM, consciousness emerged as a theme among the participants. Bruscia (1998) describes that the GIM therapist shifts consciousness throughout a GIM session with the client. During a GIM session, the GIM therapist constantly moves between an ordinary state and a non-ordinary state of consciousness. But when something, whether it be an internal or external factor, stops GIM therapists from naturally shifting their consciousness, they experience unanticipated reaction; and when something requires GIM therapists to shift consciousness more quickly than usual, they also experience unanticipated reactions.

### **Before Cognitive Awareness**

Another commonality among all participants was that they had reactions before they were cognitively aware of them, whether countertransference, somatic, intuitive, or emotional reactions. Even when they stayed in conscious mind, they were not aware of it in that moment. Participant 5 experienced an intuitive reaction and explained as "[it happened] without even trying and they had done it before when it was really cognitive [P5B5]." Participants, therefore, sometimes made connections to come to an understanding of their reactions after the session.

The immediacy of these reactions had potential to work negatively in a GIM session. For example, Participant 2 had a countertransference reaction which led directly to the demanding question of "How long are you gonna sit here?" Awareness came right

after they said it and they instantly knew that it was wrong. Participant 2 shared the following example.

Example 1-11

This moment was different in that I didn't have the sense of knowing before the intervention came out of my mouth. The intervention, it felt like the intervention literally flew out of my mouth without any conscious awareness [P2B12]

On the other hand, because of the immediacy of these reactions, GIM therapists can quickly learn what is needed in the moment. For Participant 6, the need was to protect themselves from getting traumatized by the client's imagery. Because of the somatic reaction of floating up to the ceiling, the participant did not experience as much damage from the client's destructive imagery as they could have. Because of the reaction, they were able to continue working with the client.

Unanticipated reactions can occur to GIM therapists before any cognitive awareness of them. Sometimes this immediacy saves the therapist from experiencing a negative effect from the client, but at other times the therapist can make an intervention without any conscious awareness, which has potential to turn out both positively and negatively. Because GIM therapists can have unanticipated reactions before any cognitive awareness, it is important for them to engage in self-reflection.

### **Timing of Reactions**

The timing when the participants had unanticipated reactions was a common theme. The participant had unanticipated reactions at any point of a GIM session. For

Participant 3 and 7, it was in the preliminary conversation; for Participant 1, 2, 4, 5, and 6,<sup>77</sup> it was during the imagery experience; and Participant 4 and 6 also had reactions after the session. Although unanticipated reactions could happen at any point of a session, more participants experienced during the client's imagery experience, possibly because of the spontaneity of the process with the music.

Similarly, the participants had unanticipated reactions at any point of the GIM series of sessions with the client. While Participant 1, 2, and 3 had worked with the client over ten sessions when they experienced unanticipated reactions, Participant 4, 5, 6 and 7 had the session with the client for the first time or had only a few sessions with them. Because Participant 2 and 3 had a long relationship with the client, they had a countertransference reaction to the client. On the other hand, Participant 4, 5, and 7 had not developed a therapeutic relationship with the client, so they tended to stay in the cognitive mind while providing the session. It is difficult to predict at what point of the therapeutic process with the client these unanticipated reactions are likely to occur.

It was more likely that GIM therapists have unanticipated reactions during the imagery experience with music, but unanticipated reaction may occur at any point of the GIM session or the GIM series of sessions with the client. This implies that it may be important to be aware of unanticipated reactions especially during the imagery



experiences, yet it is still challenging to prepare GIM therapists for unanticipated reactions based on the timing in a GIM series.

### **Process of Unanticipated Reactions**

Through the cross-case analysis of unanticipated reactions of the participants, it is concluded that GIM therapists experience some reactions in response to the client's experiences that was unexpected for them. In the process of the reaction, firstly, the participants all had an immediate reaction, which directly led to an intervention or after which they needed further processing to make an intervention. For example, Participant 2 had a countertransference reaction when the client was about to make peace with their father in their imagery. This reaction led directly to the intervention of "How long are you gonna sit here?" In this case, the therapist came to know that the verbal intervention was a mistake as soon as they said it. On the other hand, Participant 6 experienced a kinesthetic reaction of dissociation, which was floating up to the ceiling when they were guiding the traumatic imagery experience of the client. This reaction notified them of the need to protect themselves from getting traumatized by the client's traumatic memory.

Several participants experienced secondary reactions after the immediate reaction. For example, Participant 3 had the first reaction of frustration, followed by the secondary reaction of gut feeling that informed them of the music program to be used in the session. Similarly, Participant 1 had an immediate emotional reaction of wanting to stop the client

from standing up. But this caused the participant to shift their consciousness to check the <sup>79</sup> environment to see if it was possible. Participant 1, then, had another gut feeling reaction that said "maybe we could." The reaction supported them to say "Let's give it a whirl."

GIM therapists may experience a single unanticipated reaction or multiple unanticipated reactions when they encounter occurrences out of their expectations. When they had the first reaction they either make an intervention immediately, which could turn out either positively or negatively, or experience another reaction before making any interventions. Some GIM therapists could experience reactions one after another before making an intervention. One research study presented the process of the therapist in the moment of their temporary disconnection from the client (Gross & Elliott, 2017). Various reasons such as overwhelming experiences of the client, over-identification with the client, frustration, and feeling too much responsibility led to the therapist's action of being detached from the client for a moment. Following the actions of detachment, therapists experienced an immediate reaction of anxiety and panic, which was followed by the secondary reaction of regret and feeling guilty after a while. Gross and Elliott (2017) stated that self-awareness, self-inquiry, peer group, and supervision were very important in preventing the detachment of therapists from clients. It is also critical for GIM therapists to recognize, understand, and work on the process of unanticipated reactions.

## Sub Research Question 2

The second sub-research question was "How do GIM therapists continue the GIM session after having unanticipated reactions?" In the process of decision making after experiencing various unanticipated reactions, there were several themes that emerged through analyzing the textural and structural descriptions of all participants. I will discuss each theme to answer the research question above. Table 6 shows the theme and sub-themes emerged from the cross-case analysis.

*Table 6*  
*Themes Emerged for the Sub Research Question 2*

<b>Themes</b>	<b>Sub-themes</b>
Self-Mediation	
Cognitive Foundation	
Self-Awareness	
Therapist's Past Experiences	
Trust	Client Therapist Process
Surrender	
Being Present for the Client	
Integration	
Self-Care	
Taking a Risk	
Addressing Unanticipated Reactions in GIM	

### **Self-Mediation**

In the moment of unanticipated reactions, several participants suggested the importance of the process called "self-mediation." Participant 2 mentioned a "mediation" in the interview, but there was a need to add "self" to make the meaning clearer after

interviewing other participants. A self-mediation is a rather cognitive process of collecting information in order for the GIM therapist to make a decision. It allows GIM therapists to stop for a moment, understand what was happening in the moment, and see all of their responses to the client's experiences. Although Participant 2 did not have this self-mediation when they had the unanticipated countertransference reaction, they shared that the self-mediation would have allowed them to feel what the client was experiencing, think what the music was doing, and check how they were experiencing including countertransference. They continued that the therapist should take all information into consideration and only then, make a decision of what would be most helpful for the client in the moment.

#### Example 2-1

That screen is really important. That screen that says "how long are you gonna sit here! God! If that was my father, I would be so angry and I would be feeling this and I would be wanting to do this and I would be telling him to fuck off and I would do this!" And then "Oh yeah, that was my experience. Where [are they]? This is a precious moment for [them] and it is hard earned. 20 or 30 sessions it took [them] to get to this moment." [P2B16] [Then the] decision is made by taking all the information into account and using it to gauge what will help the client be as present to that moment as they can be [P2B15]

For Participant 1, this process was emerging out of the irrational mind into conscious awareness of the environment. Sudden awakening was one of the unanticipated reactions that they experienced, but by doing so, they were able to receive necessary information about the environment to keep the client safe. For Participant 5, it was a

small battle between intuition and cognition, in which their cognitive mind challenged them if their intuitive knowing was accurate. 82

Furthermore, because GIM therapists could have unanticipated reaction immediately after an unusual occurrence with the client, sometimes they are required to make a decision in that immediate moment. Participant 1 shared that they went from an irrational to rational mind in a nanosecond of decision-making. Especially those unanticipated reactions seem to happen before cognitive awareness, this self-mediation becomes essential for GIM therapists in decision-making. As mentioned earlier, Bruscia (1998) described the cognitive level of experiences in the process of GIM, in which therapists are required to step out of the experience to observe, think, and search for the meaning of what is happening in the moment to gain insight. This process sounds similar to the self-mediation discussed here. In decision-making, GIM therapists go through self-mediation to cognitively understand and gain information from their unanticipated reactions.

### **Cognitive Foundation**

One of the themes in decision-making of GIM therapists was the importance of having the cognitive foundation in dealing with unanticipated reactions. As discussed earlier, the GIM training can create expectations for GIM therapists, such as the client closes their eyes for the imagery experience or the client does not stand up in the middle

of the imagery experience. But without the solid foundation gained through the GIM trainings and other learning opportunities, GIM therapists cannot make any well-reasoned decisions in the process. Participant 6 said, "All the cognitive learning is really important... it's one of the foundational pieces. By knowing, you have the variety of interventions to be able to choose from [P6B36]." But it seemed that the decision could not have been made only by this cognitive foundation when the participants had unanticipated reactions. Participant 5 said, "You have to keep learning and keep learning and keep getting it in your bones and yes, you have to have foundation of knowledge and foundation of skills [P5B18]." GIM therapists need to build their GIM practice on the basic cognitive foundation through learning, practicing, and experiencing, so that they are better able to deal with their unanticipated reactions.

### **Self-Awareness**

As it is stressed in studies in psychotherapy, this study depicted how crucial it was for GIM therapists to have self-awareness gained through supervisions and personal sessions to enhance good decision-making during GIM. The client in GIM could have a deep and profound experience because of the three major components – NOSC, music, and spontaneous imagery – GIM therapists could become entangled in their experience whether they had a long therapeutic relationship or not. It is normal for GIM therapists to have feelings for the client; therefore, they could unexpectedly have reactions including

countertransference. Countertransference, however, can be a good source of information<sup>84</sup> for GIM therapists when they are aware of it. For example, Participant 4 was anxious even before the client got to the office because of their countertransference reactions, so they took time to prepare themselves before the session more than they usually did. Their countertransference reaction, therefore, was informative of the need.

Similarly, Participant 6 had a countertransference reaction in a form of somatic sensations during and after the session. Athanasiadou and Halewood (2011) pointed out that somatic countertransference was often underestimated and therapists went through the process from denial, cognitive reflection, to owning and working with it. They also suggested that somatic countertransference could affect the therapeutic alliance if therapists were not aware of them. Participant 6 in this study was aware of the somatic countertransference and was able to process it so their somatic reaction informed them of the need to stay grounded with both feet on the ground, have an anchor for their own safety, and detox their body afterwards to go back to their life. Participant 6 stated as follows:

### Example 2-2

[Their] history, [their] vulnerability, the nature of [their] imagery, [their] difficulty with expressing [their] emotions, [their] body language, and difficulty with eye contact, and my reactions to [their] very troubled imagery, the physical feeling of floating away. All these contributed to my knowing that I needed to ground myself more than usual, thereby protecting myself from unknowingly taking on [their] trauma and negativity... reducing the countertransference. [P6B26]

On the other hand, Participant 2 recognized that they did not have the self-mediation discussed above; therefore, they were not able to manage their countertransference. As a result, they unintentionally asked a demanding question to the client which came out of nowhere. Without processing, countertransference could work negatively for the therapist and for the client. Participant 2 said the following:

### Example 2-3

If we all don't do our own therapy, if I can't sit and be present to myself, then I get in the way, then the moments like this happen and I get in the way of clients being present to themselves. [P2B17]

It is GIM therapists' ethical responsibility to receive supervision and personal sessions to practice GIM required by the Association for Music and Imagery (AMI). Many research studies of therapists' reactions emphasized the importance of raising self-awareness and increasing one's capacity to recognize the reactions through supervisions, support groups, and personal therapy (e.g. Athanasiadou & Halewood, 2011; Comeau, 2004; Gross & Elliot, 2017; Quiroga, 2015; Shevade, Norris, & Swann, 2011; Smith, Kleijin, & Hutschemaekers, 2007). Bruscia (1998) also pointed out the importance of being aware of the therapist's countertransference and listed several



methods to assist in the awareness of the countertransference such as self-inquiry, supervision, and personal sessions while working with clients. Countertransference, both positive and negative, has the potential to provide a fruitful source of information of how to continue the session. Whether to make it a resource or not depends on the GIM therapist's awareness and good judgement on it through self-mediation. It is, therefore, essential for GIM therapists to make continuous efforts in increasing self-awareness. There are many ways to decrease the negative effect of countertransference. It is the therapist's responsibility to be aware of their own internal process in ethically practicing GIM.

### **Therapists' Past Experiences**

The past personal experiences of GIM therapists can be another source of information in decision making after unanticipated reactions. In one example, Participant 1 and 3 understood the need for the client's experience because of their own past experiences. Participant 1 had not been allowed to stand up during the imagery experience as client, and even though they were not aware of it in the moment of decision making, they felt an understanding of the need "in the cells of [their] body." This might have led to the gut feeling of "maybe we could." For Participant 3, it was the understanding of being indecisive about resigning the job. In this case, however, it led to the countertransference reaction of frustration that they felt with the client. In both cases,

the past experiences caused some reactions in the therapist, which helped them make decisions in the moment.

Example 2-4

I mostly had a body feeling of understanding as I initially thought "no" and then thought "we could do this." I don't recall my previous travel actually being in my consciousness in those split seconds of decision making. But I do know I felt an understanding of the need in the cells of my body. [P1B17]

In the other example, Participant 3 and 5 reflected on their past experiences of choosing the music. Participant 3 had a negative experience with the music program as a client and thought one of the pieces in the music program was sinister. Although they barely used the program in their practice, their frustration with the client resonated with the frustration that they felt in that past session with the particular piece of music, and therefore stimulated them to use the piece for the client. Participant 3 shared the following example.

Example 2-5

I think you can draw on your own experience of programs in terms of making choices, you know, for your clients. I think this case, obviously, I was not aware of it... I was not aware of it consciously but maybe that's what I felt in my body [P3B17]

On the other hand, Participant 5 said they had a positive bias toward the music programs through their past experiences as a traveler and as a guide. They said this bias might be related to the intuitive knowing that was helpful in decision making. Both participants said they were not aware of their past experiences in the moment of decision-making, but suggested the possibility that their gut feeling was caused by their

past experiences with the music. In both cases, their past experience helped them make the decision, which in turn, helped the client with their process. <sup>88</sup>

Interestingly, awareness of past experiences did not influence the process for the client or the outcome of the therapy unlike countertransference reactions in this study. The participants said they were not aware of their past experiences in the moment of decision making, but they suggested that their past experiences could have led to their unanticipated reactions, especially somatic ones. Although the lack of the research in this area was evident through the database search, one research study suggested the clinical experience of the therapist in the past was helpful in the first session with the client (Nakash & Alegía, 2012). The study, however, did not mention the personal experience of the therapist in the past was helpful in the therapeutic process. This theme suggests that the therapist's personal experience in the past can be a beneficial resource of information in decision-making. This may be considered unique in GIM as GIM trainees are required to receive many personal sessions to become a qualified GIM therapist. This may also indicate the importance of continuing personal work in GIM after becoming a qualified GIM therapist to increase resources for decision-making.

### **Trust**

Another theme in decision making of GIM therapists was their trust in the client, themselves as therapist, and the process. First, it was important for participants to trust

the client. For example, Participant 1 had a good understanding of the client through their<sup>89</sup> work with the client for a long time. They knew who they were, how the client traveled in the past sessions, and what they were working on. When their client stood up in the middle of the imagery experience, the participant first thought they could not. But by having a good understanding of the client and their process, Participant 1 trusted the client that they could do it.

Example 2-6

And then I thought well you know maybe [they] could. Like [they] know what [they are] doing, [they are] very much in [their] body... and [they have] also travelled a lot, so I just thought, "Yeah maybe [they] could"[P1B7]

Even when the participants did not have a long relationship with the client, they had a sense of trust in client. For Participant 5, it was the first session with the client, but they felt more connection to the client than other clients at their first session. This connection also had led to their unanticipated reaction of a gut feeling to switch the music program. Similarly, in their first session with the client, Participant 7 trusted the client's intuition and made the decision to follow the client with their choice of music. GIM therapists' trust in the client, therefore, is an important element in decision-making.

It is widely known in psychotherapy that trusting alliance between the client and the therapist contributes to a positive therapy outcome regardless of therapeutic modality and outcome measurements (e.g. Ardito & Rabellino, 2011; Horvath, Del Re, Flückiger, & Symonds, 2011; Kim, Wampold, & Bolt, 2006; Reandean & Wampold, 1991;

Wampold & Brown, 2005). This is possibly common in GIM, but trusting the client seemed more than just building a therapeutic relationship. Clients in GIM are the individuals who have the willingness and capacity to explore and work on their inner process and achieve self-growth through the process (Summer, 1988; Ventre, 2002). In the interview with participants, it sounded like GIM therapists knew that it was the client's process and they could achieve what they needed through GIM. Using cognitive judgement on the client, this trust in client might provide essential support in decision-making of an intervention.

Secondly, the participants trusted themselves as therapists based on their training and clinical and personal experiences that they could handle the unexpected situation. More than a half of the participants emphasized the importance of cognitive foundations gained through the GIM training. Participant 4 clearly said that therapist must be experts and professionals. By gaining knowledge of other therapeutic modalities, personal wisdom, experiences as client, skills as therapist developed through practice contributed to them trusting in themselves. By trusting themselves as therapist, Participant 1 was able to say "maybe *we* could."

I trusted that I was an experienced enough clinician, both therapy clinician as well as GIM guide... I was an experienced enough clinician that I could interrupt it if I need to. That I would know how to do that. [P1B19]

One research study in psychotherapy depicted that what influenced the decision-making of experienced therapists in earlier work with the client was their expertise and experience (Oddili & Halvorsen, 2012). Knowing that they could handle the situation no matter what the client experienced contributed positively in the decision-making.

Thirdly, the majority of the participants mentioned that they trusted the process. Grof stated that the therapist did not need to have special techniques in the work of NOSC, but rather needed to unconditionally "accept and trust the spontaneous unfolding of the process" (Grof & Benett, 1993, p. 210) even when they did not clearly understand what was going on with the client. This became the basic concept of "trusting the process" for GIM therapists. Likewise, what it meant by trusting the process in this study sounded close to being fine with not knowing what might happen in the session. All participants except for Participant 2 shared that they did not know what was going to happen but they made an intervention anyway. They simply trusted the process.

Participant 4 said the following regarding trusting the process.

I just rely on "trust the process," but I also truly believe that each client has their own answers inside them. Again, I have to have expertise and professionalism. They have to come to the answers [P4B12]

Although it was a small theme, trusting the process was found to be important in decision-making by evidence-based psychotherapists working with clients diagnosed with post-traumatic stress disorder (Cook, Simiola, McCarthy, Ellis, & Stirman, 2018). It seems important that trusting the process is accompanied with the trust in the client and the trust in the therapist themselves. When GIM therapists are able to trust the process, they can make the needed decisions in the therapeutic process.

### **Surrender**

Another theme that emerged from participants' experiences in decision-making after unanticipated reactions was "surrender." Three participants shared that they were in a cognitive place before making the decision. Participant 4 was staying cognitive unlike their usual sessions when working with the client; Participant 5 was cognitive in choosing music for the client in the pre-session; and Participant 7 sought a cognitive solution until they put themselves into the corner. Each of these participants had difficulty in the session because they cognitively thought about what they should do. At one point in the session, however, they gave up on their cognitive thinking. Participant 4 shifted consciousness and became more sensitive to the energy of the client and what it was telling them, and Participant 7 let go of all cognitive activities including pressure,

judgement, and fear to follow the client's intuition with the music. Participant 5 still had a<sup>93</sup> battle between cognitive mind and intuitive mind when they experienced the sudden intuitive knowing. They were unfamiliar with the intervention to change the music in the middle of the imagery experience and tried to talk themselves out of that intuitive decision. But eventually they gave up on cognitive answers and decided to follow the intuition. When GIM therapists let go of cognitive thinking and surrender to where they are with the client, they are able to follow the needs of the client. Participant 7 described the process of surrender as follows:

Example 2-14

I think I finally stopped judging the objectively fragmented sounds of the piece, and stopped feeling like I had to reject that part of [them] and “take [them] somewhere safe.” Instead I accepted it as a healthy impulse to connect to [themselves]... [I said,] "I'm gonna turn off my brain and just let it happen." [P7B18]

Ghent (1990) described the aspects of surrender that it is a phenomenon of "being 'in the moment,' totally in the present, where past and future, the two tenses that require 'mind' in the sense of secondary processes, have receded from consciousness" (p.111). When an individual surrenders, there is no dominance, and "its ultimate direction is the discovery of one's identity, one's sense of self, one's sense of wholeness, even one's sense of unity with other living beings" (p.111). When GIM therapists let go of their cognitive thinking and surrender, they are finally able to be with the client.



## **Being Present for the Client**

After surrendering, GIM therapists are present for the client. Participant 5 said they were present for the client as a human being, and when they connected to the energy of the client, everything coalesced into one moment of intuitive knowing. For some participants, however, they had to make the maximum effort to be present and bear witness for the client. Participant 4 was present for the client despite the feeling of being unsettled, but it was not easy for them. They used breathing and tapping on the chest to remind them to be present and not to dissociate. Similarly, all Participant 6 could do during the client's imagery experience was to be present and bear witness in working with the severely traumatized client. To do so, they had to stay grounded with both feet on the ground, hold pointy stones as an anchor, and use the music for themselves. They stated "Our task is to open ourselves to the therapeutic situation, in the present moment, where we are in attendance for the client...many term this as being the sacred witness [P6B35]."

Both Participant 4 and 6 had the clients who were extremely traumatized. The therapist had to engage themselves in grounding to be present and bear witness; however, their genuine presence was all the client needed from the therapist. Because the GIM therapist is fully present for the client and bears witness, the client's spontaneous experience emerges.

Muller (2008) explored what it meant to be present to the client in music therapy and suggested that when the therapist was being present to the client, they experienced blurred boundaries with the client, understood the client closely, and related to the client in various ways. For the participants in this study, however, the difficulty was the blurred boundary, which required them to be grounded more than usual. Bruscia (2014) described what's meant to "be there" for the client as one way to help them in music therapy as follows:

To be there is to be available to another person to the extent possible and appropriate – to open oneself up to the other person's experience, to understand the person's circumstances, to bear witness to the person's dilemma, to accompany the other person on [their] journey, to offer whatever assistance and support is appropriate, to provide guidance if necessary, and to care about the other person, the journey, and the outcome (p. 76)

This definition can be applied to the current theme of being present for the client in GIM.

In GIM, the presence of the therapist is very helpful for the client especially at the significant moment in the process (Grocke, 1999). To be present for the client not only helps the therapist in making decisions, but also helps the client with their process of therapy.

### **Integration**

Several participants shared that they were all integrated in the moment when they are present for the client. This integration was described differently by the participants. Participant 1 took in all the information, both rational and irrational, and integrated into

themselves so that they could make the decision. Participant 2 wished that they had felt<sup>96</sup> the client, thought of the music, checked themselves, and then had taken all the information into account and gauged what would be helpful for the client in the moment. For Participant 4, it was the integration of all their experiences, wisdom, knowledge, and the energy that they felt in the session into themselves as a being, which led to the decision to be present for the client. Participant 6 said they made the decision based on the informative countertransference, which was possible through integrating cognitive foundation, self-awareness, understanding of the client, and openness to the situation in the moment. Finally, Participant 5 integrated their foundational training in GIM as a trainee, skills gained as a GIM therapist, somatic sensations as a GIM client, and all teaching as a GIM trainer.

#### Example 2-9

Because I'm accessing myself as a traveler kinesthetically. That decision happened, I'm accessing myself as a guide in other sessions, and I'm accessing myself as a trainer, and thinking about how I've talked about it, and how I teach about it... It's all there. It coalesces, it just coalesces into one moment of, "Do this." That's the magic of GIM to me. [P5B18]

GIM therapists integrated all aspects of themselves, including their cognitive foundations, past experiences as a traveler, guide, and trainer, and all information gained in the moment about the client and themselves to make a decision. Bonny (2002f) stated that GIM therapists bring expertise and their personal qualities to support the client's process in GIM. Similarly, Grocke (2005) stated that GIM therapists use themselves in

the process which is founded by their received trainings, personal being, spirituality, therapeutic orientations, and understanding of the music. Participant 5 said, "Eventually they integrate. As they integrate it becomes a knowing that's bigger than the pieces [P5B18]." By integrating themselves in the moment, GIM therapists can know more than just pieces, which helps them make decisions.

### **Self-Care**

In the process of decision-making after unanticipated reactions, the participants stressed the importance of self-care. Because they took care of themselves, they were able to be fully present for the client with the integrated self and make the needed decision for the client and the therapist. This self-care is more than just gaining awareness about themselves. Participant 4 had countertransference reactions even before the client got to their office, so they engaged themselves in spiritual preparation for the client and the session. They shared as follows:

#### Example 2-11

When I know I have really difficult clients, I place God in the room. I practice the presence of a higher power in the room and I pray just to be a vessel and it's not me doing the work. It's not me with the answers. I just pray to be clear and to be a vessel for the work of a higher power and it's [their] healing... [That's] spiritual preparation [P4B10]

This spiritual preparation allowed Participant 4 to be open to the process and be ready for the client and consequently for possible unanticipated occurrences.

During the session, participants made maximum effort to be grounded and bear witness for the client especially in the session with severely traumatized clients.

Participant 4 shared, "I breathe, I practice myself to breathe and take a breath into my belly. Sometimes I tap my chest just to say, 'Be here. Stay here,' not go out into the dissociative or anything [P4B10]." Participant 6 kept both feet in reality and had a pointy stone in the pocket to stay grounded for the client. GIM therapists often work with clients with a history of severe trauma, and that comes up during the session, especially in the imagery. A study in dance movement therapy noted the importance of grounding and breathing during the session to recognize and manage somatic reactions (Palmer, 2015). It is also essential for GIM therapists to take care of themselves and protect themselves so that they do not dissociate and fail to be fully present for the client.

Furthermore, after a particularly difficult session, GIM therapists need to cleanse what they have taken in to themselves during the session. In working with the traumatized client in psychotherapy, it was common for therapists to have a client who affected them more than other clients and therapists internally felt the presence of the client even after the session and they experienced a prolonged impact, such as anxiety and fear (Bimont & Werbart, 2018). In severe cases, these symptoms can lead to compassion fatigue or secondary traumatic stress which occurs naturally to an individual's emotions and behaviors as a result of empathizing to another person's trauma

and trying to help them (Figley, 1995). Participant 6 felt so anxious and unsettled that they could not go back to their daily life right after the session.

Example 2-12

I had my feet back on the ground and I had settled. [But] I was taking on a lot of [their] energy. I was feeling it physiologically, kinesthetically [P6B13]. We have to be able to have signs of knowing for ourselves when we're uncentered, when we're thrown out of our own center, then have techniques to re-center again. [P6B29]

The technique for Participant 6 in this case was improvisation and it took them three hours on the piano to detox the aftermath of the session. If they were not aware of the impact of the heavy session, they might have experienced burnout like other therapists who had given up on the client before them. Because GIM therapists work with a wide range of clients, it is possible that they experience strong reactions that continue after the session. GIM therapists must firstly be aware the impact of the work with the client and secondly have a method to cleanse themselves after the session.

In addition to the continuous effort to increase self-awareness, self-care before, during, and after a session is vital for GIM therapists to keep working with clients. Because GIM therapists have unexpected reactions often before cognitive understanding, sometimes they must work on self-care without knowing exactly what the result is. As Participant 4 mentioned in the following example, by engaging themselves in self-care, they were more able to handle unusual occurrences and their unanticipated reactions.

Self-care is really important, so that when you do run into a client who, "Whoa, I didn't expect that," you can handle it. But if you don't take care of yourself and you run into a client like that, you can't handle it [P4B9]

### **Taking a Risk**

All participants who went through the decision-making process did not know what would happen as a result of their decision, but they made an intervention/action which went beyond their GIM training or usual practice. This means that they all took a risk in some way. Taking a risk sometimes means practicing against the cognitive foundation gained through the GIM training or going beyond their usual clinical practice. For example, Participant 1 allowed the client to stand up, which was not recommended in their training due to the safety issue. Similarly, Participant 6 decided to keep both of their feet on the ground, but generally GIM therapists are trained to keep one foot in reality and the other in the client's world. These cases show that GIM as a method cannot address these unexpected occurrences only by the current training and GIM therapists experience unanticipated reactions. Sometimes GIM therapists must go beyond the foundational GIM training to meet the needs of the client.

Participant 7 shared, "I felt this feeling of wanting to take a risk... it was like a kind bravery to brave those waves instead of running for safety... it was really a drastic change in my attitude [P7B15]." For Participant 7, what triggered them to take a risk was

a feeling of openness of curiosity that occurred after surrendering. They felt "what if we<sup>101</sup>  
don't drown in these waves?" They shared the following example.

Example 2-15

For me, it was a risk to let go of my impulse and follow [them] down to where [they were]. But by following [them], it was almost like it pushed us up [P7B18]. [By taking a risk,] I felt like a new dimension of therapy had opened up for me, just like a new dimension of [themselves] had emerged for [them]! [P7B22]

A study portrayed two types of process in risk-taking of counsellors (Knox, 2007).

One was to precede with a feeling of anxiety and doubt in taking the risk and the other was to take a risk instinctively without cognitive consideration. In this study, Participant 5 had a doubt and experienced a cognitive fight between the intuitive and cognitive mind, while the process for Participant 7 was more instinctive as shown in the study of Knox. No matter how GIM therapists take a risk, the risk-taking must be based on all themes that have been discussed here, including the cognitive foundation, self-awareness, past experiences, trust in the client, the therapist, and the process, self-care, integration, being present for the client, and surrendering to the situation in the moment. Participant 6 said as follows:

Example 2-16

Taking a risk as a therapist could lead to a new interventions... If we're listening to ourselves in a way or whether it's our physical body or whatever comes to us, maybe our own images, um, come to us and it hardly even feels like taking a risk. [P6B36]

Risk-taking interventions of GIM therapists may not be familiar for them and may be beyond the GIM training, but it is conducted within the scope of ethical practice as long



as they continuously try to increase self-awareness, engage in self-care, and be fully present for the client in the moment as an integrated self. When GIM therapists take a risk through the decision-making process, it can stretch the skills of GIM therapists as well as the potential of GIM.

#### Example 2-17

I like to think that risk-taking interventions are useful to the client when they come from informed intuition!... our task is to open ourselves to the therapeutic situation, in the present moment, where we are in attendance to the client...many term this as being the sacred witness. From this place risk-taking interventions that are useful to the client, can emerge seemingly spontaneously. [P6B35]... Taking a risk as a therapist could lead to a new interventions [P6B36]

### **Addressing Unanticipated Reactions in GIM**

GIM therapists normally develop some expectations for the session, the client, or the client's process in GIM through their GIM trainings, clinical practices, and relationship with the client no matter how much they are engaged in self-awareness. As a result of unmet expectations, GIM therapists experience unanticipated reactions. It is, however, impossible to predict all unanticipated occurrences in GIM. Although the participants recognized the importance of foundational knowledge gained through the GIM training, the training itself could not address those unusual occurrences that the participants experience in their sessions. Participants, however, found the solution through all factors stated as themes in this study. In addition to their cognitive foundation, they had the self-awareness, past experiences, and trust in the client, themselves, and the

process; surrendered to where they were with the client; integrated all aspects of themselves; were fully present for the client; engaged in self-care; and then finally were able to make a decision that went beyond their foundational training or ordinary practice. The code of ethical conduct of AMI requires GIM therapists to engage in individual self-care and professional growth, specifically personal growth, supervision/consultation, and continuing education (AMI, 2015); therefore, GIM therapists can deal with unanticipated reactions within the scope of ethical practice in GIM. Participant 6 said, "those unexpected moments in GIM can stretch our potential as a GIM guide, also can stretch the Bonny Method as well [P6B36]." By working with the GIM therapists' unanticipated reactions to clients' experiences and by going through the decision-making process for a risk-taking intervention, GIM therapists can expand their capacity as a therapist as well as the potential of GIM as a method.

**CONCLUSION**

The purpose of this study was to explore unanticipated reactions of GIM therapists to clients' experiences in GIM. Here, I present the following distilled essence that emerged through the cross-case analysis of all participants' experience of unanticipated reactions.

**Distilled Essence**

The process of unanticipated reactions starts with the expectations of the GIM therapist for the client, the session, or the process naturally developed through their GIM training, clinical practice with clients, and working with the client. When the client presents something that does not meet the GIM therapist's expectation, the GIM therapist experiences unanticipated reactions at any point in the GIM series and before, during, and after a GIM session. Unanticipated reactions include countertransference, emotions, somatic sensations, intuitive knowing, and/or a combination of them. When a GIM therapist does not go through a decision-making process, unanticipated reactions can cause harmful results for the client; however, these unanticipated reactions can be an effective and informative if the GIM therapist understands and processes them.

There are many essential factors for the GIM therapist in making decisions after experiencing unanticipated reactions. First, GIM therapists must have a split second of

self-mediation in which they can stop and think about what is happening. Second, factors<sup>105</sup> such as cognitive foundations, self-awareness, past personal experiences of the GIM therapist can be helpful for the GIM therapist in making decisions. Third, having the trust by understanding the client and being confident as a clinician is important in dealing with the occurrences that caused unanticipated reactions to the GIM therapist. Fourth, the GIM therapist lets go of their cognitive thinking and surrender to the situation in the moment. Fifth, the GIM therapist becomes fully present for the client in the moment as they integrate all aspects of themselves; however, to do so, they must engage in self-care before, during, and after the GIM session. And finally, the GIM therapist can make decisions which can be risk-taking that go beyond the foundational GIM training and their usual clinical practice. Although cognitive learning through the training cannot address all unanticipated reactions of GIM therapists, these elements allow GIM therapists to deal with unanticipated reactions and to make risk-taking decisions. Therefore, GIM therapists can deal with unanticipated reactions within the scope of practice in GIM. By taking a risk after making all efforts to deal with unanticipated reactions, GIM therapists can stretch their skills as a GIM therapist and the potentials within GIM as method are highlighted.

The findings of this qualitative research study suggest that it is normal for the GIM therapist to have unanticipated reactions to clients' experiences in GIM due to their expectations. But when the GIM therapist goes through the decision-making process, they can use these unanticipated reactions to continue the session. With the understanding that these reactions are normal, the GIM therapist needs to understand and work on their reactions through self-reflection, supervision, and peer-support to prevent malpractice and burnout. The GIM therapist can deal with, work on, and even use these unanticipated reactions through self-mediation to continue the session with the client. To successfully deal with unanticipated reactions, the GIM therapist must have the cognitive foundations, self-awareness, and trust in the client, themselves, and the process. When they finally let go of cognitive thinking and surrender to the situation with the client, and when they are able to be fully present for the client in the moment with the integrated self which requires self-care, they can make a decision on a risk-taking intervention that is beyond the GIM training and their usual clinical practice. Although it seems that the GIM training does not prepare GIM therapists for those unanticipated reactions, GIM therapists can still practice GIM within the scope of practice as AMI states personal growth, supervision/consultation, and continuing education of GIM therapists to be essential in their code of ethical conduct (AMI, 2015). As GIM therapists practice widely

throughout the world with various populations, using different adaptations of GIM as well as the pure Bonny method, they may encounter unanticipated reactions that they have not experienced before. As participants in this study stated, GIM therapists must engage in self-awareness, self-care, and continuing education so that they can deal with unanticipated reactions when they happen.

### **Guidelines for Processing Unanticipated Reactions of GIM Therapists**

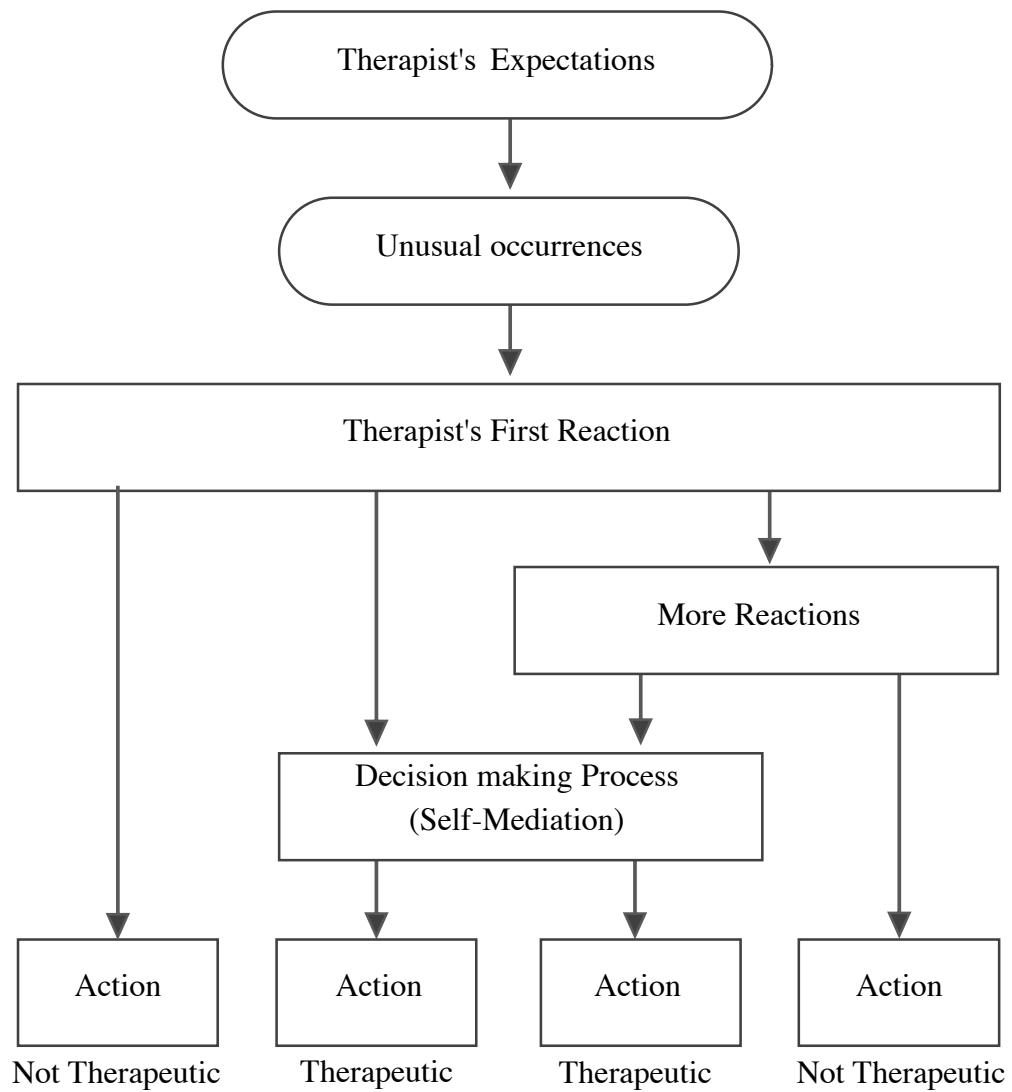
Based on the cross-case analysis and the distilled essence written above, I propose two guidelines that may be helpful during the process of GIM that may assist therapists in the moment of unanticipated reactions. One is the guideline for processing unanticipated reactions of GIM therapists, which describes the process that the therapist may go through to make decisions when they experience unanticipated reactions. The second is the guideline for the possible process of risk-taking decision-making by GIM therapists.

**Guideline for processing unanticipated reactions of GIM therapists.** The first guideline describes the possible process of unanticipated reactions of GIM therapists that leads to decision making (see Figure 1). The process starts with the GIM therapist's expectation for the client, their process, or the therapist's behaviors in GIM, which create unusual occurrences for the therapist. As a result, the GIM therapist experience unanticipated reaction. There are three different process that the GIM therapist are likely to go through after unanticipated reactions. The first is that the unanticipated reaction

directly leads to an intervention without any involvement of a decision-making process,<sup>108</sup> so that the intervention is not therapeutic. The second is that the therapist goes through the decision-making process and uses their unanticipated reaction to make an action. This results in a therapeutic outcome. The third is the GIM therapist experiences more unanticipated reactions consecutively. The outcome may turn out positively if the GIM therapist goes through the decision-making process, while it may turn out negatively if they do not.

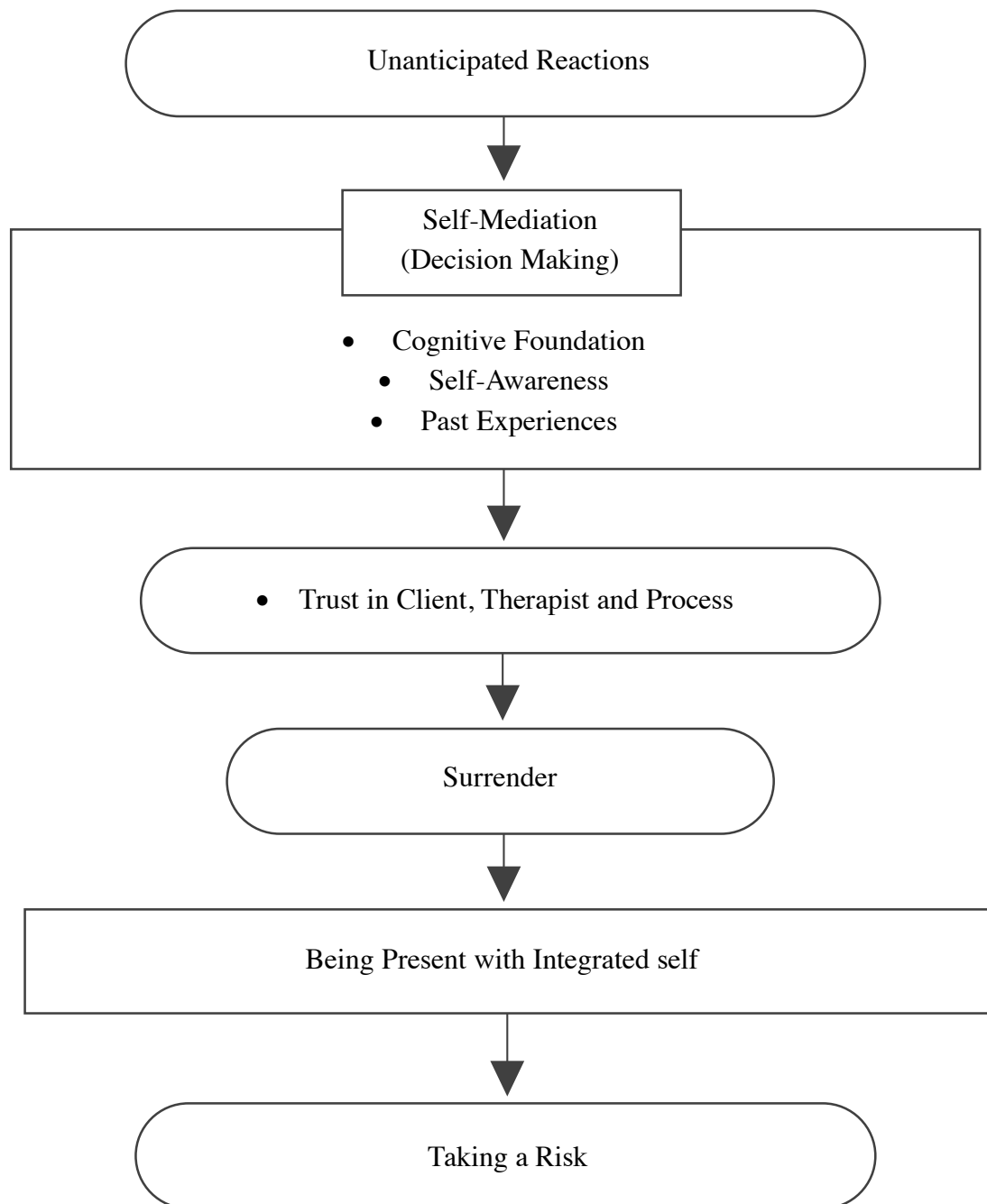
#### **Guidelines for risk-taking and decision-making of GIM therapists.**

Presented in the following Figure 2 is the guideline for the risk-taking decision-making process of GIM therapists in the moment of unanticipated reactions. When the GIM therapist experiences unanticipated reactions, it may be important to go through the self-mediation to bring some understanding of the reactions through the cognitive foundation, self-awareness, past experiences. To make a decision on an intervention, GIM therapists may need to have the trust in the client, the therapist, and the process. Then the GIM therapist may be able to let go of cognitive thinking and surrender to the situation with the client, and they may become fully present for the client with the integrated self, which requires self-care before, during, and after the GIM session. And finally, a GIM therapist may be able to make decisions on a risk-taking intervention that is beyond their foundational GIM training and their usual practice in GIM.



*Figure 1.* Guideline for processing unanticipated reactions of GIM therapists.





*Figure 2.* Guidelines for the risk-taking decision making process of GIM therapists.

These two guidelines propose a possible process for GIM therapists who encounter unanticipated reactions. They emerged in this phenomenological study after examining the lived experiences of the participants. These guidelines need to be elaborated on in the future as more researchers explore the process of being GIM therapists. It is hoped, however, that these guidelines may help GIM trainees and newer GIM therapists gain understanding of the process of unanticipated reactions and decision-making of a risk-taking intervention.

### **Implications for Clinical Practice**

Implications of this study to clinical GIM practice especially for GIM trainees and newer GIM therapists may be the gained awareness of their unanticipated reactions and the understanding that these reactions are normal. Unanticipated reactions have various forms and can occur to any GIM therapists before, during, and after a GIM session. It is important for GIM therapists to be open without fear of these unanticipated reactions. When GIM therapists experience unanticipated reactions, they can be aware of the process that they take to make a decision on an intervention after these reactions. This study may offer some supportive guidance in understanding the process at a moment of unanticipated reactions. When necessary, it is required by the code of ethical conduct by AMI (2015) to receive supervision or consultation to gain an understanding of the whole process of unanticipated reactions. This study also implies that GIM therapists sometimes

need to work on unanticipated reactions without cognitively understanding them. It may<sup>112</sup> be important for GIM trainees and newer GIM therapists to have some method to deal with uncertain discomfort before, during, and after a GIM session. It is hoped that this study will serve as a guideline for GIM trainees and newer GIM therapists in understanding what was missing in their process of decision making after unanticipated reactions and what they need to work on for the future practice with clients.

### **Limitations**

This study has several limitations. The first was that I was the only person who conducted the whole research process. Although the research supervisor and dissertation committee oversaw the process, it was still possible that my values, assumptions, GIM experiences as therapist and client, and my GIM training had influenced the process of research particularly the analysis. The second was the limited diversity in the participants. Although I contacted GIM therapists with different racial background located in Asia, Australia, Europe, and North America including Canada, the US, and Mexico, all of the participants were Caucasian and the majority practiced GIM in the North America. No participant mentioned unanticipated reactions caused by cultural differences and this could be because of the lack of diversity in the participants. Lastly, the majority of the participants were educators and GIM trainers. I contacted only experienced GIM therapists to exclude unanticipated reactions caused by the lack of experience, GIM

trainers may have a different perspective on GIM than experienced GIM therapists who<sup>113</sup> are not trainers. These limitations should be considered in understanding this phenomenological study.

### **Further Research**

The lack of literature that explored the process of GIM therapists was evident through the search of related literature. Because the GIM therapist has an important role in the client's process in GIM, there is a need for more studies on the process of the GIM therapist. Each theme of this current study could be an individual topic for further study, especially self-care, surrender, and risk-taking. Because GIM therapists work in the non-ordinary state of consciousness (NOSC) with the client, they may need a different method of self-care. As one participant shared, the use of music as self-care for GIM therapists may be worth exploring. The process of surrender of the GIM therapist also needs to be further explored. This phenomenon of surrender may be shared by many GIM therapists and seems to have importance in the process of GIM. Additionally, taking a risk in GIM should be carefully considered and further studied. This study portrayed what led to the risk-taking decision of GIM therapists, but there still remain questions such as what risk-taking interventions GIM therapists make; when GIM therapists take risks and when they do not; and how GIM therapists experience risk-taking.

One of the unexpected reactions in this study was the intuitive. I could not identify any studies in the related field that mentioned intuitive reactions. It is too early to determine this is a unique phenomenon of GIM therapists, but it may be worth exploring further.

Another implication for a further study is the individuation process of the GIM therapist from the training and possibly from their trainers. In unanticipated moments, GIM therapists must go beyond the GIM training to make an intervention. From my experience of GIM training, GIM trainers were very important and I used to practice GIM like they did for a while after completing my training. If the GIM therapist makes an intervention that is beyond the training, I assume there may be a struggle with the individuation from their trainers.

Parallel processing between the client and the therapist is another possible topic for further study. It did not emerge enough to become one of the themes, but I noted that parallel process between the client and the therapist in the therapeutic process. For example, Participant 2 became aware of their own issue through the work of the client. Participant 7 said "By taking a risk, I felt like a new dimension of therapy had opened up for me, just like a new dimension of the client had emerged for them." Personally, I often realize in my practice that what the client is experiencing resonates with my current or

past situations and it happens more frequently than to be considered a coincidence. This<sup>115</sup>  
may be one phenomenon in GIM that is worth exploring.

As the GIM practice is broadening, more studies on the process of GIM therapists  
are required for both bringing understanding for the GIM therapist and ethically  
practicing GIM.

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## APPENDIX A

## CERTIFICATION OF APPROVAL



Research Integrity & Compliance  
Student Faculty Center  
3340 N. Broad Street, Suite 304  
Philadelphia PA 19140

Institutional Review Board  
Phone: (215) 707-3390  
Fax: (215) 707-9100  
e-mail: [irb@temple.edu](mailto:irb@temple.edu)

Certification of Approval for a Project Involving Human Subjects

Date: 27-Apr-2018

Protocol Number: 25032  
 PI: BROOKS, DARLENE  
 Review Type: EXEMPT  
 Approved On: 27-Apr-2018  
 Approved From: 27-Apr-2018  
 Approved To:  
 Committee: A2  
 School/College: BOYER COLLEGE OF MUSIC & DANCE (2200)  
 Department: BOYER: MUSIC THERAPY (22070)  
 Sponsor: NO EXTERNAL SPONSOR  
 Project Title: An Exploration of Therapists' Unanticipated Reactions to Clients' Experiences in GIM

The IRB approved the protocol 25032.

If the study was approved under expedited or full board review, the approval period can be found above. Otherwise, the study was deemed exempt and does not have an IRB approval period.

If applicable to your study, you can access your IRB-approved, stamped consent document or consent script through ERA. **Open the Attachments tab and open the stamped documents by clicking the Latest link next to each document.** The stamped documents are labeled as such. Copies of the IRB approved stamped consent document or consent script must be used in obtaining consent.

**Before an approval period ends, you must submit the Continuing Review form via the ERA module.** Please note that though an item is submitted in ERA, it is not received in the IRB office until the principal investigator approves it. Consequently, please submit the Continuing Review form via the ERA module at least 60 days, and preferably 90 days, before the study's expiration date.

**Note that all applicable Institutional approvals must also be secured before study implementation.** These approvals include, but are not limited to, Medical Radiation Committee ("MRC"); Radiation Safety Committee ("RSC"); Institutional Biosafety Committee ("IBC"); and Temple University Survey Coordinating Committee ("TUSCC"). Please visit these Committees' websites for further information.

Finally, in conducting this research, you are obligated to submit the following:

- **Amendment requests - all changes to the study must be approved by the IRB prior to the implementation of the changes unless necessary to eliminate apparent immediate hazards to subjects**

- **Reportable new information - using the Reportable New Information form**, report new information items such as those described in the Investigator Guidance: Prompt Reporting Requirements HRP-801 to the IRB **within 5 days**
- **Closure report** - using a closure form, submit when the study is permanently closed to enrollment; all subjects have completed all protocol related interventions and interactions; collection of private identifiable information is complete; and Analysis of private identifiable information is complete.

For the complete list of investigator responsibilities, please see the Policies and Procedures, the Investigator Manual, and other requirements found on the Temple University IRB website: : <http://research.temple.edu/irb-forms-standard-operating-procedures#POLICY>

Please contact the IRB at (215) 707-3390 if you have any questions

**SAMPLE INVITATION LETTER TO CANDIDATES**

Dear \_\_\_\_\_;

I invite you to participate in a qualitative research study for my PhD dissertation at Temple University. The purpose of the study is to explore therapists' unanticipated reactions to client's experiences in GIM. I am contacting you because your name is listed on the online directory of the Association for Music and Imagery or other equivalent international GIM organizations. You are eligible to participate in this study if you 1) are/were a qualified GIM therapist; 2) are able to understand and communicate in English; 3) aged over 25; 4) have practiced GIM over three years as a qualified GIM therapist; 5) 5) have provided a minimum of 30 GIM sessions as a qualified GIM therapist; and 6) have experienced unanticipated reactions to clients' experiences in a GIM session. If you agree to participate, I will need approximately 60 to 90 minutes of your time for an interview, and another period of about 30 minutes to review the transcript of that interview. If you reply with an interest in participating in the study, I will send you the study consent form. Please contact the investigators as listed below if you have any questions.

**Darlene Brooks, PhD, MT-BC**

Fellow of the Association for Music and Imagery (FAMI)

Dissertation Chair, Associate Professor

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Phone number: +1 (215) 204-8301

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**Nami Yoshihara, MS, MT-BC**

Fellow of the Association for Music and Imagery (FAMI)

PhD Candidate

1654 Shimokurata-cho, Totsuka-ku, Yokohama, 244-0815 JAPAN

Phone number: +81 (80) 5049-1737

E-mail address: [nami.yoshihara@temple.edu](mailto:nami.yoshihara@temple.edu)

Thank you for your time and consideration. I look forward to hearing from you.

Sincerely Yours,

Nami Yoshihara

**INFORMED CONSENT FORM****Title of Research:**

An Exploration of Therapists' Unanticipated Reactions to Client's Experiences in GIM

**Investigator and Department:**

Dr. Darlene Brooks, Research Supervisor, Associate Professor  
Nami Yoshihara, Doctoral Student  
Music Therapy Department  
Boyer College of Music and Dance  
Temple University

**Introduction:**

You are invited to take part in a qualitative research study that explores unanticipated reactions to client's experiences in GIM. You are eligible for the study if you:

- 1) are a current or former qualified GIM therapist
- 2) are able to understand and communicate in English
- 3) aged over 25 years old
- 4) have practiced GIM over three years as a qualified GIM therapist
- 5) have provided a minimum of 30 GIM sessions as a qualified GIM therapist
- 6) have experienced unanticipated reactions to clients' experiences in a GIM

session.

**Why is this research being done?**

The purpose of this study is to explore therapists' unanticipated reactions to client's experiences in GIM. Because any GIM therapist can have unanticipated reactions in GIM, this study aims to provide an in-depth understanding of therapists' experience of unanticipated reactions. The findings of this study may help GIM therapists be more aware of their reactions to client's experiences, which may help GIM therapists make better decision for an intervention or may motivate GIM therapists to seeking supervision. This study, therefore, may provide a resource for GIM therapists to reflect on their practice by bringing awareness to their reactions to client's experiences.

**What happens if I agree to be in this research?**

Once you agree to participate in this study, I will contact you to schedule an interview at your convenience. The interview will last 60 to 90 minutes. I will use a HIPAA compliant

video chat for the interview or a communication method of your choice. The questions 139 during the interview will include your background information, GIM practice, and your experience of unanticipated reactions to client's experiences. Your interview will be audio recorded and transcribed by myself and/or a professional transcriber. I will provide you with a copy of the transcript to ensure its accuracy. I will analyze the transcribed data to understand unanticipated reactions shared by GIM therapists. I may also contact you for further explanation or another interview, if needed. This study may be published or presented at professional conferences in the future.

**Is there any way being in this research could be bad for me?**

Because of the topic of the research, you may experience psychological discomfort by disclosing GIM practice that you now feel might not have been your best or that was not completely safe for your clients. In addition, even though I will keep your personal information anonymous, there is a potential that some people could guess the participants due to the small size of the GIM community.

**Will being in this research help me in any way?**

It cannot be promised, but you may gain insights or new perspectives into your practice, your clients, or yourself.

**What happens to the information collected for this research?**

The audio recordings of your interview data will be stored in my password protected computer and USB. The transcribed data will be stored anonymously on my password protected computer and USB. I will store all data for five years after completion of the study and then will adequately destroy. To the extent allowed by law, I will limit the viewing of your anonymized personal information to the research supervisor and myself. The IRB, Temple University, Temple University Health System, Inc. and its affiliates, and other representatives of these organizations may inspect and copy your information.

**What will I be paid for taking part in this research?**

There will be no compensation for this research.

**Your rights as a research participants.**

Please take as much time as you need to discuss your participation with your family, friends, or anyone you wish to. Your decision to participate or not to participate is entirely up to you. You have the right to change your mind and leave the study at any point. Your decision will not be held against you. Please ask all the questions you want before your decision.

**Contacts:**

If you have questions, concerns, or complains, or think the research has hurt you, please contact me, the researcher, or my research supervisor.

## Student Researcher

Nami Yoshihara

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nami.yoshihara@temple.edu

## Research Supervisor

Dr. Darlene Brooks

(215) 204-8301

dmbrooks@temple.edu

This research has been reviewed and approved by Temple University **Institutional Review Board**. You may contact them at (215) 707-3390 or e-mail them at [irb@temple.edu](mailto:irb@temple.edu) for any of the following:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.
- You have questions about your rights as a research subject.
- You want to get information or provide input about this research.

**Consent:**

I understand all information provided in this document and I will voluntarily participate in this study.

Your name:

Date:

## SAMPLE OF INTERVIEW SCHEDULE

### **SECTION 1: General Background Information**

- How do you identify your gender?
- Which continent do you practice GIM?
- Which ethnicity do you identify yourself?
- What is your age range?
- What is your highest level of formal education?
- What is your primary profession?
  - How long have you been practicing?

### **SECTION 2: GIM Background**

- How long have you been practicing GIM as a Fellow of the Association for Music and Imagery?
  - Roughly how many sessions have you provided to your clients after becoming a Fellow?
  - How frequently do you practice GIM?
- With what populations do you use GIM?
- In which setting do you practice GIM?
- What forms of GIM do you frequently use?
- Is there any training did you receive in addition the traditional training of the Bonny Method of Guided Imagery and Music?
- Have you sought supervision in GIM after becoming a Fellow?
  - If yes, how often do you receive supervision?

### **SECTION 3: Unusual moments in GIM**

In this study, I am exploring unanticipated reactions that you had to any client's experiences in GIM. Unanticipated reactions are any feelings, thoughts, physical sensations, intuitions that you had in response to clients' experiences in GIM. You may have been surprised during a session. I am going to ask several questions related to your unanticipated reactions.



- Can you describe any unanticipated reactions to client's experiences in GIM? 142
- What was the client experiencing when you had unanticipated reactions?
- How did you feel when you became aware of those reactions?
- After experiencing those reactions, how did you continue the session?
- How did you make decision on how to continue the session?
  - Was there anything that informed you about what you chose to do after those reactions?
  - Did your reactions guide your decisions on interventions?
  - If so, in what ways did your reactions guide you?
  - Was there any difference in your decision making between this particular session and your usual sessions?
- Could you share another unanticipated reaction to your client's experiences during a GIM session?

## SAMPLE OF WITHIN-CASE ANALYSIS

Participant 6

Meaningful Unit: What happened during the session

Significant Statements	Memos
<p>Sometimes I get sometimes I get, um, lots of energy in my hands... and sometimes I-I feel, um, that I have to get my feet on the ground. [P6B6]</p>	<ul style="list-style-type: none"> <li>➤ MEMO: For this TH, physical reactions are natural, it's unusual when the energy is too much.</li> <li>➤ [Flip-Flop] I HAVE TO get my feet on the ground I NEVER have to get my feet on the ground = this sounds unsafe to me...TH will be lost with the CL</li> <li>➤ MEMO: It was unusual because it was both feet on the ground instead of one foot (usual GIM)</li> </ul>
<p>With one client in particular, I used to feel like I needed a sharp stone in my pocket and to keep putting my feet on the ground because I kept floating up because his imagery was so destructive and so painful and I think I was wanting to escape. [P6B6]</p>	<ul style="list-style-type: none"> <li>➤ MEMO: This statement is VERY important: Unusual experience of the TH. Not just feeling in the body, but floating up.</li> <li>➤ MEMO: Is this dissociation?</li> <li>➤ PERSONAL THOUGHTS: This is an extreme case that the TH needed to stay grounded. The CL's trauma was that severe... I have never needed to stay grounded like this.</li> </ul>
<p>I could feel myself drifting up to the ceiling. I had to get myself--get my feet on the ground to just listen and-and to bear witness [P6B7]</p>	<ul style="list-style-type: none"> <li>➤ MEMO: What caused this "drifting up?" The TH feels in the body, so this is the "reaction" of the TH</li> <li>➤ MEMO: JUST listen and to bear witness. Not to give intervention, make verbal interaction, or anything... JUST to be there... Which is very unusual for a GIM session</li> <li>➤ [CM] I make this note after all other notes. I think the word "just" here means maximum not minimum. So it could be "the most I could do was to listen" or "even to listen was so</li> </ul>

	<p>hard". The interpretation of "just" as minimum colors your interpretation throughout.</p>	144
<p>I had this sensation that I was almost like being dizzy but not being dizzy, like you-you're lifting up off the ground [P6B9]</p>	<ul style="list-style-type: none"> <li>➤ [CM] Is the dizziness her own process of dissociation? – NY: I think so... what else can it be? dizziness happens when someone is in NOSC. It sounds here that they was unconsciously lifting up, I think that caused the dizziness.</li> <li>➤ MEMO: Why did this "lifting up off the ground" happen? Who caused this? The TH? or the CL?</li> </ul>	
<p>It was, it was hard for me to hear how awful that was... It was so painful and dark and so I think that I-- My psyche was having trouble to hear it. [P6B9]</p>	<ul style="list-style-type: none"> <li>➤ MEMO: This is a significant statement as the TH recognized their wish to "escape" (the term she used earlier P6B6). The TH did not want to hear it!</li> <li>➤ PERSONAL THOUGHTS: It almost sounds like the TH was getting traumatized by hearing the CL. Almost like the process of dissociation as if the TH is being abused themselves. Shutting off all senses and separate mind and body, etc... all sound like the defense mechanism.</li> </ul>	
<p>I needed both my feet on the ground... Just by listening to him and his imagery, it was taking- it was taking both my feet off the ground... I needed to ground myself fully and I did it in-in with both my feet on the ground and I would carry a stone every session with him. I would keep the stone in my pocket that had a sharp point on it... It was just little with a sharp point... that I can press my thumb on it, you know. [P6B10]</p>	<ul style="list-style-type: none"> <li>➤ MEMO: For what did the TH needed to keep both feet on the ground? This is the decision after the unexpected reaction.</li> <li>➤ PERSONAL THOUGHTS: What would have happened if the TH didn't keep their feet on the ground?</li> <li>➤ PERSONAL THOUGHTS: The TH wouldn't have been able to listen, would have escaped, wouldn't have been able to be the TH. Possible harm for the CL.</li> <li>➤ PERSONAL THOUGHTS: This might have been the very sensitive, subtle line between being in the CL's imagery and staying conscious, moreover, being the therapist and not being the therapist.</li> </ul>	

	<ul style="list-style-type: none"> <li>➤ MEMO: This was inevitable for her to be there for the CL to keep her stay grounded in reality, not in unconscious or in CL's imagery.</li> <li>➤ MEMO: Bruscia often talks about one foot on the reality, one foot in the CL's imagery. It took her BOTH feet on the reality to stay there as the CL's therapist. It was unusual for GIM practice</li> </ul>
<p>It's like a reminder, you know, a good-- Just a physical-- It grounded me... It just grounded me... So that I could stay present with him. [P6B11]</p>	<ul style="list-style-type: none"> <li>➤ MEMO: "It's just grounded me" because earlier she stated that she was floating. [HS] The sensation from the pointy stone kept her grounded in her own physical reality, separate from the CL.</li> <li>➤ MEMO: As the TH said earlier that she was lifting up because she wanted to escape, it sounds important for her as well to keep their feet on the floor and had the pointy stone.</li> <li>➤ PERSONAL THOUGHTS: I think it was also for the TH to protect themselves from being traumatized (as the TH described about their experience of dissociation which was similar to what happens when an individual is being abused).</li> </ul>
<p>If I let his-the horror of what he was reporting affect me, what my response seemed to be was to just drift off and lift up and just disappear. [P6B18]</p>	<ul style="list-style-type: none"> <li>➤ MEMO: This is the answer to the earlier question what would happen if the TH put their foot into the CL's imagery... drifting off, lifting up, and disappear – meaning could not continue the therapy as the therapist, because the trauma of the CL was so severe.</li> </ul>
<p>I needed both my feet on the ground... Just by listening to him and his imagery, it was taking- it was taking both my feet off the ground... I needed to ground myself fully and I did it in-in with both my feet on the ground and I would carry a stone every session with him. I would keep the stone</p>	<ul style="list-style-type: none"> <li>➤ MEMO: For what did the TH needed to keep both feet on the ground? This is the decision after the unexpected reaction.</li> <li>➤ MEMO: What would have happened if the TH didn't keep their feet on the ground?</li> <li>➤ PERSONAL THOUGHTS: The TH wouldn't have been able to listen, would have escaped, wouldn't have been able to be the TH. Possible harm for the CL.</li> </ul>

<p>in my pocket that had a sharp point on it... It was just little with a sharp point... that I can press my thumb on it, you know. [P6B10]</p>	<p>➤ MEMO: This was inevitable for her to be there for the CL to keep her stay grounded in reality, not in unconscious or in CL's imagery.</p> <p>➤ MEMO: Bruscia talks about one foot on the reality, one foot in the CL's imagery. It took her BOTH feet on the reality to stay there as the CL's therapist.</p>	146
<p>It's like a reminder, you know, a good-- Just a physical-- It grounded me... It just grounded me... So that I could stay present with him. [P6B11]</p>	<p>➤ MEMO: "It's just grounded me" because earlier she stated that she was floating.</p> <p>➤ MEMO: As the TH said earlier that she was lifting up because she wanted to escape, it sounds important for her as well to keep their feet on the floor and had the pointy stone.</p> <p>➤ PERSONAL THOUGHTS: I think it was also for the TH to protect themselves from being traumatized (as the TH described about their experience of dissociation which was similar to what happens when an individual is being abused).</p>	
<p>It was a few weeks that I was really aware of that. It didn't go on for the whole time that we worked together. I always had a stone in my pocket when I worked with him... That was my safety, anchor. You know... For myself... so, that I was going to be functional for him... I needed to be functional for him [P6B12]</p>	<p>➤ MEMO: What is safety?</p> <p>➤ MEMO: To answer the question in P6B11, it was for the TH's safety as well to keep the sharp stone in their pocket.</p> <p>➤ MEMO: So for anchor. Usually in GIM, the TH is the anchor for the CL, connecting the reality and the imagery world. But in this unusual case, the TH needed an anchor to stay functional. [P6B12]</p> <p>➤ MEMO: What does the TH mean by "functional" here.</p> <p>➤ Merriam-Webster Definition of "Functional"</p> <ol style="list-style-type: none"> <li>1) connected with, being a function, affecting physiological or psychological functions, but not organic structure</li> <li>2) used to contribute to the development or maintenance of a large whole</li> <li>3) performing or able to perform a regular function</li> </ol>	

	<p>Antonym: Broken, dead, inactive, inoperative, kaput, nonactivated, non-functional, non-functioning, nonoperating, nonoperational, nonoperative</p> <p>➤ PERSONAL THOUGHTS: This sounds to me, that the TH was not trying to be the best therapist, instead, the TH was trying to fill the minimal requirement to be a therapist, which also sounds like the best she could have done at that point...</p>	147
<p>unless I get some signs, physiologically, that there's some energy that-that I am taking on- [HS P6B17]</p>	<p>➤ [CM] the TH paid attention to “signs”. It seems the body responded first before the mind.</p> <p>➤ [CM] Awareness of signs within the session, are emulated by awareness of signs after the session.</p> <p>➤ MEMO: Body responds to trauma quickly. Refer to Lavine "The Body keeps the score"</p> <p>➤ MEMO: Because somatic reactions occur quicker than cognitive understanding, it saved the TH from getting traumatized.</p> <p>➤ [Cross Case Memo] PT4 also talked about reactions in the body and body stores traumas</p>	
<p>sometimes I make connections after the session and A-HA, that was it. [HS P6B33]</p>	<p>➤ [CM] “How do we know ...” One way is post-session processing.</p> <p>➤ MEMO: it sounds important that the therapist comes to an understanding whether during or after the session.</p> <p>➤ MEMO: This means, sometimes TH must work on and detox somatic reactions without complete understanding.</p>	

\* CM stands for committee member

\* I separated Memos and Personal thoughts to clarify what is based on the data and what may include my personal reflection of the data.

## DESCRIPTIONS OF WITHIN-CASE ANALYSIS

The meaningful units and descriptions emerged from the within-case analysis.

### Participant 1

#### 1. The Client

The client was an experienced traveler who had had between 10 to 20 sessions with me. They were very body oriented and found benefit from moving their body and they were working on reclaiming their body and owning it. So, I was not surprised that it was them, although what happened was surprising for me.

#### 2. What Happened

In the middle of a session, the client decided that they needed to stand up. The client was lying on the futon, but all of a sudden, they sat up and said "I need to stand up." I certainly could have said "no" but they were already standing up. It was very unexpected for me, but it was very natural for them and they would be surprised if I told them it was out of ordinary. With their eyes closed, they moved slowly and expressed with their body for the entire piece for about four minutes. I kept the distance of a foot or two between us and energetically held their space. Although I could not have done anything, I tried to give them the feel that "I'm here."

#### 3. The experience of the TH

When the client said "I need to stand up" and stood up in one moment, I was taken back and felt a little bit out of control. The client was ready, but I was not. My first reaction was a flinching to stop them. I thought "you can't" because that was something I was not trained to let it happen and also I had not had any client who initiated standing up. But then I had the gut reaction that said "maybe we could." I had no idea what was going to happen, but I thought nobody was going to initiate such a movement unless they were ready for it. They were an experienced traveler and I felt I could keep them safe. I felt "Let's give it a whirl"

#### 4. TH's past experience

I remember one time when I was a client, I asked my therapist if I could stand up and they said "Oh no." I just lay because I was compliant, but I felt "argh, but I need to!" The therapist used the pillow to give me the illusion of standing up, but it really was not the

same. So, when the client said "I need to stand up" I truly understood the feeling of needing to stand up. I did not recall my previous travel actually being in my consciousness in those split seconds of decision making. But I did know I felt an understanding of the need in the cells of my body.

#### 5. Trust and Taking a Risk

In this process, there was a mutual trust between the client and I. I trusted the client and their body that they were experienced and should be coordinated enough to do all that they needed. They probably trusted me to keep them safe. I also trusted myself as a clinician that I was experienced enough to know how to interrupt if I needed to. They could not have stood up alone, it was our work. Because of this trust, I thought "we could" and I was able to take a risk.

#### 6. Safety

In usual GIM sessions, physical safety of the client is not a top concern because they usually lie down and their interactions are minimal. In this case, however, all of a sudden, keeping physical safety got elevated to the highest level of concern.

#### 7. Rational vs Irrational

As we guide, we always toggle between the rational and irrational brain. But this emergent need for the client's physical safety took me out of the irrational brain, which allowed me to experience the client's world, and made me spike into rational brain. I glanced around the room, checked the environment, and watched her more carefully. I took in all information in a nanosecond and I decided, "Let's give it a whirl."

### **Participant 2**

#### 1. Relationship with the Client

I had this client over 20 sessions and I felt comfortable working with them. I related to them in all the ways their father had broken their heart because my father had broken my heart. This was because I had a motherly role for them which was rather controlling. I was directive about what they were doing with their life. When I said "how long are you gonna sit here?" I was testing their allegiance.

#### 2. What happened in the session

In this session, there was nothing unusual and I felt so comfortable. Then, the client had an imagery of a sanctuary in which their father was dead and laid out like for a funeral and they were sitting next to him. It was a beautiful moment in retrospect. All of sudden, I had this shocking, blooming awareness that over these last 20 or 30 sessions, they had been sitting there by his side ever since he died 20 years ago and they would not leave his



side. And much to my sheer, horror, I asked "How long are you going to sit here?" It was a demanding statement instead of an open-ending question and the minute I said it, I knew I was wrong. I was not managing my countertransference well at all.

(They didn't hear my question, but they were aware it was so painful and important. I don't remember much afterwards. They probably had some more minutes by his side and moved on as the music changed.)

### 3. The therapist's experience

The question flew out of my mouth without any conscious awareness and it was completely unexpected. It was my countertransference reaction because I was abandoned by my own father and had not been able to grieve over the separation. The question was my question to myself. But more importantly, I was meeting my own personal need through their session by living vicariously through them. I wanted them to get back to fighting with him because that was the fight that I needed to have with my own father. I was essentially trying to get the client to keep doing the work that I needed to do. So, my younger self took over me and said "Holy Crap! You are about to forgive your father for all the shit that he just did and we are not going there!" I was not ready to make peace with my own father, so I stopped it. I was so unprepared for their change. When I realized this, I felt horrified and ashamed. There was a ton of work that could have done in the moment. It was a precious moment for them and it was hard earned. It took them 20 or 30 sessions to get to the moment. And I stole it from them.

### 4. Post Session

Even in the post session, my younger self was in charge and would not admit the mistake. The client was curious about what I said because it was so painful for the client. But I did not have a gut to tell her what I said. Eventually I told them what I said and we processed why it was so painful for them.

### 5. Usual Sessions

When I give an intervention, all of myself is open and available to respond with curiosity to the client in the moment. I would take all the information into account and then think what the client needs to hear from me. In this case, it was "Stay right her, be so present."

### 6. Mediation and Decision Making

I wish I had a mediation in that session which would have allowed me to feel how the client was experiencing, think of the music and what it was doing, check how I was experiencing the session and my countertransference, and then I could have taken all information into account and gauged what would help the client be as present to that moment as they could be. All in a split second and only then, I would make an

### **Participant 3**

#### **1. The Client and the TH's Relationship with the CL**

The client was likely to stay in their head and for 45 sessions over several years, they had been caught between two things. They wanted to leave their job, but they did not. We have worked on what was keeping them there, using music programs like Mostly Back and Affect Release. I was a sounding board for them and helped them make connection between childhood experiences and current situations. Sometimes I challenged them, but they did not go there. They would probably be frustrated and feel anger about their situation. I was receiving supervision and I knew I got wrapped in it.

#### **2. Frustration: The Same Thing!**

I had all sorts of feelings with them that I did not think I would ever had with other clients. The major one was frustration. I had worked with them for 45 sessions and I was so sick and tired of hearing the same argument again and again. I was frustrated because I was expecting to hear that they were succeeded in leaving the job. They did resign but would go back to the same job with a different position. I asked what would take for them to actually leave the job.

It was not a question of the therapeutic relationship. I used big programs with them such as Mostly Bach, Affect Release, and Emotional Expression I, but nothing was breaking through. I felt that I was not doing my best therapy work because I thought they should have gotten through by then. It confronted me with the fact that the Bonny Method and me as the therapist had not been able to shift this thing that they had been talking for years.

But this frustration became the catalyst for this session and motivated me to say "We are going to do something really different today! I'm giving you this music that I think is a quite sinister."

#### **3. The Therapist's Experience**

The whole experience was unusual for me. I chose Menotti, but it was not the way I normally would think or practice. I often feel kinesthetic sensations, but this gut feeling was different that said "I'm going to give you a piece of music that is really tricky to see if that would break through." I was really fed up with them repeating the same argument again and again and I thought "I'm going to give you Menotti," which almost felt like "I'm going to punish you!" I felt like I had tried everything else, and nothing made a difference so now you got the sinister piece of music to see if that would make a difference. I was surprised by the way I chose the music program and I was uncomfortable with my own feeling.

#### 4. The Therapist's past experiences of retirement

As I reflect on myself, I retired the previous year from the job which I had worked for 38 years. For me it was a tug instead of frustration, but I really felt for this "will I stay or will I go." So, it was hard to hear the same story again and again because there was a little bit element of a countertransference.

#### 5. The music

I really think Menotti is sinister and I rarely used it. Menotti had the quality that is nasty, strange, weird, macabre, and seductive. Although I was not aware in this session, I remembered one time when I traveled to Menotti. I was in some music club and I saw a brightly colored ball that kept going round and round and round. I really wanted to smash the ball, but it was way up high. I remember feeling annoyed because I was absolutely stuck with the silly thing. Maybe that was the countertransference that I felt in my body which said "I'm going to give you Menotti!"

#### 6. Results of the Session

I was so excited to see the Mandala of a pale blue egg with a crack that they drew in the post session. I thought Menotti did work. I believe Menotti was the catalyst and opened up something for them in this session.

### **Participant 4**

#### 1. What Happened

As in usual sessions, I explained the typical process of GIM to the client and that they did not have to follow, and they said "Well, I will sit and I will keep my eyes open." It was very clear. It took them about four or five sessions to actually close their eyes, so for a while, they were able to make eye contact if they wanted to during the imagery experience. They were my first client who kept their eyes open for the entire session. Even after that they would say "I'm done" right in the middle of the session, and it was done. We moved on to the post session processing.

#### 2. The Therapist's Experience

I had countertransference reaction even before they got to my office. I was anxious and I felt I was not very well prepared. I knew they would be prickly and I felt it was difficult working with them. They would not close their eyes during the music phase, I felt unsettling because I did not expect that. I was so used to having clients close their eyes and it was new territory for me. As I reflect back now, they were in NOSC with their eyes open as in deep meditative state; however, I interpreted as they was in ordinary state of consciousness at that time. So, I felt we were in direct relationship as an individual unlike

usual imagery experiences. This made me stay on the conscious plane and make sure that I was always available for them. I was self-conscious and I could not expand, had less feeling of the session with my body, and had less intuitive sense as I guided because I knew at any moment they could look right at me. I had to think what I was going to do with this person. And even though I had no idea what was going to happen, I just did it. I did not have to know what might happen and it was OK to not know. I trusted the process.

Even after the session, I felt unsettled. I wondered if GIM was the right method for them and if I was the right therapist for them, but the client said they felt better.

### 3. Decision and Integrative Process

The decision can be made by integrating my experiences, wisdom, knowledge of different therapeutic models, and sense of energy into me as a being and by being present for the client. It is humanistic in that sense. GIM therapists have to be experts, we have to be professionals, but it is not our work and I trusted the process. GIM therapists need to be present for the client as whole, the integrative presence. For me, I was particularly sensitive to the energy of the client and what it was telling me. This integrative presence really helps the client; however, it takes a toll on the therapist. Therapists must proactively engage in self-care so that when they encounter an unexpected occurrence, they can handle it. Before each session, it was important to engage in spiritual preparation, and during the session, I often used breathing and tapping my chest to be present for the client.

### 4. The Client and the Relationship with Them.

The client was about my age, recovering alcoholic, and dealing with severe trauma of abuse by their father. They had seen psychiatrists and counselors and none of them was able to work with them. They needed an experiential form of therapy and someone who would be there with them and not run away. I was very aware of their anxiety and their distrust of me, but it was distrust of everything. There was a strong energy in the room and it took me a while to learn to work with this strong dynamic. But opening their eyes contributed to building trust between us because I let them always be in charge. In a sense, there was a re-parenting process for them to feel safe with a strong male figure. And their body began to heal as they entered into a healthy trusting relationship within therapy. I felt unsettling in many ways. 1) they kept their eyes open so that we were in direct relationship, 2) the client was highly anxious, 3) I was self-conscious, and 4) we did not have a trusting relationship yet.

### 5. Trust

Even when I did not know what was going on, I trusted the process. I trusted what I felt

in my body and trusted my expertise and professionalism to help them find their own answers inside them. Because of this trust, I was OK with not knowing what was going to happen. And to trust, the therapist must engage in self-care.

#### 6. Detox

After the sessions with him, I held lots of energy in my body. It was very important for me to detox in order to keep working with him.

### **Participant 5**

#### 1. Deep Knowing

I had this deep intuitive knowing that said "Dirge" It was very different from my usual decision making which rely on cognitive thinking of what would be just right for this client right now. This deep knowing brought me the choice of music which was more accurate for this particular client than my conscious mind could cognitively understand. But it's not that the deeper knowing is separate from the cognitive knowing. It's all integrated.

#### 2. Doubt

When I have an idea, I always doubt myself because I will not know if it is accurate until the client confirms it. So when I had an intuitive knowing of changing the music program, there was a little bit of hesitancy because I was not necessarily trusting myself for having that intuition. I felt that changing the music program was too directive as an intervention. There was the struggle between my intuition and cognition. Cognitively I was thinking, "That's a big change" and I was trying to talk myself out of it. But my gut kept telling me "No, you need to make a turn." It was a challenging decision for me.

#### 3. Connection

- With the client

In the pre-session, I felt connected to the client in a deeper place because of what they spoke about and how they presented themselves. And then I went into the stream of experience with the client.

- With the music

As a person who did not have classically trained music background, I rarely change the music during the imagery experience. Also I did not receive a training which I was expected to change the music. When I do, it is based on my cognitive decision making. But it was so different in this case. I have a positive bias toward both of these two music programs because of my past experience as a traveler and as a guide. So it was unusual for me to interrupt Williams. But my gut said to go to Dirge.

- Deeper Connection

When both the client and the therapist move into the non-ordinary state of consciousness together, we can access to a more intuitive sense of what is being experienced by the traveler. It is our deep connection with others' humanity and it allows us to access information that we cannot get cognitively.

#### 4. Unusual Experience

As a person who did not have classical music training, I rarely change the music in the middle of a program unless I had a cognitive reason to do so. But in this session, I had an intuitive knowing which was not cognitive. When the first two pieces of the Expanded Awareness program was approaching to the end, I felt the energy that the client was holding in their body. Their body, as holding hands tightly, was saying "I'm going to struggle." So, I might have overestimated where we were by even choosing expanded awareness. Then without trying, a piece of music came to my mind and I switched the program from Expanded Awareness to Paradox, which was completely different from each other. It was unusual for me that intuitive knowing came before cognitive thoughts like this but I trusted that intuitive knowing. (I felt I might have overestimated where we were by even choosing expanded awareness.)

#### 5. Unusual Decision Making

Unlike my usual sessions, the decision making in this session was not cognitive. I was surprised by my own experience of having a clear sense of wanting to change the music. It was more surprising that I did not even doubt myself and just felt "I need to go to dirge." I was more comfortable to take a risk in this situation where we had time, where we had the space, and where the client was a GIM person. But more importantly, in that moment, I was present as an integrated self of my past experiences as a traveler, guide, and trainer, connected to the client at deeper level, and more into the NOSC with the client than usual. I gave up on my cognitive thinking, trusted the process, and took the risk.

#### 6. Usual Decision Making (Or the first choice)

It was a cognitive thought process that I chose Expanded Awareness for this client. I thought they needed a program that is mostly positive and growth oriented.

#### 7. Integration

The foundational learning allowed me to be more open to other resources of information. But in that moment, there were my foundational training in GIM, my skills as a guide, myself as a kinesthetic traveler, and my teaching as a trainer. I was not even who I was in the world. I was a human being. When I was connected to the client and felt the energy in their body, it all coalesces into one moment of "Do this." When it all integrates, it

## 8. Results

The client said the session was incredibly profound as the last piece of the program was their familiar song and they were able to sing with the song. I would never know this unless I was connected to them somewhere in the depths of consciousness. Somewhere in depth of unconscious, I was connected to the client and had this intuitive knowing, which was never reached if I stayed cognitive. I had the foundational training where I did not expect myself to change the music program in the middle of the session. But because of the experiences like this, I think I am more able to trust my intuitive knowing.

