Measuring effect of modified individual GIM with traumatised refugees – a pilot study
Bolette Daniels Beck, PhD student, Aalborg University, Denmark

Aim
To investigate quantitative and qualitative outcome measuring methods with traumatised refugees suffering from PTSD in six months of weekly individual modified GIM therapy.

Methods prepared
Pre, post and follow up salivary cortisol tests, measuring diurnal variation. Questionnaires (translated into mother tongues): Harvard Trauma Questionnaire part IV, WHO Quality of Life-Bref, Herth Hope Scale, a modification of Akerstedts' Sleep Diary. Other data collection methods: structured visitation and evaluation interviews, analysis of reported imagery and drawings for “trauma imagery” and “resource imagery”.

Results
A) Data collection: Because of a weak framework, fragile therapeutic alliances at start of therapy due to PTSD symptoms (withdrawal, limited concentration and energy) and illiterate (mostly Middle-Eastern) women, only one participant agreed to participate in research. She filled out questionnaires. Scores: 2,7 in the HTQ which indicates PTSD (cut off value 2,5), Herth Hope score was 37 out of 90, QOL-Bref is not yet calculated.

B) Analysis of sessions with GIM/music and artwork: The number of sessions with resource imagery plus combinations of trauma and resource imagery is 30, which is 81 % of the sessions with GIM/music and artwork: Despite the small sample modified GIM can be seen as a resource stimulating method with this population.

C) Research methods: The lesson learned from this project is that research methods with this population have to be culturally adjusted, non-intrusive and easy to administer, and that the framework has to be strong.

Figure 1: Distribution of sessions on trauma and resource imagery

GIM stimulates contact with resources
Resource-related and trauma-related imagery from reported GIM experiences, music and drawing/painting and Visual Explorer (pre-GIM tool using photos as symbols) was investigated and counted as well as the number of sessions with both kinds of imagery. When both kinds of imagery were present, the process almost always resulted in resourceful experiences or states.

Figure 1: The percentage of sessions with resource imagery plus combinations of trauma and resource imagery is 81 % of the sessions with GIM/imagery work: modified GIM can be seen as a resource stimulating method with this population.

Pendulum movement between trauma and resource imagery
Pendulum movements between trauma and resource experiences in kinesthetic, emotional and visual experiential modes (imagery) are part of an inherent mechanism aimed at resolving traumatic freeze states in the nervous system (Levine, 1997). When treating traumatised refugees, resourceful states can be difficult to access, but is needed to enhance resiliency (Levine, 2006). A cyclic movement between the two kinds of imagery is often seen in GIM with traumatised clients (Körlin, 2004, p.14).

Figure 2: Illustration of pendulum movements from session to session, no isolated traumatic imagery were experienced in this particular therapy.
Modifications of BMGIM for trauma therapy
A modification of the Bonny Method of Guided Imagery and Music adjusted for traumatized refugees to prevent hyper arousal and retraumatization is used. The GIM method is able to stimulate the contact with resources and resourceful states including parasympathetic activity, access to positive emotional and kinesthetic experiences in clients that normally have a very poor access to their resources. Description of the adjustments aimed at giving the client the highest degree of control and empowerment in the situation: In most cases the client is sitting in a chair, not lying down. As preparation for the music the therapist is mentioning the possibility to keep eyes open, giving instructions in ways to return to the here-and-now if overwhelmed, and receiving feedback from client on the volume of the music. Therapist guides relaxation with special attention to pain areas, sometimes using attention or tension instead of relaxation. Focus: nature imagery, themes or words from conversation, or open. Music: 2-7 minutes, "small containers" as Pachelbel’s Kanon, Bizet’s Intermezzo from Carmen, new age music (Secret Garden, Kajagoogoo), and carefully selected music from homelands with lyrics checked with the help from translator (Ex.: Fayruz: The Lady and the Legend #6, Feroho: Listen to the Nai (Ma’awash, Radio Kabul). After music the option to draw a mandala is given. In this project clients have preferred to either listen, or paint while listening to music. A pre-GIM tool has been used to introduce the use of symbols and imagery: Visual Explorer, a presentation of photos from which the client chooses one or two, discuss the themes and associations and work with coping methods (Palus, 2001).

Definitions for the analysis of imagery
In order to identify traumatic imagery I have looked for imagery that
a) is a re-experience of traumatic situations or
b) is imagery that creates unpleasant states in the client, for example increased anxiety, pain or grief.
In order to identify resource imagery I have looked for
a) re-experiences of positive situations or relations
b) symbols of inner and outer resources
c) positive experiences (for ex. relaxation)

Discussion of research methods to use with traumatised refugees
The number of published studies on psychotherapy with traumatized refugees are sparse (22 studies identified). The methods used are questionnaires, analysis of medical records, and interviews. Although music therapy with refugees have been reported (Orth 2001, 2004, Zharinova-Sanderson 2002, 2004), van Bruggen-Rufi (2006), Allanne (2004) no quantitative research has yet been published. The lesson learned from this project is that research methods with this population have to be non-intrusive and easy to administer. It has shown difficult to obtain baseline measurements because of:
• decreased ability to relate to and trust in the therapist/therapy (obviously following experiences of persecution, torture, violence and loss, as well as withdrawal as part of PTSD symptoms)
• lack of concentration and impaired cognitive abilities (part of PTSD symptoms)
• limited psychic and physical energy to overcome filling out of questionnaires due to pain and fatigue
• lack of school education and difficulties in reading and writing (especially women from Middle-East countries)
• possibility of cultural bias to the understanding of concepts in questionnaires (importance of using questionnaires that have been checked cross-culturally as Harvard Trauma Q. and Hopkins Symptom Checklist 25).

The importance of a strong framework
An earlier pilot study (Beck & Mørch, 2004) was carried out in a psychiatric hospital with four Afghan men, who were invited in collaboration with a social worker. A self made 12-item questionnaire was filled out before and after six months of group music therapy with mixed therapy methods. It showed a decrease in self-perceived anxiety for all participants and a minor decrease of sleep problems, flash backs and isolation for three participants. Group GIM seemed to fit this population well, as the participants could relax to the music and use it as a "safe place". The present study is lacking the same strong framework, as the local psychiatry could not provide a placement within the system, and as the collaboration with the social workers was problematic because of administrative changes and poor trust between social workers and the refugees.

Useful research methods
• Short questionnaires translated into the mother tongue or filled out with the help of the therapist/translator/ proxima rating (social worker)
• Blood samples with the help of a nurse to investigate cortisol or other biomarkers
• Data from medical journals? Qualitative interviews (semistructured or open)
• Qualitative investigation of process, music, relation (not with clients that have been interrogated or persecuted)
• Photographs of drawings and other visual material

Less useful research methods
• Video taping (because of intrusion and trust issues from trauma stories)
• Measuring blood pressure, heart rate variability and brain wave activity etc. (activation of traumatic states by the use of equipment may interfere with the therapy, demands large samples)
• Measuring skin resistance (both positive excitement and anxiety arousal would create the same kind of reaction)
• Single case studies with pre-arranged pauses in therapy

Literature: