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THE EFFECT OF GUIDED IMAGERY AND MUSIC WORKSHOPS ON LOCUS OF CONTROL AND SELF CONCEPT OF MENTAL HEALTH OUTPATIENTS

Roberta Wigle Justice, M.M.

Western Michigan University, 1998

The purpose of this study was to determine the effect of guided imagery and music (GIM) in a group format on the locus of control and self concept in mental health outpatients. Twenty adult mental health consumers took part in the experimental study with 10 subjects in the experimental condition and 10 subjects in the control condition.

The revised Tennessee Self-Concept Scale (TSCS:2) short form (Fitts & Warren, 1996) was used to measure self concept and the Levenson Locus of Control Scale (Levenson, 1981) was used to measure locus of control. Pre and posttest data collected from these instruments revealed no significant change on the scores of either scale for the participants of either group.

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Roberta Wigle Justice

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CHAPTER I

INTRODUCTION

Forms of treatment for people with a variety of mental health diagnoses have undergone, and are still undergoing, a change in this half century. In Western countries, including the United States, there has been a shift from long term inpatient stays and institutionalization, to shorter inpatient stays and more outpatient forms of treatment (Nieminen, Isohanni, & Winblad, 1994). State and private psychiatric hospitals are either being closed or downsized. This is in part a reaction to the belief that human beings should be able to function at their highest potential in the least restrictive environment, and a reaction to financial concerns and pressures. As managed care has become the primary mode of health care payment, the emphasis on cost effectiveness has continued to increase. Inpatient stays are focused to be specific to immediate symptoms or life threatening issues. Long term (greater than three weeks) hospital treatments are becoming increasingly rare. As this trend continues, therapists and researchers are searching for effective and cost efficient treatments that can be provided in outpatient or community settings.

Need for the Study

In the search for more effective and cost efficient treatments in mental health, a variety of different formats are being tried. These formats include day treatment programs, intensive outpatient programs,

clubhouse models, and services taken to clients directly in their supported apartments and group homes. These programs can, but do not always, include specific treatment approaches like cognitive behavioral therapy, supported employment programs and/or recreational/social activities. Most programs provide services only during the week days. In residential service programs (supported apartments and group homes) staff are available in the evenings and nights, mostly for the purpose of daily living activities like preparing meals, doing laundry and dispensing medications.

Also in the search for effective and cost efficient treatments, therapeutic approaches that are not limited to strictly verbal techniques are gaining more attention. These "holistic", "complimentary", or "alternative" therapies include a wide range of approaches like yoga, massage, bio-feedback, and creative arts therapies, including music therapy. Music therapy has been part of psychiatric inpatient programs for over fifty years and part of psychiatric day treatment programs for over twenty years in some instances (Kenney, 1982; Priestly, 1994). Little experimental research was found about the use of music therapy as a form of traditional psychiatric outpatient work, in either individual or group formats.

In 1976, Helen Bonny began the development of a psychotherapy technique using music called the Bonny Method of Guided Imagery and Music (or "GIM") that is currently practiced by trained clinicians. The Bonny Method of GIM is defined as a dialogue between a traveler (client) in an altered state of consciousness and a guide (therapist). The content of

the dialogue revolves around the traveler's responses to specifically selected programs of classical music. This is followed with processing of the traveler's responses in a non-altered, or normal state of consciousness. The majority of written material found is descriptive, and generally focused on GIM in individual outpatient work (Pickett, 1992; Borling, 1992; Lewis, 1993; Ventre, 1994). Group GIM work, which is an adaptation of traditional GIM, has been reported to be effective with inpatient psychiatric populations (Goldberg, 1994), the elderly in supported living (Steenrod, 1995), and with people hospitalized with eating disorders (Justice, 1994). While Summer (1988) describes some use of GIM with various psychiatric populations, no research in GIM group work specifically with psychiatric outpatients was found.

The purpose for this study is to investigate the effect of an extended half day (4 hour) group workshop using GIM group therapy techniques on the self concept and locus of control of psychiatric outpatients. It is possible that such workshops may find a place in a weekend retreat or workshop as part of the continuum of care in mental health.

Statement of the Problem

Group work is generally recognized as more cost efficient than individual work. Extended outpatient groups have been shown to be effective with some adult populations (Allen, 1990b; Frey, 1987; Gilovich & Miller, 1994; Winick & Levine, 1992). A review of literature yielded a variety of studies with extended groups. These ranged from four hour groups to weekend long marathons, and were used in several different

areas, including substance abuse (Winick & Levine, 1992), incest survival (Gilovich & Miller, 1994), and adjusting to a divorce (Byrne & Overline, 1991; Byrne, 1990). The majority of these studies focused on verbal group therapy techniques, while some included gestalt and experiential techniques. Only one study was found which focused on the effectiveness of extended group work in conjunction with ongoing outpatient individual therapy (Yalom, 1977). No studies were found which explored the use of music or GIM in extended groups. This suggests a need to examine the effects of music therapy including GIM as part of extended group work.

Research Subproblems

Assumptions

It is expected that this study will be viewed as an exploratory study of the effect of participation in The Bonny Method of GIM on self concept and locus of control. It is further assumed that the instruments employed for measuring self concept and locus of control measured what they were intended to measure.

Delimitations

The results of the study are applicable only to the participants of the study in Washtenaw County, Michigan. Caution is suggested in generalizing the results to other people involved in outpatient programs or therapy. The intent of this study was to examine one treatment, the

Bonny Method of GIM, and its effect on self concept and locus of control in people in outpatient psychiatric work. The research was conducted over a two week period for each individual, a seven month period to complete the total number of workshops. Each individual's two week period included participation in one four hour workshop. It is conceivable that research conducted over a longer period of time for each individual, with a greater number of sessions, may develop carry over of material from one session to the next and produce different results. It is also conceivable that a larger number of subjects representing a wider variety of backgrounds and residing in a broader geographic locations may produce different results.

CHAPTER II

REVIEW OF RELATED LITERATURE

Current Psychiatric Treatment Options

A continuum of care in psychiatry currently exists in which inpatient hospitalization is generally focused on crisis intervention, and return of the individual to the ongoing community components of his/her treatment. These components include day and partial hospitalizations, outpatient group therapy and support groups, and individual outpatient therapy.

Inpatient hospitalization can be expensive, are often recurrent, and are a target for financial watchdogs in insurance companies (Alonso, 1994). Twenty four hour care requires nursing staff around the clock, as well as dietetics, maintenance, security, and housekeeping personnel. If a person is in immediate crisis, this environment can provide much needed support. Typically the goals of responsive inpatient programs are: to quickly and accurately assess the current state and situation of the patient; stabilize the patient through containment and supportive therapy; and plan follow-up work (Smith, 1995).

This is a reactive system in which a patient has to reach a crisis before being admitted. These crises usually center around the sense of loss of control over one's life and emotions, and/or a lack of mastery in one's environment. The structure and support of the inpatient setting helps the

person regain a sense of personal control and mastery, (Silk, Eisner, Allport, DeMars, Miller, Justice, & Lewis, 1994).

A recent partial solution to crisis admissions is the concept of intermittent inpatient admissions. Intermittent inpatient treatment programs admit people with chronic mental illness or emotional illnesses at regularly scheduled time periods for short term inpatient stays. One of the purposes of these programs is to intervene before struggles reach crisis stage and maintain the person outside of the hospital as much as possible. Short term inpatient settings follow guidelines for structured treatment goals that are developed in the outpatient setting with the patient (Nehls, 1994; Silk et al., 1994). The goals are based on a variety of cognitive-behavioral and psycho dynamic approaches, and are individualized to the needs of the patient. This approach is intended to keep the patient functioning at an acceptable level of independence and self care in what is hopefully a balance of cost and intensity of treatment.

After discharge from a short inpatient hospitalization, the individual can find him or herself back in the stressful and tenuous life situations that were often part of the exacerbation of symptoms. Outpatient groups can provide support weekly, but the transition from twenty four hour a day care to a once a week group is a great difference in the amount of personal contact and support. This may leave the person once again feeling isolated. Individual therapy or case management is reported to be significantly helpful as a form of outpatient support. Group and interpersonal therapies have been shown to be as effective as individual work, particularly with the four diagnostic categories to be

discussed; depression, bi-polar illness, borderline personality disorder, and eating disorders (Persons, Thase, & Crits-Cristoph, 1996; Scott, 1995; Solomon, Keitner, Miller, Shea, & Keller, 1995; Monroe-Blum & Marziali, 1995; O'Leary, 1996).

Groups in Therapy

People with chronic depression, anhedonia, interpersonal difficulties, and chronic suicidality have been shown to respond well to a focused, time limited inpatient program (Silk et al., 1994; Nehls, 1994). Fundamental in this type of inpatient programming is group participation and the effect of a therapeutic community. Several of Yalom's (1975) curative factors found in group psychotherapy are also found in the patient networking that occurs in this therapeutic community. The patients begin to connect with others in a variety of formal groups, which can include music therapy and group GIM techniques, and continue this in informal time playing cards, watching movies, or talking around the smoking table. They develop their own open ended support group which carries into the community. The factors most clearly seen in this type of setting are interpersonal input, catharsis, cohesiveness, interpersonal output, universality, and identification.

Structure, support, and the ability to hear and give feedback to others in a variety of group settings enables the patient to reassess his or her way of being in the world and try new behaviors. The presence of these factors leads to a sense of connectedness with other people which promotes a sense of self worth (Allen, 1990b; Nehls, 1994). A sense of

connectedness in the external community, along with a feeling of personal control, has been helpful in decreasing inpatient dependency (Nehls, 1994; Solomon, Keitner, Miller, Shea, & Keller, 1995). Marathon and weekend groups provide a similar type of structure to the three to seven day stays on an inpatient psychiatric unit, and might be useful on a regular basis in outpatient settings, to help increase connectedness in the community and decrease isolation and loneliness.

Group work is often more cost efficient than individual work. In an inpatient setting, the therapist is paid an hourly rate regardless of how many people he or she sees in that time period. Since more than one person is seen in a certain time period by one therapist, the cost per person is lower than individual work. Outpatient per person rates for group work are expected to be lower than individual rates by providers and consumers, and this is reflected in fee schedules of therapists. HMO's are moving toward capped dollar amounts that they will pay per year for therapy, limiting the amount of money available to people. Since groups cost less per person, individuals can "stretch" their therapy dollars by attending therapy groups. Individuals are able to attend more sessions for the same amount of money in groups than in more expensive individual work. Additionally there is a current focus of third party payers on treatment "value", that is, getting the most effective treatment in the most efficient way (Miller & Silva, 1996).

Part of the reason inpatient stays are helpful is due to a combination and intensity of group experiences that add to the person's insights and life coping skills (Silk et al., 1994). In addition to cognitive-behavioral

groups, traditional leisure activities and informal socializing, there can be experiences offered through music therapy that provide for self exploration and intense group process interactions. This combination, traditionally found in inpatient settings, is not often found in outpatient groups or in verbal retreats. Retreats and/or marathon type extended group settings using verbal and gestalt techniques have been shown to be useful as reported below. A search of the research literature did not produce any descriptions of inpatient, outpatient or community programs using music and GIM group techniques in retreat style formats. Using the adapted group form, the Bonny Method of GIM lends itself well to insight oriented work, group process (Goldberg, 1994) and extended time periods (Clark, 1977; Beck, 1988).

As in marathon groups where the length of the group and inherent fatigue of the individual break down defenses and allow breakthroughs, GIM experiences reach past defenses and allow breakthroughs. The use of GIM techniques can enable a person to access a deeper part of him or herself than when working with cognitive verbal skills, and make shifts on a subconscious or unconscious level that increase belief in personal efficacy, sense of control and worthfulness (Goldberg, McNeil & Binder, 1988; Goldberg, 1994).

Types of Extended Groups and Uses

Extended groups have been cited as being effective with different populations in various parts of the literature. The initial concept was to provide a setting where the sheer duration of the group process would

break down the participants' defenses and provide opportunities for affective breakthroughs (Allen, 1990b; Frey, 1987; Gilovich & Miller, 1994; Winick & Levine, 1992). Extended groups can vary from four hour groups to one day workshops to weekend marathons, where the participants stay together for the entire time, eating and sleeping en masse. Several different aspects of the extended group have been examined, mostly comparing their effectiveness to traditionally structured groups. Much of the research found in the literature examining the intense marathon form was based in the 1970's with substance abuse clients. These groups were used to break through typically strong defense mechanisms, particularly denial and projection. More recently, Winick and Levine (1992) described the use of a 54 hour marathon as a yearly part of their substance abuse therapeutic community program. This particular program was specifically for women who were survivors of rape. Although no numerical measurements were taken, follow-up reports were collected from the participants several months after the group concluded. These subjective reports of the participants indicated feelings of significant personal growth which the participants attributed directly to the marathon experience.

A slightly modified marathon structure, called a weekend retreat, has been used for adult and adolescent female incest survivors (Gilovich & Miller, 1994). In Gilovich and Miller's study, as in the marathon studies, the group members experienced pressure to participate and break through defenses due to the length of the session(s). The authors identified four issues where this experience was most helpful for members of their groups: positive identification with others, negating perceived culpability,

grieving a lost childhood, and altruism and self esteem.

Weekend workshops have also been used with incest offenders (Frey, 1987). As in previous studies, Frey found that the extended face to face contact in the sessions resulted in heightened self disclosure and break through of defenses. In sexual awareness educational workshops, Voss and McKillip (1979), found that although the weekend workshop format did not impart significantly more information, it did have the effect of changing the participant's attitudes. Other reported uses of the workshop or marathon format have included affectively blocked patients in ongoing group therapy (Biggs, Felton, & Hirsch, 1976); people adjusting to a divorce (Byrne & Overline, 1991; Byrne, 1990); women with bulimia (Gendron, Lemberg, Allender, & Bohanske, 1992) and people in ongoing individual therapy (Yalom, 1977).

Kilman, Sotile, and Fritz (1978) explored the effect of marathon groups versus a more traditional encounter group treatment on self actualization with undergraduate university students. The findings suggest that a combination of weekly groups with periodic extended groups may be the most effective over a long period of treatment, as there were no significant differences between the two groups. Members of both groups experienced positive or neutral change. Uhleman and Weigel (1977) explored the changes towards individualized behavioral goals and found that marathon group treatment was effective in producing significant changes in university students who sought counseling. Loomis (1988) suggested that immediate learning is stronger in twice weekly groups, but members of the marathon group continued to integrate and

augment their learning for some period of time after the session. This possibility was also seen by Johnson and Johnson (1979) when exploring the effectiveness of various group approaches to self actualization.

Diagnostic Categories With Potential for Use of Extended Groups

People in several diagnostic categories who have been adversely effected by the changes in the delivery of mental health care, might find extended group work helpful as part of the current care continuum. These people often experience recurrent psychiatric inpatient stays, and carry one or more of the following diagnoses; Schizophrenia, depression, Bi-Polar disorder, Borderline personality disorder, and eating disorder. Since the present study excluded people with active psychoses, schizophrenia will not be addressed.

Depression is one of the most common mental/emotional afflictions. People with this disorder generally are allowed three to seven day inpatient stays by their insurance providers, in order to alleviate immediate symptoms and interrupt feelings of suicidality. Yet people with depression are rarely "cured" in that length of time, and often continue in outpatient treatment. Outpatient treatments usually include medication alone, some combination of medication and group or individual psychotherapy or psychotherapy alone. Various forms of psychotherapy have been used with this population, including cognitive therapy, behavior therapy, brief psycho dynamic psychotherapy and interpersonal therapy. Scott (1995) reviewed treatments for depression and outcome studies of these treatments. She found that the approaches were equally

effective. Persons et al. (1996) reviewed depression treatment practice guidelines published by the American Psychiatric Association (APA) and the Agency for Health Care Policy and Research (AHCPR). This review reported conflicting information between the two regulatory agencies. APA guidelines indicate that behavior, cognitive and psycho dynamic therapies have better results when done individually than in group, while the AHCPR guidelines show no difference in effectiveness between individual and group work.

After the onset of the illness, people with Bi-Polar disorders struggle with mood swings for the duration of their life . They may receive some relief from medications, but receive greater relief with a combined medication and psychotherapy approach(Solomon et al., 1995). Current therapies that have been effective with this population include family therapy, cognitive-behavioral therapy and group or interpersonal therapy. Psycho social treatment and social support have decreased the number of hospital admissions in bipolar patients, if not the recurrence of symptoms and episodes (Solomon et al., 1995).

People with the diagnosis of borderline personality disorder are often recurrent psychiatric inpatients. Statistics indicate the prevalence of patients with borderline personality disorder in hospital settings is increasing, and there is a prediction that people with this disorder will replace persons with schizophrenia as the chronic population in hospital settings (Nehls, 1994). Inpatient stays for people with this diagnosis have ranged from months to years in the past, as long term treatment is necessary for psychic restructuring to take place (Hull, Clarkin, & Kakuma,

1993). Current treatment strategies involve a continuum of care that is predominantly outpatient work, individual and/or group, with brief, focused inpatient stays. (Silk et al., 1994; Monroe-Blum & Marziali, 1995). Models of therapy used with this population include cognitive, cognitive-behavioral, psychodynamic and interpersonal therapy.

Since people with eating disorders often require long term treatment for permanent change, inpatient lengths of stay of up to two years have not been unusual historically. Current lengths of stay are shorter, again due to insurers' reluctance to fund long term stays. Currently inpatient work is focused on re-feeding, or breaking bulimic binge-purge patterns, and the long term psychological work is done on an outpatient basis. As with borderline personality disorder, psychic restructuring takes a long time, and people with these disorders often relapse and experience rehospitalization. Medications are used to alleviate or control symptoms, but not as a "cure" for these disorders. Again, individual and group therapy may be cognitive-behavioral, interpersonal, or psycho dynamic in nature. Recently it has been shown that a retreat model of therapy is as effective as traditional group therapy in long term outcomes in the treatment of bulimia (Gendron, Lemberg, Allender, & Bohanske, 1992).

Use of Music in Psychotherapy

A proposed stratification of music therapy practices used in psychiatry (Wheeler, 1983) is adapted and cited in other sources in the music therapy literature (Unkefer, 1990; Davis, Gfeller, & Thaut, 1992). In

this system, three levels of music therapy experiences are defined on a continuum to meet various levels of need of psychiatric patients. The first level is labeled supportive, activity oriented music therapy. At this level music therapy experiences are generally success oriented, structured and socializing in nature. At this level the therapeutic benefits are focused on the participation in the music experiences; not insight derived from this participation.

The second level in this hierarchy is labeled reeducative, insight and process oriented music therapy. Experiences in this level add processing of one's feelings regarding the music experiences, and cognitive behavioral techniques of looking at one's behaviors in the present. In this level participation in the music experiences are processed to lead to insight about the person in the here and now, but not to uncover issues in the subconscious.

The third level is labeled reconstructive, analytically and catharsis oriented music therapy. In this level music therapy experiences are used to uncover, relive or resolve subconscious conflicts. These experiences are processed to lead to insight for the person regarding unresolved issues and lead to potential personality reorganization (Wheeler, 1983). How experiences in music can reach the subconscious and produce personality change is a complex topic which requires advanced training and understanding by the therapist. Several theories regarding music in this capacity have been generated over the last hundred years.

Noy (1966, 1967) undertook a review of psychoanalytic and other literature related to understanding the psychodynamic meaning of music.

The analysis of the arts was focused on examining the works for unconscious and unresolved regressive issues of the artist in the musical work. The nature of music makes it difficult to analyze the process of the listener in this way, except in the form of "phantasies" or dream-like reactions to the music.

It is with the understanding of ego development that a greater understanding of the effect and use of music in therapy arises, particularly in the concept of mastery. According to the ego development approach, there is no passive participant, but the listener acts in the music by organizing the auditory precepts, making sense of them, and thus "mastering" them.

Kohut (as cited in Noy, 1966) discusses music from the structural point of view, seeing a different effect on the id, ego, and superego.

..first, music allows catharsis for primitive impulses, music is an emotional experience. Second, musical activity constitutes an exercise in (substitutive) mastering, music is a form of play. Third, music as an expression of rules to which one submits, becomes a task to be fulfilled, music is an aesthetic experience. (p. 133)

Menninger (as cited in Noy, 1967c) believes human responses to music decrease self destructiveness by strengthening the instinctual force of love. Perhaps this makes more sense if thought of in the ego psychologist's view. By strengthening one's sense of positive mastery, the forces of self destructiveness are, in time, weakened and unnecessary.

Kris (as cited in Noy, 1967c), coined the phrase "regression in the service of the ego" and states that "the integrative functions of the ego include voluntary and temporary withdrawal of catexis from one area or another to regain improved control."(p. 88) Friedman (as cited in Noy,

1967c) states

It was speculated that a musical theme represents an affect which temporarily activates some unconscious conflict. In listening, we participate in the temporary regression offered by the primary process transformations of the thematic material and achieve temporary mastery over this conflict. This mastery is experienced as aesthetic pleasure by the ego.(p 88)

The concept of mastery and organization of the several layers and forms of auditory stimuli presented in music is supported by several authors as having importance in understanding the human response to music. Kohut and Levarie (as cited in Noy 1967c) believe that a major function of music is through regression which allows the ego to acquire the capacity for mastering. Sterba (as cited in Noy, 1967c) delineates this regression through the element of motion in music, which he likens to an infant beginning to control his movements. At this stage the ego is not yet differentiated from the external world, and this regression reenacts the barriers of our adult ego, conveying an "oceanic" (undifferentiated) feeling, and allowing the listener to feel as if he is about to unite with the universe and "even to master it." (Noy, 1967c, p. 83)

Other theories of the organization and function of music are also pertinent to this paper. Gutheil (as cited in Noy 1967c) believes that the experience of an external, permanent and organized world maintains an inner balance. Thus, "an organization of the outside world into routine designs therefore brings about a feeling of calm and self-assertion into the individual." (p.90)

Meyer (1956) goes into depth regarding the expectations of a listener about the form music "should" take, versus the changes that actually

occur in melodic, harmonic, rhythmic and loudness components in complex music. He feels that the unexpected turns in complex music raise questions in the mind of the listener, who then develops a sort of answer to the "problem". The more complex the music, the more ambiguities there are, and the wider variety of responses, "answers" or meanings that might be found in it. Music that has a consistent and unidirectional path is primitive, and can be considered trite or boring. Music with many deviations from the expected path is interesting, and of value. Music which is simple and offers a quick, easy solution does not require much energy to achieve mastering by the listener. According to Noy (1967c) "the more frequent the unexpected situations, the greater the danger of losing control, the more energy needing to be mobilized [by the ego] to cope with the stimuli." (p. 93)

The completion of the original musical goal (resolution) offers the discharge of tension, or gratification. Deviations and interruptions in the music require maturity [of the ego] to be able to delay gratification in the listener, and to bear uncertainty.

These concepts of the effect of musical structure, complexity, and ambiguity on the listener are some of the basic concepts used when choosing music for therapy in GIM. GIM theory teaches that the listener can make best use of the music to generate meaningful images when the levels of structure, complexity and ambiguity in the music most closely match the ego strengths and psychological needs of the listener.

In the Bonny method of GIM, the client listens to specifically selected programs of classical music while relaxed, and dialogues with the

therapist about his or her responses to the music. The formulation and meaning of the symbols in this process parallel and reflect the process of symbol formation in human development.

Theories of Symbol Formation

Imagery, symbols and metaphor have all been used in a variety of therapies with a variety of theories or models, and various comparisons are available in the literature (Furth, 1983; Blum, 1978). Freud and the early psychoanalysts held to the theory that primary process images or symbols in the unconscious were a result of repression of unfulfilled drives or wishes, and needed to be analyzed similarly to dreams, from a set of universal meanings for each type of symbol. Because, according to this theory, these symbols developed in the preverbal time of sexual and libidinal development, Freud related all repressed or unconscious images to this period of development.

Psychoanalytic symbols derive from unconscious instinctual conflicts, and require and are related to repression. What is not repressed, does not need to be symbolically expressed (Blum, 1978; p. 456).

Later analysts theorized that symbol formation had a defensive function, moving it beyond a primary process function. Jones (as cited in Blum, 1978) tied the primitive defenses of displacement, projection and introjection to symbol formation, stressed the defensive formation and function of symbolism and the relation of symbolic substitution to sublimation and adaptation. Rycroft (as cited in Blum, 1978) stated that the process of symbol formation presupposes some degree of ego development

and the functions of perception and memory. He proposed that symbolism was not exclusive of the primary process or in the service of the unconscious, but a general tendency of mind. He also proposed that the primary and secondary processes as well as conscious and unconscious mental activity are on a continuum and symbolism would serve both unconscious fantasy and reality-enriching imagination (Blum, 1978).

Linguistic theorists have also explored the development of symbols, and appear to hold that primary process symbolism which is preverbal and "knows no grammar" precedes but coexists with secondary process symbols that are interdependent with language development. According to Blum (1978) "The unconscious symbolism of agoraphobia and claustrophobia coexists beside and beneath the conscious linguistic meaning of 'street' and 'room'." (p. 459)

Piaget focused on the development of thought and concept formation, but also observed a developmental symbolic process, which is similar to, but differs some from the psychoanalytic model (Blum, 1978; Furth, 1983). Piaget described early symbolic play closely connected to the capacity for deferred representational imitation. These early play symbols take place when symbolic play reproduces an absent object, the present object evoking the absent one. This symbolic play continues to develop and become more defined and differentiated. The symbols move into representational imaginings, and pretending becomes an available tool for the child, as do drawing, dreams and fantasy.

In an examination of conceptual models and symbol formation in latency, Donnellan (1980) described a two stage ego restructuring and

development closely connected to the development of symbols in latency aged children. Freud (as cited in Donnellan, 1980) suggested that fantasy was used as a defense in latency aged children, to ward off instinctually infiltrated wishes, and to permit the deinstinctualized expression of drives and refusion of sexual and aggressive drives. Sarnoff (as cited in Donnellan, 1980) demonstrated wide reaching changes in the functioning of the ego during latency that cluster around the ability to better use symbols. Sarnoff suggested that fantasy becomes the vehicle through which this change takes place, that the child gains mastery through fantasy. Both Piaget and Singer (as cited in Donnellan, 1980) suggest middle childhood is a time of unfolding in cognitive and affective areas. In connecting this to ego development in this developmental period Donnellan (1980) believes that imaginative behavior requires a high level of personality organization, that fantasy techniques can be an aid in strengthening the ego, and that fantasy fosters and integrates cognitive abilities, in what Piaget calls the "assimilation of affective schemas." (p. 295)

Donnellan (1980) proposes that the two stage theory of latency is supported, as well as the following points: fantasy is normal to development; fantasy develops conjointly with motor expressions (play) and later separately from them; verbal fantasy and motor expression are separate but interrelated components of development; and active fantasy may promote the development of more symbolic modes of thought and language. He states that fantasy is central to both cognitive and ego development, and states that the behavioral changes during latency reflect

the process of restructuring at the neurobiological, perceptual and cognitive levels. During this time the child begins to move from the motoric modes of expression of impulses to verbal modes, using more symbols. This series of organismic-developmental transformations is towards an end, the sense of personal meaning.

Donnellan states that representation is the unique and novel function of symbols, that they represent "intentionality-the person as the creator of meaning" (p. 297). Symbols are the messengers of intentionality, the keystone to the cognitive and emotional developmental transformations of childhood. The importance of this is that the restructuring through symbols demonstrates that children attribute meaning to themselves and their actions, and that gaining mastery through fantasy fosters this. He also states that a child's success or failure at symbolizing carries over into adulthood, and that both adults and children can suffer interference in the use of symbols for representation and intentionality. Since he also states that the role of symbolization is a deinstinctualized mode for the child to organize, modulate and express himself, it follows that the loss of the symbolization ability could result in the loss of the ability to organize, modulate and express oneself, impacting negatively on a sense of personal mastery and meaning. These symptoms are often seen in psychiatric patients. Perhaps then, experiences in symbolization as manifested through imagery, can help restore these abilities in adulthood.

Imagery in Therapy

The connection to the symbolic language of a person through imagery has been used in therapy in several ways. Winnicott (1953) stated that symbols for perception are identified and used by the developing person to establish meaning to those perception. These symbols make sense of the world and the self in it. Emotions are labels for meanings of some perceptions. For a person who has not developed a sense of meaning of perception, one who cannot label or understand emotions, working through this stage can help develop a sense of internal control, and a better understanding of oneself and one's emotions/reactions to the world. Relationships can be strengthened and a sense of happiness and well being can be approached. The working through of this developmental stage can be accomplished using imagery. Images are the symbolic language of this stage, they can represent experiences that are beyond words, or experiences that have not yet been understood in words. The images are explored in therapy and worked with as the infant would use transitional objects, and thus become transitional phenomena. Depending on the type of imagery therapy used the work may be accomplished without direct connection to the conscious state (as in manipulating or changing the imagery) or the connections may be made through interpretation of the symbols and the use of words.

Grof (1975) looks at images as symbols or metaphors, but symbols that have many levels of meaning, as they are connected in his thinking to many experiences that are similar in nature but different in time. Working with the images helps the client work through the trauma, and

move to a healthier, more balanced state of the psyche. By working with the images and emotions directly, Grof too, enters the "place of human experience" of Winnicott, that place of trying to make sense of the human perception.

Achterberg (1985) relates historical information about the use of imagery in healing of various cultures. Always this is accomplished in an "altered" or non-ordinary state of consciousness, whether the consciousness state is that of the patient or the healer. What is consistent in her findings, and in her work using imagery in medical settings, is that the most powerful images for change come from the patient or client. Many times these images are of the type that would be considered archetypal, transcending culture and age. Leuner (1969) catalogued some of these images and developed specific uses in treatment for them. For example, he asserted that an image of a meadow connects the person with feelings and images from his young childhood, and can access that level of consciousness as well as those memories. How the person experiences that image, and what occurs in the fluidity of imagery changing in time has to do only with the individual's experiences, and can bring material for work to the consciousness, or can work directly on the material in a symbolic form. Again, it is important to note that the imagery comes from the client.

Assagioli (1965) and Grof (1988) support the importance of client generated imagery for therapeutic work. Although a specific starting point may be chosen by the therapist to begin a session, the resultant responses are of the client and from the client's experiences. Often in Grof's work

there is no specific starting point. Through an altered state the client brings to awareness his or her physical feelings, tensions and images. These connect with what Grof calls a matrix and leads through the tension to resolution.

Imagery is often interpreted as dreams are, through meanings that have been attached to symbols across several cultures and spanning hundreds of years of human experience. Additionally, the client connects a specific meaning of his or her own to the imagery. This client-generated meaning is considered extremely important by all the above authors. Symbols and feelings experienced in imagery during altered states give clues as to the struggles experienced by the person on an unconscious level as well as the conscious level, and can be used to help the person develop insight into his/her feelings, reactions and behaviors. In the more fluid form, images develop and work through aspects of growth process by themselves, and knowledge of the archetypes and stages of the aforementioned theoreticians can aid the therapist in directing the therapy.

Music and Imagery

In his thorough evaluation of the human experience of the perception of music, Meyer (1956) connected it to heard and felt movement towards and away from a stable acoustic state. This movement includes the tensions of harmony and rhythm; and anticipations, delays of, and resolution of these tensions. He states that through these perceptual mechanisms "music may give rise to the images and trains of

thought which, because of their relation to the inner life of the individual may eventually culminate in affect [emotion]." (p. 256)

Some of these images are clearly conscious. The individual knows what the image is, what it is about, and why he/she feels a certain way about it. The individual can often clearly express this verbally or through art work or movement. Often these are connected with memories or thoughts about a piece of music. Sometimes, however, the images seem to be unconnected to the piece of music or the individual, or do not present themselves clearly as images at all, but only in the form of emotion. He talks about these image processes as being unconscious, or of the unconscious.

What specifically is it about music that gives rise to these emotions and/or images? How is it that this medium affects us so deeply? Kenny (1982) states:

Patterns of tension-resolution, melodic and rhythmic motifs and themes, repetitions, compositional forms, dynamics, all combine to weave complex patterns in sound. Pitch, time and volume are the key modes which utilize and communicate tension-resolution patterns. Within these three modes we experience the elements of music: melody, harmony, rhythm, meter, timbre, dynamics and texture. In a musical composition, these modes often inter-relate, setting up complex crossings of patterns. The appreciation of patterns is an aesthetic experience (p. 65)

As stated earlier, Meyer (1956) explores the perception of music in humans in detail, examining, among many things, the relationship between knowledge of music and musical style and emotional response. His conclusion includes the thought that the trained listener will hear the music differently than the non-trained listener, for example from the standpoint of good or bad periodic form, or good use of instrumentation.

There seem to be however, some generalizations that can be drawn; that all listeners expect and react to the music's resolution through melodic phrasing, harmonic textures, rhythmic tensions, rhythmic textures, and interplay among timbre.

When listening to music the images that arise will be a result of the combination of these musical aspects, their level of perceived ambiguity, and the psychological state of the listener. What the person experiences is a result of the person him or herself, environmental background, current psychological state, repressed issues and memories.

Meyer states that it is ambiguity and uncertainty about the resolution of different concurrent components of music that leads the listener to respond affectively, that is, through unconscious images, trying to make sense of what is perceived. Since music is processed in the relational parts of the brain, the parts that operate on Gestalt patterns, the available response will be also relational in nature, through symbols, images and emotion. This is more likely to occur when the listening focus is not on the analysis of the technicalities of the music itself. When the levels of ambiguity found in the music match the psychological state of the listener, more images will be produced, for the listener can more "lose himself" in the stimulus. If the music is perceived as too wild or too weird, with too many ambiguities for the individual at the time of listening, the tendency will be to negate the experience, as the amount of tension will not be able to be tolerated. The listener will be uncomfortable with a sense of chaos or lack of enough boundaries that are comfortable for him. If the music is perceived as too structured, with not enough

ambiguity, the experience will again probably be negated.

When the musical fit is good, the existence of music sequentially in time will allow the listener to experience progressions of images, to explore difficult issues in the psyche, to solve problems in a symbolic way, and to work within the Gestalt. The music can lead or support the listener's images in development, will provide areas of tension for conflict experiences, and will provide resolution as well, for almost all pieces of music resolve to some degree at the end. Obviously this means that one piece of music will not fit for every man, woman and child, or that the same piece of music will elicit the same response in the same person at two different times.

Guided Imagery and Music in Therapy

If music is to be used to generate symbols from the unconscious through imagery, it is then the specific responsibility of the therapist to be trained in the use of and effects of music, in order to choose the "best fit" for the situation. Beginning in the early 1970's Dr. Helen Bonny (1978a, 1978b, 1980) developed a process called the Bonny Method of Guided Imagery and Music (referred to as GIM) using Western Art Music (generally called classical, but not necessarily only of the classical period) to stimulate the listener's deeper levels of consciousness for therapeutic processing. GIM utilizes music to evoke imagery, emotions and other responses in the listener. This experience is similar to dreaming in the awake state, and is believed to be able to access the subconscious and unconscious levels of the listener as dreams do. The careful use of music

is specific to this therapeutic process, and the practitioner is trained in an in depth program combining the study of psychotherapy, imagery and music. GIM is practiced either individually or in groups.

GIM is a relatively new music therapy practice, and as such has a limited, but growing research base. A review of the current literature reveals case studies with a variety of trauma survivors, and descriptive studies of group work in psychiatric settings. Blake and Bishop (1994) found that the use of GIM in the treatment of post traumatic stress disorder (PTSD) with hospitalized psychiatric patients relieved hyper arousal and improved concentration. Additionally, GIM allowed the patients to work with their images, emotions and memories, and share these with a sense of control and meaning. Finally the authors reported that GIM sessions helped patients with empowerment and hope, finding new or underdeveloped strengths.