### **Participant 6**

#### 1. What happened: DURING THE SESSION

I usually have physical reactions when providing GIM sessions, but with this particular client, I felt dizziness and kept floating up to the ceiling while the client experienced imagery with music. The client was severely traumatized and it was hard for me to hear how awful that was. My body reacted with physical sensations before my conscious mind and sometimes I made connections after the session. My response was as if my psyche wanted to escape and disappear because I felt like being traumatized by engaging in the client's destructive and painful imagery. I had to keep both my feet on the ground and have a stone with sharp points so that I could stay present and functional as a therapist for the client and that I could have an anchor for my own safety. The most I could do was to listen and to bear witness.

#### 2. What happened: AFTER THE SESSION

Despite my external solutions during the session, such as keeping my feet on the ground for grounding and holding the pointy stone for an anchor, the internal influence of the work with this client continued even after sessions. After sessions with the client, I started to look at things in life negatively. I noticed the importance of having support and supervisions, keeping solid boundaries with the client, and making time to cleanse myself in order to protect myself. I wanted to continue the work with them because I liked them and to do so, self-care was the most important. After one heavy and dark session, I was really ruffled and unsettled all through my body as the residue of the session and I knew I needed to cleanse myself and be centered again. I called up my GIM colleague and we improvised together for three hours. It was loud, dissonant, and long, as if I was doing my own trauma work with a therapist.

#### 3. About the Client

The client was the most extremely traumatized among all my trauma clients and the way

that they lived their life was disoriented, detached, and dissociated. Their imagery<sup>157</sup> therefore, was dark and self-destructive, including the memories of all kinds of abuse. Because of severity of their trauma, none of their past therapists were able to support them. The client needed someone who could witness.

(But to witness, the therapist needed to make a maximum effort for self-care and self-protection)

#### 4. About the process

I took an integrated approach to the client including gestalt, GIM, and improvisation. In some sessions with the client, the music took the role of a primary therapist and I was being present as a witness without applying my value judgements in my action. Even after imagery phase, we improvised together for processing instead of verbal talk, in which the music integrated their experience and I supported and reflected their process.

#### 5. How the therapist experienced

It was a very hard work for both the client and myself as a therapist. I experienced a wide range of feeling from real sadness to outrage. I felt like I needed to be on guard (not to be drawn in these emotions), which I normally do not feel at all. I had to protect myself more than usual from unknowingly taking on the client's trauma and negativity.

#### 6. The Music

The beauty of the method is the presence of recorded music, which is always solid and reliable even when I am ruffled and not centered. In the work with this client, the music sometimes took the primary role as the therapist. Because the music was holding and supporting the client, they were able to go into their trauma. Unconsciously, the music helped me as well by giving me all qualities, structure, and form that I needed to hold the space in myself to keep the appropriate distance from the client's experience. Although I did not go into the imagery with the client during the music, in the post session, I was in the music with the client through improvisation as if it was the therapy for both of us.

#### 7. Decision making

To make decisions, it is important to have cognitive foundation, self-awareness, understanding of the client, and openness to the situation in the moment, which lead to informed intuition. All of these elements allow GIM therapists to have an encompassing framework to process atypical reactions. In my case, my own reactions such as the physical sensation of floating away informed me that I needed to protect myself from taking on his trauma and negativity. When GIM therapists take risks to deal with unexpected reactions based on cognitive foundation and informed intuition, they can stretch their ability as a GIM guide and potential of the method.



### 8. The role of the therapist/ Therapist-client relationship

My role for the client was a witness who felt compassion and held the space for them. The client did not need interventions but a witness.  
(music took the primary therapist role).

### 9. Countertransference

I often get kinesthetic reactions which are taught as countertransference. If you do your own work, countertransference can be very informative and help me quickly make decisions during the session. And then after the session, we gained understanding of what had happened.

In GIM, we open up ourselves so sometimes we have deep feelings. GIM therapists must have done our own work, received supervision, and had support, which then allows us to be more open. Because of the atypical countertransference in this session, I became aware of the importance of being on guard in working with this client.

## **Participant 7**

### 1. Before the session (Referral)

This client was referred to me for a one-time session by a talk therapist. This therapist regarded me as "music healer" and gave an incredible expectation to the client that they would have a transforming experience with me in one session.

I was angry at the therapist for giving such a high expectation for the client that I was going to fix them in one session and for restricting it to only one time. This expectation created a pressure on me to do a good session as well as on the client to be a good client.

### 2. Prelude

In Prelude, the client was operatic. They were very fragmented and meandering all over the place like the recitative, and then became very emotional and sobbing like an aria, thinking they were having such a great session. I feel the fragility of the client, which limited the kind of music session that I could have with her. I did not want the client to continue talking so I asked them to share their music to bring a focus for a Resource Oriented Music and Imagery session.

I felt the unconscious pressure to give a great session and the client probably felt the pressure to be a good client. Unlike usual sessions, this put me to a very cognitive place.

### 3. Music

The client chose the music that was the opposite of what I wanted it to be. It was so crazy which had no form, no consistency, and no structure and it exactly represented the client's state being very fragmented and unstable. I had expected that the music would bring her

back to center, but the music was not what I would call resource oriented. It was ~~159~~ unhealthy and I would not encourage it. Despite my intension, the client was very centered on this piece of music, instead of meandering around the pile of CDs as she did in the prelude.

The piece that they chose was completely unexpected. I felt "Oh my god, this music can't work! What am I gonna do?" I had felt that I had to give a good session for them, but now I felt that I had to keep them safe. I was cognitively thinking about the piece and analyzing it rather than feeling it with the client.

#### 4. The therapist's intention (Expectation)

I had some intensions for the client and for the session because of the pressure that I felt to have a good session with them. I wanted to give a Resource Oriented Music and Imagery so that they would be centered in themselves despite their fragility. And when they brought up the music, I wanted to take them to a safer place instead of diving into the rough waves with them with the music.

#### 5. The therapist's experience of "trapped"

When I heard the music, I felt very trapped as if I put myself in that corner. I was very scared because there was no solution of which I could cognitively think. I felt there was no way that the session would come out well in the way I wanted it. It went from the feeling of wanting to do a good session to the realization that I needed to do no harm to the client. I was only thinking cognitively to do a good session and I felt as if everything I had have done led to the crazy Miles Davis piece. I was so afraid to dive into the rough waves with them and my fear made me want to take them to a safer shore. I wanted to get out of there.

#### 6. Decision Making

Then, all of sudden, and I am still not sure what was the trigger, but I finally surrendered to where "we" were. It was the moment when something in me let go of my wish to have a good session, fear, impulse to get out to a safer place, cognitive judgements of the music, and rejection of the part of the client. When I gave up, I had a feeling of wanting to take a risk, bravery to jump into scary waves with the client, and openness of curiosity. I felt "Screw this! I'm gonna do it!" I turned off my brain and just let it happen. The very thing that I was scared of was exactly what the client needed to do. My cognitive impulse was to go up, but their impulse was to go down. When I followed the client, the results were so far beyond what I could have imagined.

#### 7. Results

The client heard creativity in the music that I did not hear by cognitively judging it. The

music was mirroring her fragmented and weirdly uncentered emotional state, but they did not hear it. Instead, they enjoyed the creativity that they heard in the music. It was the music that brought us the feeling of creativity that we cannot access without it. By taking a risk, I felt like a new dimension of therapy had opened up for me, just like a new dimension of the client had emerged for them!

## SAMPLE OF CROSS-CASE ANALYSIS

Sub-Research Question 1

**Theme 2: Unmet Expectations**

Sub-Theme	Textural and Structural Descriptions
Countertransference	<ul style="list-style-type: none"> <li>• It was my countertransference reaction because I was abandoned by my own father and had not been able to grieve over my own experience (PT2)</li> <li>• I was meeting my own personal need through their sessions by living vicariously through them (PT2)</li> <li>• It was a precious moment for them and hard earned after 20 or 30 sessions, and there was a ton of work that could have done in the moment, but I stole it from them because of my countertransference (PT2)</li> <li>• It was hard to hear the same story again and again because there was a little bit of an element of a countertransference (PT3)</li> <li>• Although I was not aware of it during the session, this feeling was similar to the frustration that I felt with this client. It could have been another countertransference which led to the gut feeling of "I am going to give you Menotti" (PT3)</li> <li>• I had countertransference reaction even before they got to my office because I knew they would be prickly and I felt it would be difficult working with them (PT4)</li> </ul>
Somatic Reactions	<ul style="list-style-type: none"> <li>• Then, I had this gut feeling which said, "Maybe we could" (PT1)</li> <li>• Because of this experience, I had a deep understanding of the need for standing up in the cell of my body although I was not aware of it in that moment. This might have led to my gut feeling of "maybe we could" (PT1)</li> <li>• suddenly, I had this gut feeling which said, "I'm</li> </ul>

	<p>going to give you Menotti" (PT3) <span style="float: right;">162</span></p> <ul style="list-style-type: none"> <li>• I felt dizziness and kept floating up to the ceiling which was as if my psyche wanted to escape from their imagery and disappear. I felt like being traumatized by engaging in their destructive and painful imagery (PT6)</li> <li>• The kinesthetic reaction, or countertransference, informed me that I needed to protect myself (PT6)</li> <li>• I was ruffled and unsettled all through my body as the residue of the dark and heavy session (PT6)</li> </ul>
<p>Intuitive Reactions</p>	<ul style="list-style-type: none"> <li>• Then, all of a sudden, without even trying, a piece of music came to my mind. I was very surprised because it was a deep intuitive knowing rather than a cognitive idea which I had no idea where it came from (PT5)</li> </ul>
<p>Emotional Reactions</p>	<ul style="list-style-type: none"> <li>• It was very unexpected and my first reaction was to flinch to stop them. I was taken back for a moment and felt a little bit out of control (PT1)</li> <li>• It challenged me that the Bonny Method and I as the therapist had not been able to shift this thing that they had been working on for years. I was very frustrated (PT3)</li> <li>• It was very unusual for me and I felt unsettled (PT4)</li> <li>• I also felt anxious because I did not have a therapeutic relationship with the client yet (PT4)</li> <li>• I was anxious and felt unprepared so I took time for spiritual preparation before they came (PT4)</li> <li>• And after the session, I felt anxious and I had to detox what I had taken on to my body unconsciously (PT4)</li> <li>• I felt I might have overestimated where they were by even choosing Expanded Awareness (PT5)</li> <li>• I experienced a wide range of feelings from real sadness to outrage (PT6)</li> <li>• I felt there was no way that the session would come out in the way I wanted it to and I was very scared (PT7)</li> <li>• I was so afraid to dive into the rough waves with the</li> </ul>

	<p>client and my fear made me want to take them to a 163 safer shore (PT7)</p> <ul style="list-style-type: none"><li>• I had this feeling of wanting to take a risk, bravery to jump into scary waves with the client, and openness of curiosity (PT7)</li></ul>
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**LIST OF GIM PROGRAMS RELATED TO THIS STUDY**

Emotional Expression II (Helen Bonny)

1. Brahms: 3rd Symphony, Allegro Con Brio
2. Menotti: Piano Concerto in F, II Lento
3. Shostakovich: 5th Symphony, Moderato (excerpt)
4. Shostakovich: 5th Symphony, Lento

Expanded Awareness (Linda Keiser-Mardis)

1. Vaughan Williams: Fantasia on a them by Thomas Tallis
2. Vaughan Williams: 5th Symphony, I Romanza
3. Vaughan Williams: The Lark Ascending

Paradox (Sierra Stokes-Sterns)

1. Corigliano: The Red Violin, Anna's Theme
2. Corigliano: The Redo Violin, Main Title
3. Fleshes and Bones: Pagan Saints, Dirge
4. Fleshes and Bones: Pagan Saints, Throes
5. Elias: The Prayer Cycle, Hope
6. Sound track from Gladiator: Now We Are Free

Resource:

Bruscia, K. (2014). *Discography of Guided Imagery and Music (GIM) Programs*.  
University Park, IL: Barcelona.

Atlantis Institute for Consciousness and Music (n. d.). *GIM Training Material*.