Beck (1988) examined the effects of participation in a one day GIM workshop on first time mothers. Group GIM was used to explore the feelings and issues around the transition from single person and partner to motherhood. Beck noted that the theme of polarities and conflict emerged for all participants during the workshop, with 80% reporting an increased awareness of their personal conflicts around motherhood. Awareness of such unrecognized conflicts allows for the process of resolution to occur.

Summer (1981) reported that the use of group GIM with the elderly helped break through ruminative thought patterns and stimulate new ideas, as well as increasing interactions and peer support in the group

members. Steenrod (1995) found that participation in group GIM was effective in increasing life satisfaction in the elderly living in a senior's independent living setting. Additionally, participants receiving GIM reported feeling more relaxed and increased sleep at night.

Goldberg (1994) describes the adapted use of group GIM in acute psychiatric hospitals. She states:

In GIM, the defensive maneuver is manifest first of all in symbol formation, images which represent issues symbolically, rather than directly and concretely. This gives the client more distance and enables problem solving that may not be possible other wise.....(pg. 22)

She further states:

The process of evoking and dealing with images brings a sense of control over the mind, leading to a sense of mastery, and the internal experience is validated through group sharing. Images provide tangible, reality based, here and now material for the group to explore, which furthers the group psychotherapy process (pg. 26)

Goldberg's modification of the GIM session allowed for the group members to work with a structured image and share each other's experiences, limiting the potential for emotional overflowing, and maximizing the possibilities for exploration, group process and growth.

Justice (1994) described the use of Goldberg's adapted techniques to increase self awareness in people with eating disorders. The use of symbols and images allows the person to have distance on the difficult issue of body image and begin to work with it, in conjunction with self image. Goldberg, McNiel and Binder (1988) found that psychiatric patients experienced music group psychotherapy as being greater in increasing interpersonal communication, insight, support and emotional expression than verbal therapy.

Statement of Hypotheses

The literature reviewed suggests that experiences in music and experiences in symbol formation can help a person gain a sense of mastery. GIM is a technique which uses experiences with music and symbol formation to actuate self understanding and personal growth (Bonny, 1989). It may be that experiences in GIM, strategically placed in a continuum of out patient care, can help a person maintain a more positive sense of self concept, and a greater sense of personal control.

It appears from the literature that there is a history of positive results from the use of extended groups for people with a variety of diagnoses who use outpatient services, and that there is support for using experiential techniques in these groups. Given this, there may be a place for periodic extended GIM groups in the continuum of care for mental health, either in a weekend retreat or workshop format. It would be helpful to know whether participation in extended group GIM workshops has any effect on how a person views him/herself in the world (sense of self) or feels in control of him/herself versus being controlled by external forces in the world (locus of control).

The purpose of the current study, therefore, is to examine the effect of an extended half day (4 hour) group workshop using GIM group therapy techniques on self concept and locus of control in people in outpatient settings. The following null hypotheses were developed:

Hypothesis 1: There will be no significant interaction between time and group on Tennessee Self Concept Scale (TSCS:2) scores.

Hypothesis 2: There will be no significant interaction between time and group on the Levenson Locus of Control Scale Internal control (LOI) subscale scores.

Hypothesis 3: There will be no significant interaction between time and group on the Levenson Locus of Control Scale Chance (LOC) subscale scores.

Hypothesis 4: There will be no significant interaction between time and group on the Levenson Locus of Control Scale Powerful Others (LOP) subscale scores.

CHAPTER III

METHOD

Subjects and Setting

Selection of Subjects

The sample groups for this study were randomly selected from people self referred through outpatient programs of the University of Michigan Medical Center, SYNOD Residential Services, Chelsea Hospital, and Washtenaw County Community Mental Health programs. Participants were recruited through letters sent to local therapists (Appendix D), flyers posted at community programs (Appendix E), and oral presentations made to community program participants. Membership was strictly voluntary. Thirty three of the thirty four people who volunteered to participate in the study met the specific selection criteria which included current involvement in outpatient treatment, and near normal hearing and communication capabilities. One person who was experiencing auditory hallucinations was excluded from the study. Thirty three individuals volunteered to participate, with two withdrawing at the initial interview, four failing to attend their scheduled sessions due to interfering life circumstances, one being hospitalized in crisis, five not returning phone calls for interview appointments, and one individual being unavailable for posttesting.

Description of Subjects

Twenty individuals participated in this exploratory study, with ages ranging from 22-60 years old (mean age of 41). Nine participants were in individual outpatient therapy only, seven were consumers of a residential program, and four were members of the local mental health consumer clubhouse.

Thirty-five percent (7) of the participants were male, while sixty-five percent (13) were female. Eighty-five percent (17) had been in therapy or had been mental health consumers for longer than five years. Eighty percent (16) reported that they had been hospitalized psychiatrically at some point in their life, while fifty percent (10) had been hospitalized in the twelve month period prior to their participation in the study. Several participants did not complete all of sections on the demographic questionnaire. Of the eighteen who completed most of the form, all reported a strong interest in music. More than half reported using music for relaxation (15), social interactions (14), to validate their feelings (13), to express themselves (13) and as sound in the background (11). About sixty percent (11) reported previous experience with imagery for relaxation, and thirty-three percent (6) reported previous experience using imagery with music for therapy. Twenty five percent (5) of the participants reported no previous experience with music therapy at all. Comparisons of answers between the experimental and control group members are shown in Tables 1 and 2. Numbers of respondents are shown in each category, as well as percentages of the participants who answered the relevant section. Some participants did not answer questions in all sections. For most of the

Table 1
General Demographic Information by Group Condition

<u>Group</u>	<u>Information</u>				
	Average Age	Male	Female	in treatment <5 yrs	in treatment >5 yrs
Experimental group	38.8 yrs	4	6	2	7
Control group	36.7 yrs	3	7	1	9

questions that were answered, similar percentages are seen in both groups.

Setting

The research site was the investigator's private practice music therapy studio located in Washtenaw County in southeast Michigan. The studio was located in an older warehouse type building with many art, dance and music studios. It is a fully carpeted twelve by twenty foot room up a flight of fourteen stairs. All but one sessions were facilitated in this room. One session was held in a similar but smaller carpeted room on the ground floor to accommodate a client's physical inability to climb stairs. A variety of appropriate seating options were available in each room, including straight back chairs, soft chairs, and a couch. The option of lying down for the imagery portions of the workshops was available using mats, futon chairs, bean bag chairs, and large sitting pillows. A table was available for drawing or writing. Musical instruments, song books, movement scarves and balls, drawing and writing materials, were

Table 2
Music Experiences Questions by Group Condition

<u>Group</u>	<u>Information</u>				
Uses of music	Relax	Exercise	Social inter- actions	Background sound	Work motivation
Experimental group	9 90%	5 50%	8 80%	6 60%	3 30%
Control group*	7 100%	3 43%	6 85%	5 71%	4 57%
Uses of music	Validate feelings	Express self	Reinforce beliefs	Get to sleep	Improve creativity
Experimental group	7 70%	8 80%	3 30%	4 40%	3 30%
Control group*	6 85%	5 71%	4 57%	4 57%	4 57%
* Only seven people responded to the questions in this section of the form					
Previous experiences with music therapy	None	Individual work	Group Activities	Group Process	
Experimental group (eight respondents)	4 50%	2 25%	4 50%	3 37%	
Control group (seven respondents)	1 14%	2 28%	6 85%	2 28%	
Previous experiences with imagery	None	For relaxation	For therapy no music	For therapy with music	
Experimental group (nine respondents)	1 11%	7 77%	2 22%	4 44%	
Control group (five respondents)	1 20%	4 80%	0	2 40%	

available for exploration or stimulation of ideas. A refreshment area with

tea, water, soft drinks, fruit, cookies, cheese and crackers was set up in each room, and lamps and art works were around each room to create a trusting and comfortable atmosphere conducive to music listening and group interaction. The office area for the investigator's use was a separate room with a locking file cabinet for data materials, and a telephone.

Consent and Approval

This research project was proposed to the administration of Washtenaw Community Mental Health Department and written approval was given to conduct the research (Appendix A). Approval was also granted from the Western Michigan University Human Subjects Institutional Review Board (HSIRB) upon completion of the HSIRB Application form and completion of the application process including a full board review (Appendix A). Following approval, written and oral recruitment, and individual interviews, a total of twenty six people signed the consent form (Appendix B) and release of information form (Appendix C), and completed the pre-test questionnaires. Due to withdrawal of six people, a total of twenty participants were included in the study.

Experimental Design

A pretest-posttest control group design was employed for this study using the following model:

R	OO	X1	OO
R	OO	X2	OO

R = random assignment

0 = instruments (two) used for testing

X1 = condition 1 (four hour GIM workshop)

X2 = condition 2 (four hour music activity group)

The dependent variables were the Tennessee Self Concept Scale (TSCS:2 short form) (Fitts & Warren, 1996), and the Levenson Locus of Control Scale (Levenson, 1981). The independent variables in the study were the two conditions, the four hour GIM workshops and the four hour music activity groups.

Of the twenty one subjects who participated in the group experiences, eleven were randomly assigned to the experimental condition and ten were randomly assigned to the control condition. The subjects were then assigned to a group meeting time based on their availability. All groups were scheduled 1:00 on Saturday afternoons. Six people were initially scheduled for each group. When participants did not attend their scheduled session, they were rescheduled for the next session. Due to consistent absences of participants and rescheduling of groups, smaller than anticipated groups occurred as shown in Table 3. One participant in the experimental condition did not complete the post tests, leaving twenty subjects in the study.

Equipment and Materials

Musical selections recorded on cassettes were played on an RCA 70 watt surround sound stereo system (Model RP9540). Pencils, paper and art materials were available for writing or drawing imagaic material, which

Table 3
Number of Participants in Groups

<u>Group</u>	<u>Condition</u>	<u>Number of Participants</u>
1	Experimental	3
2	Control	2
3	Experimental	2
4	Control	2
5	Experimental	2
6	Control	3
7	Experimental	2
8	Control	3
9	Experimental	2

were used by all the participants in the experimental condition. A three octave set of Schulmerich handbells, various percussion instruments, and songbooks were available and used by the participants in the control condition.

Instruments

Information regarding age, gender, type and length of time in outpatient work, and experiences with music and imagery was obtained through a demographic survey administered at the time of the individual interview (Appendix H). Two psychological instruments were used to

measure the dependent variables. They were both administered at the beginning of the experiential sessions.

The Tennessee Self Concept Scale, second revision, short form (TSCS:2) was used to measure a general sense of self concept, which was defined as the score obtained on the instrument. This instrument consists of 20 questions and may be self administered with responses in a five section Likert scale ranging from always false to always true. Formal tests of reliability and validity have been performed. Internal Consistency reliability is reported as having a median score of .80; and Test-Retest Reliability: is reported as having a median score of .76 (Fitts & Warren, 1996). Validity of several factors of the test are discussed in Fitts and Warren (1996, p. 62-70). The self concept dimensions are found to be strong, while other factors that are not of interest in this study as they are not relevant to the short form of the instrument, are found to be somewhat weaker.

The Levenson Locus of Control Scale (Levenson, 1981) was used to measure a sense of personal control over one's life versus feelings of being controlled by chance or powerful others, which was operationally defined as the score obtained on the internal control subscale (LOI) versus the scores obtained on the powerful others (LOP) and chance (LOC) subscales. Higher internal subscale scores and lower chance and powerful others subscale scores indicate a greater belief in a sense of personal control. This instrument consists of 24 questions and may be self administered with responses in a six section Likert scale ranging from strongly disagree to strongly agree. Formal tests of reliability and validity have been

performed. Test re-test reliability with a 1 week interval range between .60 and .79, while a 7 week interval produced values between .66 and .73 (Lefcourt, 1991).

The General Well Being Survey was developed by the investigator and completed by each participant immediately after the experiential session (Appendix I). This informal survey consisted of ten questions, five each selected from the two psychological scales used before the session, and was self administered. The rating scale was a five question Likert scale ranging from strongly disagree to strongly agree. No reliability or validity has been shown for this instrument.

Procedure

Consent

Prior to treatment, the investigator met with each of the participants for approximately 15 minutes to explain the purpose of the study, and obtain consent to participate. A sheet containing information about the study (Appendix G) was given to each participant, and the materials in it were verbally reviewed by the investigator, while the participant visually reviewed the material. Any questions were answered to the best of the investigator's ability. The informed consent form was verbally reviewed by the investigator while the participant visually reviewed the material. After the informed consent form was signed, the participant was asked to sign a release of information form to allow the investigator to contact the therapist or case manager only if the content of the session should activate any self destructive feelings. After the release

of information form was signed, the participant was asked to complete the demographic survey.

In the beginning of the study, the investigator met with each participant individually for the consent process. Halfway through the study, (after eight participants had completed their study participation) the next group of participants requested that the consent process be changed to be done in a group on the day of the music experience. The remainder of the participants experienced the consent process in a group, meeting fifteen minutes prior to the start of the actual group experience.

Pretest

At the beginning of the session, each participant was asked to complete the Levenson Locus of Control Scale and the Tennessee Self Concept Scale, revised, short form. All but two of the participants completed the forms independently, with those two individuals who possessed reading difficulties requiring the investigator to verbally read the questions and mark the score sheets.

Following the pretest, the focus of each session was explained to the participants, and that session began.

Experimental Condition

All experimental groups received group GIM experiences. They met in the same room and at the same time of day and day of the week as the control group. Each group met for approximately three hours, instead of the planned four hours. This was due to the small number of people in

each group. (Four hours had been allotted for group discussion of six to eight people.) Each session was conducted using the same procedures.

The sessions began with a welcome, introduction of the leader, introductions of participants, purpose for the session, and a review of the ground rules for the group. These were established by the leader as willingness to participate and share experiences in the group, willingness to listen to others and give feedback, and willingness to keep all material in the group confidential. At this point, an opportunity for participants to leave was given. After verbal agreement to continue was made, the session began with the prelude.

The prelude began with the participants sharing their experiences with music and with imagery, and an introduction to types and forms of imagery that might be experienced. A majority of participants had experienced imagery for relaxation purposes, and shared those experiences. Those who had not had these previous experience were given the opportunity to experiment with this concept. Different types and forms of imagery were explained to the groups, and the focus of the imagery for the session was discussed. The idea of using the imagination to construct and connect with a place or "nest" associated with safe feelings was introduced as a technique for use in crisis. It was explained that each individual would be allowed make themselves comfortable either sitting or lying down, an opening induction would be given, and the music would start. The participants were instructed that they could begin to draw or write about their imagery experience at any time after the beginning of the music, and not have to wait for the music to end. They were informed

that if they were in a deeply relaxed state, the music would be paused briefly after the first piece on the tape was finished to allow them time to bring their awareness back to the room and draw or write about their experience. This process allowed the participants to have as much control over their experiences as they wish to use. Participants were then given a second opportunity to leave the group.

Four of the participants chose to lie down on the futons provided and close their eyes. Two sat on the floor, leaning against the wall with pillows and blankets, effectively making a physical "nest" in which to relax. One participant sat in a relaxed position on a futon chair. Three sat in chairs at the table for the whole process. Nine of the ten participants closed their eyes until they began to draw or write.

After the participants made themselves comfortable, a brief autogenic relaxation was used (1-2 minutes) focusing on breathing, and allowing progressive muscle groups to relax. The following verbal induction was used with all groups.

In your mind's eye, in your imagination, find a place that is safe and comfortable for you. It may be inside or outside. It may be someplace you have been, or someplace you would like to go to. It may be a real place or an imagined place. As you become aware of this place, focus on everything you can about it, what size or shape it is, what colors are there, what fragrances you might smell, sounds you might hear, textures and temperatures you might feel. Breathe in the air from this place, and bring in peace and a sense of security and safety with the air. As the music comes on, let it help you to connect with this place, and explore it as deeply as you can.

At this point in the process the music was started, and the investigator continued with some focused verbal suggestions.

As you become more aware of this place, focus on bringing in some

specific things or images. Bring in colors that are soothing, any things that might be comfortable for you, like furniture, or pets. Focus on bringing in things that are enjoyable for you to do. Focus on bringing in pictures or images of people that are supportive for you, or the people themselves. Bring in things that give you strength. Bring in things that make you smile. Let the music help you to explore this place and the things that you have brought in, and whenever you're ready, you can draw or write about this experience.

At this point, the music continued uninterrupted until the end of the first piece on the tape. At that time, the music was paused and those participants still relaxed and not yet drawing or writing were given the following gentle verbal suggestions.

Gradually bring your awareness back to this room, to the sounds and temperatures in it. Be aware of and move your fingers and toes, arms and legs. Feel the air on your face. When you're ready, open your eyes, and begin to write or draw about your experience.

The volume of the tape was lowered slightly to be present but not overpowering during the drawing/ writing process. The tape was taken off pause, and the second and final pieces on the tape were allowed to play to completion. During this time (approximately 20 minutes), the participants wrote (1 participant) or drew (9 participants) about their imagery experience.

Taped classical music was chosen by this investigator to best fit the needs of the group of that day. Two tapes were programmed for this study, only one of those was chosen on the day of each group by the investigator as best fitting the needs of the group that day. Both programs had three selections ending with the same piece, and were approximately thirty minutes in length.

The postlude began at the completion of the writing and drawing, and the music. During this time the participants shared their experiences with the rest of the group, and were assisted in verbally processing the material by the investigator through the interventions of exploration, validation, and relating the experience to life situations. Group members were asked to participate in the discussions, ask questions, and give feedback to each other. The group came to a close when each participant expressed a sense of completion with his/her processing. Several participants asked if there would be similar groups in the future they could attend, indicating a desire for further experience in GIM.

Control Condition

Most of the control groups met in the same room and time of day and week as the experimental groups to participate in music activities. One session took place in a similar room at the same time and in the same building on the ground level due to the inability of a participant to climb stairs. The participants were informed that the purpose of the study was to examine the effect that participating in music experiences had on an individual's feelings about him or herself.

The sessions began with a welcome, introduction of the leader, introductions of participants, activities for the session, and a review of the ground rules for the group, which were the same as those for the experimental group. At this point, an opportunity for participants to leave was given. After verbal agreement to continue was made, the session began with an introduction to the instruments and activities available, a

discussion of the participants' prior experiences in music, sharing of musical tastes and interests and a decision by the group regarding what activity should be selected to begin the session. The majority of groups chose to begin with singing and playing percussion instruments, which occurred for about sixty to ninety minutes and then changed to playing handbells for the remainder of the group time. Song choices were made by the participants from songbooks compiled by the investigator and used in structured music therapy groups. Choices were a variety of popular, rock, and folk songs from the 1960's through the 1990's. The session ended when all participants expressed a sense of completion with the amount of singing and playing, usually after about three hours. Originally the time was planned for four hours, but the small group size limited variety and numbers of musical selections. Since this shorter time corresponded to the shorter time spent in the experimental condition, it was seen as acceptable by the leader. Although no forms of verbal processing of musical material or of the total group experience was facilitated by the leader of the session, some participants made spontaneous comments about the session. Several participants commented that it had been enjoyable or fun, and three commented that agreeing to participate in the session had forced them to get up and into the community that day. Several participants asked if there would be similar groups in the future they could attend, indicating a desire for further experience in music activities.

Posttest

At the end of each session, the participants were asked to complete

the General Well Being questionnaire and reminded that they would be contacted after two weeks to complete the TSCS:2 and Levenson Locus of Control scale a second time. Each individual was given an option of having the forms brought to them individually in an appointment or sent to them to be returned by mail within the time frame. One individual chose to have an appointment and filled the forms out at that time. A second person chose to have an appointment, but at the appointment time asked to be able to take the forms home and return them by mail, which was permitted. All other individuals received and returned the forms by mail. All posttests were completed two weeks post session.

CHAPTER IV

ANALYSIS AND RESULTS

Analysis

Data was analyzed using the SuperAnova computer program for Macintosh. The statistical procedure used was a mixed analysis of variance, with one within variable (pre and post test scores) and one between variable (group).

Results

Hypothesis 1

There will be no significant interaction between time and group on Tennessee Self Concept Scale (TSCS:2) scores.

The results failed to reject this hypothesis at the .05 level, $F(1,18) = .033$, $p = .86$. An independent t test was applied to the pretest scores of both groups. No significant difference was found between the groups $t = -.12(p > .05)$. Results can be seen in Tables 4 and 5, and Figure 1.

Hypothesis 2

There will be no significant interaction between time and group on the Levenson Locus of Control Scale Internal control (LOI) subscale scores.

Table 4
Tennessee Self Concept Scale Scores^a

<u>Group</u>	<u>S</u>	<u>Pre-test</u>	<u>Posttest</u>
Experimental	1	67	70
	2	66	67
	3	69	79
	4	66	77
	5	58	56
	6	71	73
	7	63	62
	8	66	66
	9	45	60
	10	79	79
Control	1	52	48
	2	53	55
	3	83	83
	4	47	64
	5	65	69
	6	64	78
	7	75	76
	8	86	87
	9	65	68
	10	66	72

^a n=20

The results failed to reject this hypothesis at the .05 level $F(1,18) = .40, p = .53$. An independent t test was applied to the pretest scores of both groups. No significant difference was found between the groups; $t = .64$ ($p > .05$). Results can be seen in Tables 6 and 7, and Figure 2.

Hypothesis 3

There will be no significant interaction between time and group on

Table 5

Average^a Tennessee Self Concept Scale Scores Pre and Post Intervention

Means and Standard Deviations			
	Experimental		Control
Pre	65	(8.87)	65.6 (12.91)
Post	68.9	(8.12)	70 (12.07)

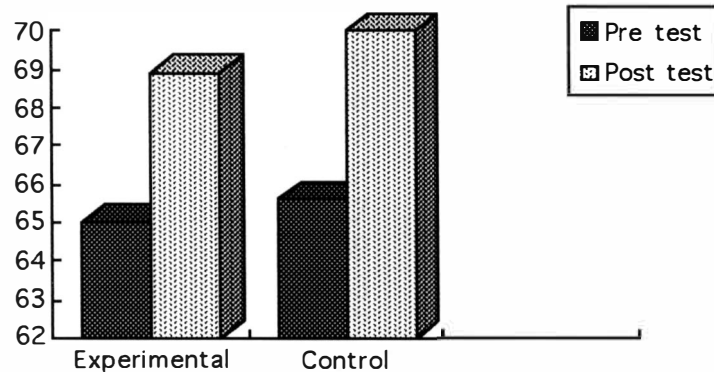
^a Standard deviations in parentheses

Figure 1. Means of Pre and Post Test Scores of Tennessee Self Concept Scale.

the Levenson Locus of Control Scale Chance (LOC) subscale scores.

The results failed to reject this hypothesis at the .05 level, $F(1,18) = .38$, $p = .55$. An independent t test was applied to the pretest scores of both groups. No significant difference was found between the groups; $t = .02$ ($p > .05$). Results can be seen in Tables 8 and 9, and Figure 3.

Table 6
Levenson Locus of Control Internal Control Subscale Scores^a

<u>Group</u>	<u>S</u>	<u>Pre-test</u>	<u>Posttest</u>
Experimental	1	43	43
	2	37	29
	3	26	35
	4	34	41
	5	45	47
	6	28	29
	7	39	36
	8	26	21
	9	28	23
	10	33	33
Control	1	19	19
	2	36	31
	3	47	45
	4	27	24
	5	27	23
	6	39	27
	7	33	40
	8	27	32
	9	31	29
	10	32	31

^a n=20

Hypothesis 4

There will be no significant interaction between time and group on the Levenson Locus of Control Scale Powerful Others (LOP) subscale scores.

The results failed to reject this hypothesis at the .05 level, $F(1,18) = .46$, $p = .50$. An independent t test was applied to the pretest scores of both groups. No significant difference was found between the groups; $t = -.32$

Table 7

Average^a Levenson Locus of Control Internal Control Subscale Scores Pre and Post Intervention

Means and Standard Deviations		
	Experimental	Control
Pre	33.9 (6.97)	31.8 (7.71)
Post	33.7 (8.46)	30.1 (7.79)

^a Standard deviations in parentheses

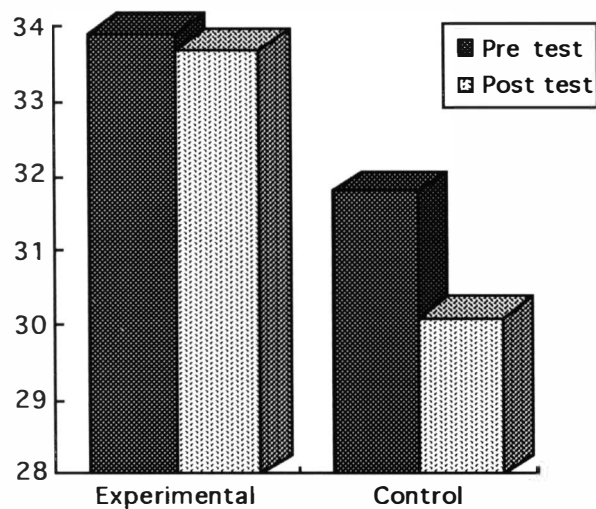


Figure 2. Means of Pre and Post Test Scores of Levenson Locus of Control Internal Control Subscale.

($p > .05$). Results can be seen in Tables 10 and 11 and Figure 4.

Although no statistical significance was found on either of the measuring instruments used in this study, some comparative information

Table 8
Levenson Locus of Control Chance Subscale Scores^a

<u>Group</u>	<u>S</u>	<u>Pre-test</u>	<u>Posttest</u>
Experimental	1	24	14
	2	19	21
	3	17	21
	4	10	5
	5	10	5
	6	20	22
	7	29	21
	8	11	13
	9	35	19
	10	32	33
Control	1	15	14
	2	12	11
	3	14	16
	4	28	14
	5	32	35
	6	36	32
	7	16	19
	8	12	10
	9	13	12
	10	28	26

^a n=20

is available.

The Tennessee Self Concept Scale has normed scores for the TSCS:2 short form used in this study. Ninety percent (18) of the 20 subjects in this study scored in the low half of the percentile ranks, with one person scoring in the 65th percentile both pretest and posttest, and one person scoring in the 75th percentile both pretest and posttest. The mean percentiles for both experimental and control groups are seen in Table 12.

Table 9

Average^a Levenson Locus of Control Chance Subscale Scores Pre and Post Intervention

Means and Standard Deviations		
	Experimental	Control
Pre	20.7 (9.14)	20.6 (9.30)
Post	17.4 (8.46)	18.9 (8.99)

^a Standard deviations in parentheses

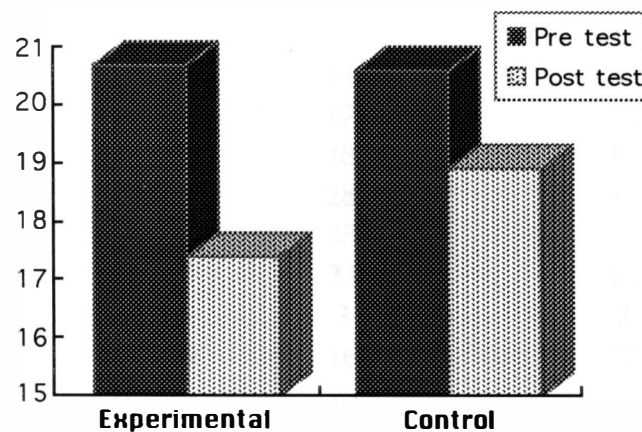


Figure 3. Means of Pre and Post Test Scores of Levenson Locus of Control Chance Subscale.

Although the Levenson Locus of Control scale is not standardized, 51 studies with United States citizens yielded a selection of sample means from varying populations (Levenson, 1981) for each of the subscales [internal(LOI), chance (LOC) and powerful others (LOP)]. A comparison

Table 10
Levenson Locus of Control Powerful Others Subscale Scores^a

<u>Group</u>	<u>S</u>	<u>Pre-test</u>	<u>Posttest</u>
Experimental	1	16	13
	2	15	15
	3	11	11
	4	6	4
	5	6	16
	6	10	10
	7	32	28
	8	26	21
	9	44	24
	10	28	29
Control	1	23	33
	2	11	7
	3	27	33
	4	18	17
	5	28	37
	6	35	25
	7	23	13
	8	3	2
	9	16	17
	10	26	25

^a n=20

between average mean and standard deviation scores of psychiatric patients and control adults in these studies, and the scores of this study's subjects (experimental and control groups 1997) are shown in Table 13.

As this was a preliminary study, post-hoc comparisons on the data were conducted to examine the possible effects of previous experiences of the participants on the results. Based on answers given to the

Table 11

Average^a Levenson Locus of Control Powerful Others Subscale Scores Pre and Post Intervention

Means and Standard Deviations		
	Experimental	Control
Pre	19.4 (12.61)	21 (9.26)
Post	17.1 (8.20)	20.9 (11.69)

^a Standard deviations in parentheses

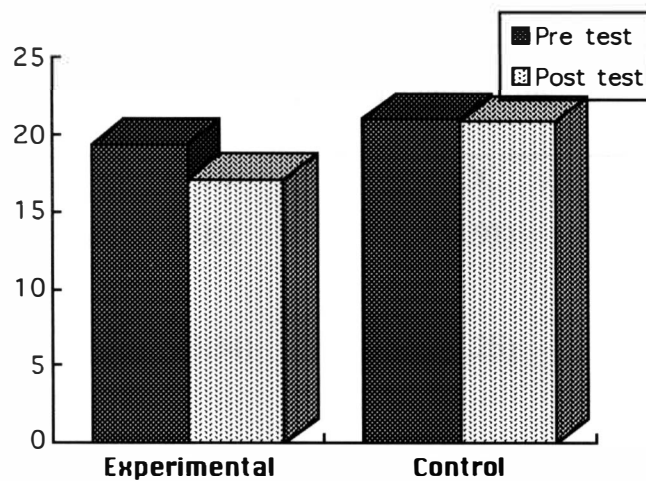


Figure 4. Means of Pre and Post Test Scores of Levenson Locus of Control Powerful Others Subscale.

demographic survey, data of the following sub-groups were examined.

In the experimental condition, those participants who experienced GIM, three sub groupings were examined. The first comparison was made

Table 12

Average Tennessee Self Concept Scale Percentile Scores Pre and Post
Intervention

Means		
	Experimental	Control
Pre	36.3	37.7
Post	39.9	41.4

Table 13

Average^a Levenson Locus of Control Subscale Scores

Means and Standard Deviations			
	LOI	LOC	LOP
Psychiatric Patients	35.1(7.98)	22.56(9.91)	24.5(11.63)
Levenson, 1981			
Control Adults	36.98(5.34)	17.05(7.25)	19.03(7.42)
Levenson, 1981			
Experimental group, 1997			
pretest	33.9(6.97)	20.7(9.14)	19.4(12.61)
posttest	33.7(8.46)	17.4(8.46)	17.1 (8.20)
Control group 1997			
pretest	31.8(7.71)	20.6 (9.30)	21 (9.26)
posttest	30.1(7.79)	18.9 (8.99)	20.9(11.69)

^a Standard deviations in parentheses

in subgroup 1, between the pre and post test scores of those participants

who reported having previous music therapy experiences(5) with those who reported having none(4). An ANOVA run on the scores in this sub grouping showed significant differences only in the chance locus of control subscale of the Levenson Locus of Control Scale; $F(1,7)=15.52$, $p=.005$. An independent t test indicated that there was no significant difference between the pre test scores of the two groups; $t=$ $p>.05$. Subsequent comparisons were run between each of these two groups and the scores of the control group with significant differences found between the group with previous music therapy experiences and the control group, $F(1,12)=7.91$; $p=.02$. Results are shown in Table 14.

Table 14

Average^a Levenson Locus of Control Internal Control Scores Pre and Post Experimental Intervention Subgroup 1

Means and Standard Deviations			
	Previous Music Therapy Experience	No Previous Experience	Control Group
Pre	36 (7.79)	30.25 (3.86)	
Post	33.2 (10.63)	34.5 (5)	

^a Standard deviations in parentheses

The second comparison in the experimental condition was made in subgroup 2, between the pre and post test scores of those participants who reported having previous experience using music for relaxation(7) with those who who did not report any previous experiences with music for

relaxation(3). An ANOVA run on the scores in this sub grouping showed no significant differences in the scores of either the TSCS:2 or any of the Levenson Locus of Control subscales.

The third comparison in the experimental condition was made in subgroup 3, between the pre and post test scores of those participants who reported having previous experience with imagery and music for therapy(4) and those who reported no previous music therapy experience at all(4). An ANOVA run on the scores in this sub grouping showed significant differences only in the chance subscale of the Levenson Locus of Control Scale; $F(1,8)=19.68$, $p = .002$. An independent t test indicated that there was no significant difference between the pre test scores of the two groups; $t = p > .05$. Subsequent comparisons were run between each of these two groups and the scores of the control group with significant differences found between the group with previous music and imagery experience and the control group; $(1,12) = 7.91$, $p = .02$. Results are shown in Table 15.

One post-hoc comparison was examined in the control group (subgroup 4). Those participants who reported previous experience with music therapy activities(6) were compared with those who did not report any previous experiences with music therapy activities(4). An ANOVA run on the scores in this sub grouping showed significant differences only in the chance subscale of the Levenson Locus of Control Scale; $F(1,8)=5.09$, $p = .05$. An independent t test indicated that there was no significant difference between the pre test scores of the two groups; $t = p > .05$.

Table 15

Average^a Levenson Locus of Control Chance Subscale Scores Pre and Post Intervention Subgroup 3

Means and Standard Deviations			
	Previous Music and Imagery Experience	No Previous Experience	Control Group
Pre	24.5 (10.66)	18.17(7.93)	20.6 (9.30)
Post	14.75 (7.13)	19.16(9.43)	18.9 (8.99)

^a Standard deviations in parentheses

Subsequent comparisons were run between each of these two groups and the scores of the experimental group with no significant differences found in either comparison. Results are shown in Table 16.

The General Well Being Survey was administered immediately upon completion of the music session. Although the scores from this instrument could not be statistically compared to the pretest and the posttest, an independent t test was run to compare the mean scores of the two groups. No significant difference was found between the groups; $t = -.998$ ($p > .05$). Results are shown in Table 17.

Table 16

Average^a Levenson Locus of Control Chance Subscale Scores Pre and Post Intervention Subgroup 4

Means and Standard Deviations		
	Previous Music Activity Experience	No Previous Experience
Pre	19.5 (8.33)	22.2 (11.73)
Post	20.17 (8.87)	17 (10.13)

^a Standard deviations in parentheses

Table 17

Average^a General Well Being Survey Scores Post Intervention

Means and Standard deviations	
Experimental	Control
34.9(5.36)	37.6(6.67)

^a Standard deviations in parentheses

CHAPTER V

DISCUSSION

The results of this study indicate that exposure to GIM or music activities did not significantly increase a positive sense of self or an internal sense of locus of control in the participants of either the experimental condition or the control condition. However trends were found which merit further study.

In both groups posttest scores on the TSCS:2 were higher than the pretest scores. This could indicate a possible strengthening in a positive sense of self in both groups. It is possible that the music activities used in the control group had more effect on people than originally thought, even though these music activities were not designed to be nor implemented as therapy. There was no processing at the end of the group as to the meaning of the experience in the lives of the participants, nor any of the songs chosen. However, it was a social time, and the participants spontaneously selected the music to be played or sung, occasionally making comments about why they liked a particular song. The handbell experience was designed by a therapist to be successful, and all experiences were conducted by a music therapist. Since, no attempts were made to develop insight, the experiences do fit the first level category of supportive, activity oriented music therapy (Wheeler, 1983), where music therapy experiences are generally success oriented, structured and socializing in nature.

At this level the therapeutic benefits are focused on the participation in the music experiences, not insight derived from this participation. Although Wheeler states that the therapist in these experiences focuses on overt behaviors; the therapist in this study did not focus on behaviors at all, but on enjoyment. Even though these experiences are designed for the lower functioning person, they can be beneficial for higher functioning people (Davis et al., 1992). It may be that participation in structured, success oriented music experiences led by a music therapist has a greater effect on improving sense of self than previously assumed.

In the experimental group, there was virtually no change in the Internal Sense of Control scores, while the Powerful Others and Chance scores decreased. This could indicate a strengthening of belief in personal control versus the effects of powers outside of oneself. In the control group, there was a decrease in the internal control scores versus no change in the score of control by powerful others, and a smaller decrease than the experimental group in control by chance. Although these findings could indicate a weakening in belief in personal control, they should be interpreted with caution. The members of the experimental group had over-all higher scores on the internal control pretest than the control group, and may generally have had a higher sense of internal control which could have been reinforced by the experimental condition.

Post-hoc examination of the data in subgroupings may indicate factors that need further investigation. In the experimental condition it appears that those participants with previous music therapy experience

and/or previous music and imagery experience demonstrated a decrease in the belief that their fate is controlled by chance, as compared with those with no such previous experience. The same participants with previous experience demonstrated a consistency in the level of the belief that their fate is controlled internally. Levenson (1981) indicates that if there is no significant change on the internal locus of control scores, with a simultaneous decrease in the chance (or powerful others) locus of control scores, the interpretation may be cautiously made that the participants' belief in internal sense of control has strengthened by comparison. This might indicate that participation in more than one GIM workshop may have the potential for greater and more significant change in a person's sense of locus of control than a single session.

Examining the control group raises interesting questions. Seven participants completed the section of the demographic survey indicating previous experiences in music therapy. Six of those participants reported previous experience with music therapy activities, specifically music activities similar to those experienced in the control sessions. Only one participant reported no previous music therapy experience. It is possible that the familiarity of the music activities was comforting and reinforcing, helping to increase a positive sense of self, as reflected by the higher TSCS:2 and General Well Being Survey scores in this group.

Comparing the scores on the Levenson locus of control scales of those participants who reported previous similar music activity experiences with those who did not report such experiences indicates a significant difference in the chance subscale between the two groups,

similar to that which was seen in the experimental group. However, in contrast to the results seen with the experimental group, the decrease in the belief of chance to control one's life is indicated in those not reporting previous music therapy activity experiences. It is possible that the novelty of the music activities experience for the participants with no reported similar previous experience led to a shift in locus of control which might diminish over a longer time period of participation.

The General Well Being questionnaire could not be statistically compared to the pretests or posttests. Five of the questions were taken from the TSCS:2 and five from the Levenson scale, but the Likert scale used was different from each of the two other instruments. An independent t test applied to the means of the two groups showed no significant statistical difference, but the mean score of the control group was higher (37.6 of a possible 50 pts) than the mean of the experimental group(34.9). The range of scores was also greater in the control group (26-48) than in the experimental group (26-44). Given the closeness of the pretest scores of both groups on both the TSCS:2 and Levenson scales, it is possible that this difference in the immediate post intervention General Well Being Survey scores may indicate a trend supporting findings seen in the literature by Loomis (1988) which suggested that immediate learning is stronger in groups that use structured cognitive or educational techniques, but that attitude changes and long term personal growth are stronger in groups that use techniques to break through defenses such as marathon or gestalt groups,(Voss & McKillip, 1979; Johnson & Johnson, 1979).

The General Well Being surveys were also visually scanned and

individual questions were compared to the same questions on the pretest. It was noted that the most consistent changes (greater than 50% of the participants) were increases on the question "It is easy for me to learn new things" in the control group alone, and decreases on the question "I do not feel at ease with other people" (indicating an increase in a feeling of ease with others) in both groups. Changes in other questions varied greatly.

The imagery experiences of the participants in the GIM group varied greatly. Four participants experienced rooms with specific items of comfort and pleasure, including pictures of supportive people in their lives. One of the rooms generated in the imagery was a specific room from the participant's life, and the other three were imaginal. One of the participants with an imaginal room initially reported the experience to be sad, because it was not felt to be an attainable goal. Other group members pointed out how this could be used as a personal imagery for peace and comfort, and not used as a concrete goal for actual attainment. The participant was able to reframe the experience to be a more positive and useful one. The other three participants with room imagery expressed feelings of comfort and pleasure from the experience.

The remaining six participants experienced more open out doors settings. Several expressed difficulty settling on one place, and moved from place to place. Three experienced difficulty remaining focused on the place, as external forces and events impinged on their peacefulness. It had been explained in the prelude that the music can suggest different things to different people, and participants were encouraged to allow whatever surfaced for them that day. These experiences, and the participants'

drawings of them, were processed in the group facilitated by the researcher with input from the other group members. The focus of this processing was to validate the experiences, explore them further, and relate the experience to the participant's current life situations. During this processing, the participants were encouraged to look at their images as puzzles from their subconscious. Using this frame of reference the participants were able to identify some personal strengths and make choices of actions they might take regarding the life situation connected with the image. Group support and sharing of similar situations were evident in the processing, and members related openly to each other and the investigator.

The intent of this study was to look at the effect of participation in an intensified extended group experience using guided imagery and music techniques on psychiatric clients' sense of self and locus of control. Part of the reasoning given for looking at this included the positive effects of participation in extended groups cited in the literature with other client groups (Biggs et al., 1976; Yalom, 1977; Kilman et al., 1978; Voss & McKillip, 1979; Frey, 1987; Allen, 1990b; Byrne, 1990; Byrne & Overline, 1991; Winick & Levine, 1992; Gendron et al., 1992; and Gilovich & Miller, 1994). Since using the group form of the Bonny Method of Guided Imagery and Music (GIM) lends itself well to insight oriented work and group process (Goldberg, 1994) as well as extended time periods (Clark, 1977; Beck, 1988), it was felt that GIM in an extended group form could produce significant changes in the participants.

The amount of impact of the group process was less than intended

in the design of the study, as the size of each group was much smaller than planned. Although members of each group did process openly and intensely with each other and the therapist, a larger number of people would have given each person in the group opportunity to hear a wider range of thoughts, reactions and suggestions to his/her imagery experience which may have lead to greater insight (Goldberg, 1994). As insight is defined as understanding of the self, and as understanding of the self leads to a sense of mastery and control, the measured effect on the participants sense of self and locus of control may have been greater with larger groups.

Another aspect of the intent of this study was to explore a potential intervention that might help decrease the use of psychiatric inpatient hospitalization by people in crisis. It was thought that if interventions can be found which provide opportunities for significant personal change before a crisis stage is reached, people may be able to function better in an outpatient setting. However, there is a saying in Asian martial arts training that states "when the student is ready, the teacher will appear." People who are in the hospital in crisis are often desperate for change in their lives at that time, and the impact of therapeutic interventions when they are most in need may be greater because of this. Human beings need to be motivated to change in order to do so. People functioning in the community, however marginal it appears to others, may be comfortable with their lives, and have no immediate need for change. The impact of therapeutic interventions may be less at these times. It may be that in therapy, as in music, timing is essential for success.

Recommendations for Further Study

Trends seen in this study indicate that both conditions using music may have a positive effect on the participants. Further exploration of each of these conditions separately using control subjects with no music involvement is suggested.

Size of the groups in this study may have had an impact on the outcome. Although the numbers in the group in both conditions were similar, it is suggested that further study involve larger groups to allow for more group interaction and process.

Although the General Well Being Survey used exact questions from both of the instruments used for pre and post test, it is recommended that shortened instruments like this use the same Likert scales as the other instruments, even if it requires two or more sections with different scales.

Finally it is suggested that further research be done involving the impact of group and individual GIM on self concept and locus of control involving a series of groups instead of one workshop.

Appendix A

HSIRB Approval Forms

Human Subjects Institutional Review Board



Kalamazoo Michigan 49008-3899

WESTERN MICHIGAN UNIVERSITY

Date: 18 April 1997

To: Brian Wilson, Principal Investigator
Roberta Wigle-Justice, Student Investigator

From: Richard Wright, Chair

Re: HSIRB Project Number 97-03-06

This letter will serve as confirmation that your research project entitled "The Effect of Four Hour GIM and Music Based Workshops on Locus of Control and Self Concept" has been **approved** under the full category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may **only** conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: 18 April 1998

Human Subjects Institutional Review Board



Kalamazoo, Michigan 49008-3899

WESTERN MICHIGAN UNIVERSITY

Date: 15 August 1997

To: Brian Wilson, Principal Investigator
Roberta Wigle-Justice, Student Investigator

From: Richard Wright, Chair

A handwritten signature in black ink that reads "Richard A. Wright".

Re: Changes to HSIRB Project Number 97-03-06

This letter will serve as confirmation that the changes to your research project "The Effect of Four Hour GIM and Music Based Workshops on Locus of Control and Self Concept" requested in your memo dated 5 August 1997 have been approved by the Human Subjects Institutional Review Board.

The conditions and the duration of this approval are specified in the Policies of Western Michigan University.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: 18 April 1998

Appendix B
Informed Consent Form

Western Michigan University

Department of Music Therapy

Principal Investigator: Brian Wilson, MM, RMT-BC

Research Associate: Roberta Wigle Justice, RMT-BC

I agree to participate in a research project entitled "The effect of Guided Imagery and Music workshops on locus of control and self actualization." I understand that this research is intended to examine the effect of participation in a four hour workshop on how people feel about themselves. I further understand that this project is Roberta Wigle Justice's thesis project.

My consent to participate indicates that I agree to attend a brief interview, and a four hour workshop with Roberta Wigle Justice, at no cost to me. I understand that there will be no more than nine other mental health consumers in the group I am assigned to attend, and that I may leave the group and end my participation in this project at any time, with no prejudicial feedback given to my primary therapist. During the interview I agree to fill out a release of information form to allow Roberta Wigle Justice to share information from the workshop with my primary therapist only if I experience any self destructive feelings, a demographic survey that includes my general psychiatric history, and two other questionnaires, the Tennessee Self Esteem inventory, and the Levenson Locus of Control form. I agree to fill out the self esteem and locus of control forms once more, two weeks after the workshop. I agree to fill out a brief questionnaire regarding my sense of well being immediately prior to and after the workshop. If I am unable to complete the forms I will be excluded from the remainder of the project, and if appropriate, will be provided with emergency services numbers.

As in all research there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate measures will be taken, however no compensation or treatment will be made available to me except as otherwise specified in this consent form. I understand that one potential risk of my participation in this project is that my participation will identify me as a mental health consumer to other members of my group. Another risk is that I might be upset by the content of the workshop. I understand that should I become significantly upset I am able to leave the workshop, and that phone numbers for emergency counseling will be available. I understand that Roberta Wigle Justice has my permission to contact my

therapist to inform him/her only in the case of any self destructive feelings I may experience.

One way in which I may benefit from this activity is having the chance to connect with others in pursuit of positive personal growth, and learn from mutually shared experiences. Research indicates that group process in this area may be as beneficial as individual work, and some participants rate music therapy as effective as verbal groups. I also understand that others may benefit from the knowledge that is gained by this research, and that this may enable further work of this type to be more readily available as a treatment option or in conjunction with current treatments.

I understand that all the information collected from me is confidential. That means my name will not appear on any papers on which this information is recorded, nor will any representation of me that would identify me from the other participants. The forms will be coded, and Roberta Wigle Justice will keep a separate master list with the names of participants and the corresponding code numbers. Once the data are collected and analyzed, the master list will be destroyed. All other forms will be retained for three years in a locked file in the researcher's treatment facility.

I understand that I may refuse to participate or quit at any time during the study without prejudice or penalty. If I have questions or concerns about this study, I may contact either Roberta Wigle Justice at 313-529-5298, or Brian Wilson at 616-387-4679 . I may also contact the Chair of Human Subjects Institutional Review Board at 616-387-8293 or the Vice President for Research at 616-387-9298 with any concerns that I have. My signature below indicates that I understand the purpose and requirements of the study and that I agree to participate.

_____ Signature	_____ Date
_____ Researcher Signature	_____ Date

Appendix C
Release of Information Form

Roberta Wigle Justice, RMT-BC
 PO Box 7996 Ann Arbor, MI 48107
 313-529-5298

Release of Information form (To)

I, _____, authorize release of information to the individual listed below for the purpose of sharing information from my participation in a four hour music workshop if, and only if, I experience self destructive feelings during the workshop. I understand that this information will remain confidential to the parties exchanging information, that is, secondary release will not occur without a separate release form. This release is terminated after the exchange of the identified information specific to this workshop.

Release from: Roberta Wigle Justice, RMT-BC
 Music and Creative Arts Therapy
 Studio 7-B, 111 Third Street
 Ann Arbor, MI 48107

Release to: _____

 Signature/ date

 Witnessed by: Signature/ date

Appendix D
Letter to Therapists

Roberta Wigle Justice, RMT-BC PO Box 7996 Ann Arbor, MI 48107

May 1, 1997

Therapists and case managers,

I am a music therapist in private practice in the Ann Arbor area, currently pursuing my Graduate degree in Music Therapy, and Fellowship in the Bonny Method of Guided Imagery and Music. I am looking for voluntary participants for my thesis research. Candidates should be mental health consumers who might benefit from, and be willing and able to participate in, one four hour workshop using music based activities or music and imagery techniques. The study itself involves looking at the effect of guided imagery and music workshops on one's perceived locus of control and self concept. Please see the attached informational form for descriptions of the workshops.

The participants will be asked to fill out a brief demographic form, two pre and posttest scales, and the same two follow up scales again two weeks after the workshop. On the day of the workshop each participant will be asked to fill out a ten question general sense of well being survey before and after the workshop. Each participant will be asked to sign a release of information form to allow me to forward information regarding your client from the workshop to you, if, and only if, any difficulties arise for your client in the workshop itself that cause him/her to experience self destructive feelings.

Volunteers being sought need to be between the ages of 18 and 60, currently in some form of therapy, and be free from current active psychosis. Additionally it is requested that participants of at least normal to near normal cognitive, hearing and verbal capabilities to facilitate processing. Musical background or ability is not necessary, or a component for consideration.

There will be four workshops, held on separate days, and participants will be randomly assigned to one of the four days. There will be no more than ten people in each group. Two workshops will be focused on the use of music and imagery for personal strength and safety, and two will be focused on music activities, such as singing, drumwork, and handbell playing, for socialization and enjoyment. The tentative dates are in June and October 1997.

Each workshop will be free with light refreshments provided, and will meet in the Music and Creative Arts Therapy Studio at 111 Third street in

Ann Arbor. This studio is up a flight of fourteen stair steps. If a client wishes to participate who cannot negotiate these steps, I will make arrangements to meet elsewhere.

Please discuss this with any clients you feel are appropriate and might benefit from participating in this project, and give them the enclosed self referral form and self addressed, stamped envelope. The cut off date for referrals is currently June 13, 1997. Thank you .

Roberta Wigle Justice, RMT-BC

Information sheet

What is Guided Imagery and Music (GIM)?

Developed by music therapist Dr. Helen Bonny, GIM is a form of therapy, healing, or self actualization. In it's classic form it involves individual imaging to specifically selected music in a relaxed state of consciousness while dialoging with a trained guide. In it's adaptive and group forms it involves developing personal metaphors for specific aspects of life within a group process to deepen one's insights. This process also allows for immediate altruism and connectedness, two of Yalom's curative factors for groups.

Who is the therapist?

Roberta Wigle Justice, RMT-BC is a board certified, registered music therapist with 23 years of clinical experience in inpatient, outpatient and partial hospital programs in adolescent and adult psychiatry. She has expertise and training in a variety of music, art, and movement therapy techniques. She has led personal and professional growth workshops for other professionals in the areas of GIM, music therapy and eating disorders, pain and stress management, music and movement and relaxation. She is currently in private practice in music therapy including guided imagery and music in Ann Arbor, and is a candidate for fellowship in GIM through the Association for Music and Imagery and also a candidate for Master's of Music Therapy at Western Michigan University.

The structure of the four hour GIM session is as follows:

1. Welcome, introduction of leader and purpose for the session, review of ground rules, chance for participants to leave, introductions of participants, filling out of tools.
2. Introduction of types of imagery
Participants experience structured focused imagery of one object, describe imagery experience; leader activates group process to compare experiences; leader explains types of imagery.
3. GIM
Participants experience individual imagery to selected music around building a safe place/ nest for self. Images processed as group, leader facilitates process.
4. Group singing

5. closure, good-byes and filling out of tools.

The structure of the four hour music playing session is as follows:

1. Welcome, introduction of leader and purpose for the session, review of ground rules, chance for participants to leave, introductions of participants, filling out of tools
2. Introduction to drum patterns and rhythmic improvisation
- 3 . Introduction to handbells or choirchimes and playing
4. Group singing
5. closure, good-byes and filing out of tools.

Appendix E
Recruitment Flyer

MUSIC THERAPY WORKSHOPS

(free to participants)

Roberta Wigle Justice, a music therapy graduate student is conducting a study looking at the effects of participation in four hour music workshops on how participants feel about themselves

If you are between the ages of 18 and 60, and if you are in outpatient therapy work or have a case manager, you may be eligible to participate in this study. This would involve your participation in one workshop that is four hours long using music activities or music and imagery. The study is confidential and involves filling out two forms looking at the effect of the workshop on how you feel about yourself. Workshops are free, with refreshments provided. You may ask your therapist or case manager for a self referral form.

You do not need to have any background or training in music to participate in or benefit from these workshops. Music therapy serves all who have a willingness to engage in the use of music to heal and grow.

All of the workshops will be held at the Music and Creative Arts Therapy Studio on the corner of Third and Huron in Ann Arbor, unless you are informed otherwise. All of the workshops will be held on separate days in June or October.

If you are interested, and your therapist does not have the project information, please call 529-5298, leave your name, and the name and phone number of your therapist or case manager. Or you could ask your therapist or case manager to call for more information, and get you a referral form .

Workshops facilitated by Roberta Wigle Justice, board certified, registered music therapist.

Appendix F
Self Referral Form

MUSIC THERAPY WORKSHOPS
Self referral form

I would like more information about participating in the
music workshop project - please contact me

Name: _____

Phone number: _____

Date _____

Therapist's name: _____

Good times to reach me are: _____

Send to : Roberta Wigle Justice, RMT-BC PO Box 7996, Ann
Arbor, MI 48107
313-529-5298

Appendix G
Information Sheet for Participants

MUSIC THERAPY WORKSHOPS

Information Sheet for Participants

- 1. Expectations of the study:** Participants are expected to fill out several forms as listed, and participate in one four hour workshop. Participants will be randomly assigned to a specific day, and will need to attend on that day.

Forms include:

- A survey rating 100 statements 1 through 5 (false to true) to be filled out once before the workshop and once two weeks after the workshop
- A survey rating 24 statements from agree to disagree to be filled out twice, at the same times as the 100 question survey
- A ten question survey rating statements from agree to disagree immediately before and after the workshop.
- A demographic information survey regarding experience with therapy and with music
- A release of information form to allow the workshop leader to contact your therapist if you have any difficulty with the materials in the workshop that may affect your health.
- An informed consent form that indicates an understanding of and agreement to participate in the study.

- 2. The goals of the workshops** are to provide different types of music experiences in a four hour workshop setting.

3. The ground rules

- A. Any individual may discontinue his or her participation in the project at any time without prejudice from the researcher and without prejudice from the researcher to the primary therapist. Leaving the project will in no way effect the participant's potential for using music therapy in the future.
- B. All individuals are required to treat all other individuals in the workshop with respect.
- C. All individuals are required to keep information about the content of all other individual's material, as well as their identity, confidential to the workshop.

- 4. The content of the workshop** will be some form of music experience, for example, music and imagery, singing or drumming. Some workshops will require verbal processing and some will not. Assignment to your workshop will be done on a random basis, that is the researcher will not knowingly assign any person to any specific group.

5. The qualifications of the leader 313-529-5298

Roberta Wigle Justice, RMT-BC is a board certified, registered music therapist with 23 years of clinical experience in inpatient, outpatient and partial hospital programs in adolescent and adult psychiatry. She has expertise and training in a variety of music, art, and movement therapy techniques. She has led personal and professional growth workshops in the areas of GIM, music therapy and eating disorders, pain and stress management, music and movement and relaxation.

Appendix H

Demographic Survey

Demographic Survey

Code: _____ Age _____ Sex: Male / Female

Current therapeutic environment
(please mark times per week for all that apply)

_____ out-patient therapist (how many? _____)

_____ case manager _____ therapy group

_____ support group

_____ partial hospitalization program

_____ Supported living environment (group home, supported apartment)

_____ Clubhouse

Approximately how long have you been in therapy or a mental health consumer?

_____ less than five years _____ longer than five years

How do you currently use music in your life? (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> 1. For relaxation | <input type="checkbox"/> 6. To validate my feelings |
| <input type="checkbox"/> 2. To exercise to | <input type="checkbox"/> 7. To express myself |
| <input type="checkbox"/> 3. For social interactions | <input type="checkbox"/> 8. To reinforce my beliefs |
| <input type="checkbox"/> 4. As sound in the background | <input type="checkbox"/> 9. To get to sleep |
| <input type="checkbox"/> 5. To motivate me to do work | <input type="checkbox"/> 10. To improve my creativity |

What experiences have you had with music therapy?

- | | |
|---|---|
| <input type="checkbox"/> 1. none | <input type="checkbox"/> 3. group activities (singing, bells) |
| <input type="checkbox"/> 2. individual work | <input type="checkbox"/> 4. group process (improvisation, lyric analysis, creative writing) |

What experiences have you had with imagery?

- | | |
|--|---|
| <input type="checkbox"/> 1. none | <input type="checkbox"/> 3. imagery for therapy without music |
| <input type="checkbox"/> 2. imagery for relaxation | <input type="checkbox"/> 4. imagery for therapy with music |

Appendix I
General Well Being Survey

General Well Being Survey

Please rate how you feel right now about these ten statements. There are no wrong answers, so please describe yourself as honestly as you can. Read each statement and decide how much it describes you at this moment in time, using the following scale:

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
1	2	3	4	5

- | | |
|---|-----------|
| 1. I have a lot of self control | 1 2 3 4 5 |
| 2. I do not feel at ease with other people | 1 2 3 4 5 |
| 3. I solve my problems fairly easily | 1 2 3 4 5 |
| 4. It is hard to protect myself from bad luck | 1 2 3 4 5 |
| 5. My friends have no confidence in me | 1 2 3 4 5 |
| 6. When I make plans, I am almost certain to make them work | 1 2 3 4 5 |
| 7. What happens in my life is mostly determined by others | 1 2 3 4 5 |
| 8. I feel good most of the time | 1 2 3 4 5 |
| 9. I am satisfied to be just what I am | 1 2 3 4 5 |
| 10. When I get what I want it's usually because I'm lucky | 1 2 3 4 5 |

Appendix J

Musical Selections Used in the Experimental Condition

Musical Selections used in the Experimental Condition

Tape One

Selection One

Haydn

Cello Concerto in C, Adagio, Cadenza,
Tempo 1

Selection two

Bach

Concerto for Two Violins, Largo ma non
tanto

Selection three

Pachelbel

Canon in D

Tape Two

Selection One

Beethoven

Piano Concerto #5, Adagio

Selection two

Beethoven

Piano Concerto #3, Largo

Selection three

Pachelbel

Canon in D

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